ARMC		NEW ADMINISTRATIVE POLICIES
Policy Number		**Policy Title**
110.45		Traffic and Parking Control, Citation Issuance and Vehicle Towing
110.46		Roles of Residents, Medical and PA Students, App's (RNP & PA), RN's and Others During Surgery
110.47		Patient Notification of Adverse Event/Medical Error
200.23		Separation from Employment
200.24		Contracted Service Provider Personnel
220.08		Management of Students and Student Placement
220.11		American Heart Association Card Renewal
240.05		Use of Personal Electronic Devices Including Cellular Phones, Smartphones, Smart Watches, and Radio Transmitters
240.06		HEART Employee Behavioral Standard Examples
300.05		Patient Safety Evaluation System
400.26		Decentralization of Intravenous Pumps
400.27		(RPT) Relocatable Power Tap Policy
500.04		Staff Verification of Medical Staff and Allied Health Membership and/or Clinical Privileges and Resident Competency
500.05		Medical Student Supervision
600.04		Therapeutic Limit Setting
610.34		Involuntary Holds On Non-Psychiatric Units
610.35		Magnetic Resonance Imaging and Computerized Tomography Perfusion Stroke Series Policy
610.36		Arterial Line: Insertion and Management
610.37		Care For Patients With Stroke Symptoms Greater Than 8 Hours After Symptom Onset
610.38		Discharge Planning Activities
610.39		Accepting Practitioner Orders
610.40		Management of Observation Patients
610.41		California End of Life Option Act
610.42		Wound Dressings, Ordering Using Wound Algorithm
610.43		Code Sepsis
610.44		Discontinuing a Urinary Catheter Utilizing the HOUDINI Protocol

ARMC		NEW ADMINISTRATIVE POLICIES
Policy Number		**Policy Title**
620.09		Screening And Managing In-Patients At Risk For Suicide
620.10		Fall Program
650.12		Non-Obstetric Surgery During Pregnancy
670.16		Post-Procedure Pre-Cleaning of Endoscopes
670.17		Receiving and Storage of Endoscopes
670.18		Cleaning of Endoscope Cabinets
670.19		Guidelines for the Administration of Hypertonic Sodium Chloride 23.4% Solution
670.20		Telemetry: Care of the Patient on Centralized Telemetry Monitoring
670.21		Procedure for Endocavity Transducer High Level Disinfection
670.22		Cleaning and Preparing Endocavity and Trans-abdominal Probes
670.23		Operative and Other Invasive Procedures
670.24		Orthopedic Guidelines for Trauma Room Fracture Wash Outs
670.25		Alcohol Withdrawal: Management of Patient in Telemetry Unit and Intensive Care Unit (ICU)
670.26		Administration of Influenza and Pneumococcal Vaccines
670.27		Non Chemotherapy Extravasation
670.28		Spinal Orthotic Devices and Management
670.29		Code White
690.28		Patient's Home Medications
690.29		Medical Device Alarm Safety
690.30		Wound Care Referral Process
690.31		Chain of Command: Duty to Intervene and/or Conflict Resolution
690.33		Self-Administration of Hospital Acquired or Patient's Own Medications
690.34		Code Green – Missing/Eloped Patient
690.35		Multi-Dose and Single-Dose Medication Containers
690.36		Intravenous Admixture and Administration
690.37		Drug Shortages
690.39		Intensivist Policy

ARMC		NEW ADMINISTRATIVE POLICIES
Policy Number		**Policy Title**
700.20		Laptop Computer Use and Security
700.21		Data Storage
700.22		Data Integrity and Internal Data Validation
700.23		Electronic Health Record Documentation Requirements Policy
830.05		Medical Record Corrections, Late Entries and Addendums
830.06		Do Not Use Abbreviations
900.05		Limited English Proficiency Effective Communication
1000.27		Removal of Protected Health Information From Hospital Premise
1000.29		Compliance Officer/Reporting to the Joint Conference Committee (Board)
1000.30		Conflict of Interest – Prevention of
1000.31		Anti-Kickback and Stark Laws
1000.32		Personal Representative of Patients
1000.33		Health Information Exchange
1000.34		Uses and Disclosures of Decedent Information
1000.35		Breach Notification
1000.36		Disclosures of Protected Health Information to Law Enforcement
1000.37		Verification of Identity and Authority to Disclose Protected Health Information
1000.38		Disclosure of Patient Information to Family and Friends
1000.39		Patient Directory
1000.40		Patient Privacy Protections
1000.41		Use and Disclosure of Patient Information for Fundraising
1000.42		Uses And Disclosures Of Protected Health Information That Require Authorization
1000.43		Use and Disclosure of HIV Test Results

SECTION:	ADMINISTRATIVE	SUB SECTION:	OPERATIONS

SUBJECT: TRAFFIC AND PARKING CONTROL, CITATION ISSUANCE AND VEHICLE TOWING

APPROVED BY: _____
Chief Executive Officer

POLICY

It is the policy of the Arrowhead Regional Medical Center (ARMC) to promote the efficient use of the hospital's parking facilities and to enforce the San Bernardino County Code and the California Vehicle Code. Policy is established by hospital Administration and enforced by the hospital Security Department.

PROCEDURES

I. **General Overview**

The traffic and parking regulations of the Medical Center shall be enforced under 53.064 of the San Bernardino County Code (SBCC) and sections 21113 and 22651 of the California Vehicle Code (CVC). The Security Department shall be responsible for enforcement of the medical center Traffic and Parking Control, Citation issuance, and Vehicle Towing indicated in the following guidelines. This enforcement shall apply to moving and stationary vehicles.

A. All persons entering or remaining on the grounds of the medical center must comply with the traffic laws of the State of California and are subject to the restrictions and penalties prescribed therein.

B. Permission to enter or remain on the grounds of the medical center may be revoked at any time by the Director of ARMC or his/her authorized designees.

C. Speed limits are limited to the speed posted and in no case greater than 15 miles per hour.

D. Pedestrians are required to use crosswalks and sidewalks where provided and may walk on the side of the driveway which faces oncoming traffic, where there are no sidewalks.

E. The operator of any vehicle must obey all instructions of any traffic control device, Security Technician of the medical center Security Department or any officer of a law enforcement agency or fire department.

F. Barriers, fences, or posts may be placed at any point deemed necessary for safety or convenience at the discretion of the ARMC Security Department. These items may not be removed, except in emergencies, without authorization from the Security Department or from the Director of ARMC or his/her authorized agents or Security Manager after notifying the Security Department.

G. No vehicle shall be driven on any area or parked in any way that is not designed for such purpose.

H. Vehicle parking must be in accordance with posted signs or markings on pavement or curb. Vehicles may not occupy more than one parking space.

I. Parking lots are restricted for various purposes and will be posted as being restricted. Parking lots may be restricted in emergencies or special occasions, or for repairs and maintenance as specified by Administration, Facilities Management or the Security Department.

J. Vehicles may be towed away at the owner's expense when parked so as to cause an obstruction, or that have been abandoned or stored at the medical center without appropriate approval or for other reasons.

K. Motorcycles are to be parked in areas designed for motorcycle parking or may be parked in a vehicle-parking stall.

L. Bicycles and mopeds must be parked in designated areas and must be kept locked at all times when unattended.   Bicycles that are left in other areas will be impounded by the Security Department, and will be turned over to the Colton Police Department for disposition if owner cannot be located.

M. No vehicles may be parked in any of the following locations unless directed to do so by a Security Technician.

    1. On a sidewalk
    2. Within an intersection or roadway
    3. Within 20 feet of a fire hydrant
    4. On or over a crosswalk
    5. In any red zone or posted no parking area
    6. In any white or unpainted zone or zone posted, "patient drop-off only" longer than loading or unloading of passengers or freight – not to exceed 15 minutes (vehicle may not be left unattended for any amount of time).
    7. In a blue disabled zone unless displaying an authorized state disabled parking permit or a DP or DV license plate.
    8. In Law Enforcement and Ambulance parking unless with said agencies and in marked vehicles used for official purposes only
    9. Volunteer Parking without the appropriate permit issued by Volunteer Services
    10. In Physician parking without an authorized permit issued by the Medical Director
    11. Carpool/Vanpool parking without the permit issued by the Human Resources Department in conjunction with the South Coast Air Quality Management District
    12. Employee of the Year parking without the permit issued by the ARMC
    13. In Special Vehicle parking without Administration approval
    14. In Chaplain parking without appropriate identification
    15. In County Vehicle parking without a vehicle displaying a County logo
    16. Parking in any area specifically designated for other use.
    17. Parking in the Loading Dock area shall be for the immediate loading and unloading of equipment and supplies only unless otherwise marked. Any vehicles that are parked for extended period of time, appear unattended, or are parked for purposes other than stated on posted signage and as stated above shall be cited.

II. **Parking Sign Notification and Postings**

A. All signage/postings are official notifications to be adhered to.

B. Located at the entrance to all parking lots are two signs posted on a pole, one sign above the other. The signs are with red lettering. The top sign reads:

"Parking in designated areas only. Vehicles parked unlawfully may be cited or towed at owner's expense. 53.064 SBC and 22651 *CVC."*

The lower sign reads:

"All California vehicle codes relating to traffic are applicable and are enforceable upon entering this parking facility (21113 (a) *CVC*)."

C. Other parking spaces or areas have color-coded paint on the curb and/or the ground, and have signage posted. These areas include, but are not limited to Staff, Patient and Visitor, Volunteer, Carpool/Vanpool, Physician, Administration, Handicapped, Special Vehicle, and Vendor Parking as well as Short Term and Drop-off parking.

D. All red curbing are considered fire lanes.

III. **Patient-Visitor, Employee, Physician, Car Pool, Temporary Agency and Student Parking Compliance**

A. Patient-Visitor parking is restricted to Lots 2-6, 10, overflow 14, and 15 (disabled only).

B. From 6:00 AM – 4:00 PM employees shall park in any of the employee lots which are: Lots 1, 7, 11, 12, 13, and 14. These are gated lots, however Lot 14 is open during the day for overflow, registry staff, staff without their badge and students.

C. All Students are to park in Lot 14.

D. Residents shall park in the designated spaces in Lot 6.

E. Lot 9 is restricted to Behavioral Health and Law Enforcement vehicles.

F. Physician parking is located in Lots 8, 10 and 12. Appropriate decals issued to physicians shall be prominently displayed.

The County of San Bernardino encourages employees to car pool. ARMC has twenty eight car pool spaces in Lot 12 and currently one in Lot 8. Car pool spaces are routinely evaluated based on the number of permitted car pool drivers. Car pool spaces are intended for those that have two or more people driving in the same car on any particular day. Days where there is only one occupant, then use of the car pool space is prohibited, regardless of vehicle permit.

IV. **Open Parking Times and Locations**

A. After 4:00 PM, and on weekends, off-shift employees may park in the Patient-Visitor parking provided they vacate the spaces on weekdays by 6:30 AM to accommodate incoming patients and visitors.

V. **Citations and Enforcement**

A. The Security Department will issue parking citations to all vehicles illegally or improperly parking on medical center property. A picture of the vehicle in violation will be kept with the security citation copy on file.

B. The parking citation is a two-part violation, with the copy/envelop placed on the windshield of the vehicle, and the original turned-in to the Security Manager's office.

C. The parking citation must be paid in full to the citation service listed on the envelope within 21 days, or penalties will accrue. Failure to pay citations may result in the owner's inability to register their vehicle with the DMV.

D. Citations will not be waived without Associate Administrator of Support Service review and approval. All employees, physicians, patients, visitors, temporary agencies and students are expected to follow the SBCC and CVC ordinances.

VI. **Vehicle Towing**

Should it become necessary to tow a vehicle, the Security Department will observe the following guidelines:

A. With Administrative or Security Managers approval, Security will call the towing service to give them the information for the vehicle to be towed.

B. Security will meet the towing service driver and identify the vehicle to be towed.

C. The owner of the vehicle will be held liable to pay any towing expense and impound fee to the towing service.

REFERENCES: **San Bernardino County Code, California Vehicle Code**

DEFINITIONS: **Special Vehicle Parking – This is for Clergy, County Vehicles, `Surveyors, Law Enforcement, and Board Members. It is to be used for Short Term use not exceeding four (4) hours. Administrative Staff may use these spaces if they are leaving the hospital on a regular basis for meetings off-site. They are not regular parking spaces for Administration.**

ATTACHMENT: **N/A**

APPROVAL DATE: __N/A__   **Policy, Procedure and Standards Committee**

              __6/18/19__   **William L. Gilbert, Hospital Director**
                                  Applicable Administrator, Hospital or Medical Committee

              __8/6/19__   **Board of Supervisors**
                                  Approved by the Governing Body

REPLACES: **Environment of Care Policy No. 3017**

EFFECTIVE: __8/9/16__   **REVISED:**   N/A

REVIEWED: __2/07/19__

SECTION:	ADMINISTRATIVE	SUB SECTION:

SUBJECT: ROLES OF RESIDENTS, MEDICAL AND PA STUDENTS, APP'S (RNP & PA), RN'S AND OTHERS DURING SURGERY

APPROVED BY: _____
                                                Chief Executive Officer

_____

POLICY

No House Staff may start a case without the attending surgeon present unless specified below. "In house" means the operating attending surgeon is physically in the hospital.

I.   Residents

   A)   Surgical residents practice under the supervision of the attending surgeon who is responsible for the entirety of the patient's care. The responsibilities given to residents are based upon their knowledge, skills and experience and upon the complexity and risks associated with a procedure. They may function as a 1st or 2nd assistant.

   B)   General surgery (GS) residents

      1.   If in the opinion of the operating attending surgeon,   a general surgery resident has the appropriate skills to open, then a general surgery resident may open after in house communication with the operating attending surgeon with the RN circulator. The circulating RN must record such communication in the patient's OR record.

      2.   If in the opinion of the operating attending surgeon, a general surgery resident has the appropriate skills to close, then a general surgery resident may close after face to face communication by the operating attending surgeon with the RN circulator. The circulating RN must record such communication in the patient's OR record.

   C)   Orthopedic residents -

         If in the opinion of the operating attending surgeon in charge, an orthopedic resident has the appropriate skills to close or open, then an orthopedic resident may open or close after in house communication by the operating attending surgeon with the RN circulator . The circulating RN must record such communication in the OR record.

   D)   Neurosurgery residents –

      1.   If in the opinion of the operating attending surgeon a neurosurgery resident has the appropriate skills to open, then a neurosurgery resident may open after in house communication by the operating attending surgeon with the RN circulator. The circulating RN must record such communication in the patient's OR record.

      2.   If in the opinion of the operating attending surgeon , a neurosurgery resident has the appropriate skills to close, then a neurosurgery resident may close after face to face communication by the operating attending surgeon with the RN circulator. The circulating RN must record such communication in the patient's OR record.

3. In the event of an emergency as determined by the operating attending surgeon (1) and after telephone communication by the operating attending surgeon with the in house trauma surgeon,(2) and communication with the circulating RN, a neurosurgery resident that has the appropriate skills to open, may open.

II. Physicians Assistants

A. Physicians Assistants perform all medical activities under the supervision of an Attending physician as a 1st or 2nd assistant.

III. Registered Nurse

A. Registered Nurses may not function as 1st assistant , however Registered Nurses may function as a 2nd assistant, i.e. for the purpose of holding retractors, camera, etc.as designated by the attending surgeon.

IV. OR Surgical Technicians

A. OR Surgical Technicians may not function as a 1st assistant, however Surgical Technicians may function as 2nd assistant; i.e. for the purpose of holding retractors, camera, etc. as designated by the attending surgeon.

V. Medical and Physician Assistant Student

A. Medical students and Physician Assistant students may assist with direct supervision of the attending surgeon.. Medical and physician assistant students with the direct supervision of the operating attending surgeon may participate in skin closure.

VI. Nursing Student

A. Nursing Students are not used in an assistant role.

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VII. Definitions of 1st and 2nd assistant: CAVEAT In the event of an emergency situation anyone can first assist until the resident or attending arrive. The circulating RN must record the emergency situation in the patient's OR record.

A. Intraoperative surgical 1st assisting , includes but not limited to:

1. Using instruments/medical devices,

2. Providing exposure

3. Handling and/or cutting tissue,

4. Providing hemostasis, and

5. Suturing.

B. Intraoperative surgical 2nd assisting includes:

1. Holding retractors, cameras, etc.

REFERENCES: **Regulatory Standards Surgical Services**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL   DATE: **N/A**   **Policy, Procedure and Standards Committee**

                              6/18/19   **William L. Gilbert, Hospital Director**
                                          Applicable Administrator, Hospital or Medical Committee

                              8/6/19   **Board of Supervisors**
                                          Approved by the Governing Body

REPLACES: **Operative Services Policy No. 118.22**

EFFECTIVE: **01/01/99**   **REVISED:**   **03/15/02, 08/04/04, 02/2014**

REVIEWED: **03/2005, 01/2008, 12/2010, 10/2013, 06/2015, 2/07/19**

SECTION:	PERFORMANCE IMPROVEMENT	SUB SECTION:	GENERAL

SUBJECT: PATIENT NOTIFICATION OF ADVERSE EVENT/MEDICAL ERROR

APPROVED BY: _____

Chief Executive Officer

PURPOSE

The purpose of this policy is to provide caregivers with practical guidelines to assist them in responding to, and providing information about adverse medical events to patients/families. The purpose of this policy is two-fold:

1. To set expectations and provide guidance for caregivers in responsible, empathetic, and supportive care of the injured patient and family, care that restores and justifies their continuing trust.

2. To improve patient safety by learning from errors and adverse events and changing systems to minimize the likelihood of recurrence.

POLICY

In keeping with Arrowhead Regional Medical Center's (ARMC's) mission to provide quality care to the community, we are dedicated to give safe, patient-centered care. It is consistent with our vision to improve the health of the community by being the provider of choice for health care delivery and education, by involving patients and families as partners in all aspects of their care.

ARMC is committed to organizational transparency. That is, we strive toward open and honest communication with our patients and the community, removing barriers to knowledge about care processes and patient outcomes, including disclosure of adverse events when they occur. This communication process forms the context for a trusting caregiver-patient relationship.

We approach these issues from the patient's point of view, asking ourselves, "What would I want or need if I were harmed by my treatment?" When adverse events occur, the caregiver's primary role is to provide comfort and support and to consider the full breadth of patient's needs. While hospitals and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

Our commitment to providing safe patient care requires ongoing self-examination and implementation of proactive system improvement strategies. Open communication about adverse events is an essential element in fostering a safety-oriented culture.

ARMC is committed to providing emotional, professional, and legal support to all caregivers involved in adverse events. This commitment includes providing ongoing education and training programs for caregivers to improve communication skills when responding to adverse event situations.

PROCEDURES

I. Initial Response to the Event

    A. When an adverse event occurs, the caregiver's first priority is to protect the patient from further harm by providing required medical care.

    B. Take whatever action is needed to stabilize the patient, mitigate any injury, and prevent further harm.

    C. Take immediate action if necessary to eliminate any obvious remaining threat of patient safety such as faulty equipment, impaired caregiver, unsafe systems, etc.

D. Secure any implicated drugs, equipment, and records.

E. Notify the Attending Physician, Administration and Risk Management. Senior Leadership and Risk Management will be involved in coordinating the organizational response and situation management process.

F. Key care team members are identified and meet to discuss the situation as soon as possible, so that all members are fully aware of the issues and subsequent communications with the patient and family are consistent.

G. Decide immediately who will have primary responsibility for communicating with the patient and family about the event.

H. Determine the circumstances surrounding the event and contributing factors as soon as possible while it is still fresh in the memories of those involved. This information may be crucial to the immediate plan of care for the patient.

II. Communicating with the Patient and Family

A. Prompt, compassionate, and honest communication with the patient and family following an incident is essential. Because of the emotional effects of these events on both the patients and caregivers, this communication process can be difficult for everyone. If handled poorly, injury to both patient and caregivers can be compounded, damaging the patient-caregiver relationship. Open communication and authentic apologies help to dissipate patients' feelings of anger and mistrust.

B. Who should communicate?

1. Ideally, the initial communication should be from a person with whom the patient has a trusting relationship. Usually, the physician who is responsible for the patient's care is the most appropriate person.

2. Sentinel events resulting in harm from a licensed independent practitioner [LIP], should have the communication disclosure done with a hospital representative present.

3. Sentinel events resulting in harm from an employee or the care environment should have the communication disclosure done by a selected member of the hospital staff. Physician participation is recommended, to allow the patient immediate answers to questions relating to medical impact and needs resulting from the event.

4. When other physicians may be involved in further care (as in transfer to ICU), caregivers from both settings should be included.

5. In some cases, it may be appropriate for members of Administration or Clinical Leaders to be involved in ongoing communications and to make apologies.

6. Considering the patient's preference, include selective members of the patient's family or support persons in the discussions. If the patient lacks capacity, discussions should be held with the person next-in-line for consent purposes.

7. Include a caregiver who has a positive relationship with the patient in the discussions, such as a primary nurse, to participate, observe, and support.

C. When to Communicate?

1. Communication of an adverse event will take place within 24 hours whenever possible or as soon as practical after the event has occurred or been identified.

2. The patient's physical and emotional readiness for receiving information related to adverse events must be assessed before the initial communication.

3. In some situations, communication of an adverse event may cause more harm than good to a patient. Valid reasons for withholding or postponing the communication of information should be documented. Initial discussions are only the beginning of an ongoing series of discussions, including after discharge, that demonstrate continued support, concern, and commitment to preventing future events.

4. Follow up meetings will be arranged after each discussion in order to keep patients and their families apprised as information becomes available.

5. Whenever possible, pre-schedule the meeting, choosing a quiet, private area that supports both confidentiality and respects the feelings of the patient and family.

6. A single room in the hospital, a private office or conference room, or a visit to the patient's home (if outpatient treatment or after discharge) may be appropriate.

7. Go to the patient and family's location rather than summon them to an executive office.

D. What to Communicate?

1. Communicate objective, factual information known at the time, avoiding speculation.

2. Include all available information regarding what happened, why it happened, how it will affect the patient's long- and short-term health status, and what steps are being taken to ensure it will not happen to others in the future.

3. Convey compassion and empathy for the patient's and family's pain and suffering.

4. Extend an authentic apology to the patient. Even when the cause may not yet be known, it is appropriate to say something like, "I'm so sorry that this has happened to you."

5. Provide assurance that we are dedicated to meeting the patient/family's ongoing needs and will take their questions and concerns seriously.

6. Provide assurance that a thorough investigation will be conducted and that we will share additional information as it becomes available.

7. Address reimbursement or compensation questions by assuring the patient and family that the matter has been referred to the Risk and Claim Management departments for review and early claim management.

8. Describe the plan for follow-up care, giving time estimates for investigation and subsequent meetings and/or discussions.

9. Provide names and phone numbers of contact persons for ongoing communication and encourage the patient/family to call if they have questions.

10. Provide psychological and social support as needed.

11. Audio/video taping may not be done during the disclosure communication.

E. What Not to Communicate?

1. Avoid defensiveness, making excuses, accusations and assigning blame.

2. Avoid being evasive, misleading, mysterious, or "spinning" the facts.

3. Avoid premature speculation regarding the root cause of the event. Some events may not be preventable or may not be due to negligence on anyone's part.

4. Avoid premature promises regarding how the medical/hospital/physician bills will be handled as a result of the event.

5. Don't overwhelm the patient with information but don't oversimplify either.

6. Do not provide "Confidential" information or documents as determined by state and federal law (e.g. generated through peer review, Performance Improvement or Risk Management activities).

F. How to Communicate?

1. Be prepared. The initial communication team meets, reviews facts known, discusses content of the communication, anticipates questions, practices responses, etc.

2. Discuss each team member's role and responsibility in the communication process before the initial communication.

3. Recognize your own feelings about what has happened and be aware of your own emotional response to the event.

4. Maintain an open posture, i.e. eye level, arms uncrossed, concerned expression, eye contact, empathetic and active listening.

5. Provide qualified interpreter services when needed. Do not rely on family members to interpret.

6. Use clear and consistent terminology considering the patient's individual ability to understand.

7. Focus on the patient's needs, acknowledging and validating the patient's and family's feelings, complaints, concerns and questions.

8. Validate the patient/family's understanding about what they have been told.

9. Provide an accessible resource to the patient/family to listen and respond to their ongoing concerns, e.g. Department Manager or Patient Relations Representative.

10. Keep the caregiver team informed about the communication process to avoid giving conflicting or confusing information to the patient and family.

III. Documentation

A. Following an adverse event, a complete, accurate and factual description of pertinent clinical information related to the event should be entered into the patient's medical record by the appropriate caregiver. This includes actions taken to care for the patient and ongoing treatment plans.

B. All communications with the patient and family are also documented by the designated primary communicator, usually the patient's physician. Proper documentation supports the best interests of both the patient and caregivers and advances good patient care.

C. Avoid derisive or derogatory comments about other caregivers and entries that appear self-serving or assign blame.

D. Documentation of the Event should include:

1. Objective details of the event, including date, time and place.

2. The patient's condition immediately before and after the event

3. Medical intervention and patient response

4. Time, date, and place of discussions

5. Names and relationships of all those present at the discussions

6. The content of the conversations

7. Patient or family reaction and the perceived level of understanding

8. Offers to be of assistance and the responses to it

9. Patient and/or family's questions and responses given

10. Note that as further information becomes available it will be shared with the patient

11. Next steps to be taken and follow-up meetings planned

IV. Special Circumstances

It is presumed that adverse events will be disclosed to the harmed patient and appropriate family members. In very rare situations where the decision is made not to disclose information, documentation outlining the circumstances and the rationale leading up to the decision is very important. In these cases the documentation may be separate from the medical record in order to protect the safety or welfare of the patient.

V.   Support of Caregivers
    A. Like patients and their families, caregivers are significantly impacted, emotionally and functionally, following an adverse event. Arrowhead Regional Medical Center is committed to providing institutional support that enables them to recover, to heal, to communicate and apologize effectively to the patient, and to return to their professional duties as soon as possible. Support to caregivers may come from a variety of sources, e.g., Clinical Social Work, Bioethics team, Employee Assistance Program.

    1. Caregivers are given structured assistance in debriefing sessions after an adverse event occurs.

    2. Caregivers are coached and provided emotional, professional, and legal support during the emotionally difficult period immediately following an event.

    3. Caregivers are given specific instruction in documenting adverse events and subsequent communications in the medical record.

    4. Involved caregivers have a support system readily available, providing counseling and stress management services to meet the individual caregiver's needs.

    5. Administrative policies ensure that caregivers are provided with appropriate adjustment of responsibilities or time off if necessary to allow for healing.

LEARNING FROM THE EVENT

Administrative policies ensure that caregivers are provided with appropriate adjustment of responsibilities or time off if necessary to allow for healing.

Identification of all possible contributing factors is the first step in identifying and correcting system failures.

Additionally, patients harmed by adverse events have a right to know, to the extent it is possible, what the causes of the event were and what is being done to remedy them. Most patients are very concerned that the same event could happen to another patient.

Finally, we have an ethical obligation to protect future patients everywhere; to identify potential safety hazards and to share the information with other health care organizations.

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DEFINITIONS:

A. **Adverse Event:** An injury that was caused by medical management rather than the patient's underlying disease; also sometimes called "harm", "injury", or "complication".

   1. Sentinel events are adverse events, but not all adverse events may be defined as a sentinel event.

   2. An adverse event may or may not result from an error. See further classification of preventable and unpreventable adverse events below.

   3. Medical Management refers to all aspects of health care, just the actions or decisions of physicians or hospital staff.

B. **Authentic Apology:** One that is heart-felt and driven by true regret or remorse. An authentic apology shows the patient that you:

   1. Respect them,

   2. Are taking responsibility for the situation,

   3. Are empathetic.

C. **Disclosure:** Providing information to a patient and/or family about an incident. Because this term suggests revealing of privileging information and implies an element of choice, the term communication is used to convey a sense of openness and reciprocity [a mutual, cooperative, collaborative exchange].

D. **Incident:** An adverse event or serious error; also referred to as an event.

E. **Preventable Adverse Event:** An injury (or complication) that results from an error or systems failure. Even if one agrees that the individual errors are often the result of system failures, the errors are still perceived by patients and caregivers as very personal events. It is useful to distinguish three categories.

   1. Error by the attending physician. (e.g. technical error during performance of a procedure; decision errors.)

   2. Error by anyone else in the healthcare team. (e.g. a nurse administrators wrong medication; a radiologist misses a lesion.)

   3. System failure with no individual error. (e.g. IV pump failure that causes drug overdose; failure of system to communicate critical test results to ordering physician.)

F. **Provider:** Is defined as any person furnishing medical or other health care services.

G. **Sentinel Event:** An event that results in an unanticipated death or major permanent loss of function not related to the natural course or underlying condition.

   1. Medical Error: the failure of a planned action to be completed as intended or the set of a wrong plan to achieve an aim. Medical Errors include serious errors, minor errors, and near misses. (Note: A medical error may or may not cause harm. A medical error that does not cause harm does not result in an adverse event.)

   2. Serious Error: An error that has the potential to cause permanent injury or transient, but potentially life-threatening harm.

   3. Minor Error: An error that does not cause harm or have the potential to do so.

   4. Near Miss: An error that could have caused harm but did not reach the patient because it was intercepted.

H. **Situation Management:** A process for timely, effective, and truthful communication in the face of an adverse event. The process ensures that the patient/family needs are adequately addressed, provides support for the patient care team and facilitates organizational learning.

I. **Situation Manager:** A role in which one helps all parties work through a situation where there has been a significant adverse outcome.

J. **Transparency:** a transparent organization related with patients, families, and the public through open and honest communication, removing barriers to knowledge about care processes and patient outcomes, strengthening individual and community trust in the organization.

K. **Unpreventable Adverse Event:** An injury (or complication) that was not due to an error or system failure and is not always preventable.

   1. Common, well-known hazards of high-risk therapy. Patients understand the risks and accept them in order to receive the benefit of the treatment. (e.g. complications of chemotherapy.)

   2. Rare but known risks of ordinary treatments. The patient may or may not have been informed of the risk in advance. **(**e.g. side-effects of medication; certain wound infections.)

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                    6/18/19   **William L. Gilbert, Hospital Director**
                    Applicable Administrator, Hospital or Medical Committee

                    8/6/19   **Board of Supervisors**
                    Approved by the Governing Body

REPLACES: **Administrative Policy No. 300.02 Issue 6**

EFFECTIVE: **5/26/05**   **REVISED:**   **5/22/08, 1/20/11, 03/14/13, 05/22/18**

REVIEWED: **N/A**

SECTION:	HUMAN RESOURCES	SUB SECTION:	EMPLOYMENT PRACTICES

SUBJECT: **SEPARATION FROM EMPLOYMENT**

APPROVED BY: _____
                                         Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) is committed to establishing guidelines to ensure uniform and consistent procedures for employee, Medical Staff, Student, Resident, and Contract separations, both voluntary and involuntary.

PROCEDURES

I.   At the time of notification of the employee's, Medical Staff's, Resident's, or Contract's separation from ARMC, the manager:

   A.   Sends an email to ARMC-HR Separations containing the employees name and employee ID number notifying of the employees separation date. The e-mail activates the termination of the employees access to include but not limited to:
      1.   Medi-Tech
      2.   Active Directory
      3.   Building access
   B.   Completes the Separation Check-list, see Attachment A
   C.   Completes the Separation Report

II.   The Separation Check-list and the Separation Report are turned into Human Resources on the employees last working day at ARMC. Medical Staff Checklist will be returned to the Medical Staff Office, Resident Checklist will be returned to the Graduate Medical Education Office.

III.   The employee, Medical Staff, Resident, and Contractor who are separating are required to turn in property to his or her manager/supervisor, including but not limited to identification card, uniforms, keys, tools, laptops, hospital-issued cell phones, parking decal, computer materials, and electronic equipment on or before his/her last day of work. It is the responsibility of the manager/supervisor to ensure that hospital property is returned to the appropriate unit or department.

IV.   In unusual circumstances it may be necessary to expedite the de-provisioning of an employee's access to critical systems. Managers are expected to exercise appropriate judgement in identifying such circumstances and take immediate actions when warranted. Human Resources should be consulted if there are any questions.

REFERENCES: **Administrative policy 700.04**

DEFINITIONS:

Dismissal - Probationary employees may be dismissed without right to review or appeal, unless based on political affiliation, unlawful discrimination or any other reason proscribed by law. Regular status employees in the Classified Service may be dismissed only for cause. Dismissal actions are handled by the department Human Resources Officer (HRO). Refer to Personnel Rule 10, Disciplinary Actions; Sections 1 and 2.

End of Temporary Employment - An extra-help or recurrent employee can be terminated at any time by the appointing authority.

Job Abandonment - An employee absent without approved leave for three (3) consecutive work days who fails to notify the immediate supervisor and provide an acceptable reason for the absence to the appointing authority shall be considered to have automatically resigned as of the last day on which the employee worked, unless the appointing authority or Director of Human Resources (HR) or designee approves leave with or without pay to cover the absence. Refer to Personnel Rule 9, Section 6

Layoff - A layoff is the involuntary separation or reduction of a regular employee to a lower classification without fault of the employee. Layoff applies only to regular positions. A layoff occurs only when there is a surplus of employees, a position is to be deleted from the authorized table or organization, or when funds are withdrawn from a previously funded position. Refer to Layoff Article in appropriate MOU

Left Without Notice - An employee who does not provide advance notice of their intention to terminate County employment is considered to have left without notice.

Resignation in Lieu of Termination - An employee may be allowed by the appointing authority to resign in lieu of termination.

Resignation Pending Administrative Action - An employee may be allowed by the appointing authority to resign when administrative action is pending. Generally associated with a disciplinary action.

Retirement - An employee considering retirement should be advised to call SBCERA at least two (2) months before their chosen retirement date to schedule an appointment with a Retirement Specialist to discuss available options. Refer to Personnel Rule 9, Section 8.

Termination of Contract - An employment contract may be terminated by either party at any time within an agreed upon time period or immediately by the County for just cause.

Voluntary Resignation - An employee wishing to leave in good standing shall file a written resignation with the appointing authority in the form of a Resignation Notice or a letter. The employee shall give at least two (2) weeks notice of intention to leave the service, unless the appointing authority consents to the employee leaving sooner. Failure to provide a written resignation and/or at least two (2) weeks notice may result in an employee being marked as ineligible for rehire. Refer to Personnel Rule 9, Section 7.

ATTACHMENTS: **Attachment A - Separation Check-list**

APPROVAL   DATE:

10/14/16   **Policy, Procedure and Standards Committee**

10/14/16   **Human Resources**
Applicable Administrator, Hospital or Medical Committee

10/14/16   **Administration**
Applicable Administrator, Hospital or Medical Committee

5/2/17   **Board of Supervisors**
Approved by the Governing Body

REPLACES: **NA**

EFFECTIVE: **10/14/16**   **REVISED**:   **N/A**

REVIEWED: **N/A**

SEPARATION CHECKLIST

Last Name, First Name	Employee ID	Position Title	Department

Upon separation from ARMC employment the following actions must be taken **immediately**:

☐ Send email notification to ARMC-HR Separations
☐ Collect the following County property, as applicable:

☐ Badge

☐ Keys – number of keys: _____

☐ Pager – phone #: _____

☐ SpectraLink – phone #: _____

☐ Cell phone – phone #: _____

☐ Laptop computer – ID#: _____

☐ Tablet – ID#   _____

☐ USB Flash Drives   _____

☐ Uniforms   _____

☐ Credit Cards   _____
☐ Any other County
issued property: _____

_____

♦ Complete the following:

☐ Separation Report completion date:
☐ Computer Sign-on Request (CSOR), send to Information Management (IM) to *cancel e-mail account and remove access to all specialized databases, such as Medi-Tech, Pyxis*

Completed By	Date

SECTION:	HUMAN RESOURCES	SUB SECTION:	EMPLOYMENT PRACTICES

SUBJECT: **CONTRACTED SERVICE PROVIDER PERSONNEL**

APPROVED BY: _____
                                                    Chief Executive Officer

POLICY

Any non-county personnel who is working on site at Arrowhead Regional Medical Center (ARMC) is subject to the guidelines listed below as they align with the requirements for county personnel. Non-county personnel include individuals working on site at ARMC such as, but not limited to, employees of contracted service providers. This ARMC Policy No. 200.24 does not apply to temporary help agency personnel, registry agency personnel, students, interns, consultants or corporate staff.

PURPOSE

To provide guidelines that will ensure that non-county personnel working on site at ARMC maintain defined standards that align with the requirements for county personnel. ARMC Human Resources (ARMC HR) along with the Department Manager maintain primary responsibility for assuring that contracted service provider personnel meet defined standards for health requirements, qualifications of employment, mandatory orientation requirements and performance review.

OBJECTIVES

I.   To ensure that non-county personnel have the required qualifications, licensure and/or certification.

II.   To ensure that job performance meets defined standards.

III.   To ensure that department standards are maintained.

IV.   To assure that guidelines for non-county personnel are maintained by the contracted service provider.

PROCEDURES

I.   It is the policy of the Board of Supervisors to utilize the services of Internal Service Departments and Divisions pursuant to County of San Bernardino Policy No. 11-03 *Use of Services Provided by County Internal Service Departments*, then when necessary, may utilize a Board of Supervisors approved contract with outside service providers in accordance with County of San Bernardino Policy No. 11-05 *Procurement of Services*.

II.   Departments must follow Contract Standards (No. 11-06) in the County of San Bernardino Policy Manual.

III.   Department Managers must get ARMC HR approval to request a new contract with a service provider that would allow non-county personnel to work on site at ARMC. The contract shall be

reviewed by ARMC HR during establishment of the agreement in accordance with ARMC Administrative Operations Manual Policy No. 110.23 *Contract Services – Establishment of Agreement* and are maintained on file in the respective department and ARMC HR.

IV. Before non-county personnel are allowed to work on site at ARMC, the contracted service provider must provide a Contracted Service Provider Personnel Certification Form to the Department Manager and ARMC HR. Unless otherwise stated in the contract, the Contracted Service Provider certifies that the employee has met the following requirements and must be able to provide documentation to support the certification upon request:

A. Health screenings requirements in accordance with ARMC Administrative Operations Manual Policy No. 220.01 *Pre-Employment Medical Evaluation* and ARMC Infection Control Manual Policy No. 501 *Pre-Employment and Annual Screenings* (if applicable).

B. Drug screening and medical evaluation in accordance with ARMC Administrative Operations Manual Policy No. 220.01 *Pre-Employment Medical Evaluation* and County of San Bernardino Policy No. 07-14 *Pre-Placement Drug Testing*.

C. Criminal background check in accordance with ARMC Administrative Operations Manual Policy No. 220.06 *Background and Reference Checks.*

D. Employment and education verification in accordance with ARMC Administrative Operations Manual Policy No. 220.06 *Background and Reference Checks* (if applicable)

E. Verification of license/certification in accordance with ARMC Administrative Operations Manual Policy No. 220.05 *Licenses, Certificates, Registration – Verification Of* and Policy No. 220.06 *Background and Reference Checks* (if applicable)

V. It is mandatory that non-county personnel attend orientation in accordance to ARMC Administrative Operations Manual Policy No. 220.02 *Orientation - New Employee*. For the orientation process for individuals who are on site 30 days or less, refer to ARMC Administrative Operations Manual Policy 220.03 *Orientation for Individuals On Site Less Than 30 Days*.

VI. An ARMC identification badge is requested by completing the Badge Request and Authorization Form. Or a temporary identification badge can be obtained through security which must be returned before exiting the building.

VII. Non-County personnel are also required to complete the Annual Employee Update (AEU) annually in accordance to ARMC Administrative Operations Manual Policy No. 220.04 *Annual Employee Update*.

VIII. Education shall maintain records of the non-county personnel's attendance at orientation, completion of the AEU and required annual competencies (if applicable).

IX. ARMC HR will maintain a file for all non-county personnel working on site that contains the following:

A. Copy of contract for professional services
B. Contracted service provider personnel certification form
C. Job description of the non-county personnel's duties and responsibilities if not included within contract
D. Copy of California driver's license
E. Completed orientation checklist and acknowledgment form(s)
F. Written communications with the contractor related to the non-county personnel as necessary
G. License and certifications (if applicable)

H.   All applicable policy acknowledgment forms
I.   All applicable competencies

REFERENCES: **County of San Bernardino Policy No. 11-03 Use of Services Provided by County Internal Service Departments**
County of San Bernardino Policy No. 11-05 Procurement of Services
County of San Bernardino Policy No. 11-06 Contract Standards
County of San Bernardino Policy No. 07-14 Pre-Placement Drug Testing
Administrative Policy No. 110.23 Contract Services – Establishment of Agreement
Administrative Policy No. 220.01 Pre-Employment Medical Evaluation
Administrative Policy No. 220.02 Orientation - New Employee
Administrative Policy No. 220.03 Orientation for Individuals On Site Less Than 30 Days
Administrative Policy No. 220.04 Annual Employee Update
Administrative Policy No. 220.05 Licenses, Certificates, Registration – Verification Of
Administrative Policy No. 220.06 Background and Reference Checks
Infection Control Policy No. 501 Pre-Employment and Annual Screenings

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Contracted Service Provider Personnel Certification Form**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                          6/18/19   **William L. Gilbert, Hospital Director**
                                            Applicable Administrator, Hospital or Medical Committee

                          8/6/19   **Board of Supervisors**
                                            Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**1/13/17**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

CONTRACTED SERVICE PROVIDER PERSONNEL CERTIFICATION FORM

Please submit this form to the appropriate department and Human Resources at least 3 weeks before personnel begin working on site (Incomplete forms will not be accepted.)

I.   PLACEMENT INFORMATION

1. Employee Name: _____

2. Contracted Service Provider Name: _____

II.   DEPARTMENT INFORMATION

1. Responsible Department: _____

2. Department Manager Name: _____

III.   HEALTH REQUIREMENTS

Checking of the following requirements certifies they are met:

□	**TB/PPD:** Documentation of negative TB test within past 12 months. Initial 2-step TB screening and annual single step thereafter. If skin test position, a negative chest x-ray and annual symptom assessment on file.	□	**SEASONAL INFLUENZA VACCINATION OR DECLINATION (FLU SHOT):** Documentation of seasonal influenza vaccine or a singed informed declination on file.
□	**MMR: One of the following is required:** Documentation of 2 doses of MMR vaccine; Positive titer showing immunity to all three diseases; or Birth before 1957.	□	**TETANUS, DIPHTERERIA, PERTUSSIS (Tdap):** Documentation of 1 dose of Tdap vaccine; Single Dose of Tdap vaccination is recommended for all health-care workers
□	**VARICELLA: One of the following is required:** History of chicken pox; History of herpes zoster diagnosed by health-care provider; Documentation of 2 doses of varicella vaccine; or positive titer showing immunity or confirmation of disease.	□	**HEPATITIS B: (If duties may bring employees into contact with blood, blood products, or POIM or sharp)** Documentation of titer showing proof of immunity or three-step Hepatitis B vaccine. If declined, signed informed declination on file.
□	**DOCUMENTATION OF HISTORY AND PHYSICAL CLEARANCE:** The report indicates that the employee does not have any health condition(s) that would create a hazard to themselves, employees, or patients.		

IV.   **ADDITIONAL REQUIREMENTS**

The following is the contracted service provider's responsibility to verify and maintain on file per the contract:

□ Background check clearance with employment verification

□ Current contract

□ Job description (if not contained in current contract)

□ License and certifications (if applicable)

□ Orientation checklist

□ Employee has completed applicable ARMC Orientation Requirement

I certify that each of the above requirements has been met for the employee(s) listed on the following page and that supporting documentation for verification purposes is maintained at the contracted service provider institution and is easily retrievable upon request. It is acknowledged that the records shall be maintained for at least five (5) years after the employee's last contact with ARMC.

_____
Signature of Contracted Service Provider

_____
Print Full Name

_____
Title

_____
Date

Submit form to:
Human Resources
Arrowhead Regional Medical Center
400 N. Pepper Avenue
Colton, California 92324
Fax: (909) 580-1323

SECTION:	**HUMAN RESOURCES**	**SUB SECTION:**	**ORIENTATION**

SUBJECT: **MANAGEMENT OF STUDENTS AND STUDENT PLACEMENT**

APPROVED BY: _____
                             Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) provides the opportunity for students to gain experiences in their respective area of study in various departments. ARMC provides clinical experience in patient care and non-patient care areas as per affiliation agreements between hospital administration and the participating school or college. These written agreements are kept in the Administration office and reviewed by the Hospital Compliance Officer.

To support ARMC's mission to provide educational experiences for future health care providers, efforts are made to accommodate students while maintaining the highest level of patient safety and quality care. Collaboration between hospital staff, clinical faculty, and students ensures that patients and families continue to receive excellent care.

PROCEDURAL GUIDELINES

I.   AFFILIATION AGREEMENTS

     A.   An affiliation agreement establishes an umbrella relationship between an institution and ARMC. The Affiliation agreement must be in place before students can be placed into any ARMC departments. Agreements must be approved by the Board of Supervisors and are kept with Administration through the hospital's Contract Compliance office.

     B.   Department Heads, or designee, interested in having students placed in their Department must first verify that an affiliation agreement is currently in place by contacting ARMC's Contract Compliance office. If an affiliation Agreement is in place, the Department Head, or designee, may set up arrangements with the school.

     C.   If an affiliation agreement is not in place, please see Administrative Policy No. 110.25, Contract Services – Affiliation Agreements for contract development.

II.   BACKGROUND CHECK REQUIREMENTS

     See Administrative Policy No. 220.06, Background and Reference Checks

III.   MEDICAL STUDENTS

     A.   The Graduate Medical Education Office Manager, or designee, is responsible for oversite of the following tasks for medical student placement:

1. Verify that an affiliation agreement is currently in place. Monitor and maintain obligations as defined in the agreement.
2. Develop a department plan for the management of students considering the School's clinical objectives and student's application and experience as determined by the semester/quarter/module within their programs.
3. Verify that the student(s) Health Screening Requirements have been met. School maintains copies of the health records and makes them available upon request.
4. Provide orientation for the student. A copy of the test is retained within the department and must be made available upon request. Department submits a monthly completion report to Education Department. See Administrative Policy No. 220.03, Orientation for Individuals on Site Less Than Thirty (30) Days and All Students.
5. Assign and schedule the student's clinical activities.
6. Arrange for ARMC identification badge for student. See below.
7. Supervise the student's clinical activities.
8. Ensure the student's clinical performance is evaluated by appropriate faculty members as outlined in the specific medical school clinical training manual.

IV.   NURSING AND ALLIED HEALTH STUDENTS

A.   The Education Services Supervisor, or designee, is responsible for oversight of the following tasks for nursing and allied health student placement:

1. Verify that an affiliation agreement is currently in place. Monitor and maintain obligations as defined in the agreement.
2. Obtain the Student Placement Certification Form for each student or student group.

   a. A Student Placement Certification form covering each student is submitted by the school to the Education Department before the student(s) begin a rotation at ARMC. The school thus certifies that the student(s) has met the requirements listed on the form.
   b. Documentation to support the certification must be retained by the school for a minimum of 5 years from student's last contact with ARMC and must be made readily available upon request.

3. Obtain the School's clinical objectives.
4. Assign and schedule the student's clinical activities in collaboration with the school's faculty.
5. Distribute and track orientation training materials, see Orientation requirements below. Schools are responsible to retain a copy of the student's test and must be made available upon request.
6. Arrange for ARMC identification badge for student or faculty. See below.

B.   The Department Head, or designee, is responsible for oversight of the following tasks for students placed in their department:

        1.   Verify that an affiliation agreement is currently in place. Review the agreement in its entirety. Monitor and maintain obligations as defined in the agreement.

        2.   Develop a department plan for the management of students considering the School's clinical objectives and student's experience as determined by the semester/quarter/module within their programs.

        3.   Provide department specific orientation to the student and faculty, see below

        4.   Supervise the student's clinical activities.

        5.   Evaluate the student's clinical performance.

C.   Student Placement Certification Form

        1.   A Student Placement Certification form covering each student is submitted by the school to the Education Department before the student(s) begin a rotation at ARMC. The school thus certifies that the student has met the requirements listed on the form.

        2.   Documentation to support the certification must be retained by the school for a minimum of 5 years from student's last contact with ARMC and must be made readily available upon request.

        3.   The Education Department maintains the Student Placement Certification form on file for each student or student group.

D.   Health Screening Requirements
Students must meet the Health Requirements as listed on the Student Placement Certification form.

E.   Orientation Requirements

        1.   Students and faculty must receive an orientation to ARMC. See Administrative Policy No. 220.03 Orientation for Individuals on Site Less Than Thirty (30) Days and All Students and the Student/On-site Faculty Orientation Checklist (Attachment A) at the commencement of the student's placement.

        2.   The Education Development Department is responsible for updating the Orientation Resource and Safety Booklet.

        3.   The Compliance Department is responsible for updating the HIPPA Training Booklet.

V.   DRESS CODE

A.   Instructors must wear a lab coat in the acute inpatient areas and the school's identification badge while supervising students. Dress must be neat, clean, and professional in appearance.

B.   Students must wear a school uniform and their school's identification badge while providing patient care. When students are here to prepare for a clinical day or attend an educational event, they may dress casual (no jeans) with a lab coat and their school identification badge. In addition, students must follow the ARMC dress code policy, which includes no artificial nails, no visible body piercing or tattoos; see Administrative Policy No. 200.06 Standards of Dress and Appearance.

VI.   IDENTIFICATION BADGES, See Administrative Policy No. 210.02 Employee Identification Badge.

   A.   Students are required to wear their school issued photo identification badge at all times while at ARMC. Students who receive an ARMC badge wear both.
   B.   Clinical on-site faculty is issued temporary identification badges for each new rotation. Faculty still wears their school's photo identification badge as this designates their school affiliation. The ARMC badges are used to identify them as "Clinical Instructors" and to gain entry to locked areas on the units (units, supply room, restroom, etc.).
   C.   Faculty must immediately report lost or stolen badges so that access may be stopped. Security is notified. Replacement cost for the badge is $10.

VII.   SUPERVISION OF INSTRUCTOR-LED CLINICAL GROUPS

   A.   The clinical instructor makes student's patient assignments in collaboration with the unit charge nurse or area supervisor to ensure that quality patient care is maintained. The unit's Nurse/Department Manager has overall responsibility for care provided on the unit.
   B.   Student assignments are made by the clinical instructor ideally the day before (giving the student opportunity to research medications, diagnosis, etc.). These students have patient assignment priority due to their preparation activities. When patients are not pre-assigned, students are to be familiar with the patient, medications, and required treatments prior to initiating patient contact.
   C.   Students are under the direct supervision of the instructor(s) provided by the school. The phrase "direct supervision", however, can be extended to include a designated staff member who would **visually** supervise student actions. In such instances, the instructor must communicate with the staff member regarding previous validation of skills to be performed.
   D.   Medication Administration:
         In programs where medication administration is part of the training, for example Registered Nurse, Licensed Vocational Nurse, Respiratory Care Practitioner, etc., students:

         1.   Administer medications in accordance with ARMC's medication administration policies
         2.   May administer medications except those outlined in the Scope of Practice section of this policy
         3.   Supervision:

               a.   Students enrolled in the first semester/quarter/module of their programs **are not permitted to prepare or administer medications without the direct supervision of their instructor(s)**.
               b.   Students in subsequent semesters/quarters/modules are permitted to prepare and administer medications as per the guidelines listed in C above.

   E.   Clinical instructors are to ensure that students communicate closely with the staff member regarding changes in the patient's condition and to perform patient handoff procedures (give report) prior to leaving the unit. Close instructor

supervision is essential, pertaining to co-signing of documentation (monitoring accuracy and thoroughness of Intake and Output, flow sheets, vital signs, progress notes, etc.); ensuring absolute compliance to Infection Control Policies (Standard and Isolation Precautions, Hand Hygiene, etc.); HIPAA regulations; and ensuring delegated and agreed upon tasks have been completed.

F.   The overall responsibility for student performance rests with the clinical instructor(s).

G.   Staff members should first contact the clinical instructor with any concerns or questions about an individual student or the care provided. The Education Director and/or the department's manager may be contacted for any unresolved issues.

VIII.   SUPERVISION OF PRECEPTED CLINICAL EXPERIENCES

A.   The Preceptor Instructors/Faculty contacts the Department Manager/Supervisor, or designee, to discuss:

1.   Course objectives and expectations
2.   Formulate a mechanism for communications between the preceptor and preceptor faculty for ongoing student evaluation
3.   Review student's knowledge, skills, and past experiences in order to develop a learning experience tailored to the student's needs

B.   Schools must provide contact information to both ARMC and the individual preceptor so that the preceptor faculty and school can be contacted in case of an emergency.

C.   The precepted experience is a partnership in which students are supervised for patient care activities. The staff preceptor is responsible for providing the unit specific orientation.

D.   Students enrolled in programs where medication administration is part of their training, for example Physicians, Registered Nurse, Licensed Vocational Nurse, Respiratory Care Practitioner, etc., may perform medication administration under the direct **visual** supervision of the preceptor, except those outlined in the Scope of Practice section of this policy.

E.   During the precepted experience, any issues are reported to the Nurse Manager/Supervisor and Preceptor Faculty immediately.

IX.   PCS, PYXIS ACCESS, AND POINT OF CARE TESTING

A.   Computer access is only granted to instructors and students in a RN and LVN program.

B.   Nursing Clinical Instructors are required to complete a one-time training session of Meditech Patient Care System (PCS) documentation prior to accompanying students to ARMC. During the training session, instruction is provided on PCS documentation, Enterprise Medical Record (EMR), and the electronic Medication Administration Record (eMAR).

C.   Once training has been completed by the Nursing Clinical Instructor, computer access passwords are issued to both the instructor and students provided a student roster has been submitted.

D.   Clinical Instructors and students receive a <u>new</u> Meditech password with each clinical rotation group.

E.   Clinical Instructors and students who are employed by ARMC will have two (2) access sign-ons for Meditech: Employee access is used during work hours; Instructor and Student access is used during clinical rotations.

F.   Nursing Clinical Faculty is provided a Pyxis password in accordance with Pharmacy Department policy.

G.   Any computer program or diagnostic equipment requiring an access code cannot be used by the instructor or student unless an authorized code has been received.

H.   Performance of blood glucose monitoring and any point of care testing (POCT) are limited to employees of ARMC who have demonstrated competency. Students and instructors may not perform POCT using access codes of ARMC employees. Students are encouraged to observe POCT as a learning activity.

X.   SCOPE OF PRACTICE

Under the supervision of a licensed ARMC staff member, students may observe but not directly participate in:

A.   Chemotherapy medication administration

B.   Administration of medications for procedures to be done under sedation

C.   Administration of investigational medications

D.   IV (intravenous) medication drips (e.g., heparin, aminophylline, cardiac medications, etc.), IV push medications, and ARMC listed high-risk medications are administered only when done under the direct **visual** supervision of the Attending Physician, RN, or clinical instructor and requires independent validation and documentation by two RNs per Department of Nursing (DON) Policy 571.00 Medication Administration: General Guidelines and Safe Practices. Note: IV fluids and medications given other than IV push may be given by the RN student but must be verified/documented by the RN or clinical instructor.

E.   Signing documents that require a licensed care provider such as waste of controlled substances and witness of consents

F.   Verification of blood products for blood administration or verification of blood draws for type and crossmatch or type and hold

G.   Taking verbal/telephone orders or signing off any orders. Taking physician orders over the phone or verbally must involve an ARMC RN listening in person or via conference call.

XI.   ALLIED HEALTH

A.   Allied Health students that are in a precepted experience students function under direct supervision of qualified personnel at ARMC and under the general supervision of school instructors who maintain overall responsibility for student performance. The participating department is responsible to provide oversight and department/unit orientation to each student

B.   Regional Occupation Program (ROP) students are high school students enrolled in special health careers programs supported through the school district and special funding and/or grants. These students are provided opportunities to pursue their interests in Health Occupations through a "community classroom" internship. The students may be placed in a variety of departments within the hospital to "job shadow" or gain hands-on experience under the supervision of the instructor or department staff. These students work under the direct

supervision of qualified personnel at ARMC and under general supervision of school personnel.

C.   Medical Assistant / Surgical Technician and other programs are offered through various community and college-affiliated vocational programs. These students are assigned to specific units or areas and receive direct supervision by an on-site instructor. The instructor works closely with the Nursing staff in the validation of required student competencies and meeting clinical objectives.

D.   Externships/Internships are provided to requesting programs and other allied health programs. The externship is the last module of training the student completes as part of their program, and provides the student with an opportunity to apply skills and knowledge acquired during the program. Externs work under the direct supervision of qualified personnel at ARMC and under general supervision of school personnel.

REFERENCES: **Administrative Policy No. 110.25 – Contract Services – Affiliation Agreements**
Administrative Policy No. 220.03 – Orientation for Individuals on Site Less Than Thirty (30 Days) and All Students
Administrative Policy No. 220.06 – Background and Reference Checks
Administrative Policy No. 210.02 – Employee Identification Badge
DON Policy 571.00 Medication Administration: General Guidelines and Safe Practices
Infection Control Policy 501- Pre-employment and annual screenings
Survey Agency Standards

DEFINITIONS: **School:** A Board approved contract affiliated education facility that places students at ARMC for educational purposes.
Student: Individuals pursuing an academic degree or certification at a college, university or vocational program.
Clinical Group: Group of students who are assigned to a specific unit(s) or departments and are under the direct supervision of a clinical faculty from an affiliated education facility.
Precepted Learning Experience: Extended number of clinical hours whereby students are linked with one or more staff to learn their role. Typically, the responsible preceptor instructor will make site visits to communicate with the preceptor and student to validate progress as measured against predetermined goals and objectives.
Clinical Instructors/Faculty: Individuals working for an affiliated education facility who provide direct supervision and have responsibility for a group of students or individuals assigned to a specific unit(s) or department(s).
Preceptor Instructors/Faculty: Individuals employed by an affiliated education facility who are the responsible contact person(s) for students who are participating in a precepted learning experience.
Staff Preceptor: Staff who provides direct supervision for a student.

ATTACHMENTS: **Attachment A: Student/On-site Faculty Orientation Checklist**

APPROVAL DATE:

| 9/21/15 | **Policy, Procedure and Standards Committee** |

| 7/21/15 | **William Berkley, Human Resources Officer** |
| | Applicable Administrator, Hospital or Medical Committee |

| 1/12/16 | **Board of Supervisors** |
| | Approved by the Governing Body |

REPLACES: **N/A**

EFFECTIVE: **1/12/16**   **REVISED**:   **N/A**

REVIEWED: **N/A**

STUDENT/ON-SITE FACULTY ORIENTATION CHECKLIST

ITEM	CONTENT DESCRIPTION	ON-SITE FACULTY	STUDENT
1.	Mission of Hospital	Allied Health and Nursing Faculty Annual Employee Update	Orientation & Safety Resource Booklet
2.	Organizational Structure • ARMC • Department/Area	Allied Health Faculty Department Specific Orientation	Orientation & Safety Resource Booklet School Onsite Faculty, Preceptor or Department Designee
3.	Safety Procedures	Nursing Faculty	Orientation & Safety Resource Booklet
4.	Infection Control	Nursing Clinical Instructor Orientation	Orientation & Safety Resource Booklet
5.	Hazardous Waste & Materials Safety		Orientation & Safety Resource Booklet
6.	Employee Health and Wellness		Orientation & Safety Resource Booklet
7.	Confidentiality – HIPAA; Information Management & Access		Orientation & Safety Resource Booklet HIPPA Training Booklet
8	Patient Rights		Orientation & Safety Resource Booklet
8.	Security • Personal Safety • Parking • ID badges		Orientation & Safety Resource Booklet
9.	Rules of Conduct		Orientation & Safety Resource Booklet
10.	Dress Code		Orientation & Safety Resource Booklet
11.	Tour	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee
12.	Staff in Department/Area • Roles and responsibilities • Introductions	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee
13.	Department/Area-Specific Standards of Care and/or Practice	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee

14.	Department/Area-Specific Documentation	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee
15.	Other Department/Area-Specific Information - Patient population - Layout of unit (supplies, fire alarms, extinguisher, evacuation route, reference books) - Chain of Command - Patient Care emergency procedures - Documentation procedure - Equipment review/Device Safety - Pertinent policies and procedures	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee
16.	Duties, expectations and responsibilities of: - Student - Faculty/Preceptor Student goals/objectives Preceptor expectations (work hours, who and how to report information, sign-in and sign-out, sick calls, etc.) - Evaluation process	Department Head, Manager or Designee	School Onsite Faculty, Preceptor or Department Designee

SECTION:	**HUMAN RESOURCES**	**SUB SECTION:**	**ORIENTATION**

SUBJECT: **AMERICAN HEART ASSOCIATION CARD RENEWAL**

APPROVED BY: _____
                                     Chief Executive Officer

POLICY

I.   The American Heart Association's (AHA) Resuscitation Quality Improvement (RQI) Program promotes constant competency and certification for staff through completion of quarterly reviews, hands on demonstrations, and a cognitive portion within the HealthStream Learning Management System (LMS). RQI is the preferred method for recertification of Cardiopulmonary Resuscitation (CPR) skills as evidenced by Best Practice recommendations through the AHA.

II.   Arrowhead Regional Medical Center (ARMC) staff whose position description requires Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) provide their certification card from an approved American Heart Association course to Human Resources. Education staff document the certification in the employee's education record in HealthStream.

III.   Participation in the HeartCode BLS RQI education program, in place of traditional BLS recertification, is mandatory for ARMC staff whose position description requires BLS certification.

IV.   Participation in the HeartCode ACLS RQI education program, in place of traditional ACLS recertification, is mandatory for ARMC staff whose position description requires ACLS certification.

V.   RQI carts with mannequins and supplies are available to staff throughout ARMC's inpatient and outpatient care areas and at the Westside Family Health Center.

VI.   Staff whose BLS or ACLS card expires while they are away for any leave of absence are required to attend a full BLS or ACLS course.

PROCEDURES

I.   Employees required to participate in the HeartCode BLS RQI and HeartCode ACLS RQI complete one psychomotor activity each quarter (every 3 months) and one annual didactic activity. Required activities must be completed by 11:59 pm on the last day of the quarter for which the activity is assigned.

II.   Completion of each required RQI activity extends the recommended renewal date for BLS and/or ACLS certification for a period of 3 months.

III.   Though it is the employee's responsibility to periodically monitor their HealthStream account for new trainings, notification of new quarterly activity assignments are:

       A.   Issued via the employee's HealthStream account for employees who provide a current, correct email address
       B.   Posted at the beginning of each quarter

IV.   HealthStream reports are sent to managers for outstanding or missed required RQI activity.

V.   Disciplinary action begins at 3 months of inactivity in the RQI program. Disciplinary action is prescribed using the Just Culture Algorithm, escalating as needed, see Administrative Policy 240.03, Employee Discipline.

VI.   Certification records are kept electronically via HealthStream and are updated in Human Resources.

VII.   Employees requesting verification of BLS and/or ACLS certification may printout a HeartCode RQI certificate of completion. Employees requiring a physical copy of their BLS or ACLS card(s) may request a copy through the AHA via HealthStream at the employee's expense.

VIII.   Newly hired employees

A.   For enrollment into the RQI program, participants are required to have a minimum of 6 month until BLS and/or ACLS card expiration. New employees with fewer than 6 months need to attend an initial training within 30 days of hire as listed below.
B.   New employees are enrolled and begin the RQI program within 30 days of their start date.
C.   Initial training may be completed by:

1.   Taking a HeartCode BLS or HeartCode ACLS blended learning class. Please inquire at the Education Department for specific instructions
2.   Attending a traditional initial BLS or ACLS certification at an outside agency at the employee's expense

REFERENCES: **Administrative Policy No. 240.03 Employee Discipline**

DEFINITIONS: **Didactic Activity:** Learning activity consists of an online lesson. No psychomotor skills are required to complete the activity. Goal of didactic activity is to enhance knowledge and comprehension.
Heart Code: Web-based, self-paced instructional program that uses eSimulation technology to allow students to assess and treat patients in virtual healthcare settings.
Psychomotor training: Skill-based training; hands-on practice on mannequins
Resuscitation Quality Initiative: Comprehensive program comprised of all elements that enhance patient resuscitation, e.g. certification or simulation

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **5/9/18**   **REVISED**:   **N/A**

REVIEWED: **2/7/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

| SECTION: | HUMAN RESOURCES | SUB SECTION: | MISCELLANEOUS |

SUBJECT: USE OF PERSONAL ELECTRONIC DEVICES INCLUDING CELLULAR PHONES, SMARTPHONES, SMART WATCHES, AND RADIO TRANSMITTERS

APPROVED BY: _____
Chief Executive Officer

POLICY

I.   Arrowhead Regional Medical Center (ARMC) acknowledges the benefit of permitting electronic devices into the healthcare environment. However, the use of electronic devises cannot compromise our responsibility for assuring patient privacy and confidentiality, environmental safety, and a therapeutic environment.

II.   It is the responsibility of patients, visitors, and ARMC staff to use electronic devices, including cell phones, smart phones and smart watches, appropriately and in accordance with ARMC policies, regulations, and procedures.

III.   To provide a safe environment with respect to the utilization of personal electronic devices at ARMC, it is our policy to:
   A.   Avoid interference problems between radio frequency transmission devices and patient care equipment, see Environment of Care Policy 6011, Use of Cellular Phones/Radio Transmitters in Patient Care Areas.
   B.   Eliminate distractions that interfere with ARMC staff's ability to focus on their general duties and/or patient care responsibilities.
      1.   Avoid using electronic devices while walking and/or in the hallways of the hospital.
         a.   Staff must be available to patients, family members and others to offer assistance when needed and to walk individuals to their destination as appropriate.
         b.   When unavoidable, follow the "rules of the road" when using an electronic device in the hallway:
            i.   Move to the side of the hallway and stop walking
            ii.   Quickly consult your electronic device
            iii.   Watch for others while in hallways so unintended collisions do not occur
            iv.   Continue to greet others to promote a caring, friendly environment
      2.   Avoid using earbuds in the hospital.
         a.   Staff may wear one earbud during breaks in breakrooms and in non-public locations when exercising i.e., indoor and outdoor walking paths.
         b.   Earbuds can:
            i.   Be a safety concern by reducing staff's ability to hear important overhead paged safety notifications/codes
            ii.   Interfere with customer service initiatives and a welcoming, helpful environment for our patients and visitors
      3.   Avoid the use of electronic devices for checking email, taking calls, etc. during meetings and educational programs as it is a distraction, interferes with productivity, and is discourteous to others. With this:
         a.   Use of cell phones and WiFi phones, like Spectralink, is prohibited.

                     i. In an urgent or emergent situation where a response is necessary, staff should excuse themselves to answer the phone outside the conference room

       b. Cell and WiFi phones are to be placed on silent or vibrate mode.

C.   Utilize personal electronic devices by ARMC staff only when:

         i. On non-work time (breaks and lunch)
        ii. Located in designated break and lunch areas and/or outside of the building
      iii. In receipt of information about personal circumstances demanding immediate attention and/or response
      iv. Necessary to perform a job function. (See Section IX).

D.   Display of Electronic Devices

       a. As it is a distraction and a safety hazard, personal cellular (cell) phones, i-pads, tablets, and other personal electronic devises may not be visible (i.e. desk tops, etc.) or in use. This includes but is not limited to work stations where staff have direct contact with the public, families, visitors, other ARMC staff, etc. in person or via telephone.

IV.   ARMC staff maintain patients' right to privacy and protect confidential information from being mishandled or inadvertently exposed.

V.   ARMC posts and/or provides written materials that explain provisions of this policy.

VI.   Possession and use of personal electronic devices by patients, employees, contractors and visitors is permitted in ARMC patient care areas subject to the provisions of this policy.

VII.   Employees and contractors are prohibited from using their own personal electronic device(s) in patient care and non-patient care areas or while involved in the direct care of patients <u>unless the use of such device is necessary to perform their job function</u>.

VIII.   Staff may not transmit patient information via text message and/or send or receiving patient information via text message without the use of encryption technology

IX.   When a personal electronic device(s) deemed necessary to perform a job function is being used by ARMC staff, that device is appropriately encrypted, see Administrative Policy No. 700.19, Data Encryption.

X.   Patients, employees, contractors and visitors are prohibited from photographing and recording any individuals and/or feigning or threatening to photograph or record any individuals unless otherwise authorized by ARMC Administration, or designee, in accordance with ARMC privacy regulations and procedures; provided, however, that duly authorized investigatory or oversight entities may take photographs or make recordings in the course of carrying out their official responsibilities.

A.   Staff, patients, and visitors are prohibited from photographing any patients or staff without authorization from the patient or staff member. No images of patients are permitted for personal use or publication.

B.   Any recording of patients (video, photo, or audio) is only permitted for patient treatment or operations purposes using ARMC designated equipment with patient consent, see Administrative Policy No. 640.02, Consent – Patient Photography.

XI.   If there is reasonable cause to believe that an electronic device has been used to take a photograph or recording in violation of this policy, staff:

      A.   Remind the photographer/videographer of our policy and explain why this policy is in effect. May point out wall signage

      B.   For photography/recording of a patient without their consent:
1. Inform the photographer/videographer of the patient's right to privacy and confidentiality
2. When appropriate, ask the photographer/videographer to stop photographing and/or recording the patient
3. Phrases that may be helpful in explaining include:
   a. "Your loved one is really not at their best right now. Let's hold off capturing this memory and wait until they are doing better."
   b. "Are you sure your loved one would want to have this picture taken at this time and shared with others?"
   c "Is taking this picture in the best interests of the patient and their desire for privacy?"

      C.   For photography/recording of a staff member:
1. Consider that this action is likely being done out of concern. Stop and address their concerns by saying, for example, "You seem concerned about this procedure. We want to ensure you understand and are comfortable with what is taking place. Do you have any questions that I can answer for you?"
2. Politely ask the photographer/videographer to stop photographing/recording you and/or another staff member
3. I the photographer/videographer persists, the following phrases may be helpful in explaining:
   a. "You do not have my permission to photograph me. Please stop now."
   b. "I am not comfortable with you recording me while I perform this procedure. Please stop recording now or I will have to ask you to step out of the patient's room."
   c. "Please stop recording me. I find it distracting and difficult to concentrate."

XII.   Failure to Comply With the Policy:

      A.   Patients and visitors who fail to comply with the provisions of this policy may be asked to leave if they are interrupting the patient care duties of ARMC staff.

      B.   Employees who violate this policy may be subject to disciplinary action.

      C.   Contractors who violate this policy may be subject to action under the contract, including contract termination.

POLICY EXPANSION

Electronic devices are used by ARMC's healthcare professionals to access medical resources, organize patient care plans and needs, keep calendars, and collect and access other important information. For an individual hospitalized, maintaining connection to natural supports in the community facilitates their own recovery and successful re-integration into the community.

The benefit of permitting electronic devices and the skills gained in handling computer and communication technology as an aspect of recovery must not compromise ARMC's responsibility for assuring patient privacy, confidentiality, public safety and a therapeutic environment.

PURPOSE

I.   This policy outlines the use of cell/smart phones and other electronic communication devices within the hospital, onsite and offsite clinic environments, including special issues related to camera phones.

II.   This policy applies to ARMC patients, employees, contractors, and visitors.

III.   This policy is not intended to impede the use of electronic devices as accommodations for individuals with disabilities such as hearing, seeing, speaking or immobility disabilities. The use of video phone methods for communication that includes a person who is deaf is one such example, provided that the use occurs in a place and manner that is protective of the privacy of others.

PROCEDURES

I.   See Administrative Policy No. 700.01, Information Security – General Requirements for the role of employees in ensuring a safe environment that protects patient health information.

II.   Ensuring a Positive Image When Using an Electronic Device in the Presence of the Patient and/or Family
        It is understandable that patients and families may misinterpret staff's use of an electronic device as neglecting the patient/family to respond to personal concerns. Therefore, it is important for staff to communicate/explain their use of the electronic device to the patient/family. Examples include:

        A.   "Let me look up the side effects of this medication on my phone."
        B.   "I am looking at my To Do List for your plan of care."
        C.   "I am checking my notes on your case."
        D.   "I have several very good resources here on my tablet. Let me look that up."

III.   Personal cell phones, WiFi phones like Spectralink, and tablets are cleaned and disinfected in accordance with Infection Control Manual Policy 308, Cleaning and Disinfection of Patient Care Items and Equipment.

REFERENCES: **Administrative Policy No. 110.01, Customer Service – Provision of**
                         Administrative Policy No. 100.08, Medical Photography Management
                         Administrative Policy No. 110.16, Spectralink Telephones
                         Administrative Policy No. 640.02, Consent – Patient Photography
                         Administrative Policy No. 700.01, Information Security – General Requirements
                         Administrative Policy No. 700.10, Device and Media Controls
                         Administrative Policy No. 700.17, Portable Storage Device and Media Management
                         Administrative Policy No. 700.19, Data Encryption
                         Administrative Policy No. 900.01, Patient's Rights
                         Administrative Policy No. 1000.16, Communication of Protected Health Information
                         Administrative Policy No. 1000.27, Removal of Protected Health Information from Hospital Premise
                         Infection Control Policy 308, Cleaning and Disinfection of Patient Care Items and Equipment

Security Department Policy 101.605, Use of Cellular Phone and Other Radio Transmitters in Patient Care Areas

DEFINITIONS: **Electronic Devices:** Electronic equipment for communication and personal use which include, but are not limited to, the following: laptops and personal computers with and without Wi-Fi capabilities, iPods and other MP3 players with Wi-Fi capabilities, cell phones, smart phones, smart watches, iPads and any other Wi-Fi compatible devices, and any communication devices that contain built-in cameras, audio or video recording devices.

Immediate Patient Care Areas: Immediate patient care areas include but are not limited to patient rooms, operating rooms, nursing stations, recovery rooms, places where patients receive care or treatment, such as x-ray and therapy areas, halls and corridors immediately adjacent to patient rooms and patient care and treatment areas and admitting and registration areas.

Non-work Areas: Non-work areas include but are not limited to the cafeterias, the gift shops, break rooms, employee lounges, restrooms, locker rooms, lobbies, the front entrance of the Hospitals, Clinics and parking areas.

Work Time: Work time includes all time when an employee is required to perform his/her job duties for the Hospital/Clinic, but does not include an employee's own time such as meal or break period or before or after work.

ATTACHMENTS: **N/A**

APPROVAL DATE:
____N/A____   **Policy, Procedure and Standards Committee**

____6/18/19____   **William L. Gilbert, Hospital Director**
                  Applicable Administrator, Hospital or Medical Committee

____8/6/19____   **Board of Supervisors**
                  Approved by the Governing Body

REPLACES: **Environment of Care Policy 6011, Use of Cellular Phones/Radio Transmitters in Patient Care Areas**

EFFECTIVE: **5/7/19**   **REVISED**:   **N/A**

REVIEWED: **2/7/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	HUMAN RESOURCES	SUB SECTION:	EMPLOYMENT PRACTICES

SUBJECT: HEART EMPLOYEE BEHAVIORAL STANDARD EXAMPLES

APPROVED BY: _____

<div align="center">Chief Executive Officer</div>

POLICY

The purpose of this policy is to establish examples of HEART value-based behavior standards for ARMC employees separate from the "Code of Conduct". The acronym HEART stands for the ARMC Values of Honor, Engaged, Accountability, Respect, and Teamwork. The value behavior examples were developed through different management, administration, and peer groups with the goal of uniting staff in creating a positive collaborative environment for employees to thrive while fostering quality patient care.

The behavior examples encourage hospital wide "Team Agreements". They are meant to exemplify the HEART Values in word, thought, and deed. The behavior standards examples are built on a foundation of compassion, courtesy, and professionalism between co-workers, colleagues, patients, patient families, and visitors. The HEART Value system spotlights ARMC accepted norms as a basis for individual and team alignment, action, accountability, and recognition. The Standards benchmark the beliefs, morals, and philosophies of ARMC in everyday practice. These ARMC value examples are not exclusive, they represent clear guiding principles and protocol for employee interaction with each other at every level and position within the hospital as well as interactions with the public and out patients within the hospital.

PROCEDURES

Arrowhead Regional Medical Center employees are required to read the Employee Behavioral Standards Examples together in their department. This ensures that every employee understands how to become recognized by peers, leaders, patients, and visitors. The examples should be discussed openly and transparently so each staff has an opportunity to ask questions and provide feedback on ARMC's first level of formal recognition. Receiving formal value based recognition is the first step of eligibility for the employee/s of the year.

New employees will be introduced to the HEART Employee Recognition Program and the HEART Value Behavior Standards Examples at ARMC New Hire orientation.

Department leadership will review the HEART Employee Recognition Program and the Employee Behavioral Standards Examples bi-annually with all employees to support the message of continued and purposeful positive interaction with both co-workers, patients, and visitors.

REFERENCES:	N/A

DEFINITIONS: Employee means all regular employees, volunteers, per-diem contract, and service contract providers, students of allied health programs, medical students, resident physicians, and attending staff.

ATTACHMENTS: **Attachment A: ARMC HEART Employee Behavioral Standards**

APPROVAL   DATE: N/A   Policy, Procedure and Standards Committee
_____

              6/18/19   William L. Gilbert, Hospital Director
              _____
              Applicable Administrator, Hospital or Medical Committee

              8/6/19   Board of Supervisors
              _____
              Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **5/7/19**   **REVISED**:   **N/A**

REVIEWED: **2/7/19**

ARMC HEART Behavioral Standards Examples

Honor: <u>We honor our patients' rights to compassion, dignity, and confidentiality</u>
> **Examples of honorable behaviors:**

- Honoring patients, co-workers and visitors by acting ethically, morally, and with the highest integrity at all times
- Honoring the differences in personal beliefs and cultures
- Honoring patients by conveying concern, empathy, and a willingness to serve
- Honoring my colleagues by managing-up to build patient trust and confidence in the abilities of others
- Honoring every patient's right to quality healthcare, regardless of their social, economic, or educational status
- Honoring the human spirit and supporting its capacity to heal the heart, mind, and body
- Honoring patients, co-workers, and visitors by maintaining a professional appearance
- Honoring professional boundaries with co-workers and patients

Engaged: <u>We engage patients and co-workers with our sense of purpose, passion, and</u> <u>positivity</u>
> **Examples of engaging behaviors:**

- Promoting an engaging relationship with patients, families and co-workers by consistently using AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank-you)
- Seeking to be understood by speaking clearly and courteously with others
- Using easily understood language and terms when explaining healthcare treatment plans to patients and families
- Using human interaction for complex problem solving and sensitive issues
- Greeting and smiling at co-workers, patients, and visitors when they are in my immediate area or path
- Giving credit where credit is due and recognizing the good work of others
- Happily giving directions and/or showing visitors the way
- Providing a warm welcome to new team members and offering mentorship and support

Accountable: <u>We build individual staff accountability through shared responsibility,</u> <u>accomplishments,</u>
> <u>and quality care</u>
> **Examples of accountable behaviors:**

- Taking responsibility for my actions and following through on commitments and obligations
- Being a self-starter and striving to do my best everyday
- Participating in my own growth and development
- Being responsible for the cleanliness of the hospital
- Ensuring a positive patient experience by ensuring patient needs and concerns are met
- Not engaging in gossiping, back-biting or undermining co-workers
- Knowing, understanding, and supporting the ARMC values, mission, and vision
- Immediately reporting near misses, safety and ethical issues
- Answering call lights/alarms promptly and asking how I may help

- Enthusiastically participating in continuous system improvements, efficiency and innovation
- Thinking safe, acting safe, and staying safe

Respect: <u>We respect and celebrate individuality and diversity among our team and the community we serve</u>
Examples of respectable behaviors:

- Treating others with compassion, dignity and grace
- Focusing on problem solving and respecting the views of others
- Valuing visitors by allowing them to enter and exit hallways, elevators, and reception areas, before me
- Holding the door for patients, visitors, and co-workers in close proximity
- Reserving convenient parking for patients and visitors by parking in designated employee areas only
- Being respectful of patients resting patients by providing a quiet workplace
- Refraining from discussing patients in public areas even when not referencing names
- Conducting phone conversations with patients in a discreet and professional manner
- Refraining from personal conversations within earshot of patients and visitors
- Not burdening patients with my problems
- Answering the phone with a greeting, stating my name and asking how I can help
- Periodically checking with people on hold and apologizing for the wait

Teamwork: <u>Through teamwork, we share a universal commitment to provide the most heartfelt patient experience possible</u>
Examples of teamwork behaviors:

- Working collaboratively with co-workers towards achieving common organizational, departmental, and team goals
- Contributing positively to the work environment
- Actively listening to the views of the team and collaborating even when I don't agree
- Raising the spirits of team members suffering from compassion fatigue
- Believing that your success and my success is "our" success
- Acknowledging the strengths and expertise of co-workers and their contributions
- Working towards the common good
- Giving all my co-worker's in all departments the benefit of the doubt
- Believing that everyone comes to work with the best intentions
- Not making assumptions about the motives of others

SECTION:	PERFORMANCE IMPROVEMENT	SUB SECTION:	GENERAL

SUBJECT: PATIENT SAFETY EVALUATION SYSTEM

APPROVED BY: _____

<div align="center">Chief Executive Officer</div>

PURPOSE

The purpose of this policy is to describe and define the Arrowhead Regional Medical Center (ARMC) Patient Safety Evaluation System.

POLICY

The Arrowhead Regional Medical Center Patient Safety Evaluation System (PSES) shall serve as the interface for data collection and analysis between Arrowhead Regional Medical Center and its Patient Safety Organization, the California Hospital Patient Safety Organization (CHPSO). Information created, or analysis generated within this patient safety evaluation system is deemed protected patient safety work product as long as 1) Arrowhead Regional Medical Center intends to submit the information and/or analyses to its Patient Safety Organization or 2) Arrowhead Regional Medical Center authorizes its Patient Safety Organization to access such information to process and analyze similar information transmitted to its Patient Safety Organization by Arrowhead Regional Medical Center. Information removed from the patient safety evaluation system is not considered protected under the applicable privileges. This patient safety evaluation system shall be used to reduce mortality and morbidity and to improve patient care and patient safety by the identification, analysis and reduction of risks within a legally protected environment.

PROCEDURES

I. **Patient Safety Evaluation System**

   A. Arrowhead Regional Medical Center patient safety evaluation system consists of individual and committee activities, data collection processes, reports, databases, analyses, discussion, systemic review, and regular, ad hoc and specially called meeting, whether recorded in writing or otherwise that constitute patient safety work product, including but not limited to those listed below.

      1. Patient Safety Committee
      2. Quality Management Committee
      3. Medical Executive Committee

   B. The Patient Safety Officer (PSO) shall be responsible for the day to day administration of the technical aspects of the PSO activities.
      1. Confirming the information submitted to the PSES and providing quality oversight to the process for collecting, managing, analyzing, and submitting information to CHPSO;

2. Communicating the intent and purpose of the PSES with Arrowhead Regional Medical Center employees, medical staff members, agents, students, and house staff;
3. Providing guidance on the removal of material from the PSES;
4. Receiving materials created by CHPSO and distributing as appropriate with the PSES;
5. Using CHPSO as a resource and maintaining communication with CHPSO;
6. Coordinating related training upon implementation of the PSO and on an ongoing basis; and
7. Notifying CHPSO if any Arrowhead Regional Medical Center contact changes.

II. **Removal of Patient Safety Work Product**

A. Patient Safety Work Product may be removed from the PSES by Patient Safety Officer and no longer considered Patient Safety Work Product if:

1. The information has not yet been reported to CHPSO; and
2. The Patient Safety Officer documents the act and date of removal of such information from CHPSO.

III. **Disclosure of Patient Safety Work Product**

A. Patient Safety Work Product is privileged and confidential and shall not be disclosed except as provided by the Patient Safety Act.

REFERENCES: N/A

DEFINITIONS:

The following terms have the meanings assigned under the federal regulations promulgated to implement the Patient Safety and Quality Improvement Act of 2005.

Patient Safety Organization (PSO) means a private or public entity or component thereof that is listed as a PSO by the Secretary of the United States Department of Health and Human Services

Patient Safety Evaluation System (PSES) means the collection, management, or analysis of information for reporting to or by a PSO.

Patient Safety Work Product (PSWP) means any data, reports, records, memoranda, analyses, such as root cause analyses and care reviews documentation or written or oral statements, or copies of any of this material, which could improve patient safety, health care quality, or health care outcomes; and
1. Which are assembled or developed by any Arrowhead Regional Medical Center employee, medical staff member, agent, student or house staff for reporting to CHPSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO and has not yet been sent to the PSO, and such documentation includes the date the information entered the PSES; or
2. Which are developed by a PSO for the conduct of patient safety activities; or
3. Which identify or constitute the deliberations or analysis or, or identify the fact of reporting pursuant to, a patient safety evaluation system.

Patient Safety Activities mean the following activities carried out by or on behalf of the PSO or any Arrowhead Regional Medical Center employee, medical staff member, agent, student or house staff:

1. Efforts to improve patient safety and the quality of health care deliver;
2. The collection and analysis of PSWP;
3. The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;
4. The utilization of PSWP for the purposes of encouraging a culture of safety and of providing feedback and assistance to minimize patient risk effectively;
5. The maintenance of procedures to preserve confidentiality with respect to PSWP;
6. The provision of appropriate security measures with respect to PSWP;
7. The utilization of qualified staff; and
8. Activities related to the operation of the PSES and to the provision of feedback to participants in the PSES.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**11/17/16**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**02/07/19**</u>

SECTION:	SUPPORT SERVICES	SUB SECTION:	GENERAL

SUBJECT: **DECENTRALIZATION OF INTRAVENOUS PUMPS**

APPROVED BY: _____
Chief Executive Officer

POLICY

I.   It is the responsibility of each patient care unit to ensure there are an adequate number of clean Baxter Intravenous (IV) pumps and poles available for patient care.

   A.   Units are responsible to maintain their stock levels.
   B.   Units collaborate with Environmental Services (EVS) to ensure the pumps are adequately cleaned between patient use.

II.   IV Pump Storage: Nursing Tower, 4th Floor

   A.   The IV Pump Storage room is located on the 4th floor in the main guest elevator lobby, Room 4A204A.
   B.   Only clean and disinfected, covered IV pumps are stored in the room.
   C.   IV pumps needing repair are cleaned and disinfected, covered, tagged with a repair tag, and placed in the designated area (see below for more details). Pumps are neatly aligned and plugged in.

III.   IV Pump Roundup Day:

   A.   Once a week during the Charge Nurse meeting:
      1.   IV pumps over the unit's par level and not currently in use are taken to IV Pump Storage.
      2.   IV pumps are picked up from IV Pump Storage when the unit is below their par level. The Charge Nurse may delegate the moving of the IV pumps to a Nurse Attendant, Student Nurse, or Hospital Unit Assistant.

PROCEDURES

I.   Clean, disinfected, covered IV pumps are kept in the patient's rooms.

II.   When a new admission arrives, the IV pumps already on the patient will stay with the patient. The transporter will take an equal number of clean IV pumps (as they are leaving) back to their unit.

III.   Units needing additional IV pumps can:

   A.   Borrow a clean, covered IV pump from another patient room
   B.   Take a clean IV pump from IV Pump Storage
   C.   Call a sister unit and ask to borrow an IV pump

IV.   Used IV pumps stay in the patient's room until discharge.

V.   At discharge, used IV pumps in the room are cleaned and disinfected by EVS. Nurses are responsible to:

      A.   Remove tubing and medication/IV fluid bags from pumps
      B.   Leave the pump's door open

VI.   Cleaning of IV Pumps:

      A.   Cleaned IV pumps are covered with a clear plastic bag. <u>Uncovered IV pumps are presumed to be contaminated</u>
      B.   When EVS cleans the room after the patient's discharge, EVS cleans and covers IV pumps in the room.
      C.   Nurses moving a used/contaminated IV pump from one patient's room to another patient's room notify EVS to clean and disinfect the IV pump before it goes into the second patient's room. If the pump is needed immediately and EVS cannot immediately clean the pump, the nurse cleans and disinfects the IV pump. Instructions for cleaning, see Infection Control policy 308, Cleaning and Disinfecting of Patient Care Items and Equipment:
            1.   Reusable equipment, like IV pumps, are cleaned and disinfected with disposable pre-moistened antimicrobial impregnated cloths, like Super Sani-Cloths, between patients.
            2.   Use Clorox bleach wipes as indicated.
            3.   Use one or more wipes, as needed, to remove any soil (blood, sweat, etc.) on the surface. To disinfect, obtain a new clean cloth(s) and wipe the surface it remains continuously visibly wet for a full contact time as stated by the manufacturer on the container. For example, the Super Sani-Cloths with the purple lid have a 2 minute contact time. Let air dry. If using a bleach wipe, disinfect using a 3 minute contact time and allow to air dry.

VII.   IV Pumps in Need of Repair:
      A.   Biomedical Engineering comes to the IV Pump Storage room daily (except weekends and holidays) to pick up IV pumps in need of repair or maintenance. See Safety Manual policy 6007, Equipment Malfunction Reporting for the tagging procedure. See also Administrative Operations Manual, policy 110.19 Unusual Occurrences – Report of.
      B.   If an IV pump malfunction results in serious injury or death of a patient, staff follow Safety Manual policy 6002, Safe Medical Device Program.

VIII.   In order to maintain healthy battery life all IV pumps must be plugged into an electrical /outlet at all times in all areas, patient rooms, and storage rooms.

REFERENCES: **Regulatory Standards**
                       Administrative Operations Manual, policy 110.19 Unusual Occurrences – Report of
                       Safety Manual policy 6007, Equipment Malfunction Reporting
                       Safety Manual policy 6002, Safe Medical Device Program
                       Infection Control policy 308, Cleaning and Disinfecting of Patient Care Items and Equipment

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

	3/12/15	**Policy, Procedure and Standards Committee**
	3/18/15	**Nursing Executive Committee**
		Applicable Administrator, Hospital or Medical Committee
	5/11/15	**Michelle Sayre, Chief Nursing Officer**
		Applicable Administrator, Hospital or Medical Committee
	7/28/15	**Board of Supervisors**
		Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/28/15**   **REVISED**:   **N/A**

REVIEWED: **N/A**

SECTION:	**SUPPORT SERVICES**	**SUB SECTION:**	**SUPPLIES AND EQUIPMENT**

SUBJECT: **(RPT) RELOCATABLE POWER TAP POLICY**

APPROVED BY: _____

                                 Chief Executive Officer

DEFINITIONS

I. Relocatable power taps (RPT): a block of electrical sockets that attaches to a flexible cord and has an internal circuit breaker. These are also known as power strips or surge protectors.

II. Multi-plug adapters: a device that plugs into a wall outlet and allows that wall outlet to supply power to more items than originally designed. Multi-plug adapters do not provide surge protection

POLICY

I. RPTs in clinical areas are considered part of the clinical equipment and will be installed and maintained by Biomedical Engineering.
   A. RPTs in clinical areas must be UL Listed (1363A or 60601-1) and compliant with the National Electric Codes.
   B. To obtain an RPT for use in a clinical area, contact Biomedical Engineering x00079.

II. RPTs in administrative areas and support service areas including nursing stations are permitted for use on computers and other electronic equipment provided they are UL listed/certified and plugged directly into appropriate wall outlets.
   A. Appliances that use significant wattage or amperage such as portable heaters, microwaves, refrigerators, toasters, hot-plates, and toaster ovens or other appliances with compressors or heating elements, are to be plugged directly into wall outlets.
   B. Appropriate RPTs must be obtained from the Facilities Maintenance Department x00085.

PROCEDURES   **N/A**

REFERENCES: **California Code of Regulations – Title 22**
                         National Fire Protection Association – 99
                         California Electrical Code

ATTACHMENTS: **N/A**

APPROVAL DATE:	N/A	**Policy, Procedure and Standards Committee**
	6/18/19	**William L. Gilbert, Hospital Director**
		Applicable Administrator, Hospital or Medical Committee
	8/6/19	**Board of Supervisors**
		Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **12/21/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	**MEDICAL STAFF**	**SUB SECTION:**	**GENERAL**

SUBJECT: STAFF VERIFICATION OF MEDICAL STAFF AND ALLIED HEALTH PROFESSIONAL MEMBERSHIP AND/OR CLINICAL PRIVILEGES AND RESIDENT COMPETENCY

APPROVED BY: _____

Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) is responsible to provide staff with a mechanism and education to verify Medical Staff and Allied Health Professional Staff Membership and/or Clinical Privileges and Resident Competencies.

PROCEDURES

Verification of Medical Staff and Allied Health Professional Staff Membership and/or Clinical Privileges can be obtained by staff accessing the *ePriv* software program located on ARMC tools, and/or calling the Medical Staff Office. A roster and hard copy of practitioner privileges is located in the Nursing Supervisor's Office.

Verification of resident competencies can be obtained by staff accessing the New Innovation software program located on ARMC Intranet, or calling the Graduate Medical Education Department.

Department Managers are responsible to provide orientation to their staff at the time of initial hire and periodically thereafter regarding the use of these programs.

REFERENCES:	**N/A**	
DEFINITIONS:	**N/A**	
ATTACHMENTS:	**Attachment A: Nurse Alert**	
APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	6/18/19	**William L. Gilbert, Hospital Director**
		Applicable Administrator, Hospital or Medical Committee
	8/6/19	**Board of Supervisors**
		Approved by the Governing Body

REPLACES:	**N/A**		
EFFECTIVE:	**8/9/16**	**REVISED**:	**N/A**
REVIEWED:	**02/07/19**		

SUBJECT: STAFF VERIFICATION OF MEDICAL STAFF AND ALLIED HEALTH   ARMC Policy No. 500.04
PROFESSIONAL MEMBERSHIP AND/OR CLINICAL PRIVILEGES   Page 2 of 2
AND RESIDENT COMPETENCY   Attachment A

NURSE 🧰 ALERT

Before the physician or Allied Health Professional performs that procedure or test, do you know if they have been approved?

Verifying Physician and Allied Health Professional (AHP) Clinical Privileges

There are two separate tracking systems:

① **To Verify Attending Physician and AHP Privileges:**
- Go To ARMC Tools
- Click on the " **ePriv**" Folder
- You may search by "Specialty" or "Last Name"
- Click "Privileges"
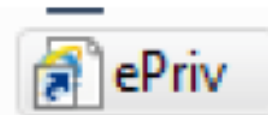
② **To Verify Resident Physician Privileges:**
- Go to ARMC Intranet
- At the very top of the screen, there is a URL subject line. Delete what is there and type the following link into that line and press enter
  - https://www.new-innov.com/Login/Login.aspx
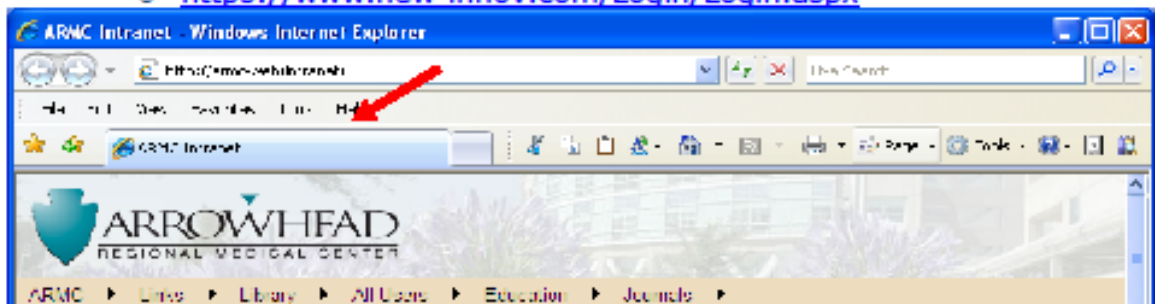
- Enter the Institute Login: **ARMC**
  Username: **narmc**
  Password: **narmc**
- On the toolbar, choose Main menu and click on "Procedure Logger"
- Choose Credentials by Physician > Type in resident name
- On the next screen, the resident's name is a hyperlink, click on their name
- On the next screen, the list of procedures the resident can perform is listed on the lower right side of the page, below the resident's picture

Nov 2015

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	MEDICAL STAFF	SUB SECTION:	GENERAL

SUBJECT: **MEDICAL STUDENT SUPERVISION**

APPROVED BY: _____
Chief Executive Officer

POLICY

I. Policy Definitions

   A. Supervision: Refers to the oversight and monitoring provided by a clinical preceptor of a medical student.

   B. Record Entries: Refers to entries of any patient information in an electronic, paper or other system to maintain patient health information.

   C. Clinical Preceptor: Refers to Members of the Medical Staff, Residents, Fellows and Advanced Practice Professionals pursuant to the Medical Staff Bylaws of Arrowhead Regional Medical Center who provide oversight and supervision of a clinical experience which allows students to apply knowledge gained in the didactic portion of a program to clinical practice.

II. General Principles

   A. The Hospital requires appropriate medical record documentation to support billing for Hospital services. Medical Documentation must adhere to CMS guidelines.

III. Faculty Responsibility

   This policy applies to all faculty including volunteer and affiliated faculty at all training sites.

   A. The ultimate responsibility for patient care is vested with the appropriately credentialed and privileged medical staff member and may not be delegated to a medical student. The assigned clinical preceptor must be available, on-site, while students are engaged in patient care activities.

   B. Medical students are non-licensed learners, must never be considered to be billing providers, and are not able to provide independent care.

   C.   It is the responsibility of the attending physician to ensure that all residents and fellows are appropriately prepared for their roles in teaching and supervision of medical students within their scope of practice.

IV. Medical Student Team Role

A. While engaged in clinical rotations or clinical activities associated with prescribed course work, medical students should be incorporated into and be accepted as an integral part of the team, permitted to participate in team care of the patient, and expected to demonstrate individual ownership of patient care responsibilities in a supervised manner that ensures patient safety.

V. Medical Student Identification

A. Identification of medical student status: Medical students must be clearly identified as such in all interactions with patients, families, and healthcare personnel. When being introduced, the phrase "medical student" is required.

PROCEDURES

I. CMS Rules Concerning the Use of Medical Student Notes

A. CMS is explicit about which medical student documentation elements can be used to support documentation of Medicare and MediCal services provided. While Medicare does not pay for any services furnished by a medical or other student, it allows the limited use of specific portions of the medical student's documentation to support a billable service. Medicare has promulgated the following rules related to medical students:

1. Neither the attending nor resident may rely on any aspect of a physical examination performed by a medical student The attending or resident must personally perform and document the physical examination, history of present illness, progress notes, medical decision making and all other required medical record elements..

2. Any medical student contribution in the performance of a billable service must be performed in the physical presence of an attending physician or a resident for a service that meets teaching physician billing requirements.

3. Medical students may document the following: medication history, review of systems, past, family history and social history. An attending or resident may incorporate the medical student's documentation of these elements into the legal record provided key items of the documentation are reviewed and verified by the attending/resident.

II. Medical Student Participation in a Billable Service

A. Any student contribution to and/or participation in the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements (other than the review of systems [ROS] and/or past/family and/or social history [PFSH]).

III. CMS Documentation and Re-Documentation

A. Students may document services in the medical record; however, the attending/teaching physician or resident may only refer to the student's documentation of an E/M service that is related to the ROS and/or PFSH.

B. Every individual who enters documentation into a medical record must do so logged in under his/her own name/password. Falsification of a medical record by allowing another person to use your name/password to enter in a medical record is prohibited by the Hospital.

C. Inappropriate use of medical student documentation by a teaching physician or resident may be considered fraudulent and may lead to allegations of violating multiple Federal and State laws.

IV. Supervisory Requirements Regarding Procedures

A. Requires Direct Supervision: Medical students may be assigned and directed to participate in additional patient care services (including complex procedures) under the direct supervision of an attending physician, fellow, resident or allied health practitioner

B. Supervisors Must be Authorized: The assigned clinical preceptor must have privileges or be authorized to perform the procedure being supervised.

C. Required Considerations: The degree of supervision must take into account the complexity of the procedure, potential for untoward effects, and the demonstrated competence, maturity and responsibility of each student in order to ensure the safety and comfort of the patient.

D. Falsification of a medical record: May result in termination of a medical student or resident and immediate disciplinary action of a medical staff member.

1. The Hospital will educate all system users, including medical students, about what to do in the event that they are asked to use another individual's login information.
2. Using functions that allow copying/pasting, copying/ forwarding, or changing of authorship from a medical student note to a resident or teaching physician note is prohibited.

REFERENCES: **The Joint Commission**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                       6/18/19   **William L. Gilbert, Hospital Director**
                                       Applicable Administrator, Hospital or Medical Committee

                       8/6/19   **Board of Supervisors**
                                       Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **2/22/18**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	**PATIENT CARE**	**SUB SECTION:**	**LEADERSHIP**

SUBJECT: **THERAPEUTIC LIMIT SETTING**

APPROVED BY: _____
Chief Executive Officer

POLICY

On occasion, patients at Arrowhead Regional Medical Center (ARMC) may experience acute decompensation of behavior which may then place themselves or others at risk for abusive and/or non-compliant behavior. Therapeutic limit setting interventions provide a prompt response to these situations in order to contain the situation and protect the patient and others in the vicinity. This policy does not pertain to any inpatients on ARMC Behavioral Health Units.

Therapeutic limit setting interventions are used for difficult, abusive, aggressive or non-compliant patients. The manner in which staff set limits influences patients' perceptions of the interactions and their emotional and behavioral responses.

For tips on verbal de-escalation techniques to effectively de-escalate a hostile/aggressive patient, please contact Social Services and/or refer to the Attachment A.

PROCEDURES

I.   Goals of Therapeutic Limit Setting

      A.   Ensure the safety of the patient, staff, and others in the area
      B.   Help the patient manage his emotions and distress and maintain or regain control of his behavior
      C.   Avoid the use of restraint when possible
      D.   Avoid coercive interventions that escalate agitation

II.   Engaging patients in an empathic manner is necessary when setting limits. When staff engage in an empathic manner, the therapeutic relationship is more likely to be preserved and the risk of aggressive responses is reduced.

      A limit-setting style characterized by empathic responding and an authoritative, rather than authoritarian interpersonal, style is recommended. An authoritative (fair, respectful, consistent, and knowledgeable), rather than authoritarian (controlling and indifferent), limit-setting style enhances positive outcomes with regards to adherence, reduced likelihood of aggression, and preservation of the therapeutic relationship.

III.   Patients That Are Difficult, Aggressive or Non-compliant

      A.   Non-compliance with the treatment plan including:

            1.   Dietary restrictions
            2.   Fluid restrictions
            3.   Prescribed medications refusal, demands on medication's administration

4.   Dictates the terms of the treatments and care including what diet to prescribe, ordering of specific pain medications and how it will be given

5.   Dictates the terms of the treatments and care during dialysis

B.   Therapeutic limit setting interventions

1.   Upon identification of difficult, aggressive or non-compliant patient behavior, the Registered Nurse (RN) talks to patient to identify issues/reasons for patient's behavior.

2.   The RN acknowledges the patient's feelings, without necessarily agreeing with what the patient states. Simultaneously the RN sets firm boundaries and insists that all staff be treated with respect just as all staff treat all patients with respect.

3.   The RN provides education to the patient regarding disease process and reasons for compliance with the plan of care including restrictions, medication regimen and/or dialysis as applicable. See Administrative Policy No. 680.01, Plan – Patient/Family Education.

4.   The RN notifies Charge Nurse, Nurse Manager, and the nursing team of patient's behavior. Place ROSE and/or TIGER LILY sign at patient's door. See Administrative Policy No. 200.17 Violence or Threats in the Workplace for more information on the ROSE program.

5.   After discussion, the unit's Nurse Manager (NM), Charge Nurse (CN) and RN may decide to speak with the patient about behavior expectations.

a.   When possible, allow the patient to explain why they are acting as they are, giving them chance to express their fears and frustrations. Ask the patient to help us understand exactly what is wrong.

b.   Use active listening so the patient feels they are being heard.

c.   NM to make it clear to patient that his behavior will not be tolerated. Repeat that all staff deserve to be treated with respect.

d.   Analyze and assess the reasons for the patient's anger and help the patient overcome their anxieties. Address unanswered questions and concerns as needed.

e.   Maintain a calm, neutral, non-reactive, and non-defensive stance and approach with an escalated patient.

6.   The NM, CN, and RN notify the Primary team within 12-24 hours of the incident of the patient's behavior and discuss the need for a consult; i.e., Psychiatric consult, Social Worker consult, dietary consult and/or consult with another member of the multidisciplinary team; based on patient's verbalized issue(s) or concern(s).

7.   The Primary Team talks to patient to within 24 hours of notification of the incident by the Nursing Team to:

a.   Analyze and assess the reasons for the patient's anger

b.   Discuss the patient's treatment plan

c.   Discuss expectations and consequences of non-compliant behavior

d.   Discuss referrals as ordered by practitioner

e.   Set firm boundaries

8.   The NM or CN notify the Patient Advocate who will see patient within 24-48 hours.

9.   Establish communication of the plan of care to the multidisciplinary team at shift Huddle and patient care handoff to report.

10.   Document in the patient's plan of care patient behavior, interventions and outcome every shift.

C.   When the patient's behavior continues to be difficult, abusive, aggressive and/or non-compliant for more than 48 hours and is:

1.   Creating a negative impact in the unit
2.   Creating hostile working environment
3.   Causing anxiety and stress to the staff due to his behavior
4.   Causing noise, by yelling and creating a hostile environment that affects other patients
5.   Disruption of other patients care and resources misuse
6.   Continuing physical aggression

The following interventions are implemented:

1.   NM or CN notify the Primary Team of continuous maladaptive behavior(s) and schedules a Multidisciplinary team conference within 48 hours.
2.   The Multidisciplinary team is composed of an Administrator, patient's primary practitioner, NM, CN, Dietitian, RN, Clinical Social Worker, Case Manager, Patient Advocate, Pre-Med-Cal Qualification Specialist, and Chief Financial Officer or representative.
3.   The Multidisciplinary team:

a.   Discuss patient's behavior and issues
b.   Review previous admissions (pattern, multiple admissions, etc.) and discharge plans or placement (issues from previous placements due to abusive, aggressive non-compliant behaviors)
c.   Develop a realistic individualize Therapeutic Limit Setting Care Plan for the patient and for the multidisciplinary team to follow.
d.   Confer with Administration, legal team, ethics team, Security, Colton Police Department's watch commander to discuss the individualized Therapeutic Limit Setting Care Plan created for the patient.
e.   Sets up a conference the patient and presents the Therapeutic Limit Setting Care Plan developed by the team. Inform the patient of the expectations and the consequences, including refusal and discontinuation of treatment, if the patient continues to be violent or non-compliant.
f.   Discusses the need for Security personnel to be in the unit or for a 1:1 patient sitter to ensure patient and staff safety and to help implement the set boundaries and behavioral expectations.
g.   Discusses the Therapeutic Limit Setting Care Plan created for the patient to everyone on the multidisciplinary team.
h.   Follows through consistently with detailed documentation on the patient's behavioral compliance with daily interactions.
i.   In the event that the patient continuous to breach the Therapeutic Limit Setting Care Plan, seek involvement of Administration, legal team, ethics team, Security, Colton Police Department's watch commander if it is determined that treatment will be discontinued and the patient will be advise that treatment will no longer be provided.

IV.   Patients That Are Verbally/Physically Abusive

A.   Examples include:

1.   Threatening and disruptive behavior

2.   Verbally abusive, daily outburst accompanied by screaming, cussing and threats.
3.   Acts of physical aggression
4.   Threats to hurt staff
5.   Threats to have staff fired
6.   Staff being verbally abused on a daily basis
7.   Drug seeking behaviors

B.   Therapeutic limit setting interventions

1.   Upon identification of difficult, verbally or physically abusive behavior, the RN talks to patient to identify issues/reasons for patient's behavior.
2.   The RN acknowledges the patient's feelings, without necessarily agreeing with what the patient states. Simultaneously the RN sets firm boundaries and insists that all staff be treated with respect just as all staff treat all patients with respect.
3.   The RN notifies Charge Nurse, Nurse Manager, and the nursing team of patient's behavior. Place ROSE and/or TIGER LILY sign at patient's door. See AOM, Policy 200.17 Violence or Threats in the Workplace for more information on the ROSE program.
4.   After discussion, the unit's Nurse Manager (NM), Charge Nurse (CN) and RN may decide to speak with the patient about behavior expectations.

a.   When possible, allow the patient to explain why they are acting as they are, giving them chance to express their fears and frustrations. Ask the patient to help us understand exactly what is wrong.
b.   Use active listening so the patient feels they are being heard.
c.   NM to make it clear to patient that his behavior will not be tolerated. Repeat that all staff deserve to be treated with respect.
d.   Analyze and assess the reasons for the patient's anger and help the patient overcome their anxieties. Address unanswered questions and concerns as needed.
e.   Maintain a calm, neutral, non-reactive, and non-defensive stance and approach with an escalated patient.

5.   The NM, CN, and RN notify the Primary team within 12-24 hours of the incident of the patient's behavior and discuss the need for a consult; i.e., Psychiatric consult, Social Worker consult, dietary consult and/or consult with another member of the multidisciplinary team; based on patient's verbalized issue(s) or concern(s).
6.   The Primary Team talks to patient to within 24 hours of notification of the incident by the Nursing Team to:

a.   Analyze and assess the reasons for the patient's anger
b.   Discuss the patient's treatment plan
c.   Discuss expectations and consequences of abusive behavior
d.   Discuss referrals as ordered by practitioner
e.   Set firm boundaries

7.   The NM or CN:

a.   Notify the Patient Advocate who will see patient within 24-48 hours.
b.   Ask Colton Police Officer to speak to the patient within 24-48 hours.

8.   The NM, CN, Clinical Social Worker, Case Manager and patient's primary practitioner discuss the discharge plan, i.e., where patient is going to be

discharged, if the patient is a placement issue, expected date of discharge, if durable medical equipment will be needed, etc.

9. Establish communication of the plan of care to the multidisciplinary team at shift Huddle and patient care handoff to report.

10. Document in the patient's plan of care patient behavior, interventions and outcome every shift.

C. When the patient's behavior continues to be verbally or physically abusive for more than 24 hours and is:

1. Creating a negative impact in the unit
2. Creating hostile working environment
3. Causing anxiety and stress to the staff
4. Causing noise that affects other patients and/or creating a hostile environment
5. Disrupting other patients care
6. Misuse of resources

The following interventions are implemented:

1. NM or CN notify the Primary Team of continuous maladaptive behavior(s) and schedules a Multidisciplinary team conference within 48 hours.

2. The Multidisciplinary team is composed of an Administrator, patient's primary practitioner, NM, CN, Dietitian, RN, Clinical Social Worker, Case Manager, Patient Advocate, Pre-Med-Cal Qualification Specialist, and Chief Financial Officer or representative.

3. The Multidisciplinary team:

   a. Discuss patient's behavior and issues
   b. Review previous admissions (pattern, multiple admissions, etc.) and discharge plans or placement (issues from previous placements due to abusive, aggressive non-compliant behaviors)
   c. Develop a realistic individualize Therapeutic Limit Setting Care Plan for the patient and for the multidisciplinary team to follow.
   d. Confer with Administration, legal team, ethics team, Security, Colton Police Department's watch commander to discuss the individualized Therapeutic Limit Setting Care Plan created for the patient.
   e. Sets up a conference the patient and presents the Therapeutic Limit Setting Care Plan developed by the team. Inform the patient of the expectations and the consequences, including refusal and discontinuation of treatment, if the patient continues to be violent or non-compliant.
   f. Huddle daily to:

      1) Review the nurse's notes
      2) Discuss patient's response/progress
      3) Evaluate outcomes, compliance and any new issues
      4) Revises interventions as needed.

   g. Discusses the need for Security personnel to be in the unit or for a 1:1 patient sitter to ensure patient and staff safety and to help implement the set boundaries and behavioral expectations.
   h. Discusses the Therapeutic Limit Setting Care Plan created for the patient to everyone on the multidisciplinary team.

       i.   Follows through consistently with detailed documentation on the patient's behavioral compliance with daily interactions.

       j.   In the event that the patient continuous to breach the Therapeutic Limit Setting Care Plan, seek involvement of Administration, legal team, ethics team, Security, Colton Police Department's watch commander if it is determined that treatment will be discontinued and the patient will be advise that treatment will no longer be provided.

REFERENCES: Regulatory Agency Standards
Administrative Policy No. 200.17, Violence or Threats in the Workplace
Administrative Policy No. 680.01, Plan – Patient/Family Education

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A:** Tips on Verbal De-escalation Techniques to Effectively De-escalate a Hostile/Aggressive Patients

APPROVAL DATE:

      8/8/16   **Policy, Procedure and Standards Committee**
                   Applicable Administrator, Hospital or Medical Committee

      12/1/16   **Quality Management Committee**
                   Applicable Administrator, Hospital or Medical Committee

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Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup

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Abstract

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Agitation is an acute behavioral emergency requiring immediate intervention. Traditional methods of treating agitated patients, ie, routine restraints and involuntary medication, have been replaced with a much greater emphasis on a noncoercive approach. Experienced practitioners have found that if such interventions are undertaken with genuine commitment, successful outcomes can occur far more often than previously thought possible. In the new paradigm, a 3-step approach is used. First, the patient is verbally engaged; then a collaborative relationship is established; and, finally, the patient is verbally de-escalated out of the agitated state. Verbal de-escalation is usually the key to engaging the patient and helping him become an active partner in his evaluation and treatment; although, we also recognize that in some cases nonverbal approaches, such as voluntary medication and environment planning, are also important. When working with an agitated patient, there are 4 main objectives: (1) ensure the safety of the patient, staff, and others in the area; (2) help the patient manage his emotions and distress and maintain or regain control of his behavior; (3) avoid the use of restraint when at all possible; and (4) avoid coercive interventions that escalate agitation. The authors detail the proper foundations for appropriate training for de-escalation and provide intervention guidelines, using the "10 domains of de-escalation."

INTRODUCTION

Go to:

Traditional methods of treating agitated patients, ie, routine restraints and involuntary medication, have been replaced with a much greater emphasis on a noncoercive approach. Experienced practitioners have found that if such interventions are undertaken with genuine commitment, successful outcomes can occur far more often than previously thought possible. In the new paradigm, a 3-step approach is used. First, the patient is verbally engaged; then a collaborative relationship is established; and, finally, the patient is verbally de-escalated out of the agitated state. In some ways, this is a return to Lazare's methods published in an article written more than 35 years ago.[1]

The traditional goal of "calming the patient" often has a dominant-submissive connotation, while the contemporary goal of "helping the patient calm himself" is more collaborative. The act of verbally de-escalating a patient is therefore a form of treatment in which the patient is enabled to rapidly develop his own internal locus of control.

When working with an agitated patient, there are 4 main objectives: (1) ensure the safety of the patient, staff, and others in the area; (2) help the patient manage his emotions and distress and maintain or regain control of his behavior; (3) avoid the use of restraint when at all possible; and (4) avoid coercive interventions that escalate agitation.

These objectives may be challenging to pursue in some situations and settings. For example, in an emergency department, both the clinician and patient can slip into irrational thinking or expediency at the price of engaging each other. A clinician who has many patients to see and too little time may prematurely use medication to avoid verbal engagement. However, using medication too quickly may seem dismissive, rejecting, or humiliating to the patient[2] and can lead to more agitation and violence.

Agitation is a behavioral syndrome that may be connected to different underlying emotions. Associated motor activity is usually repetitive and non–goal directed and may include such behaviors as foot tapping, hand wringing, hair pulling, and fiddling with clothes or other objects. Repetitive thoughts are exhibited by vocalizations such as, "I've got to get out of here. I've got to get out of here."[3] Irritability and heightened responsiveness to stimuli may be present,[4] but the association of agitation and aggression has not been clearly established.[5]

Agitation exists on a continuum, eg, from anxiety to high anxiety, to agitation, to aggression.[6] The agitated patient may be unable to engage in any conversation, and may be on the edge of new or repeated violence, requiring vastly different management than a person who may be willing and able to engage. The Project BETA (Best practices in Evaluation and Treatment of Agitation) guidelines[7] discussed in this section will help shape a practical, noncoercive approach to de-escalating agitated patients regardless of etiology or capacity to engage in a therapeutic relationship.

CLINICIAN'S APPROACH TO AGITATION

Emergency psychiatry is a well-established mental health discipline. However, the number of emergency psychiatrists and the volume of psychiatric crises they see are limited when compared to the number of emergency department physicians evaluating psychiatric emergencies. Interventions must often proceed with the agitated patient with, at best, a tentative diagnosis.

A paradigm that can be useful for both psychiatrists and emergency physicians is one in which the clinician uses rapid assessment and decision-making skills in an effort to quickly provide symptom relief. This relief, through verbal de-escalation and/or medication, enhances a positive clinician-patient relationship, decreases the likelihood of restraints, seclusion, and hospital admissions,[8] and prevents longer hospitalization, since the use of restraints has been associated with increased length of stay.[9,10] After initial stabilization of the patient's agitation, the clinician can work with the patient to establish a final diagnosis.

Regardless of underlying etiology, agitation is an acute emergency and "requires immediate intervention to control symptoms and decrease the risk of injury" to the patient or others.[11] While voluntary medication and environment planning are also important, verbal de-escalation and nonverbal communication are usually key to engaging the patient and helping him become an active partner in de-escalation.

Finally, each clinician must remember the 4 main reasons for using noncoercive de-escalation. First, when staff members physically intervene to subdue a patient, it tends to reinforce the patient's idea that violence is necessary to resolve conflict. As such, noncoercive de-escalation is a success for the patient and staff, and is in effect a form of treatment. Second, patients who are put in restraints are more likely to be admitted to a psychiatric hospital[8]

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and have longer inpatient lengths of stay.[9,10] Third, the Joint Commission and the Centers for Medicare and Medicaid Services consider low restraint rates a key quality indicator, and fourth, staff and patients are less likely to get hurt when physical confrontation is averted.

DE-ESCALATION OF AGITATED PATIENTS IN THE EMERGENCY SETTING   Go to:

General principles of verbal de-escalation can be found in specific psychotherapies, linguistic science, law enforcement, martial arts, and the nursing profession. Clinicians who work with agitated patients on a daily basis have perfected skills that frequently are in line with principles found in these resources. However, a review of the literature indicates that scientific studies and medical writings on verbal de-escalation are few and lack descriptions of specific techniques and efficacy.

There is indirect evidence from pharmacologic studies of agitation that verbal techniques can be successful in a substantial percentage of patients. In a recent study, patients were excluded from a clinical trial of droperidol if they were successfully managed with verbal de-escalation; however, the specific verbal de-escalation techniques were not identified or studied.[12]

The following guidelines were therefore developed by the consensus of the authors and a review of the limited available literature on verbal de-escalation.[13-15]

GUIDELINES FOR ENVIRONMENT, PEOPLE, PREPAREDNESS   Go to:

Guideline: Physical Space Should Be Designed for Safety

The physical environment is important for the safe management of the agitated patient. Moveable furniture allows for flexible and equal access to exits for both patient and staff. The ability to quickly remove furniture from the area can expedite the creation of a safe environment. Some emergency departments prefer stationary furniture, so that the patient cannot use the objects as weapons, but this may create a false sense of security. There should be adequate exits, and extremes in sound, wall color, and temperature of the environment should be avoided to minimize abrasive sensory stimulation. Be mindful, also, of the potential for an agitated patient's throwing objects that may cause injuries to others. Any objects, such as pens, sharp objects, table lamps, etc that may be used as weapons should be removed or secured. The clinician should closely monitor any objects that cannot be removed.

Guideline: Staff Should Be Appropriate for the Job

Clinicians who work in acute care settings must be good multitaskers and tolerate rapidly changing patient priorities. In this environment, tolerating and even enjoying dealing with agitated patients takes a certain temperament, and all clinicians are encouraged to assess their temperament for this work.

Agitated patients can be provocative and may challenge the authority, competence, or credentials of the clinician. Some patients, in order to deflect their own sense of vulnerability, are exquisitely sensitive in detecting the clinician's vulnerability and focusing on it. To work well with agitated patients, staff members must be able to recognize and control countertransference issues and their own negative reactions. These include the clinician's understanding of his own vulnerabilities, tendencies to retaliate, argue, or otherwise become defensive and "act-in" with the patient. Such behaviors on the part of the clinician only serve to worsen the situation. Clinicians need to also recognize their limits in dealing with an agitated patient, as it can be quite taxing, and sometimes the best intervention is knowing when to seek additional help.

Security and police officers, who work with agitated patients, must accept that a patient's abnormal behavior is a manifestation of mental illness and that de-escalation is the preferred treatment of choice. The Crisis Intervention Team (CIT) model is a police-based, first-responder program that has been implemented nationwide. Persons taken into custody because of suspected mental illness are taken to a psychiatric emergency service or other facility where the person can receive psychiatric evaluation and treatment. CIT officers usually volunteer for

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these teams so that an officer is not forced into taking on a role that he does not want. Training of officers is provided by mental health professionals, legal experts, and advocates.[16,17]

Natural skill at verbal de-escalation exists on a continuum. However, almost anyone can learn de-escalation techniques and use them successfully if he is well trained and adopts a certain skill set. The most essential skill is a good attitude, starting with positive regard for the patient and the capacity for empathy. Staff should be able to recognize that the patient is doing the best he can under the circumstances, ie, the patient is experiencing difficulty in conforming to what is expected of him. Clinicians in emergency settings also will need to be skilled at recognizing that the inability to conform is due to either cognitive impairment—for example, delirium, psychosis, intoxication, and intellectual disability—or the patient's lack of the skills needed to effectively get his needs met, eg, personality disorder.

Guideline: Staff Must Be Adequately Trained

Training in management of the agitated patient decreases the tendency of clinicians to avoid working with these patients. The American Psychiatric Association Task Force on Psychiatric Emergency Services[18] has recommended that staff receive annual training on managing behavioral emergencies. This training is analogous to advanced cardiovascular life support training, ie, knowledge about skills can be taught in a classroom or can be learned from a book, but skills come only with practice. De-escalation skills can be learned by role playing and can be practiced in day-by-day encounters with nonagitated patients who are considered to be difficult in the sense of not conforming to what the clinician expects.

All persons who work with agitated patients should receive training in de-escalation techniques. A person, who is appropriate for the job, as discussed earlier, should be the one who works directly with the patient. A psychiatrist, emergency physician, or any other healthcare worker can become proficient at de-escalation, and any of these can engage the patient and perform de-escalation.

De-escalation frequently takes the form of a verbal loop in which the clinician listens to the patient, finds a way to respond that agrees with or validates the patient's position, and then states what he wants the patient to do, eg, accept medication, sit down, etc. The loop repeats as the clinician listens again to the patient's response.[19] The clinician may have to repeat his message a dozen or more times before it is heard by the patient. Yet, beginning residents, and other inexperienced clinicians, tend to give up after a brief attempt to engage the patient, reporting that the patient won't listen or won't cooperate.[20]

The amount of time permitted for verbal de-escalation may vary depending on the setting and other constraints. However, it is the consensus of Project BETA De-escalation Workgroup members that verbal de-escalation frequently can be successful in less than 5 minutes. Its potential advantages in safety, outcome, and patient satisfaction indicate it should be attempted in the vast majority of agitation situations, even in very busy emergency settings.

Even the most complicated cases can be managed with a little additional time. Assuming that a single interaction of listening and responding takes less than a minute, then a dozen repetitions of the clinician's message would take 10 minutes at the most. De-escalation, when effective, can avoid the need for restraint. Taking the time to de-escalate the patient and working with him as he settles down can be much less time-consuming than placing him in restraints, which requires additional resources once he is restrained.

There are patients who cannot be effectively engaged and verbally de-escalated, eg, a delirious patient. However, training should emphasize that a patient may not respond to initial efforts to engage him in de-escalation and that persistence is indicated, especially when the patient is not showing signs of further escalation that is moving toward violence.

Guideline: An Adequate Number of Trained Staff Must Be Available

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Working with an agitated patient is a team effort and there must be an adequate number of people to provide for verbal de-escalation, offer the possibility of voluntary medication, and maintain safety if the patient's agitation escalates to violence. There is also a benefit in having enough people to provide a nonverbal communication to the patient that violence on the part of the patient will not be acceptable behavior. In a busy emergency service, the de-escalation team should consist of 4 to 6 team members made up of nurses, clinicians, technicians, and police and security officers, if available.

Guideline: Use Objective Scales to Assess Agitation

The use of objective scales to measure agitation can help mitigate defensive behaviors on the part of staff that might result in their avoiding or "ignoring" early signs of agitation. One such scale that is quite simple and easy to implement is the Behavioural Activity Rating Scale (BARS; Table 1).[21]

Table 1.
Behavioural Activity Rating Scale (BARS).[21]

The initial BARS score should be based not only on the patient's presentation, but also on his behavior before arrival at the emergency facility. Any score other than a 4 should trigger an evaluation by a clinician and establish the urgency of that evaluation. Other available scales include the Overt Aggression Scale,[22] the Scale for the Assessment of Aggressive and Agitated Behaviors,[23] and the Staff Observation Aggression Scale.[24]

GENERAL DE-ESCALATION GUIDELINES   Go to:

Guideline: Clinicians Should Self-Monitor and Feel Safe When Approaching the Patient

A clinician cannot be effective if he has too much emotion or is frightened by the patient. Keeping the clinician safe is the first step toward patient safety. Approximately 90% of all emotional information and more than 50% of the total information in spoken English is communicated not by what one says but by body language, especially tone of voice.[25] When the clinician approaches the agitated patient, he must monitor his own emotional and physiologic response so as to remain calm and, therefore, be capable of performing verbal de-escalation.[26]

Guideline: 10 Domains of De-Escalation Exist That Help Clinicians' Care of Agitated Patients

Review of the literature establishes 10 domains of de-escalation (Table 2).[27]

Table 2.
Ten domains of de-escalation.[27]

Domain I: Respect Personal Space

Key Recommendation: Respect the Patient's and Your Personal Space When approaching the agitated patient, maintain at least 2 arm's lengths of distance between you and the patient. This not only gives the patient the space he needs, but also gives the clinician the space needed to move out of the way if the patient were to kick or otherwise strike out. The clinician may want to give himself more distance in order to feel safe; and, if a patient tells you to get out of the way, do so immediately. Both the patient and the clinician should be able to exit the room without feeling that the other is blocking his way.

A high percentage of patients have a past history of trauma, and the emergency experience has the potential for repeating the traumatic experience when specific aspects of personal space are ignored. A person who lives on the street may be very sensitive about protecting his belongings. Those who have been sexually abused may be apprehensive about being unclothed, which can increase their sense of vulnerability and cause humiliation.

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Domain II: Do Not Be Provocative

Key Recommendation: Avoid Iatrogenic Escalation The clinician must demonstrate by body language that he will not harm the patient, that he wants to listen, and that he wants everyone to be safe. Hands should be visible and not clenched. Avoid concealed hands, which imply a concealed weapon.[20] Knees should be slightly bent. The clinician should avoid directly facing the agitated patient and should stand at an angle to the patient so as not to appear confrontational. A calm demeanor and facial expression are important. Excessive, direct eye contact, especially staring, can be interpreted as an aggressive act. Closed body language, such as arm folding or turning away, can communicate lack of interest. It is most important that the clinician's body language be congruent with what he is saying. If not, the patient will sense that the clinician is insincere or even "faking it" and may become more agitated and angry. It is also important to monitor closely that other patients or individuals do not provoke the patient further.

According to Lazare and Levy,[28] humiliation is an aggressive act where a person has threatened another person's integrity and very self. In some cases, humiliation itself can be traumatic. Therefore, do not challenge the patient, insult him, or do anything else that can be perceived as humiliating.

Domain III: Establish Verbal Contact

Key Recommendation: Only 1 Person Verbally Interacts with the Patient The first person to make contact with the patient should be the person designated to de-escalate the patient. If that person is not trained or is otherwise unable to take on this role, another person should be designated immediately.

Multiple people verbally interacting can confuse the patient and result in further escalation. While the designated person is working with the patient, another team member should alert staff to the encounter, while removing innocent bystanders.

Key Recommendation: Introduce Yourself to the Patient and Provide Orientation and Reassurance A good strategy is to be polite. Tell the patient your title and name. Rapidly diminish the patient's concerns about your role by explaining that you are there to keep him safe and make sure no harm comes to him or anyone else in the emergency setting. If the patient is very agitated, he may need additional reassurance that the clinician wants to help him regain control. Orient the patient as to where he is and what to expect. If the patient's name is unknown, ask for his name. Judgment is required in deciding whether to call the person by his first or last name. Although some prefer calling all patients by their last names, this formality, in some situations, can add to a patient's suspicion and appear patronizing. When in doubt, it is best to ask the patient how he prefers to be addressed; this act communicates that he is important and, from the very beginning of the interaction, that he has some control over the situation.

Domain IV: Be Concise

Key Recommendation: Be Concise and Keep It Simple Since agitated patients may be impaired in their ability to process verbal information, use short sentences and a simple vocabulary. More complex verbalizations can increase confusion and can lead to escalation. Give the patient time to process what has been said to him and to respond before providing additional information.

Key Recommendation: Repetition Is Essential to Successful De-escalation This involves persistently repeating your message to the patient until it is heard. Since the agitated patient is often limited in his ability to process information, repetition is essential whenever you make requests of the patient, set limits, offer choices, or propose alternatives. This repetition is combined with other assertiveness skills that involve listening to the patient and agreeing with his position whenever possible.[19]

Domain V: Identify Wants and Feelings Examples of wants include succorance, the wish to ventilate to an empathic listener, a request for medication, some administrative intervention, such as a letter to an employer, or intervening with a difficult spouse or parent. Whether or not the request can be granted, all patients need to be asked what their request is.[1] A statement like, "I really need to know what you expected when you came here," is essential, as is the caveat "Even if I can't provide it, I would like to know so we can work on it."

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Key Recommendation: Use Free Information to Identify Wants and Feelings "Free information" comes from trivial things the patient says, his body language, or even past encounters one has had with the patient.[19] Free information can help the examiner identify the patient's wants and needs. This rapid connection based on free information allows the clinician to respond empathically and express a desire to help the patient get what he wants, facilitating rapid de-escalation of agitation.

A sad person wants something he has given up hope of having. A patient who is fearful wants to avoid being hurt. In a later discussion of aggression, it will be apparent that the aggressive patient has specific wants also, and identifying these wants is important for the management of the patient.

Domain VI: Listen Closely to What the Patient Is Saying
Key Recommendation: Use Active Listening The clinician must convey through verbal acknowledgment, conversation, and body language that he is really paying attention to the patient and what he is saying and feeling. As the listener, you should be able to repeat back to the patient what he has said to his satisfaction. Such clarifying statements as "Tell me if I have this right…" is a useful technique. Again, this does not mean necessarily that you agree with the patient but, rather, that you understand what he is saying.

Key Recommendation: Use Miller's Law Miller's law states, "To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of."[25] If you follow this law, you will be trying to understand. If you are truly trying to imagine how it could be true, you will be less judgmental, and the patient will sense that you are interested in what he is saying and this will significantly improve your relationship with the patient. For example, if the patient's agitation is driven by the delusion that someone is following him and intends to cause him harm, you can imagine how this is true from the patient's standpoint and engage the patient in conversation as to why this is happening to him and who would want to harm him. This will convey your interest and will result in the patient engaging in conversation about that which is driving his agitation. By engaging in conversation, the patient will begin to see that you care, which in turn, fosters de-escalation.

Domain VII: Agree or Agree to Disagree
Fogging is an empathic behavior in which one finds something about the patient's position with which he can agree.[19] It can be very effective in developing one's relationship with the patient. There are 3 ways to agree with a patient. The first is agreeing with the truth. If the patient is agitated after 3 attempts to draw his blood, one might say, "Yes, she has stuck you 3 times. Do you mind if I try?" The second is agreeing in principle. For the agitated patient who is complaining that he has been disrespected by the police, you don't have to agree that he is correct but you can agree with him in principle by saying, "I believe everyone should be treated respectfully." The third is to agree with the odds. If the patient is agitated because of the wait to see the doctor and states that anyone would be upset, an appropriate response would be, "There probably are other patients who would be upset also." Using these techniques, it is usually easy to find a way of agreeing, and one should agree with the patient as much as possible. Clinicians may find themselves in a position where they are being asked to agree with an obvious delusion or something else the clinician can obviously have no knowledge of. In this situation, acknowledge that you have never experienced what the patient is experiencing but that you believe that he is having that experience. However, if there is no way to honestly agree with the patient, agree to disagree.

Domain VIII: Lay Down the Law and Set Clear Limits
Key Recommendation: Establish Basic Working Conditions. It is critical that the patient be clearly informed about acceptable behaviors. Tell the patient that injury to him or others is unacceptable. If necessary, tell the patient that he may be arrested and prosecuted if he assaults anyone. This should be communicated in a matter-of-fact way and not as a threat.

Key Recommendation: Limit Setting Must Be Reasonable and Done in a Respectful Manner Set limits demonstrating your intent and desire to be of help but not to be abused by the patient. If the patient is causing the clinician to feel uncomfortable, this must be acknowledged. Often telling the patient that his behavior is frightening or

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provocative is helpful if it is matched with an empathic statement that the desire to help can be interrupted or even derailed if the clinician feels angry, fearful, etc.

The bottom line is that good "working conditions" require that both patient and clinician treat each other with respect. Being treated with respect and dignity must go both ways. Violation of a limit must result in a consequence, which (1) is clearly related to the specific behavior; (2) is reasonable; and (3) is presented in a respectful manner.

Some behaviors, eg, punching a wall or even breaking a chair, may not automatically indicate the need for seclusion or restraint, and the patient can continue to be de-escalated with some increase in limit setting and consequences. Reassure the patient that you want to help him regain control and establish acceptable behavior.

Key Recommendation: Coach the Patient in How to Stay in Control Once you have established a relationship with the patient and determined that he has the capability to stay in control, teach him how to stay in control. Use gentle confrontation with instruction: "I really want you to sit down; when you pace, I feel frightened, and I can't pay full attention to what you are saying. I bet you could help me understand if you were to calmly tell me your concerns."

Domain IX: Offer Choices and Optimism
Key Recommendation: Offer Choices For the patient who has nothing left but to fight or take flight, offering a choice can be a powerful tool. Choice is the only source of empowerment for a patient who believes physical violence is a necessary response. In order to stop a spiraling aggression from turning into an assault, be assertive and quickly propose alternatives to violence. While offering choices, also offer things that will be perceived as acts of kindness, such as blankets, magazines, and access to a phone. Food and something to drink may be a choice the patient is willing to accept that will stall aggressive behaviors. Be mindful that these choices must be realistic. Never deceive a patient by promising something that cannot be provided for him. For example, a patient should not be promised a chance to smoke when the hospital has a no-smoking policy.

Key Recommendation: Broach the Subject of Medications The goal of medicating the agitated patient is not to sedate but to calm him. As Allen and colleagues[11] point out, a calm, conscious patient is one who can participate in his own care and work with the crisis clinician toward an appropriate treatment disposition, which is of benefit to the patient and also to the staff. It can decrease length of stay and make the emergency department experience a positive one.

When medications are indicated, offer choices to the patient. Timing is essential. Do not rush to give medication but, at the same time, do not delay medication when needed. Using increasing strategies of persuasion is a sound technique (Table 3). For example, the first step is not to mention medication at all but to ask the patient what he needs, what works. Try to get the request for medication to come from the patient himself, or perhaps the patient has a better idea.

Table 3.
Summary of strategies for broaching the topic of medication/escalating persuasion techniques.

If the patient does not mention medication and the clinician believes it is indicated, then state clearly to the patient that you think he would benefit from medication. Ask the patient what medication has helped him in the past or state, "I see that you're quite uncomfortable. May I offer you some medication?"

Gentle confrontation may also be useful: "It's important for you to be calm in order for us to be able to talk. How can that be accomplished? Would you be willing to take some medication?"

Another step is one just short of involuntary medication. "Mr Smith, you're experiencing a psychiatric emergency. I'm going to order you some emergency medicine." This strategy is authoritative, as in being

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knowledgeable and self-assured, possessing expertise, having the ability to explain one's thinking, and being persuasive. Giving the patient a choice in either oral or parenteral administration can help give the patient some control. He may willingly take medication if the means of administration is a choice, even if the administration of medication itself is not a choice. Appealing to the patient's desire to stay in control and the clinician's mandate to keep everyone safe, one might say to the patient: "I can't let any harm come to you or anyone else" or "I need to protect you from hurting someone, so I would like for you to take some medication to help you stay in control." The clinician then says to the patient as many times as necessary, "Would you like to take medication by mouth or by a shot?" Emphasizing the protection aspect is very important and can be effective in empowering the patient to stay in control. "I feel medications can help, would you like a pill you can swallow, a pill that will melt in your mouth, or a liquid? If you agree to take a pill by mouth you can avoid taking a shot." Even when there is no choice but to give an injection, the clinician can give a choice as to which drug is to be used, emphasizing that one has a more beneficial side-effect profile.

Finally, when verbal attempts to de-escalate fail, more coercive measures such as restraints or injectable medication may be necessary to ensure safety but always as a last resort.

Key Recommendation: Be Optimistic and Provide Hope Be optimistic but in a genuine way. Let patients know that things are going to improve and that they will be safe and regain control. Give realistic time frames for solving a problem and agree to help the patient work on the problem. When the patient states, "I want to get out of here," the clinician can respond, "I want that for you as well; I don't want you to have to stay here any longer than necessary; how can we work together to help you get out of here?"

Domain X: Debrief the Patient and Staff
Key Recommendation: Debrief the Patient After any involuntary intervention with an agitated patient, it is the responsibility of the clinician who ordered these interventions to restore the therapeutic relationship to alleviate the traumatic nature of the coercive intervention and to decrease the risk of additional violence.

Start by explaining why the intervention was necessary. Let the patient explain events from his perspective. Explore alternatives for managing aggression if the patient were to get agitated again. Teach the patient how to request a time out and how to appropriately express his anger. Explain how medications can help prevent acts of violence and get the patient's feedback on whether his concerns have been addressed. Finally, debrief the patient's family who witnessed the incident.

Once the patient is calm, the clinician can acknowledge and work with the patient on a deeper level, help put the patient's concerns into perspective, and assist him in problem solving his initial precipitating situation. Since prevention of agitation is the best way to treat it, planning with the patient is best: "What works when you are very upset as you were today? What can we/you do in the future to help you stay in control?"

Key Recommendation: Debrief the Staff If restraint or force needs to be used, it is important that the staff be debriefed on the actions after the event. Staff should feel free to suggest both what went well during the episode, and what did not, and recommend improvements for the next episode.

THE AGGRESSIVE PATIENT
Go to:

As previously noted the extent of aggression associated with agitation has not been clearly established.[5] However, some agitated patients are aggressive and the approach to the patient depends upon the type of aggression. Moyer[29] has defined several types of aggression, some of which are commonly seen in the emergency setting. Types of aggression also have been identified in the setting of a correctional facility[30] and by martial arts instructors.[31] These identified types can be placed in Moyer's classification and are important because principles of management have been developed for each of the different types of aggression. Some of the management techniques used in correctional facilities and taught in the martial arts are not recommended for use in the healthcare setting. However, the principles allow us to develop techniques appropriate to the healthcare setting

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and are discussed here. It will be apparent that there is always something the patient wants. As discussed earlier, identifying the patient's wants is important and, in this case, determines how the patient is managed.

Instrumental aggression is used by those who have found they can get what they want by violence or threats of violence. This aggression is not driven by emotion and can be handled by using unspecified counter offers to the aggressor's threat. If a patient threatens to hurt someone if he doesn't get a cigarette, a counter offer might be, "I don't think that's a good idea." The patient's next response may be, "What do you mean?" A counter offer would be, "Let's not find out."

Fear driven aggression is not self defense. The patient wants to avoid being hurt and may attack to prevent someone from hurting him. Give the fearful patient plenty of space. Do not have a show of force or in any other way intimidate the patient or make him feel threatened, as this will feed into the patient's belief that he is going to be hurt. De-escalation involves matching the patent's pace until he begins to focus on what is being said rather than his fear. If the patient says, "Don't hurt me. Don't hurt me." Counter with the same pace by saying, "You're safe here. You're safe here."Try to decrease the pace tohelp the patient calm down.

Irritable aggression comes in 2 forms. The first is the patient who has had boundaries violated. Someone has cheated him, humiliated him, or otherwise emotionally wounded him. He is angry and trying to put his world back together, ie, he is trying to regain his self-worth and integrity. This patient wants to be heard and have his feelings validated. This type of aggression is identified by the patient's telling you what has made him angry. De-escalation involves setting conditions for the patient to be heard. Fogging and the broken record approach[19] are most helpful. A typical scenario is the patient who found out that his girlfriend had cheated on him. His friends kidded him and a fight ensued. He was brought in by police. On arrival the patient is furious. He states that his girlfriend had cheated on him and that the police are treating him unfairly. The initial response is to agree in principle that the patient's anger is justified. This is followed by telling the patient that you want to know more but cannot until he regains control so that "we can talk." The patient may respond that nobody understands. The response is that he may be right but you would like to try to understand. This loop may need repeated a dozen or more times before the patient complies.

The second form of irritable aggression occurs in persons who are chronically angry at the world and are looking for an excuse to "go off." They give no reason for their anger. They want to release the constant pressure resulting from their world view. They make unrealistic and erratic demands and use these as an excuse to attack when their demands are not met. They get enjoyment out of creating fear and confusion and may make feigned attacks to intimidate those who are working with them. Do not react in a startled or defensive way. These patients are looking for an emotional response from anyone who is an audience. Don't give them one and remove all other patients, unnecessary staff members, and bystanders from the area. Use emotionless responses. De-escalation involves giving the patient choices other than violence to get what he wants. As he makes erratic demands, use the broken record to return to the options you can offer. Let him know you will work with him but only when he is willing to be cooperative. Set firm limits to protect staff and other patients and intervene with restraint if the limit is violated. Unfortunately, many of these patients will test the limit by doing just what you have asked them not to do and end up in restraints.

SUMMARY

Verbal de-escalation techniques have the potential to decrease agitation and reduce the potential for associated violence, in the emergency setting. But while much has been written on the psychopharmacologic approaches to agitated patients, until now there has been relatively little discussion about verbal methods.

Modern clinical thinking endorses less coercive interventions, in which the patient becomes a collaborative partner with staff members in managing behavior. These approaches may result in many benefits over traditional procedures. Patients spiraling into agitation can be calmed without forced medication or restraint; most importantly, such benign treatment can empower the patient to stay in control while building trust with

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American As...   Page 11 of 12

caregivers. This may help patients to confidently seek help earlier in the future, and avoid subsequent episodes of agitation altogether.

Footnotes

Go to:

Supervising Section Editor: Leslie Zun, MD

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SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: **INVOLUNTARY HOLDS ON NON-PSYCHIATRIC UNITS**

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) may hospitalize mentally disordered patients when a legal hold has been established. They may be hospitalized against their will on any unit in the hospital as his/her medical condition requires. Persons placed on a psychiatric hold have been determined to meet any of the conditions below:

A. Dangerous to self,
B. Dangerous to others, or
C. Gravely disabled (i.e., unable to provide for basic needs for food, clothing, or shelter)

PURPOSE

To provide guidelines for the care and management of in-patients on involuntary holds in non-psychiatric units. This policy does not pertain to patients in Behavioral Health Units or in the Emergency Department (ED).

POLICY AMPLIFICATION

I. Whether or not a patient is on a psychiatric hold is irrelevant to the provision of medical care. Once a patient has been admitted, additional treatment cannot be given without the patient's/guardian's consent, the permission of the probate guardian, permission of the court under section 3200 of the Probate Code, or in a life-threatening emergency.

II. The fact that a patient may be detained involuntarily for a mental disorder, of itself, does not allow the patient to be treated without consent for any medical or surgical condition except in a medical emergency, see Administrative Operations Manual policy 640.01, Consents – Management of. Only the medical emergency can be treated. Further treatment requires the consent of the patient, patient surrogate, or the permission of the patient's probate guardian, or permission of the court.

III. If a patient refuses care that is medically necessary to maintain health and welfare such as mobility, positioning and hygiene activities; an interdisciplinary communication should occur as soon as possible to discuss the development of a treatment plan.

IV. Involuntary hold documents, e.g., 5150, 5250, advisements, are placed in the front of the medical record as a visual cue to alert staff of the hold.

PROCEDURES

I. For 5150

A.   During the course of treatment, if it is determined by a practitioner that any patient is a danger to himself/herself, a danger to others, or meets the 5150 regulatory definition for gravely disabled the Attending Physician is notified.

B.   It is the responsibility of the Admitting Physician team to request consultation from the Department of Psychiatry staff to provide appropriate follow-up.

C.   Any patient suspected of meeting the criteria above receives continuous in-person observation when in a non-psychiatric unit, see Department of Nursing policy 314.00, Patient Safety Assistants Utilization and Responsibilities. In-person observation may be discontinued by the practitioner when it is no longer required for patient safety.

D.   If a Psychiatrist determines that an involuntary hold is necessary he/she verbally communicates to the nursing staff that a patient is on a hold, writes an order, and completes other required forms for the hold and places the hold documents in the front of the medical record.

E.   A Psychiatrist can determine that the legal hold is no longer appropriate and will document in their notes. The hold documents should be placed in the "Legal" documents section of the medical record.

II.   For 5250 Certification

A.   Patients on a 5150 may have their legal hold extended:
1.   Within 72 hours of the 5150 determination
2.   After evaluation and determination is made by a psychiatrist

B.   The following process must be completed in its entirety before the 72 hour hold expires:
1.   If a Psychiatrist determines that extension of an involuntary hold is necessary he/she verbally communicates to the nursing staff that a patient is on a hold, writes an order, and completes other required forms for the hold and places the hold documents in the front of the medical record.
2.   The Psychiatrist asks the patient's nurse or the Charge Nurse to witness the 5250. The witness signs the 5250 document.
a.   The witness is a staff member who participated* in the evaluation of the patient.
*Note: Participated is defined as visually observing the Psychiatrist making a determination to extend the hold, i.e., visually observing the Psychiatrist signing the 5250. The witness does not have to be active in the evaluation/determination.
b.   The witness can be a Registered Nurse attending to the patient, a second Psychiatrist, or a Clinical Social Worker
3.   The Psychiatrist notifies the Nursing Supervisor on duty that a certification is required. The Nursing Supervisor serves the patient by reading the 5250 Certification Advisement Script, see attachment A, to the patient including the offer of the option of a Writ of Habeus Corpus. The Nursing Supervisor signs the 5250 document and gives a copy to the patient.
4.   The original 5250 is placed in the front of the medical record.

C.   The Court appointed Patient Right's Advocate comes to ARMC to inform the patient of their rights in a hearing and answer any other questions or concerns of the patient

D.   A Psychiatrist can determine that the legal hold is no longer appropriate and will document in their notes. The hold documents should be placed in the "Legal" documents section of the medical record.

III.   Once medically cleared, patients transferring to Behavioral Health are escorted by one security officer and one clinical staff person or by two security officers.

IV.   <u>The original 5150 or 5250 document is sent</u> to the accepting Behavioral Health Unit at the time of transfer.

V.   Chart documentation is made available to the Behavioral Health unit and Patient Right's Advocate as soon as possible.

REFERENCES: **Administrative Policy No. 640.01, Consents – Management of**
Department of Nursing, Policy 314.00, Patient Safety Assistants Utilization and Responsibilities
Regulatory Standards

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: 5250 Certification Advisement Script**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**10/22/15**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

5250 Certification Advisement Script

Hi my name is _____ . Your doctor has placed you on a 5250 Certification, which means he/she thinks you need to stay in the hospital longer for treatment.

The doctor believes that you could be a:
    danger to yourself,
    danger to someone else
    or that you are having problem providing food, clothing and problem with where you're staying at this time.

The 5250 Certification can keep you in the hospital for up to 14 days and here is a copy of the 5250 Certification. (Give patient a copy of 5250).

You will have a right to have a hearing about this certification. A Patient Right's Advocate will be meeting with you to help you get ready for the hearing. The Patient Right's Advocate will also represent you at the hearing and answer other questions and concerns about your involuntary admission.

The hearing will be here at the hospital with a Hearing Officer. The officer will decide if you will to continue your involuntary admission or if you can be discharged.

You may also choose to have a "Writ Hearing", that would be held in a court before a judge. The judge will decide whether you should continue to your stay as an involuntary patient or whether your certification should be removed.

If you choose a Writ Hearing, the staff will make an appointment for you.

You have two choices you can make.

Would you like to request a writ hearing at court? Or would you like to wait for the hearing here in the hospital? You will be able to have a court hearing after the hospital hearing if you not agree with the results.

Arrowhead Regional Medical Center
Policy Outline Format

I.   Main point follows a Roman numeral.

   A. Minor points follow behind capital letters.

   B. Each minor point must refer to or be a part of the major point.

      1. If there are sub-points below the minor point, use Arabic numerals.

      2. Notice that each point is indented according to its importance.

      3. Each sub-point must be related to or a part of the minor point it follows.

         a. If there are points below sub-points, they use lower case letters.

         b. They are indented below the sub-point and are related to the sub-point or part of the sub-point above it.

            1) Sometimes, there are even smaller subdivisions.

            2) These subdivisions use Arabic numerals with a parenthesis.

   C. The next minor point below the major point.

II. Next Major point follows Roman numeral II.

   A. Minor Point.

   B. Minor Point.

      1. Sub-point.

      2. Sub-point.

This same pattern and format continues until the outline is complete.

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: MAGNETIC RESONANCE IMAGING AND COMPUTERIZED TOMOGRAPHY PERFUSION STROKE SERIES POLICY

APPROVED BY: _____

Chief Executive Officer

POLICY

Upon the initial presentation of a suspected stroke patient, whether transient ischemic attack (TIA), ischemic event or infarction, hemorrhagic stroke from subarachnoid hemorrhage (SAH), intracerebral hemorrhage (ICH), or any other type of stroke: a STAT Computerized Tomography (CT) Scan is obtained. A stroke patient is defined as one displaying or recently displayed unilateral clinical symptoms of motor or sensory changes, or acute problems with speech, hearing, olfaction or vision, or symptoms attributed to brainstem neurological abnormalities. The diagnosis of stroke itself is clinical. The diagnosis may be assisted with the imaging studies. Imaging studies also assist in determining the subtypes and cause of stroke.

PROCEDURES

I. STAT CT SCAN

   A. An unenhanced CT scan is ordered STAT upon presentation of a patient with any suspected stroke. It should be completed within 25 minutes of arrival time to the Emergency Department (ED) or within 25 minutes of stroke identification in the nursing tower and results available within 45 minutes of arrival time or stroke symptom identification time in the nursing tower.

II. CT ANGIOGRAM

   A. If the unenhanced CT scan or clinical exam suggests SAH, or acute large artery blockage without infarction, then a CT angiogram (CTA) may be ordered.

   B. CTA is completed with contrast and is a dynamic flow study. If there is no flow through a cerebral blood vessel corresponding to the area of the brain responsible for the clinical changes then a stroke is definite.

   C. An area of no flow on CTA or magnetic resonance angiography (MRA) without an underlying area of infarction but with clinical correlation of neurological deficit shall be treated emergently to restore cerebral blood flow in an attempt to prevent an infarction.

III. MRI STROKE SERIES OR CT PERFUSION SERIES

   A. If a patient has symptoms or signs of an acute (less than 24 hours) cerebral neurological deficit attributable to a stroke and the initial CT scan are negative, a Magnetic Resonance Imaging

(MRI) Stroke series or a CT Perfusion (CTP) is ordered by the Practitioner. This is done after consultation with the neurologists or neurosurgeon and should be completed prior to three hours from ED arrival time or if an inpatient, three hours from acute onset of stroke, if required to make a diagnosis for acute treatment or for acute follow-up care.

IV. ADDITIONAL CT SCAN OR MRI OR CTP

A. If a patient presents as a TIA and the signs and symptoms resolve within one hour of presentation without recurrence, and the CT scan is without infarction *or signs of ischemia* then an additional CT scan, MRI, or CTP scan is not necessary. A stroke mimic (e.g.) tumor, multiple sclerosis (MS), infection, etc. may still require a CTP or additional CT scan, requiring a neurology consult to determine additional testing needs.

V. REPEAT CT SCAN

A. If a CTP stroke series is not completed within 48 hours of arrival time in a patient with acute stroke then only a repeat CT scan may be ordered in order to document an infarction.

VI. CTP OR MRI STROKE SERIES ORDERED BEYOND 48 HOURS

A. If a CTP or MRI stroke series is ordered beyond 48 hours of emergency room arrival time in a patient with stroke, then only a repeat CT scan is completed to document an infarction unless a neurology or neurosurgery consult is obtained and supports the need for a CTP or MRI stroke series.

B. In the orders, the Practitioner must specify both the **indications** for the CTP or MRI stroke series and the **benefits** to treatment. The orders must also contain the ordering Practitioner's name, service, and pager number. The ordering Practitioner will be contacted by the Medical Imaging Department should the order not contain the preceding data prior to bringing the patient to the MRI scanner.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                           6/18/19   **William L. Gilbert, Hospital Director**
                                                Applicable Administrator, Hospital or Medical Committee

                           8/6/19   **Board of Supervisors**
                                                Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **11/4/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	SUB SECTION:	**CONTINUUM OF CARE**

SUBJECT: **ARTERIAL LINE: INSERTION AND MANAGEMENT**

APPROVED BY: _____
                                                Chief Executive Officer

POLICY

The purpose of this policy is to outline the insertion and management of arterial pressure lines used to continuously monitor blood pressure, titrate vasoactive agents, and obtain serial blood gases or other laboratory specimens in critically ill patients.

The universal pressure line tubing may be used in areas such as the Operating Room (OR) and Interventional Radiology (IR).

The SafeSet tubing must be used in the Emergency Room (ER), Trauma Room, Medical and Surgical Intensive Care Unit (MICU and SICU respectively), Burn, and Post Anesthesia Care Unit (PACU). The Flowtrac tubing may be utilized when Vigileo monitoring is ordered. It is important to not disconnect any part of the system for any reason other than to troubleshoot (example: do not disconnect the pressure bag from the system in order to transfer to ER, OR, CT, etc.)

PROCEDURES

I.   <u>PATIENT PREPARATION</u>

     A.   Identify and verify the patient using two patient identifiers.
     B.   Ensure that the patient and family/significant other understand pre-procedural teaching. Answer questions as they arise and reinforce information as needed.
     C.   Make sure that informed consent was obtained and properly executed by the physician.
     D.   Pre-medicate patient with sedatives as ordered.
     E.   Place the patient's extremity in the appropriate position with adequate lighting on the insertion site

II.   <u>PREPARATION OF HEMODYNAMIC MONITORING SYSTEM</u>

     A.   Equipment list

         1.   Pressure Bag 500 ml
         2.   Normal Saline solution 500 ml
         3.   Choice of closed transducer tubing system

             a.   Universal pressure line tubing
             b.   Safeset arterial pressure line tubing
             c.   Flowtrac Tubing with Vigileo Monitoring

4.   Appropriate cables connected to the appropriate monitors/devices
5.   70% alcohol port disinfection/protector caps

B.   Steps

1.   Ensure that the informed consent is properly executed in the chart.
2.   Perform hand hygiene thoroughly to reduce transmission of microorganisms
3.   If catheter is to be inserted in the radial artery, ensure the physician has performed and documented the Allen's test. This ensures adequacy of collateral blood flow to the distal extremity to be canulated.
4.   Use a closed tubing system. It may reduce the risk of nosocomial infection.
5.   Prepare Safeset pressure transducer tubing on arrival to critical care units with an inline blood waste reservoir to reduce risk of nosocomial anemia.
6.   Assemble the hemodynamic monitoring system keeping the end of the Safeset tubing set sterile.

III.   ASSISTING WITH INSERTION

A.   EQUIPMENT LIST:

1.   Radial Artery Catheterization Kit
2.   2% Chlorhexidine Gluconate (CHG) skin prep
3.   Sterile Gloves
4.   Shielded Mask
5.   Suture Material
6.   Bio-Patch
7.   Occlusive Dressing
8.   70% alcohol port disinfection/protector caps

B.   STEPS

1.   Perform hand hygiene thoroughly and don sterile gloves and shielded mask. Immobilize site to prevent needle from lacerating vessel wall during insertion. Assist with catheter insertion as needed.
2.   Once catheter is in place, connect sterile end of tubing with Luer-Lok adapter of arterial catheter to provide a secure attachment and allow signal to be transmitted to the monitor via transducer as evidenced by the arterial waveform.
3.   Observe waveform and perform a dynamic response test (also known as the Square Wave Test). The results indicate whether or not the system is dampened.
4.   Assist with securing/suturing catheter in place. Once secured, apply a biopatch and sterile occlusive dressing to reduce infection. Apply arm board if necessary to ensure correct position of extremity for optimal waveform.
5.   Level and zero the transducer. Set the alarm parameters according to patient's current blood pressure. Alarms should always be on to detect pulseless electrical activity, hypotension, hypertension, accidental disconnection, accidental removal of catheter, or over damping of waveform. Safeset tubing is labeled to identify it as an "Arterial Line" at the proximal and distal access ports AND "Not for IV Use" (ATTACHMENT A)
6.   Obtain baseline data by running a waveform strip and documenting baseline pressures. Never rely on digital values because the values are averaged calculations.

7.   Ensure that the Allen's test was performed and documented along with informed consent.

IV.   TROUBLESHOOTING AN OVERDAMPENED WAVEFORM

A.   EQUIPMENT LIST:

1.   Gloves
2.   10 ml Syringe
3.   Sterile 4X4 Gauze
4.   Sterile Occlusive Cap

B.   STEPS

1.   Identify the over dampened waveform. An over dampened waveform is characterized by a flattened waveform, a diminished or absent dicrotic notch, or a waveform that does not fall to baseline.
2.   Over dampening should be assessed immediately to ensure waveform accuracy and to prevent clotting of the catheter.
3.   Perform hand hygiene then check the patient. A sudden hypotensive episode can look like an over dampened waveform.
4.   Make sure the pressure bag is inflated to 300 mmHg. Under-inflation or over-inflation can distort the waveform. Perform a dynamic response test.
5.   If the waveform is over dampened, check the insertion site for catheter positioning. In the radial site, wrist movement or in the femoral site, leg flexion can cause catheter kinking or dislodgment.
6.   Check the system for air bubbles and eliminate them if found. Air bubbles can cause over dampening and more seriously, air emboli.
7.   Check the tubing system for leaks or disconnections. Ensure that all connections are tight.
8.   Attempt to aspirate and flush catheter to assist with the withdrawal of air in tubing or clots that may be at catheter tip. The steps are as follows:

a.   Perform hand hygiene, don gloves and mask.
b.   Attach a 10 ml syringe to the blood sampling port of stopcock closest to patient.
c.   Turn stopcock off to flush bag.
d.   Gently attempt to aspirate; if resistance is felt, reposition the extremity and reattempt aspiration.
e.   If resistance is still felt, stop and notify the physician.
f.   If blood is aspirated, remove 3 ml, turn stopcock off to patient and discard the sample.
g.   Hold 4X4 gauze over the blood sampling port of stopcock and activate fast-flush device to clear stopcock of blood.
h.   Turn stopcock off to blood sampling port and replace it with a sterile occlusive cap.
i.   Use fast-flush device to clear line of blood.
j.   Discard used supplies in appropriate container and perform hand hygiene.

V.   TROUBLESHOOTING AN UNDERDAMPENED WAVEFORM

A. Identify the under dampened waveform characterized by catheter fling. Systolic pressures may be read inaccurately high.

B. Perform hand hygiene to prevent transmission of microorganisms. Check system for air bubbles and eliminate if found. Air bubbles can contribute to under dampening and more seriously, air emboli.

C. Check the length of the pressurized tubing system to ensure that the tubing length is minimized.

D. Consider use of a damping device per protocol, if available. Perform hand hygiene after contact with patient.

VI. PATIENT MONITORING AND CARE

A. Monitor neurovascular and peripheral vascular assessments of the cannulated extremity immediately after catheter insertion and every 4 hours, or more often if warranted. This validates adequate peripheral circulation and neurovascular integrity. Changes in pulses, color, temperature, or capillary refill may indicate ischemia, arterial spasm, or neurovascular compromise.

B. The following conditions should be reported if they persist despite nursing interventions:

1. Diminished or absent pulses
2. Pale, mottled, or cyanotic appearance of extremity
3. Extremity that is cool or cold to the touch
4. Capillary refill time of more than 2 seconds
5. Diminished or absent sensation
6. Diminished or absent motor function

C. Check arterial line flush system every 1 to 4 hours to ensure following:

1. Pressure bag is inflated to 300 mmHg to prevent backflow of blood into catheter and tubing.
2. Fluid is present in flush bag to ensure continuous infusion.
3. Flush system is delivering 1 to 3 ml/hr to maintain catheter patency and prevent fluid overload.

D. Monitor for over dampened or under dampened waveform. An optimal damped system provides an adequate waveform with appropriate blood pressure readings.

VII. ARTERIAL LINE DRESSING CHANGE

A. EQUIPMENT LIST:
1. Central line dressing kit (includes sterile cloves, mask, skin prep)
2. Non-sterile Gloves
3. Culture Container (if site infected)
4. 2% Chlorahexadine Gluconate (CHG) skin prep
5. Bio-patch
6. 70% alcohol port disinfection/protector caps

B. Steps

1. The Center for Disease Control and Prevention recommend replacing the dressing when the catheter is replaced or when the dressing becomes damp, loosened, or soiled.

2.   Perform hand hygiene, don non-sterile gloves. Gently remove old dressing. Be careful not to place tension on arterial catheter to prevent inadvertent dislodgment of catheter.
3.   Observe for signs and symptoms of infection. If infected, notify physician, and remove catheter as ordered. Cleanse insertion site with 2% chlorahexadine solution and let air dry for maximum effectiveness and help prevent bacteria growth at the insertion site.
4.   Change to sterile gloves. Replace bio-patch and occlusive transparent dressing on catheter insertion site. Use aseptic technique to decrease risk of infection.
5.   Appropriately discard used supplies and perform hand hygiene.

VIII.   <u>OBTAINING BLOOD SPECIMEN</u>

A.   Universal Pressure Line Tubing System
B.   Safeset and Flowtrac System

IX.   <u>REMOVAL OF ARTERIAL CATHETER</u>

A.   EQUIPMENT LIST:

1.   Gloves
2.   Goggles
3.   3 ml Syringe
4.   4X4 Gauze
5.   Suture Removal Kit
6.   Pressure Dressing

B.   STEPS

1.   Perform hand hygiene thoroughly. Don gloves and goggles to reduce transmission of microorganisms.
2.   Turn off continuous infusion to prevent flush solution from leaking once catheter is removed. Turn off monitoring alarms to prevent false alarms.
3.   Attach 3 ml syringe to blood sampling port and turn stopcock off to flush bag. Draw blood back through tubing to ensure there is no clot in the catheter. If unable to draw blood back, notify the physician.
4.   Remove sutures using suture removal kit. Apply pressure distal to the insertion site. Pull out catheter using 4X4 gauze pad to cover site as the catheter is pulled out.
5.   Immediately apply firm pressure with a 4X4 gauze proximal to the insertion site to prevent bleeding. Continue to apply pressure for a minimum of 5 minutes for radial or ulnar artery site to achieve hemostasis.
6.   Longer period of direct pressure may be needed in patients receiving systemic Heparin or thrombolytics. Catheters in larger arteries such as the femoral artery also may take longer to achieve hemostasis.
7.   Apply a pressure dressing to the insertion site to help prevent rebleeding. Dressing should not encircle extremity to prevent ischemia of extremity.
8.   Appropriately discard used supplies and perform hand hygiene.

X.   <u>DOCUMENTATION:</u>

A.   Document procedure, site appearance, and if catheter tip was cultured in Nurse's Progress Record.

REFERENCES: **Lynn-McHale, Debra J. & Carlson, Karen K. AACN Procedure Manual for Critical Care 4th Edition. Philadelphia: W.B. Saunders, 2014.**

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Regulatory Agency Standards

See Healthstream "Arterial Line: Insertion and Management"

DEFINITIONS: **N/A**

ATTACHMENTS: **ATTACHMENT A: Arterial Line: Insertion and Management**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                      6/18/19   **William L. Gilbert, Hospital Director**
                                      Applicable Administrator, Hospital or Medical Committee

                      8/6/19   **Board of Supervisors**
                                      Approved by the Governing Body

REPLACES: **316.00 Critical Care Issue 4**

EFFECTIVE: **9/1999**   **REVISED:**   **9/2003, 3/2005, 2/2008, 12/18/2013, 12/28/2015**

REVIEWED: **11/2007, 11/2010, 12/18/2013, 2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
The Heart of a Healthy Community

Arterial Line:
Insertion and Management

Neil Guevara Jr, BSN RN CCRN
December 2015

www.arrowheadmedcenter.org

Objectives

- Introduction and review of anatomy
- Indications for arterial lines
- Sites for arterial pressure monitoring
- Allen's Test
- Overview of arterial line set up
- Patient monitoring
- The arterial waveform
- Arterial Line blood draws
  - Universal pressure line
  - Safeset arterial pressure line
- Care, maintenance, and troubleshooting

Introduction

- What is it?
  - A catheter is inserted into an artery that is connected to a pressure transducer system.
- What are the advantages?
  - Continual beat –to-beat monitoring of blood pressure, and continual vascular access for blood sampling.
- What are the risks?
  - Hemorrhage, Air Embolus , Thrombus, Tissue ischemia, Bacterial contamination, etc.

  The arterial line is not used for infusion by the RN!

Indications for Arterial Lines

- Intra-arterial blood pressure monitoring is indicated for any condition that compromises cardiac output, tissue perfusion, and/or fluid volume status
- Accurate BP recording is necessary even when the patient is profoundly hypotensive
- The blood pressure cuff is difficult to apply or inaccurate
- The patient is receiving vasoactive drugs that require beat-to-beat blood pressure monitoring
- The patient also requires frequent blood draws
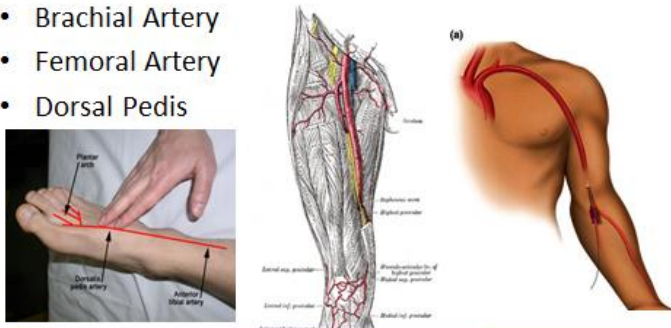
Sites for Arterial Lines

- Radial Artery (most frequently used)
- Brachial Artery
- Femoral Artery
- Dorsal Pedis

Sites for Arterial Lines

- The Radial Artery has low complication rates compared with other sites.
- It is a superficial artery which aids insertion, and also makes it compressible for hemostasis

Allen's Test

- Used to establish the presence of collateral arterial blood flow through the PALMAR ARCH via the ULNAR artery.
- Document "positive Allen's test" or "negative Allen's test" when considering RADIAL artery puncture

Overview of Arterial Line Set Up for Insertion
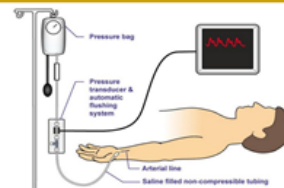
- Equipment needed: Pressure bag, 0.9% NS in 500cc bag, Transducer tubing, #20 angiocath, dressing supplies, biopatch, "dead end" (yellow) caps.
- Ensure ALL air is removed from system to include flush bag and stopcocks.
- Inflate pressure bag to 300mm.
- The purpose of pressure bag is to provide a continuous saline flush at 3-5ml/hr that will keep the line patent and prevent clotting.
- Because of this continuous flush mechanism, the line should never be disconnected until it is removed.

Patient Monitoring

- ZERO the system by laying the patient flat and placing the transducer at the phlebostatic axis (mid-axillary line, 4th intercostal space), opening the stopcock to atmospheric pressure, and zeroing the monitor.
- Once zeroed, turn the stopcock back to patient monitoring, and replace with dead-end cap.
- A BP cuff is placed on the opposite extremity and its cycling interval is determined by the person doing the monitoring (typically every hour)

Patient Monitoring (continued)

- A 5-20 mmHg difference between cuff and arterial pressure is normal, with the arterial pressure being the higher of the two.
- Arterial pressure should be documented every 5 to 15 minutes, depending on the unit protocol or case, until stable and/or blood draws frequency is reduced.

Patient Monitoring (continued)

- A 5-20 mmHg difference between cuff and arterial pressure is normal, with the arterial pressure being the higher of the two.
- Arterial pressure should be documented every 5 to 15 minutes, depending on the unit protocol or case, until stable and/or blood draws frequency is reduced.

PLEASE NOTE:

The arterial line tubing must be labeled at the catheter site, at every blood access port, at the transducer, and at the pressure bag.

The pressure bag is always pressurized and attached to the arterial tubing at all times. DO NOT DISCONNECT BAG FOR TRANSFERS TO CT, OR, ICU, etc.

The Arterial Waveform

- Represents the ejection phase of the left ventricular systole.
- As the aortic valve opens, blood is ejected and recorded as an increase in pressure in the arterial system.
- Highest point is systolic measurement.
- Dicrotic notch represents aortic valve closure and signifies the start of diastole.
- Lowest point is the diastolic measurement.
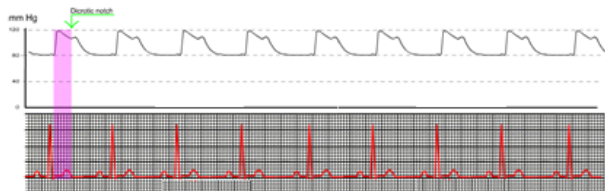
Arterial Line Blood Draws Procedures

1. Universal Pressure Line

2. Safeset Arterial Pressure Line

Arterial Blood Draw from the Universal Pressure Line

The Universal Pressure Line System can be used to monitor CVP, ICP, Bladder, and Arterial Pressures. (ARMC uses the **TRANSPAC MONITORING KIT**)

The following areas are allowed to use this kit for Arterial Pressure monitoring in the:
1. Emergency Room
2. Operating Room
3. Post-Anesthesia Care Unit
4. Interventional Radiology

Arterial Blood Draw from the Universal Pressure Line

Remove cap from proximal stopcock, attach needleless valve (clave), and attach vacutainer holder (or syringe.)

Arterial Blood Draw from the Universal Pressure Line

Open stopcock to patient and draw 5cc blood for waste.
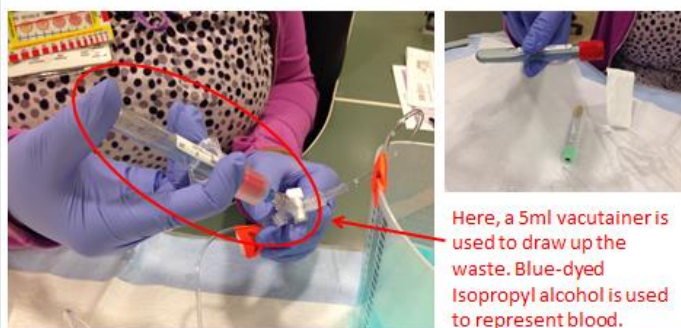
Here, a 5ml vacutainer is used to draw up the waste. Blue-dyed Isopropyl alcohol is used to represent blood.

Arterial Blood Draw from the Universal Pressure Line

Draw blood, close stopcock ,and remove vacutainer/syringe.
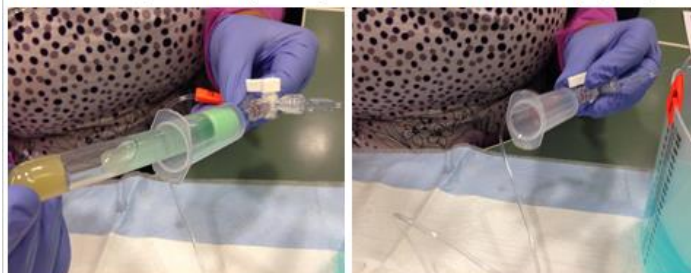
Arterial Blood Draw from the Universal Pressure Line

Flush system and replace with a new sterile clave or Curos cap.
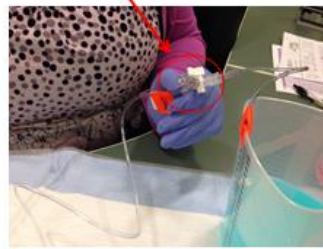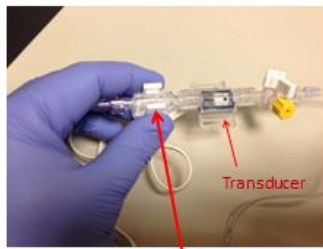
Transducer

The saline flush is delivered by squeezing the flush valve next to the transducer.

Never flush the line for more than 1-2 seconds at a time!

Arterial Blood Draw from the Safeset

The Safeset is used in the ICU. If the patient is admitted or transferred to the ICU with arterial access, the ICU will change the tubing to the Safeset tubing

Please note the waste reservoir.

Arterial Blood Draw from the Safeset

Labels!

Just in case you didn't notice...

Arterial Blood Draw from the Safeset

The plunger of the reservoir is pulled back and arterial blood is collected or "wasted"

Arterial Blood Draw from the Safeset

The stopcock is turned off to prevent the aspiration of "wasted blood" into the sampling syringe or vacutainer.

The rubber port is scrubbed with an alcohol wipe prior to access.

Arterial Blood Draw from the Safeset

Use the rubber port nearest to the patient.
DO NOT USE A NEEDLE TO ACCESS THIS RUBBER PORT.

The "*Safeset Blood Sampling Tube Holder with Blunt Cannula*" is used to access the rubber sampling ports.

Arterial Blood Draw from the Safeset

This *"Shielded Blunt Cannula"* can be used with ABG syringes or other luer lock syringes for drawing blood for AccuChek's.

Arterial Blood Draw from the Safeset

Disconnect vacutainer holder or syringe and discard in the appropriate receptacle.
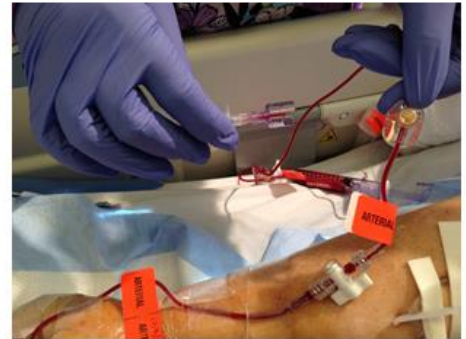
Arterial Blood Draw from the Safeset

Re-open the valve and depress the plunger to return the "waste" back into the patient.

Arterial Blood Draw from the Safeset

Depress until all the blood is returned and the syringe plunger is locked.
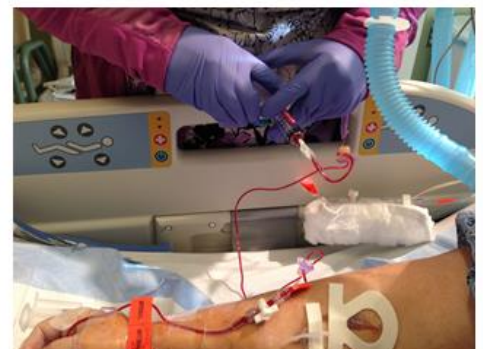
Arterial Blood Draw from the Safeset

Here, the syringe plunger is locked.
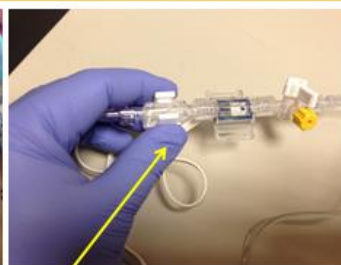
The tubing is flushed by squeezing the flush valve until the tubing is clear of residual blood.

Never flush the line for more than 1-2 seconds at a time!

Arterial Blood Draw from the Safeset

Continue flushing until the tubing is free of residual blood.
Never flush for more than 1-2 seconds at a time!
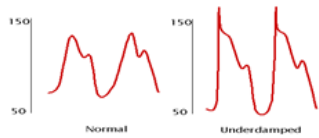
Arterial Blood Draw from the Safeset

Flushing is complete.

Troubleshooting

Dampening occurs due to:
- air bubbles
- overly compliant, distensible tubing
- catheter kinks
- clots
- injection ports
- low flush bag pressure or no fluid in the flush bag
- Improper scaling
- Severe hypotension if everything else is ruled out

This type of trace underestimates SBP and overestimate DBP

Over-dampening

Troubleshooting

Resonance occurs due to:
- long tubing
- overly stiff, non-compliant tubing
- increased vascular resistance
- reverberations in tubing causing harmonics that distort the trace (i.e. high systolic and low diastolic)
- non-fully opened stopcock valve

This type of trace overestimate SBP and underestimate DBP

Under-dampening Or "Resonant Trace"

WHAT IF THE TRACING IS FLAT OR THE TRACE IS COMPLETELY MISSING?

1. Is the arterial catheter still in place?
   Yes? Attempt to draw blood with a 3cc syringe from the stopcock. If it draws normally, then suspect a hardware problem
2. Blood does not draw:
   Is there a clot in the hub?
   Take the site dressing down.
   Is the catheter kinked at the insertion site?
   Is the patient on high dose pressors?
3. Did the cables come loose?
4. Was the arterial scale changed?
   If the scale was reduce to 50, instead of 150 or 200mm of pressure, you'll only see a flat line.
5. Is it a transducer setup failure?
   Replace pressure tubing and transducer, or Safeset.

Removal

1. Disconnect the cable from the monitor. The alarms automatically turn off.
2. Remove the sutures with a sterile kit.
3. Pull the catheter and manually compress the site with gauze for at least 3 to 5 minutes or longer if the patient is anticoagulated.
4. Ensure the patient's hand is still perfused.
5. Check for hematoma or bleeding every hour for 2-4 hours.
6. Ensure the blood pressure cuff cycling interval is set appropriately

Ending Notes

1. The arterial line is not used for infusion by the RN.
2. The arterial line tubing must be labeled at the catheter site, at every blood access port, at the transducer, and at the pressure bag.
3. Do not disconnect bag for transfers to CT, OR, ICU, etc.
4. The following areas are allowed to use this kit for Arterial Pressure monitoring in the:
   a. Emergency Room
   b. Operating Room
   c. Post-Anesthesia Care Unit
   d. Interventional Radiology
5. The Safeset is used in the ICU. If the patient is admitted or transferred to the ICU with arterial access, the ICU will change the tubing to the Safeset tubing

ATTACHMENT A (continued, Page 7 of 7)

References

1. Bhatnagar, D. http://www.slideshare.net/bhatnagartarun/arterial-line-insertion-techniquescomplications-troubleshooting Retrieved 12/7/2015.

2. Union Hospital ED. https://unioned.wikispaces.com/file/view/Arterial+Lines.ppt Retrieved 12/7/2015.

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: CARE FOR PATIENTS WITH STROKE SYMPTOMS GREATER THAN 8 HOURS AFTER SYMPTOM ONSET

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

It is the policy of the Arrowhead Regional Medical Center (ARMC) to provide a multidisciplinary, timely, and effective approach to care for patients with stroke symptoms greater than 8 hours after symptom onset.

PURPOSE

I.   To improve patient outcomes by establishing guidelines for the prompt evaluation and treatment of patients who present to ARMC with stroke symptoms beyond 8 hours.

II. The goals of the ARMC Stroke Initiative are to streamline and improve stroke procedures, coordinate stroke care, meet and/or exceed stroke performance standards, provide stroke education, follow-up stroke care, and continuously monitor and measure standards for improvement.

PROCEDURE

I.   Emergency Medical Services (EMS) may inform Arrowhead Regional Medical Center (ARMC) when possible stroke patients are en-route to the Emergency Department (ED).

A. If symptoms are less than 8 hours since time of onset, a Code Stroke is called (refer to AOM policy 610.26).

II. Preliminary screening by the Intake/Triage RN and/or ED Provider for walk-in patients determines if Code Stroke is activated for patients who present to the ED with signs consistent with stroke within 24 hours of symptom onset.

A. Intake/Triage Registered Nurse (RN) should follow this Code Stroke Algorithm:

Step 1:   Acute onset of Stroke-like symptoms within 8 hours?
          Yes, next step; No, go to step 5.

Step 2:   Is there acute onset of the worst headache of their life?
          Yes, call Code Stroke suspect Subarachnoid Hemorrhage; No, next step.

Step 3:   Are paresthesia or paresis symptoms unilateral involving face, arm or leg?

Yes, call Code Stroke; No, next step.

Step 4:   Is there expressive or receptive aphasia?
             Yes, call Code Stroke; No, next step.

Step 5:   Documented Stroke previously worked-up?
             Yes, then physician evaluation; No, continue stroke evaluation per this policy.

Personnel in ED

I.   ED Provider

II. Intake, Triage RN and/or Mobile Intensive Care Nurse (MICN)

III. NIH-certified ED Registered Nurse

PROCEDURES / RESPONSIBILITIES

I.   Intake or Triage Nurse

  A. Identifies patient with signs and symptoms consistent with stroke according to the Code Stroke
      Algorithm and determines the time of symptom onset (defined as the time the patient was last
      known normal).

  B. Places patient in an ED room.

  C. Immediately notifies the ED provider of the patient's presentation and location.

II. Emergency Department Provider:

  A. Evaluates patient for evidence of stroke.

  B. Determines time of onset (defined as the time the patient was last known normal).

  C. Orders Stroke Labs STAT.

  D. Orders Stroke CT of the head without contrast STAT.

  E. Obtains results of CT scan.

  F. Discusses therapeutic options and risks/benefits with patient, and family.

  G. Contacts admitting service and discusses admission.

  H. Initiates sub-acute stroke orders.

  I. If symptom onset is less than 24 hours and CT scan does not indicate a hemorrhagic stroke,
      neurointerventionalist may be consulted for possible intervention.

  J. If basilar artery occlusion is suspected of ANY duration, STAT neurology consult is done.

III. Emergency Department Primary Nurse:

    A. Is National Institute of Health (NIH) Stroke Certified and is available on all shifts.

    B. Obtains non contrast head CT as ordered.

    C. Obtains laboratory specimen as ordered for Stroke Labs (CBC, CHEM 7, PT/PTT INR).

    D. Assures that the correct Stroke forms are utilized.

    E. Assess vital signs and documents NIHSS.

    F. Performs point of care testing for blood glucose.

    G. Administers supplemental oxygen.

    H. Monitors cardiac rhythm and pulse oximetry.

    I. Ensures IV access.

    J. Assesses aspiration risk prior to any PO intake and documents findings in the Swallow Screen form.

    K. Monitors for signs/symptoms of bleeding, neurological deterioration, changes in vital signs.

    L. Documents the time of the CT report, and laboratory results.

    M. Initiates Stroke Nursing Flow Sheet, NIHSS recording form, Stroke admission order, and Swallow Screen forms.

    N. Transports the stroke patient to the ICU or 4-North Stroke Unit as indicated.

IV. Radiology:

    A. The CT technologists prepare the CT suite for STAT non-contrast head CT.

    B. The CT technologists will notify the Radiologist that the CT is complete.

    C. The Radiologist will dictate and document findings.

V. Laboratory:

    A. Blood is drawn by the RN and is sent to the LAB via the Central Tube System (CTS) to be processed as a STAT lab.

VI. Unit Clerk:

    A. Enters STAT orders for the non-contrast head CT.

    B. Enters STAT orders for the Stroke Labs.

VII. Admission RN and/or Bed Management:

    A. Facilitates bed placement of the patient to (ICU or 4-North).

    B. Documents the admission in the Stroke Log.

    C. Notifies the Stroke Coordinator for PI/QM and tracking purposes.

PROCEDURE for Direct Admission of Stroke Patients with symptoms beyond 24 hours

I. All Direct Admissions of Stroke patients will be directed to the ED for Stroke evaluations. The ED will be responsible for calling Code Stroke if indicated.

GENERAL PROCEDURES

I. Continuing Care

    A. All departments are responsible for Stroke Core Measures as it pertains to them.

    B. ARMC is confident in the personalized care provided to the stroke patient by the healthcare team. Electronic Stroke Algorithms are provided for reference and are not meant to substitute for physician directed patient care. Nursing Stroke Critical Pathways are also provided electronically as references.

II. Data Collection, Performance Improvement, and Discharge

    A. It is imperative for any program to be successful that the performance data be analyzed in an attempt to make further improvements. It is also important that the goals of the ARMC Stroke Initiative of streamlining and improving stroke protocols and procedures, coordinating stroke care, meeting and exceeding stroke performance standards, stroke education, and follow-up stroke care and education be continuously measured and improved.

    B. The Performance Improvement specialist, Stroke Medical Director, and the Stroke Program Coordinator will be provided with the **Stroke** date & time, patient name & medical record number, room number and admitting physician. The remainder of the data, as described in the Discharge Template will be extracted after discharge.

    C. It is expected that the discharging provider will dictate the stroke information.

    D. For stroke care to be beneficial it is essential that the patient, patient's family, or surrogate be provided with instructional material to help improve the current stroke condition and to prevent further occurrence. The patient, patient's family, or surrogate will be given personalized Stroke Discharge Instructions, Stroke Education, and an ARMC Discharge Primary Care Physician Letter. The physician will complete these forms as required. It is imperative that the nursing staff provide these forms to the patient, patient's family, and/or surrogate. It is also essential that the nursing staff provide the additional stroke information and educational material as indicated on the Stroke Discharge Instructions.

    E. ARMC will review the baseline and performance improvement data quarterly as a method to identify best practices, measure patient results and changes, develop and disseminate reports

and publications, and improve protocols, orders, algorithms, critical pathways, discharge education, and stroke education.

CONTACT THE STROKE COMMITTEE FOR MORE INFORMATION.

REFERENCES: Adams, HP, Adams, RJ, Brott, T, et al. (2003). Guidelines for the Early Management of Patients with Ischemic Stroke – A Statement from the Stroke Council of the American Stroke Association, *Stroke*, 34: 1056-1083.

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KEYWORDS: Stroke

DEFINITIONS: <u>N/A</u>

RELATED POLICIES: **Administrative Policy No. 610.25**
Administrative Policy No. 610.26
Sub-Acute Stroke Orders

ATTACHMENTS: <u>N/A</u>

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: <u>N/A</u>

EFFECTIVE: <u>11/4/14</u>   **REVISED:**   <u>N/A</u>

REVIEWED: <u>2/07/19</u>

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

_____

SECTION: PATIENT CARE   SUB SECTION: CONTINUUM OF CARE

SUBJECT: DISCHARGE PLANNING ACTIVITIES

APPROVED BY: _____
                                       Chief Executive Officer

_____

POLICY

Arrowhead Regional Medical Center (ARMC) is committed to an effective, ongoing, interdisciplinary discharge planning process that is consistent with the medical plan of care and the wishes of the patient, the patient's support person(s). Discharge planning is initiated at admission. Further patient assessment and planning for discharge takes place throughout the hospitalization, coordinated between the multidisciplinary healthcare team, the patient, the patient's support person(s), the patient's care givers and appropriate community agencies.

Case Management plays a significant role in the coordination for discharge readiness. While a practitioner may request discharge planning, no formal request or practitioner order is needed to begin the discharge process or case management involvement. Practitioner can make the final decision as to whether a discharge plan is necessary. The hospital develops a plan as requested by the practitioner.

Exceptions: Patients have a right to request or refuse services offered. If a patient declines the assistance of Case Management, that involvement is terminated and documented.

PURPOSE

To specify discharge planning procedures to ensure a safe and timely discharge that meets the patient's needs.

PROCEDURE

I. Discharge Criteria

    A. General Parameters

        1. Patients are discharged from the facility according to the following parameters:

            a. Physiologic and hemodynamic stability.

            b. Arrangements have been made for necessary equipment, supplies, and/or personnel to assist the patient at home when required.

            c. Patient demonstrates readiness for self-care or significant other demonstrates the ability to assist the patient.

2. Patients are discharged from the facility upon receiving a written order from the practitioner. Children are discharged to the care of their parents/guardian.

II. Discharge Planning

A. Discharge planning is a multidisciplinary process done in collaboration with the following disciplines to ensure that each patient has a plan for continuing care tailored to his/her needs.

1. Practitioners

2. Nursing

3. Clinical Social Work Department

4. Case Management

5. Rehabilitation Services

6. Nutrition Services

7. Pharmacy Services

8. Home Health

9. Respiratory Therapy

10. Utilization Review

11. Outpatient Diabetes Referral

12. Epidemiology

B. Patients are screened for discharge planning needs during the admission process utilizing the Patient Admission Assessment. The discharge plan is formulated with participation from the patient, patient's family and/or significant others/care givers.

1. The admitting nurse identifies actual or potential discharge planning needs consistent with the practitioner's plan of care, with other clinical disciplines and with the patient and support person(s) wishes.

2. Assessment data is obtained from the patient and support person(s) and include consideration of nutritional, functional, pain, safety, biophysical, psychosocial, financial and other factors that enable the interdisciplinary team to develop the most appropriate and least restrictive discharge plan for the patient.

3. Factors included in the assessment for discharge planning include:

a. Medical condition.

   b. Continuing care needs.

   c. Assistance required with activities of daily living.

   d. Living arrangement prior to admission.

   e. Patient's level of functioning prior to admission including mental status.

   f. Capacity to care for self and others.

   g. Patient's family/support person(s) response to present illness and services that have been provided in the past.

   h. Patient and family/support person(s) wishes and preferences.

  4. Patients are reassessed throughout the continuum of care for discharge planning needs. Collaboration among professional disciplines results in an interdisciplinary approach to identifying and planning for the patient's ongoing health care needs. Discharge plan is reassessed and discussed during weekday rounds.

   a. Ongoing reassessment may result in revisions of the discharge plan based on changes in patient condition, changes in available support, and/or changes in post-hospital care requirements.

   b. Patient and family/support person(s) are updated as plan changes.

 C. Roles in Discharge Planning

  1. Practitioners

   a. Discuss the post-discharge plan of care with healthcare team members.

   b. Discuss the post-discharge plan of care with patient/support person(s).

   c. Inform the patient/support person(s) of the discharge date.

   d. Write an order for patient discharge including destination, i.e., home, Skilled Nursing. Facility, etc.

   e. Complete the Discharge Instruction / Order Form.

   f. Complete Medication Reconciliation form.

  2. Nursing

   a. Ensures that the discharge planning needs of the patient are met.

   b. Assists in communicating with the patient/support person(s) to inform them of the discharge date and confirm transportation arrangements.

c. Identifies patient using two patient identifiers before discussing discharge or giving discharge paperwork to patient/care giver.

d. Reviews patients Discharge Instruction / Order Form to the patient, the patient's support person(s), the patient's care givers and/or appropriate community agencies with prescribed treatments, medications, diet, activity level, and scheduled follow-up appointments, if any. Provide information regarding changes in the patient's condition requiring a return to the Emergency Department and how to call for emergency transport.

e. Provides a copy of the Discharge Instruction / Order Form to the patient, the patient's support person(s), the patient's care givers and/or appropriate community agencies. Provide printed instruction sheets or brochures as appropriate.

f. Reviews the written discharge instructions including medications verbally with the patient. A copy of the computer generated medication list, a copy of the Medication Reconciliation form, and additional relevant instructions (e.g. Krames patient instruction sheets) are given to the patient/family.

g. Asks the patient, the patient's support person(s), and/or the patient's care givers to verbalize their understanding of the discharge instruction and/or give a return demonstration of procedures, as applicable.

h. Ensures that discharge teaching has been done.

i. Verifies that follow up appointments have been made or that list of available practitioners/clinics has been provided.

j. Verifies that the patient is discharged with three days' worth of medical supplies when appropriate.

k. The patient signs the safekeeping release form if valuables are in the safe. The valuables are picked up from safekeeping room and given to the patient. If articles are at the bedside during the hospital stay, the clothing sheet is signed by the patient upon release of such.

l. Ensures patients are escorted out of the facility by hospital personnel.

3. HUAs

a. Bed Management is notified via fax/telephone/computer of pending discharges when the order is received and of actual discharges when the patient leaves the nursing area.

b. Faxes Pharmacy Services the Discharge Instruction / Order Form.

c. HUA prints discharge paperwork from Meditech and verifies the correct patient's name and DOB on each piece of paper.

d. Once the patient leaves the unit, the chart is disassembled and sent to the Department of Health Information (Medical Records).

    e.   Notifies Environmental Services when bed is vacated.

    f.   Enters discharge into the computer. Nutrition Services receives notice of the discharge.

    g. Fax a copy of the instruction sheet to the patient's Family Health Center when the patient is discharged. For patients under the age of 21, fax a copy of discharge instructions to the patient's primary care provider (Attachment A).

4. Case Management

    a. Performs admission assessment on inpatients within 48 hours (excluding weekends and holidays) of admission by the Case Management staff.

    b. Identifies payor to determine resource options for patient care needs, and refers unfunded patients and patients with limited resources for government program eligibility or other community resource options.

    c. Collaborate with other members of the healthcare team to determine patient needs and to assist the patient in transitioning to an alternate level of care in a timely fashion

5. Clinical Social Work Department

    a. Participates in interdisciplinary assessments to help determine necessity of Home Health and other community care/assistive agencies.

    b. Provides education regarding continuing care, treatment, and services that the patient will need after discharge.

    c. Confirms transportation, durable medical equipment, supplies, and medications.

    d. Shares discharge recommendations for follow-up health care by a Home Health or other community care/assistive agency through documentation in the medical record and discussion during rounds.

6. Respiratory Therapy

    a. Participates in interdisciplinary assessments to help determine necessity of home oxygen.

    b. Determines home respiratory medical equipment needs.

    c. Provides patient/support person(s) education on medications, equipment use, and therapy procedures to be done at home.

7. Physical and Occupational Therapy

    a. Share discharge recommendations for equipment needs and follow-up physical and/or occupational therapy with the practitioner and health care team through documentation in the medical record and discussion during rounds.

      b. Provide instruction and training to patient/support person(s).

    8. Dietitians

      a. Participate in interdisciplinary assessments during rounds.

      b. Share discharge recommendations for specialized diets with the practitioner and health care team through documentation in the medical record and discussion during rounds.

      c. Provide instruction and training to patient/support person(s) regarding nutrition regimens and any dietary modification as indicated.

      d. Inform patient/support person(s) of available community resources, if needed.

    9. Pharmacy

      a. Assist medical staff with drug regimens.

      b. Provide patient/support person(s) with medication information.

III. Documentation of Discharge Activities

    A. Discharge planning and education interventions are documented in the multidisciplinary plan of care and entered into the Patient Care System (PCS) on the Discharge/Transfer/Teaching Summary. Participating disciplines may additionally document on service-specific tools.

    B. Documentation of Discharge is found in the Multidisciplinary Progress Note, the Multidisciplinary Plan of Care, in Meditech PCS, and/or on the Practitioner Discharge Summary Form. Discharge documentation includes:

      1. Date and time of discharge.

      2. Patient's physical status and resolved patient outcomes.

      3. Mechanisms/mode of discharge.

      4. Person accompanying the patient.

      5. Discharge destination.

      6. Review of discharge instructions given to the patient/significant other with the patient/ significant other's understanding of the discharge instructions documented.

      7. In addition, a copy of the Discharge Summary is provided to the referring and/or Primary Care Practitioner at the time of discharge.

IV. Discharge from Emergency Department

A. For patient discharged from the Emergency Department, see Emergency Department Policy 417.00 Discharging Patients from the Emergency Department.

REFERENCES: **Administrative Operations Manual, Policy 610.08, Discharge Planning/ Transfers and Change to a Lower Level of Care**
HSC 1262.5
Healthcare Facilities Accreditation Program Standards

ATTACHMENTS: **Attachment A: Practitioner Discharge Orders and Patient Instructions - English and Spanish**

APPROVAL   DATE: **N/A**   **Policy, Procedure and Standards Committee**

                          6/18/19   **William L. Gilbert, Hospital Director**
                                            Applicable Administrator, Hospital or Medical Committee

                          8/6/19   **Board of Supervisors**
                                            Approved by the Governing Body

REPLACES: **Department of Nursing Policy 533.00 Discharge Planning Activities**

EFFECTIVE: **1/29/19**   **REVISED:**   **N/A**

REVIEWED: **2/07/19**

SECTION: PATIENT CARE   **SUB SECTION:**   CONTINUUM OF CARE

SUBJECT: ACCEPTING PRACTITIONER ORDERS

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

I.   Arrowhead Regional Medical Center (ARMC) licensed staff including registered nurse, licensed practical nurse, nurse practitioner, physician assistant, pharmacist, respiratory therapist, physical therapist, occupational therapist, speech therapist, and/or dietitian are authorized to receive telephone and verbal orders within their scope of practice.

II.   Orders include the following information:

    A.   Date and time order is written

    B.   Patient name and date of birth

    C.   Medical record number and visit number

    D.   Signature of ordering practitioner for telephone or verbal orders:

        1.   Signature of order recipient

        2.   Prescriber's phone number

III. Orders written, telephone or verbal, should contain only approved abbreviations.

IV.   Verbal orders (VO) are not allowed when the prescriber is present and the patient's chart is available except during a sterile procedure or in emergency situations, in which case a repeat-back is acceptable. Verbal orders are not permitted for chemotherapy.

V.   Telephone orders (TO) are given by a prescriber who is not present at the bedside. Limited use of telephone orders is encouraged.

VI.   The order is written as either VO Read Back or TO Read Back indicating the receiver of the order has repeated back the order to the prescriber to avoid misinterpretation. The prescriber or listener should spell unfamiliar drug names and numerical digits pronounced separately (e.g., "one six" instead of "sixteen" to avoid confusion with "sixty").

VII. VO are countersigned by the responsible practitioner as soon as possible (but always within 24 hours).

VIII. Refer to the Medical Staff Bylaws, Rules, and Regulations for authorization and authentication of orders, telephone orders and verbal orders.

REFERENCES: National Coordinating Council for Medication Error Reporting. Recommendations to Reduce Medication Errors Associated with Verbal Medication Orders and Prescriptions. Available from the Internet: http://www.nccmerp.org/council/council2001-02-20.html. Accessed 5/6/2014.
Medical Staff Rules and Regulations
Department of Nursing (DON) Policy 530.00 Physician Orders
DON Policy 531.00 Physician Orders: Transcription
Nutrition Services Policy 201 Diet Order
Pharmacy Services Policy 4.1 Administration and Ordering Privileges – Requirements
Rehabilitation Services Policy 402 Documentation Standards
Respiratory Services Policy 120 Ordering Respiratory Care Services

DEFINITIONS: __N/A__

ATTACHMENTS: __N/A__

APPROVAL DATE: __6/9/14__   **Policy, Procedure and Standards Committee**

_____   **Jerome Dayao, Chief Nursing Officer**
   Applicable Administrator, Hospital or Medical Committee

_____   **Quality Management Committee**
   Applicable Administrator, Hospital or Medical Committee

_____   **Medical Executive Committee**
   Applicable Administrator, Hospital or Medical Committee

_____   **Board of Supervisors**
   Approved by the Governing Body

REPLACES: __N/A__

EFFECTIVE: __11/4/14__   **REVISED**:   __N/A__

REVIEWED: __2/7/19__

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: **MANAGEMENT OF OBSERVATION PATIENTS**

APPROVED BY: _____

Chief Executive Officer

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) to place in observation Status any outpatient requiring extended diagnostic testing and/or monitoring to determine the need to admit as an inpatient to the facility as ordered by a practitioner. In managing patients in Observation Status within the medical center, ARMC complies with all policies and procedures that govern its operation. Observation Status is considered an outpatient service by the Centers for Medicare & Medicaid Services (CMS). A patient may be placed in observation status for up to 48 hours with a Practitioner's order when the patient presents with a serious condition or a confirmed or unconfirmed diagnosis which requires further monitoring to determine the need for admission. Observation is a status not a location and all nursing units can provide observation care.

Billing for a patient in observation status is based on the length of time the patient is in observation status, and the account is billed and coded as an outpatient.

PROCEDURES

I. **Placing Patient in Observation Status**

A. Practitioner documents findings/diagnosis/treatment in the medical record to support intent to place patient in observation status (See Definitions: Outpatient Observation Status).

1. All patients pending observation status must have financial and case management clearance prior to processing.

2. Case Management reviews the observation status for medical necessity and communicates findings with the practitioner.

B. Practitioner documents a valid order to place patient in observation status.

C. Practitioner discusses observation status with patient or patient's representative.

D. The "Physician Certification" form for all Medicare patients must be completed (Attachment A).

E. Order is transmitted to Bed Management.

F. Patient is place in observation status by Patient Reception staff.

1. Patient appears in the health information system (HIS) and hospital census as "**ADM INo**".

G. Patient remains in observation status until one of the following occurs:

    1. Discharged from the hospital;

    2. Admitted as an inpatient; or

    3. Transferred out of ARMC.

H. Case Management reviews ongoing observation patients per the Case Management department policy.

I. Case Manager, or registered nurse, ensures Patient Observation form (Attachment B) is completed and signed by the patient or patient representative.

II. Upgrading Patients From Observation Stats to Inpatient

A. Practitioner reviews the medical record to ensure that clinical findings supporting the inpatient admission are clearly documented.

B. Practitioner documents to discontinue Observation and upgrade patient to inpatient status.

C. In accordance with Case Management department policy, a Case Manager reviews the medical record to confirm appropriateness of status upgrade to inpatient.

D. All orders received in Bed Management to upgrade a patient in observation status to inpatient status will be validated by Case Management for clearance.

    1. In the event Case Management determines that a patient does not meet Interqual criteria for inpatient admission, Case Management must contact the ordering provider to discuss options.

E. Patient is upgraded to inpatient status by Patient Reception staff.

    1. Patient appears in the HIS and hospital census as "**ADM IN**".

F. The "Physician Certification" for Medicare patients must be completed (Attachment A).

III. Discharge of Observation Patient

A. Practitioner determines patient is medically cleared for discharge.

B. Practitioner documents a valid order to discharge an observation patient.

C. Patient is discharged from ARMC per AOM Policy No. 610.08, "Discharge Planning-Transfers and Change to Lower Level of Care" and AOM Policy No. 610.09, "Patient Discharge Lounge", and AOM Policy No. 610.06, "Transition (Discharge) Planning Management".

IV. Transfer of Observation Patient

A. Practitioner determines the need for transfer.

B. Practitioner contacts Case Management to coordinate transfer.

C. Practitioner documents a valid order to transfer an observation patient to another facility.

D. Transfer is conducted per AOM Policy No. 610.03, "Inpatient Transfer to and from ARMC" and/or AOM Policy No. 610.05, "Transfer to and from the Emergency Room".

V. **Inpatient Admission Changed to Observation Status**

A. Practitioner determines with Case Management that inpatient admission should be managed as observation status.

B. Practitioner documents a valid order to downgrade patient from an inpatient admission to observation status.

C. All orders received in Bed Management to downgrade a patient from inpatient status to observation status will be validated by Case Management for clearance.

D. Patient is downgraded to observation status by Patient Reception staff.

1. Patient appears in the HIS and hospital census as "**ADM INo**".

2. Condition Code 44 is entered in the HIS on the B/AR page of the registration pathway in 'Codes', for any inpatient to observation status changes.

E. Patient is informed by their Practitioner, Case Manager and/or designee of the status change to outpatient observation and offers any necessary explanation.

F. For Medicare patients only: Case Management reviews coverage changes resulting from the change to outpatient observation status and what effect, if any, this change may have on the coverage of services (Attachment B).

REFERENCES: **California Hospital Association Manual 2013,** Chapter 8; Conditions of Admission

CMS, MLN SE0622: 2004 Clarification of Medicare Payment Policy When Inpatient Admission is Determined not to be Medically Necessary, Including the Use of Condition Code 44, Inpatient Admission Changed to Outpatient

CMS Benefits Policy Manual: Chapter 6 – Hospital Services Covered Under Part B

CMS 1599-F Hospital IPPS: Chapter 6 – Hospital Claim for Patient Status

DEFINITIONS: **Outpatient Observation Services:** Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the

hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department (ED) visit. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

Coverage of Outpatient Observation Services: When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 10 "Covered Inpatient Hospital Services Covered Under Part A". All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare. Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378. In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient. In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or direct referral for observation services as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about billing and payment methodology for observation services in years prior to CY 2008, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §§290.3-290.4. For information about payment for extended assessment and management under composite APCs, see §290.5.

ATTACHMENTS: **ATTACHMENT A: Physician Certification**
                          ATTACHMENT B: Patient Observation Acknowledgement Form

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                         6/18/19   **William L. Gilbert, Hospital Director**
                                          Applicable Administrator, Hospital or Medical Committee

                         8/6/19   **Board of Supervisors**
                                          Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/1/16**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

DIAGNOSIS:	PROCEDURE & DATE:

STATUS ORDER BEFORE FIRST MIDNIGHT

I certify that based on my best clinical judgment and the patient's condition as documented in the medical record, I expect the patient will need hospital services for: (check one)

LESS THAN TWO MIDNIGHTS

(Medicare generally considers patients who are expected to need hospital services for less than two midnights to be outpatients, **unless those patients are receiving an "inpatient only procedure," in which case these are inpatients**.)

☐ Place patient in outpatient status and begin observation services

☐ Admit to inpatient status—Patient requires a procedure on the **Medicare Addendum E**, inpatient only list.

<div align="center">OR</div>

TWO OR MORE MIDNIGHTS

(Medicare generally considers patients who are expected to need hospital services for at least two midnights to be inpatients.)

☐ Admit to inpatient status

☐ ED Order: admit to inpatient status per _____ Signature: _____ Date/Time: _____
                                    Admitting Physician Name   ED Physician

Verbal Order per _____ Taken/Read Back by _____ Date/Time: _____
                        Physician Name   Signature/Credential

Resident Signature: _____ Date/Time: _____

Certifying/Ordering Physician Signature: _____ Date/Time: _____

UPDATED STATUS BEFORE FIRST MIDNIGHT (when applicable)

I certify that based on my best clinical judgment and the patient's condition as documented in the medical record, I now expect that the patient will need hospital services for two or more midnights.

☐ Admit to inpatient status

Resident Signature: _____ Date/Time: _____

Certifying/Ordering Physician Signature: _____ Date/Time: _____

REASSESSMENT OF OUTPATIENT AFTER FIRST MIDNIGHT

I certify that based on my clinical judgment and the patient's condition as documented in the medical record, I expect that the patient will <u>continue</u> to need hospital services for: (check one)

ONE *ADDITIONAL* MIDNIGHT OR MORE

(Medicare generally considers outpatients who (a) already have passed one midnight in the hospital and (b) are expected to need hospital services through at least one more midnight, to be inpatients.) Admissions for the convenience of the patient or family are not appropriate under Medicare rules.

☐ Admit to inpatient status

NO ADDITIONAL MIDNIGHTS: Patient ready for discharge

☐ Discharge Patient

IF YOU ARE UNSURE IF THE PATIENT WILL REQUIRE HOSPITAL SERVICES THAT CROSS ANOTHER MIDNIGHT, CHECK ONE OF THE FOLLOWING:

☐ Keep patient in outpatient status and provide observation services

Resident Signature: _____ Date/Time: _____

Certifying/Ordering Physician Signature: _____ Date/Time: _____

PATIENT IDENTIFICATION	ARROWHEAD REGIONAL MEDICAL CENTER **PHYSICIAN CERTIFICATION** **MEDICARE ORDER FORM** **USE BAR CODED FORMS ONLY**

22-15-385 (2/15)

Staying overnight in the hospital or at least 8 hours does not always mean that you have been admitted as an" inpatient" to the hospital. Your status ("inpatient", "outpatient", or "outpatient observation") will affect how much you may have to pay out of your own pocket.

Arrowhead Regional Medical Center may be providing outpatient observation services to you when ordered by your physician. This means that the doctor may have you stay up to 48 hours to see how you are doing before deciding to admit you as an "inpatient". This type of care is called "outpatient observation services" and is covered under your Medicare Part B medical insurance.

You must first meet your annual deductible and then Medicare will pay its share of the costs. That means that either you or your supplemental insurance, if you have one, must pay the 20% Medicare-approved co-insurance or balance.

If, after further evaluation by your physician, it is determined that you require acute care, you will be admitted to the hospital as an inpatient and your insurance will be billed for an inpatient stay.

Medicare will only cover skilled nursing facility stays that follow a qualifying 3-day inpatient hospital stay. A qualifying stay is a medically necessary inpatient stay of at least three days. Please be aware that neither outpatient observation services nor an inpatient admission that is not medically necessary will count toward the 3-day stay requirement. The time period for the 3-day qualifying stay will begin only when or if your physician concludes that it is medically necessary to admit you as an inpatient and orders your inpatient admission.

Please also be aware that Medicare does not pay for all of your healthcare costs. Medicare pays for only covered benefits. Some of the items or services Medicare will not pay for include:

- Most prescription drugs provided to an outpatient (Including a patient in "outpatient observation")
- Routine physicals and most screening tests
- Dental care and dentures (in most cases)
- Routine foot care and flat foot care
- Personal comfort items
- Immunizations

Because Medicare Part B does not pay for medications that you can normally take at home (such as pills to control your blood pressure or pills to control your pain), your bill for the time you spend receiving "outpatient observation services" may include some of these type medications.

Please contact a Patient Accounts if you have any questions regarding your insurance or concerns regarding services that you will be billed for. The phone number is (877) 818-0672.

I have received a copy of the Medicare Notification regarding Observation status.

Patient's Signature: _____ Date/Time: _____

If signed by anyone other than the Patient, please indicate relationship: _____

Witness Signature: _____ Date/Time: _____

PATIENT IDENTIFICATION	ARROWHEAD REGIONAL MEDICAL CENTER
	MEDICARE REQUIREMENTS FOR NOTIFICATION OF OBSERVATION RESULTS
	USE BAR CODED FORMS ONLY

73-100304-2 (4/16)

Pasar la noche en el hospital o por lo menos 8 horas no siempre significa que han sido admitidas como un "hospitalizado" en el hospital. Su estado ("hospitalizado", "ambulatoria" o "observación ambulatoria") afectará cuánto tienes que pagar de su propio bolsillo.

Arrowhead Regional Medical Center puede proporcionar observación ambulatoria servicios cuando ordenado por su médico. Esto significa que el médico puede tener la estancia hasta 48 horas para ver cómo usted está haciendo antes de decidirse a admitirte como una "internación". Este tipo de atención se llama "servicios ambulatorios de observación" y está cubierto por su seguro médico de Medicare parte B.

Primero debe cumplir con su deducible anual y luego Medicare pagará su parte de los costos. Eso significa que usted o su seguro complementario, si usted tiene uno, debe pagar el 20% coaseguro aprobado por Medicare o el equilibrio.

Si, después de la evaluación adicional de su médico, se determina que requieren cuidado agudo, usted será admitido al hospital como una hospitalización y su seguro le facturará por una hospitalización.

Medicare cubrirá únicamente centro de enfermería especializada estancias que siga una calificación 3 días hospitalizados. Una estancia es un médicamente necesario hospitalización de al menos tres días. Tenga en cuenta que ninguna consulta externa servicios de observación ni ingreso hospitalario que no es médicamente necesario de la estancia de 3 días. El período de tiempo de 3 días estancia comenzará sólo cuando o si su médico considera que es médicamente necesaria para admitir que como paciente ambulatorio y órdenes su ingreso hospitalario.

También tenga en cuenta que Medicare no pagará todos sus gastos de salud. Medicare paga sólo los beneficios cubiertos. Algunos de los artículos o servicios Medicare no pagará por incluyen:

- La mayoría de medicamentos proporcionan a ambulatorio (incluyendo a un paciente en "observación ambulatoria"")
- Exámenes físicos de rutina y detección más pruebas
- Cuidado dental y dentaduras postizas (en la mayoría de los casos)
- Cuidados de rutina de pie y pie plano
- Artículos de comodidad personal
- Vacunas

Porque Parte B de Medicare no paga por los medicamentos que se pueden tomar en el hogar (tales como pastillas para controlar la presión sanguínea o píldoras para controlar el dolor), su factura por el tiempo que pasa recibiendo "paciente ambulatorio servicios de observación" puede incluir algunos de estos medicamentos. Póngase en contacto con un paciente cuentas si tienes alguna pregunta relacionada con su seguro o preocupaciones con respecto a los servicios que se le facturará por. El número de teléfono es (877) 818-0672.

He recibido una copia de la notificación de Medicare sobre estado de observación.

Firma del paciente:_____ Fecha/Hora _____

Si firmado por alguien que no sea el paciente, indicar relación: _____

Firma del testigo:_____ Fecha/Hora _____

PATIENT IDENTIFICATION	ARROWHEAD REGIONAL MEDICAL CENTER
	REQUISITO DE MEDICARE PARA LA NOTIFICACIÓN DE ESTADO DE OBSERVACIÓN
	USE BAR CODED FORMS ONLY

73-100305-2 (4/16)

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: **CALIFORNIA END OF LIFE OPTION ACT**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

_____

POLICY

Arrowhead Regional Medical Center has determined that the requirements of the California End of Life Option Act are more conducive to a setting and environment other than an acute care hospital. ARMC will not participate or assist in participation with activities pursuant to the California End of Life Option Act. ARMC employees, independent contractors, physicians and volunteers may not knowingly participate in, or facilitate activities under the Act, except as provided herein while: (1) on premises owned or under the management and direct control of ARMC (including but not limited to Hospital grounds and Hospital operated facilities, clinics, pharmacies, etc.) or (2) acting within the scope of any employment by, or contracted service with, ARMC.

PROCEDURES

I. Physicians, nurses and other providers are encouraged to fully explore and discuss end of life care and treatment options with terminally ill patients and their families. As part of that discussion, requests for physician-assisted death or self-administered life-ending medication may occur. While ARMC respects the rights of patients and their care teams to discuss and explore all treatment options, ARMC, its facilities, programs and on-site caregivers (or acting under ARMC Contract) may not participate in any activity under the act, including but not limited to the following:

     A. Prescribe, deliver or dispense an aid-in-dying drug to a patient or patient designee.

     B. Administer or assist with the administration of any aid-in-dying drug.

     C. Be present when a patient ingests an aid-in-dying drug.

II. When a patient expresses intent to pursue physician-assisted death the patient care team shall:

     A. Inform the patient that ARMC does not participate in activities under the Act and its physicians, employees, contractors and volunteers are prohibited from providing, delivering, administering or assisting a patient with an aid-in-dying drug.

     B. Provide patient with a copy of the End-Of-Life Option Act Talking Points handout for follow up after discharge from facility.

     C. Provide patient and families with all other requested end-of-life, hospice, palliative care and any other related services.

     D. Review any patient or patient designee requests for an aid-in-dying drug and refer to the attending physician.

III. Consistent with this policy, ARMC will continue to provide appropriate care to patients who qualify for and request end-of-life services, regardless of their stated interest in seeking an aid-in-dying drug.

REFERENCES: AB 15 – End of Life Option Act, Health & Safety Code Section 443

DEFINITIONS:

1. "Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual (as defined in the Act), which the qualified individual may choose to self-administer to bring about his or her death to a terminal disease.

2. "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

ATTACHMENTS: N/A

APPROVAL   DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: <u>10/27/16</u>   **REVISED**:   <u>N/A</u>

REVIEWED: <u>2/07/19</u>

WOUND CARE ALGORITHM: SIMPLE SOLUTIONS

REQUIRES A PHYSICIAN ORDER

Wound Depth
IS IT...?

Full Thickness and Deep: Needing Packing?

Moist: Draining moderate to heavy amounts?

1. Clean Wound
2. Pack with dry **Aquacel** hydrofiber *
3. Cover with square Mepilex **foam**
4. Change every 3 days and PRN

*With infection or necrosis use silver **Aquacel AG**

Dry: Draining very little or small amounts?

1. Clean Wound
2. Pack with **Aquacel** hydrofiber then moisten slightly with Normal Saline (use small saline from respiratory)*
3. Cover with square Mepilex **foam**
4. Change every 3 days and PRN

*With infection or necrosis use silver **Aquacel AG**

Partial Thickness: Very Shallow?

Moist: Draining moderate to heavy amounts?

1. Clean Wound
2. Apply square Mepilex **foam**
3. Change every 3 days and PRN

Dry: Draining very little or small amounts?

1. Clean wound
2. Apply **Duoderm**
3. Change every 3 days and PRN

*DO NOT use on feet (danger r/t poor circulation) If used on coccyx, sacrum, buttocks: cover with foam to prevent rolling

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: WOUND DRESSINGS, ORDERING USING WOUND ALGORITHM

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

I.   Practitioners ordering wound care, using evidence based wound algorithm and basing wound orders upon the Registered Nurse's (RN) assessment of the wound, follow the procedural guidelines outlined in this policy.

II. All wounds require orders for care.

    A. When indicated, the Registered Nurse follows the procedure below to obtain orders from the primary practitioner.

    B. Changes in wound condition indicating deterioration, including but not limited to increased redness, pain, drainage and size, require a direct assessment by the practitioner.

III. The practitioner is responsible for determining the etiology of the wound.

    A. Based upon the etiology of the wound, practitioners use the Wound Referral Algorithm as a guide for expert consultation.

    B. Arrowhead Regional Medical Center (ARMC) requires a Wound NURSE Consultation be placed for suspected pressure ulcers, either present on admission or hospital acquired. The Wound NURSE Consultation is required for regulatory tracking and reporting requirements.

PROCEDURES

I.   Primary service practitioner directs the wound care using the Solutions Algorithm
    A. Wound care orders are based upon the assessment of the wound by the RN or practitioner
    B. The most recent wound care order supersedes prior orders
    C. RN or practitioner assesses the wound based upon the following criteria
        1. Depth of the wound
           a. Superficial/partial thickness
           b. Deep requiring packing
        2. Balance of moisture in the wound based upon the amount of drainage.
           a. Low draining
           b. High draining
        3. Known infection or reasonable expectation that the wound is infected or colonized with bioburden
           a. Low expectation of infection potential
           b. Reasonable or know expectation of infection or high bioburden contamination

II. During the admission process, the admitting RN performs a complete assessment of the chronic wound(s) found on admission

A. Nurses utilize the Wound Algorithm to determine the most appropriate wound care for each chronic wound. The most appropriate wound care is based upon the RN's assessment of:
   1. Depth
   2. Amount of drainage
   3. Potential or suspected infection present

B. RN documents wound findings in the electronic medical record after admission to a unit

III. Admitting RN, or RN caring for patient when wound is discovered, calls the primary team and reports the assessment criteria and condition of the wound

A. Using the Wound Algorithm as a guide for care, the reporting RN recommends the appropriate wound care treatment to the practitioner.
B. A normal saline moist gauze dressing may be placed on the wound after assessment prior to the call to the practitioner.
C. If an order is received for care based upon the reported assessment, the nurse writes in the written chart, "Wound care read back per algorithm, see order in Meditech".
D. Reporting RN enters the wound care as a "Read Back" order in the electronic medical record under the Wound Order Set per the instructions of the practitioner.

REFERENCES: Administrative Policy 690.30, Wound Care Referral Process

Briggs M, Banks S. Documenting wound management. J Wound Care. 1996 May; 5(5):229-31.

ConvaTec. SOLUTIONS® wound care algorithm. Princeton (NJ): ConvaTec; 2013 Sep. 16 p. [103 references] https://guideline.gov/summaries/summary/47857

Mustoe TA, O'Shaughnessy K, Kloeters Chronic wound pathogenesis and current treatment strategies: a unifying hypothesis. O Plast Reconstr Surg. 2006 Jun; 117(7 Suppl):35S-41S.

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical Practice Guideline. Haesler E. (Ed). Cambridge Media: Perth Australia; 2014.

DEFINITIONS: **Chronic Wound:** Chronic wounds are defined as wounds, which have failed to proceed through an orderly and timely reparative process to produce anatomic and functional integrity over a period of 3 months
Compete Wound Assessment: Assessment of wound performed by nursing to include: Location of wound, size of wound, tissue type and color, periwound condition, presence of tunneling, exudate and odor of exudate, odor.
Full Thickness Wound: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone may or may not be exposed.
Partial Thickness Wound: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.
Wound Algorithm: Algorithm for wound care decision making for chronic wounds based upon Solution's Algorithm for Wound Care [1]
Wound NURSE Consultant: Wound specialty trained pressure ulcer nurse assumes role of tracking all pressure ulcers within the facility

ATTACHMENTS: **Attachment A: Wound Algorithm**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **2/23/17**   **REVISED**:   **N/A**

REVIEWED: **N/A**

SECTION:	PATIENT CARE	SUB SECTION: CONTINUUM OF CARE

SUBJECT: CODE SEPSIS

APPROVED BY: _____

Chief Executive Officer

POLICY

It is the policy of the Arrowhead Regional Medical Center (ARMC) to provide a multidisciplinary, timely, and effective approach to care for patients with severe sepsis/septic shock less than 6 hours after symptom onset.

PURPOSE

I.   To improve patient outcomes by establishing guidelines for the prompt evaluation and treatment of patients who present to ARMC with severe sepsis/septic shock symptoms within 6 hours.

II.   The notification of this process is called a **Code Sepsis.**

III.   The goals of the ARMC Sepsis Initiative are to promptly recognize the signs and symptoms of severe sepsis/septic shock, activate the Code Sepsis, improve sepsis procedures, coordinate sepsis care, meet the sepsis performance standards, provide sepsis education, follow-up sepsis care, continuously monitor and measure standards for improvement.

PROCEDURE

Code Sepsis called in the Inpatient Nursing Tower
   Personnel:

1. Primary registered nurse (RN)
a.   Identifies signs and symptoms consistent with severe sepsis
b.   Completes the initial severe sepsis screening criteria below:
   i.   Assess patient for suspected or known source of infection.
      ii.   Determine if patient has at least <u>TWO or more</u> of the following for systemic infection according to the Systemic Inflammatory Response Syndrome (SIRS) criteria:
Temperature greater than *38.3˚C (greater than 100.9˚F) or less than 36˚C (less than 96.8˚F)*
Heart rate (pulse) greater than 90 per minute
Respiration greater than 20 per minute
White blood cell count greater than 12,000 or less than 4,000, or more than 10 %bands
      iii.   In addition, determine if patient has at least <u>ONE</u> of the following as evidence for organ dysfunction:
Systolic blood pressure (SBP) less than 90mmHg, or mean arterial pressure (MAP) less than 65mmHg, or SBP drop more than 40mmHg
Lactate greater than 2mmol/L
Platelet count less than 100,000 /mm³
Creatinine greater than 2.0 mg/dL

Urine output less than 0.5ml/kg/hour for 2 consecutive hours
Bilirubin greater than 2mg/dL
INR greater than 1.5
PTT greater than 60 seconds
c.   If clinical criteria above are met then determine the time and date of severe sepsis
is present.
d.   Notifies the Charge Nurse immediately.
e.   Calls Code Sepsis overhead by dialing X44444 and ask for Code Sepsis; may be
delegated. The Rapid Assessment Team (RAT) Team will respond to the Code
Sepsis.
f.   Notifies the patient's physician on-call immediately and updates the patient's
findings.
            g.   Obtains blood cultures and venous blood gas (VBG) Sepsis with Lactate
specimen immediately (STAT) as ordered.
            h.   Assures that VBG Sepsis with Lactate is sent to the Blood Gas Laboratory and
blood cultures to the Main Laboratory.
i.   Assesses and documents vital signs.
j.   Administers antibiotics or other antibiotics after blood cultures are drawn.
k.   Administers supplemental oxygenation to maintain saturation by pulse oximetry to
the prescribed level, or to maintain an age appropriate saturation. Orders are obtained and Respiratory
Care notified.
l.   Ensures intravenous (IV) access and /or assists with placement of a central line.
m.   Administer 30 mL/kg crystalloid IV as ordered if initial lactate is greater than or equal
to 4mmol/L, presentation of septic shock, or hypotension present.
n.   Documents the time and date of the severe sepsis report, laboratory results, and
RAT response.
o.   Transfers the septic patient to the intensive care unit (ICU) or designated unit as
determined by physician.

        2. Patient's Physician, physician assistant (PA), or advanced practice nurse (APN)
            a.   Evaluates patient for evidence of sepsis and may call a Code Sepsis
b.   Determines time and date of severe sepsis is present
c.   Orders sepsis bundle elements to be completed within 3 hours of time of
        presentation or discovery, which are:
Draw initial arterial blood gas (ABG) with Lactate or VBG Sepsis with Lactate STAT.
Draw Blood Culture x 2 (Sepsis Protocol) prior to administration of antibiotics STAT.
Administer broad spectrum antibiotic or other antibiotics
Administer 30mL/kg crystalloid IV if initial lactate level is greater than or equal to 4mmol/L, presentation of
septic shock, or hypotension present.
d.   Orders sepsis bundle elements to be completed within 6 hours of time of
        presentation, which are:
Draw repeat ABG with Lactate or VBG Sepsis with Lactate STAT if the initial lactate is greater than
2mmol/L.
Apply vasopressors for hypotension that does not respond to initial fluid resuscitation to maintain a MAP
of above 65mmHg.
Reassess volume status and tissue perfusion and document findings in the event of persistent hypotension
after initial fluid administration
(MAP below 65 mmHg), septic shock, or initial lactate level was greater than or equal to 4 mmol/L.
Complete sepsis reassessment within 6 hours of discovery/
Presentation
            e.   Obtains result of Sepsis Labs STAT.
            f.   Discusses treatment plans, infectious process, and infection prevention such

as hand hygiene and personal hygiene with attending physician, patient and
family.
g.   Contacts admitting service and discusses transfer as indicated.
h.   Assures that the correct Code Sepsis Checklist is utilized.

3.   Rapid Assessment Team (RAT) RN
If a code sepsis is indicated, will call a Code Sepsis.
Assists with obtaining blood cultures and VBG Sepsis with Lactate STAT as ordered.
Ensures that the Lactate specimen is sent to the Blood Gas Laboratory and Blood Cultures to the Main
Laboratory.
Ensures that the correct Code Sepsis Checklist is utilized.
Assesses and documents vital signs.
Monitors cardiac rhythm and pulse oximetry.
Ensures IV access and/or assisting with placement of a central line.
Monitors for signs/symptoms of changes in vital signs.
Documents the time and date of the severe sepsis report, laboratory results, and RAT response.
Initiates, documents, and completes Code Sepsis Checklist.
Assists in transferring the sepsis patient to the ICU or designated unit as determined by physician.

4.   Respiratory Care Practitioner (RCP)
a.   Performs respiratory care assessment
Assesses oxygenation and ventilatory status of the patient and making recommendations for appropriate
respiratory care interventions.
Initiates and adjusts therapy as required, solicits orders as appropriate from RAT team physician provider
as needed.
    Obtains arterial samples for blood gas analysis as indicated and orders to
            assess oxygenation and ventilation or acid/base disturbances with lactate
            measurement.
    Advices care team of any lactate result greater than 2.0 mmol/L and need for
    repeat lactate measurement within 6 hours of presentation.

5.   Unit Clerk
Assists with entering written STAT lab orders for lactate and blood cultures as: "**Code Sepsis**".
Enters add on lab tests as ordered.

6.   Blood Gas Laboratory Department
a.   Accepts and analyzes all ABG and VBG lactates for sepsis to include lactate
as ordered.
b.   Releases the results of ABG and VBG lactates for sepsis into the Meditech system.
c.   Provides notification of abnormal results to the licensed individual as
        identified on the Blood Gas Requisition, along with notification of the reflexes
        lactate order within 6 hours requirement.
    7.   Admissions RN/Bed Management
    Facilitates bed placement of the patient to ICU or designated unit as
        determined by physician.
    Notifies the Sepsis Coordinator via email for Performance Improvement
    (PI) for tracking purposes.

II.   General Procedures

Continuing Care
Departments are responsible for Sepsis Core Measures as it pertains to them.

Code Sepsis Checklist is provided for reference and is not meant to substitute for physician directed patient care.

Data Collection, Performance Improvement (PI), and Discharge

It is imperative that the performance data be collected and analyzed in an attempt to make further improvements. It is also important that the goals of the ARMC Sepsis Initiative of promptly recognizing severe sepsis/septic shock, activating the **Code Sepsis**, improving sepsis protocols and procedures, coordinating sepsis care, meeting and exceeding sepsis performance standards, sepsis education, and follow-up sepsis care and education be continuously measured and improved.

The PI staff are responsible for collecting and analyzing sepsis data. The Sepsis Committee will be provided with the **Code Sepsis** activation date and time, patient name and medical record number, room number and admitting physician. The remainder of the data is abstracted after discharge.

For sepsis care to be beneficial, it is essential that the nursing staff provide the patient, patient's family, or surrogate instructional material to help improve the current sepsis condition and to prevent further occurrence.

ARMC reviews the baseline and PI data quarterly in an attempt to determine best practices, measure outcomes, make publications, improve protocols to care for sepsis, and enhance sepsis education.

III.   CONTACT THE SEPSIS COMMITTEE FOR MORE INFORMATION.

REFERENCES:	**Administrative Policy No. 610.28, Infection/Sepsis of the Adult Patient**
	Center for Medicare and Medicaid Services (CMS). (2018). Specifications Manual for National Hospital Inpatient Quality Measures Discharges 01-01-18 (1Q18) through 06-30-18 (2Q18). *Version 5.3a*, 1-60.
KEYWORDS:	**N/A**
DEFINITIONS:	**N/A**
ATTACHMENTS:	**Attachment A - Code Sepsis Checklist**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	6/18/19	**William L. Gilbert, Hospital Director**
		Applicable Administrator, Hospital or Medical Committee
	8/6/19	**Board of Supervisors**
		Approved by the Governing Body

REPLACES:	**N/A**		
EFFECTIVE:	**2/28/18**	**REVISED:**	**N/A**
REVIEWED:	**2/07/19**		

ARROWHEAD
REGIONAL MEDICAL CENTER
*The Heart of a
Healthy Community*

NOT PART OF MEDICAL RECORD   *RETURN TO PI DEPT*
NOT A PHYSICIAN ORDER FORM

CODE SEPSIS CHECKLIST

Ⓐ

If severe sepsis criteria are met in Section A - Continue to Section B

SECTION A

Source of Infection: ☐ Patient has suspected or known source of Infection
Discovery Date/Time: _____

SIRS criteria (at least two of the following):

☐ Temperature greater than 38.3°C (100.9°F) or less than 36°C (96.8°F)   ☐ Heart rate greater than 90 per minute

☐ Discovery Date/Time: _____   Discovery Date/Time: _____

Respiratory Rate greater than 20 per minute   Discovery Date/Time: _____
☐ WBC greater than 12,000 or less than 4,000 or more than 10% bands   Discovery Date/Time: _____

Organ dysfunction (at least one of the following): **Enter discovery date & time for each value as applicable in**

☐ Systolic blood pressure(SBP) less than 90, Mean arterial pressure (MAP) less than 65mmHg, or SBP drop greater than 40mmHg from baseline	☐ Lactate greater than 2 mmol/L	☐ Platelet count less than 100,000/mm³
☐ Creatinine greater than 2.0 mg/dL	☐ Urine output less than 0.5mL/kg/hour for 2 consecutive hours	☐ Bilirubin greater than 2 mg/dL
☐ INR greater than 1.5	☐ PTT greater than 60 seconds	

boxes

Ⓑ   *If criteria above are met, activate Code Sepsis by calling x44444 and ask for Code Sepsis*

COMPLETE WITHIN 3 HOURS OF TIME OF PRESENTATION OR DISCOVERY

☐ ABG w/Lactate #1 or VBG Sepsis w/Lactate #1

☐ Obtain blood cultures prior to administration of antibiotics

☐ Administer broad spectrum antibiotic or other antibiotics

Rev: 1/2018_PI

SECTION B

☐ Administer 30ml/kg crystalloid IV if initial lactate level is greater than or equal to 4mmol/L, presentation of septic shock, or hypotension present

COMPLETE WITHIN 6 HOURS OF TIME OF PRESENTATION

☐ A☐ w/ Lactate #2 or VBG Sepsis w/Lactate #2 if initial lactate is greater than 2 mmol/L

☐ ☐ Apply vasopressors for hypotension that does not respond to initial fluid resuscitation to maintain a MAP of   above 65mmHg (ICU only)

☐ In the event of persistent hypotension after initial fluid administration (MAP below 65mmHg), septic shock, or if initial lactate level was greater than or equal to 4mmol/L, re-assess volume status and tissue perfusion and document findings

☐ Complete Sepsis Reassessment within 6 hours of discovery/presentation

Place patient label here

SECTION:	PATIENT CARE	SUB SECTION:	CONTINUUM OF CARE

SUBJECT: **DISCONTINUING A URINARY CATHETER UTILIZING THE HOUDINI PROTOCOL**

APPROVED BY: _____
Chief Executive Officer

_____

POLICY

I.   The risk of a catheter-associated urinary tract infection (CAUTI) increases the longer an indwelling urinary catheter stays in place. The need for continued catheterization should be assessed at least daily and the urinary catheter removed by a Registered Nurse (RN) as soon as qualifying indications are no longer met.

II.   Qualifying indications for an indwelling urinary catheter are:

   A.   **H**ematuria, gross
   B.   **O**bstruction, urinary
   C.   **U**rologic surgery
   D.   **D**ecubitus ulcer – open sacral or perineal wound in incontinent patient
   E.   **I**ntake and output (I&O) - accurate measurement in critical care patients
   F.   **N**o code/comfort care/hospice care/Neurogenic bladder
   G.   **I**mmobility due to physical constraints (e.g., unstable fracture, etc.)

III.   The following patients are not included in this policy and **a physician order is required** for discontinuing indwelling urinary catheter:

   A.   Patient with a practitioner order for "Do Not Discontinue Urinary Catheter" or "Do Not Discontinue Urinary Catheter Without Practitioner Order"
   B.   Recent urologic surgery
   C.   Patients with hemodynamic instability or Shock
   D.   Continuous bladder irrigation
   E.   Bladder injury
   F.   Pelvic surgery (i.e., colorectal surgery, gynecologic surgery, etc.)
   G.   Recent surgery involving structures contiguous with the bladder or urinary tract
   H.   Epidural anesthesia
   I.   Difficult insertions, insertions performed by Urologist

PROCEDURE

I.   Physician order is written to utilize the HOUDINI protocol
II.   Patient identified as no longer meeting the qualifying indication for an indwelling urinary catheter
III.   RN discontinues the urinary catheter, see Perry and Potter, *Clinical Nursing Skills & Techniques,* Care and Removal of an Indwelling Catheter
IV.   After discontinuation of the urinary catheter, the RN assesses for patient voiding within 6 hours

   A.   If the patient has not voided within 6 hours:

    1. Assess the patient for urinary retention; see Department of Nursing (DON) Policy 546.05 Bladder Scanning. A bladder scan is done for any of the following:

        a. Patient is uncomfortable at any time, whether voiding or not
        b. Patient has an urge to void but is unable to do so
        c. Patient is incontinent at anytime

    2. If the patient is uncomfortable or if the bladder scan post void residual is greater than 400 ml, the RN initiates straight catheterization of the patient as needed, DON Policy 546.00 Urinary Bladder Catheterization
    3. Record bladder scan results and output volume with each void and each catheterization.

  B. If the patient has not voided within 6 hours after straight catheterization, notify the physician. If the physician does not respond activate the chain of command see DON Policy 408.00 Chain of Command/Conflict Resolution.

REFERENCES: **Perry, A.G., Potter, P.A., Ostendorf, W.R. (Eds.). (2018). Clinical nursing skills & techniques (9th ed.). St. Louis: Elsevier.**
DON)Policy 546.00 Urinary Bladder Catheterization
DON Policy 546.05 Bladder Scanning

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

EFFECTIVE: <u>**10/5/17**</u>   **REVISED:**   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	**SUB SECTION:**	**PATIENT ASSESSMENT**

SUBJECT:　　　　**SCREENING AND MANAGING IN-PATIENTS AT RISK FOR SUICIDE**

APPROVED BY: _____
Chief Executive Officer

POLICY

I.　　Arrowhead Regional Medical Center (ARMC) identifies patients at risk for suicide and assures that their immediate safety needs are met in the most appropriate care setting.

II.　　Assessment

　　A.　　Nursing staff screen in-patients for risk for suicide initially and daily as part of the psychosocial shift assessment using a suicide risk assessment tool, see Attachment A.

　　B.　　ARMC healthcare providers monitor patients for warning signs of suicide risk including but not limited to:

　　　　1.　　Observable signs or reports of depression, loss of appetite, decreased concentration, suicide ideation, inability to sleep
　　　　2.　　Patients between the ages of 19 and 45 years old
　　　　3.　　Previous suicide attempt or have received psychiatric care
　　　　4.　　Currently or chronically abusing alcohol or substances
　　　　5.　　Identified as having a loss of rational thought, psychosis or organic brain syndrome
　　　　6.　　Diagnosed with a chronic or terminal illness
　　　　7.　　Patients without social support
　　　　8.　　Patients who have an organized plan or have made a previous attempt to take their life

III.　　Physician Notification

　　A.　　Nurse notifies the provider when patient is evaluated as at risk for suicide to consider obtaining an order for a psychiatric consult.

PROCEDURE

I.　　For patients scoring 7-9 on the suicide risk tool or who have an organized plan or serious suicide attempt:

　　A.　　Notify the Nursing Supervisor to get a 1:1 sitter
　　B.　　Continue shift assessments
　　C.　　Notify provider to consider a psychiatric consult
　　D.　　Provide safety measures

II.　　For patients scoring 5-6 on the suicide risk tool, continue shift assessment and provide safety measures.

III. For patients scoring 0-4 on the suicide risk tool, continue shift assessment.

IV. For patients placed on a 5150 hold, see Department of Nursing Policy No. 314.00, Patient Safety Assistant Utilization and Responsibilities.

V. ARMC staff provide appropriate safety interventions for the care and management of the "at risk" patient. Interventions include:

A. Meticulous surveillance for a safe environment to decrease the potential for self-harm. Look for and remove items that might contribute to self-harm, (e.g., plastic bags, unnecessary linen, pantyhose, hairclips, belts, ties, jewelry, razors, and other sharps).
B. Utilize therapeutic communication to improve staff-patient dialog and relationships and establish rapport.
C. Observe the patient at least hourly - direct visualization is required. Sitter may be discontinued.
D. At risk patients are offered transfer to ARMC Behavioral Health or a psychiatric facility of their choice as soon as they are deemed medically stable and safe for transport.

VI. Documentation

A. Document assessment, plan of care, and safety interventions in the medical record.
B. Document discharge instructions, including suicide hotline phone number.

REFERENCES: **Joint Commission National Patient Safety Goal, 2015**
Department of Nursing Policy No. 314.00, Patient Safety Assistant (PSA) Utilization and Responsibilities
Behavioral Health Department Policy No. 818, Prevention of Suicide
Emergency Department Policy No. 426, Management of 5150 Patients

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Suicide Risk Assessment Tool**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/2/15**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

Suicide Risk			
Sex	○ Male	○ Female	
Age<19 or >45 Years	○ Yes	○ No	
Suicide Symptoms	☐ Depression ☐ Loss of Appetite ☐ Decreased Concentration ☐ Suicide Ideation ☐ Unable to Sleep		
Previous Suicide Attempt or Psychiatric Care	○ Yes	○ No	
Excessive Alcohol or Drug Use	○ Yes	○ No	
Rational Thinking Loss, Psychosis, Organic Brain Syndrome	○ Yes	○ No	
Sickness Chronic Disease Recent Terminal Diagnosis	○ Yes	○ No	
ORGANIZED PLAN or SERIOUS ATTEMPT	○ Yes ○ No ** If not already on 5150, immediately implement 1:1 Sitter, notify provider to consider Psychiatric Consult; implement Safety Measures; Q Shift Assessment		
Social Support	○ Yes	○ No	
Suicide Risk Total	Total Points: 0-4: Continue Q Shift Assessment 5-6: Continue Q Shift Assessment & Safety Measures 7-9: Immediate 1:1 Sitter; Notify Provider to consider Psychiatric Consult; Implement Safety Measures & Q Shift Assessment		

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	PATIENT CARE	SUB SECTION:	PATIENT ASSESSMENT

SUBJECT: **FALL PROGRAM**

APPROVED BY: _____

                             Chief Executive Officer

POLICY

I.   Patients receive an assessment of their potential risk for falling. The Patient Safety Fall Program is implemented for patients identified at risk for falls with intervention(s) tailored to meet the needs of each patient identified.

II.   If a falls occurs, nursing staff provide appropriate management of the patient, documentation, and ensure proper notification of Department Managers.

III.   Direct patient care providers and staff nurses receive initial training on fall prevention. Ongoing training is provided annually to increase staff's current knowledge of evidence-based, best practices on fall management.

IV.   Upon discharge, patients receive fall prevention education and handouts to help prevent falls at home and decrease readmissions due to a fall.

PROCEDURES

I.   Patient Assessment

      A.   The Morse Fall Risk Assessment Tool is used to assess patient's fall risk.
      B.   Initial fall risk assessment is performed by a Registered Nurse (RN) upon admission.
      C.   Daily re-assessment is performed by the patient's primary nurse when any of the follow occur:
           1.   Upon any change(s) in condition such as mentation, post-operatively, post-procedure
           2.   Change in medication treatment
           3.   Transfer from one level of care to another
      D.   Documentation of the Morse Fall scale is under the intervention section titled:
           1. For Intensive Care Unit (ICU) and Burn patients: ICU Core Assessment – Morse Fall Risk
           2. For medical surgical and telemetry patients: Safety & ADL Activities – Safety & Alarms/Morse/Fall*
           3. For labor and Delivery and Postpartum patients: Exam tab in Intellispace

II.   Implementation of Patient Safety Fall Program Using the Morse Scale
       The Morse Scale is a rapid and simple method of assessing a patient's risk of falling.

      A.   Patient scoring 0-44 are "low risk". Implement fall prevention strategies used for all patients aimed at reducing environment hazards, compensating for some functional limitations and education to increase patient safety and support person/family involvement, such as:
           1.   Bed in lowest position with wheels locked and bed alarm activated
           2.   Orienting patient to the environment on arrival to each new nursing care area

3. Utilize appropriate lighting on evening/night shift to allow for safe access to bathroom
4. Maintain an uncluttered path to door and bathroom
5. Call light and bedside table within reach
6. Personal items (i.e., books, glasses, TV remote, phone, etc.) within reach
7. Hourly rounding demonstrating use of the four P's (Pain, Position, Potty, Proactive measures)
8. Clean spills immediately and teach patients to call for assistance with spills

B. Patient score equal to or more than 45, implement interventions for patients at high risk for falling, see Section III below.

C. Members of the nursing team assist the nurse in implementation of the Patient Safety Fall Program.

III. Implement interventions for patients at high risk for falling (see Attachment A, Fall Assessment Check List) which may include but are not limited to:

A. Hourly Rounding to include:
1. Place call light within reach of the patient and encourage use
2. Provide assistance for timed toileting every 1-2 hours and as needed by the individual patient
   a. Emphasize the importance of using the call light for assistance. Keep the bedside commode and walking aids (i.e. walker, canes, wheel chairs, etc.) out of sight.
   b. When patient awakens from sleep, offer the opportunity to void on a regularly time basis.
3. Minimize obstacles to mobility (i.e. clutter, personal items, bedside table, etc.)
4. Position bedside table with personal items (i.e., glasses, reading materials, etc.) within reach

B. Implement the Fall Kit including:
1. Yellow non-skid footwear
2. Yellow fall signs outside the patient's room
3. Yellow patient gown
4. Yellow arm band
5. Bed alarm and/or posey elite alarm turn on (except for Labor and Delivery and Postpartum patients)

C. Answer call light(s) promptly

D. Utilize bedrails as necessary based on individual patient assessment. Keep the bed in lowest position. Use low beds and activate bed alarm, assess the need for portable alarms in addition to the bed alarm based on individual patient needs. Ensure bed brakes/wheelchair brakes are set

E. Leave a light on at night

F. Leave the patient door open to allow observation and monitoring by the nursing staff

G. Instruct patients not to get out of bed without assistance, place call light within reach and educate patient on consequences of falling including death and highlight the importance of adhering to the proposed safety plan

H. Consider, if appropriate, the feasibility of family members/caregiver staying with patient

I. Provide pre-operative teaching regarding post-operative safety issues if applicable

J. Reorient to the environment as needed

K. Implement patient safety devices as appropriate

L. Move the patient closer to the nursing station as needed

M. Occupational/Physical Therapy referral as indicated

N. Evaluate medications that may produce gait disturbances. Request a medication review for patients multiple medications looking for drug-drug interactions that may cause a change in mentation or physical instability
O. Accommodate for sensory deficits (i.e., hearing aids, glasses, etc.)
P. Identify and incorporate individual routines or preferences

IV. Plan of Care

A. Add the problem Fall Risk to the patient's plan of care
B. Include fall prevention interventions as appropriate for the patient
C. Documentation of the interventions and patient education are under the intervention section titled:
   1. For ICU and Burn patients: ICU Core Assessment
   2. For medical surgical and telemetry patients: Safety & ADL Activities – Safety & Alarms/Morse/Fall*
   3. For Labor and Delivery and Postpartum patients: Events/Remarks section in Intellispace
D. Discontinue the problem when the patient is no longer at risk for falling

V. Post Fall Management

A. Upon discovery of the patient, assess for degree of injury
   1. Examine patient before moving
   2. Ask patient to relate what happened
B. Notify the physician and report the patient's clinical condition
C. If injury is present, provide immediate care as required
D. Report clinical condition of patient to:
   1. Department manager
   2. House supervisor or designee manages the post-fall huddle
      Note: Should a patient death occur that is associated with a fall, the manager or supervisor must be notified underline immediately. If the event occurs during the evening, night, weekend, or holiday, notify the Nursing Office Supervisor who contacts the administrator on call for further evaluation.
   3. Risk management coordinator and director of case management for fall with injury
   4. Report clinical condition of patient including:
      a. Vital signs
      b. Altered mobility
      c. Mentation (confusion, disorientation and/or hallucinations)
      d. Patient statements/complaints
      e. Nursing assessment including any visible injuries
      f. Nursing interventions
   5. Perform additional vital signs and neurological checks as noted in the table below, unless otherwise ordered. For falls without injury, follow unit specific assessment frequency.

	Frequency Vital Signs and Neurological Checks	Duration Vital Signs and Neurological Checks
Fall with injury (but with no apparent head injury)	Every 2 hours	First 12 hours
Fall with head injury	Every hour	First 12 hours

VI.   Documentation
     A.   Provide accurate and complete documentation in patient medical record of the occurrence as follows:
          1.   Clinical condition of patient including vital signs and patient status
          2.   Patient statements/complaints
          3.   Nursing assessment
          4.   Nursing interventions
          5.   Patient's account of events
          6.   Time of fall
          7.   Time of physician notification
     B.   Complete an Unusual Occurrence Report
     C.   Complete a post-fall huddle and submit form to the nursing office supervisor on duty
     D.   Complete the SBAR (Situation, Background, Assessment, and Recommendation) report form
     E.   Present to the bi-monthly fall collaborative meeting

VII.   Emergency Department

     A.   Patient Assessment
          Nurse completes the Fall Assessment during triage assessment
     B.   Interventions
          1.   Nursing assesses need for immediate bed placement or alternative such as a wheelchair
          1.   Staff provides assistance as needed
          2.   Once the patient with a Morse Score of greater than or equal to 45 is placed in a room, interventions implemented in the critical care, telemetry, and medical surgical areas are followed
     C.   Documentation
          1.   Staff document in medical record interventions and reassessments
          2.   Patient's high fall risk assessment is reported at handoff and transfer of care, see Department of Nursing Policy 557.01, Patient Handoff and Communication.
     D.   Patients being discharged are assessed for Durable Medical Equipment (DME) needs.

VIII.   Pediatric Patients
     A.   Patient Assessment
          1.   The Generalized Risk Assessment for Pediatric In-Patient Falls (GRAF- Pif) assessment tool is used to assess pediatric patients at risk for fall
          2.   Initial fall risk assessment is performed by an RN upon admission.
          3.   Document the GRAF-Pif scale under the intervention section titled: for patients on the Pediatric Unit: Safety & ADL/ GRAF-PIF/Fall Ped
     B.   Implementation of Patient Safety Fall Program Using the GRAF- PIF Scale.
          The GRAF- PIF Scale is a Rapid and simple method of assessing a Pediatric Patients risk of falling.
          1.   Implement the following standard fall prevention interventions for Pediatric patients:
               a.   Orient patient/family to room and call light
               b.   Place patient in an appropriate crib/bed for development age
               c.   Set crib/bed in lowest position (unless contraindicated) with brakes on
               d.   Place crib rails to the highest level
               e.   Ensure two (2) bed rails are up

        f.   Use nonskid footwear for ambulatory patients

        g.   Place call light within reach

        h.   Provide appropriate patient/family education

        i.   Use only original securing devices with alternative baby furniture (i.e. When using a stroller use only the stroller's safety equipment to secure patient)

2.   High Risk Interventions are implemented, in addition to the standard fall prevention interventions, for pediatric patients with a total fall assessment score of 2 or greater.

        a.   Implement all Standard fall prevention interventions

        b.   Review in–patient safety education with patient/family

        c.   Place yellow "Fall Precaution" armband on patient

        d.   Post " Tipsy Turtle" sign on patients door

        e.   Place yellow non-skid footwear on the patient

        f.   Check "safe room set up" with each change of shift

        g.   Conduct hourly rounding to include safety

        h.   Include fall status in shift huddle

        i.   Consider use of additional staff support when assisting the patient

3.   Infants under 12 months of age are considered a developmental High Risk for fall patient. Implement the following Infant Fall Risk Prevention Interventions:

        a.   Review development fall safety education with family/caregivers

              1)   Do not leave infant un attended on high surface(bed, tables, couch)

              2)   Do not place infant in car seat on high surfaces

              3)   Secure infant with manufacturer safety straps in strollers, car seats, swings, etc.

        b.   Hourly Safety Rounding

              1)   Infants position

              2)   Infants pain level

              3)   Infant's diaper

              4)   Possessions are within reach

              5)   Patient "s parent/caregiver is present

        c.   Check safe room set up at change of shift

              1)   Clear walkway

              2)   Crib in lowest position

              3)   Crib with all rails up

              4)   Linen and toys are off the floor

        d.   Place yellow " Fall Precaution" armband on patient

        e.   Post "Tipsy Turtle" sign on patient door

        f.   Place yellow non- skid footwear on the patient

        g.   Include fall status in shift huddle

        h.   Consider use of additional staff support when assisting the patient

C.   Document the interventions and patient education under the intervention section titled: For patients on the Pediatric Unit: Safety & Alarms//GRAF- PIF/Fall

IX.   Post-Anesthesia Care Unit (PACU)

     A.   Post procedure patients admitted to the PACU are considered to be a fall risk.
Side rails on gurney, crib or beds should be up at all times when staff or family member is not in attendance.

B.   If the patient has received an injection of local anesthetic, received a regional anesthetic (spinal or epidural anesthesia) or received a peripheral nerve block on a lower extremity a hospital employee must be in attendance when the patient initially stands and must ambulate prior to discharge. The patient's ability or inability to ambulate should be clearly documented in the patient medical record.

C.   If the patient needs to ambulate with crutches or a walker after surgery and has not used the assistive devices in the past, the Physical Therapy department provides patient education and training.

D.   Post-operative/procedure patients are accompanied to the restroom by a staff member

E.   Patients discharged home from PACU are transported to the curbside via wheel chair or gurney if patient is not able to sit in a wheel chair.

F.   Post Fall Management
    1.   Upon discovery of the patient, assess for degree of injury
        a.   Examine the patient before moving
        b.   Ask the patient to relate what happened
    2.   Notify the primary service as well as the anesthesiologist
    3.   If injury is present, provide immediate care as required
    4.   Report clinical condition of the patient including
        a.   Vital signs
        b.   Altered mobility
        c.   Mentation
        d.   Patient statement/complaints
        e.   Any visible injuries
        f.   Any nursing interventions

G.   Documentation
    1.   Provide accurate and complete documentation in patient medical record of occurrence
    2.   Complete a Unusual Occurrence Report

IX.   Primary Care Clinics/Family Health Centers (FHCs)

A.   Fall Prevention Screening:
        Upon arrival, patients receive a fall prevention questionnaire at the registration window, see Attachment B. Patient answering yes to any of the designated questions are considered a fall risk and the following procedures are implemented:
    1.   Registration staff notify back office staff that the patient is a fall risk by labeling patient's paper In-Take Form with the Fall Precaution Chart Signage and write (or place a sticker) on the form noting "Fall Precaution" needed.
    2.   Care Assistant taking the patient's vital signs implements the Fall Prevention Intervention Procedure for patient needing additional fall precaution services.
    3.   Fall Prevention Intervention Procedure includes:
        a.   Asking the patient if they need any assistance with mobility including the use of a Durable Medical Equipment (DME) during their visit (e.g. wheelchair, cane, etc.).
        b.   Complete vital signs in the exam room and document under the Vital Page in the comment section, "Patient Identified as Needing Fall Precaution"
        c.   Document on the Fall Prevention Questionnaire interventions provided to patient or if the patient refused any assistance.
        d.   Place Fall Precaution Signage (Falling Star) outside the exam room door.

      e.   Keep door slightly ajar to allow intermittent monitoring of identified fall precaution patients alone in rooms waiting for the Provider.

      f.   Providers document fall interventions provided during the visit and Durable Medical Equipment (DME) ordered for the patient in the progress notes.

      g.   Providers and Care Assistants actively involved in the care provide fall prevention educational material to the patient and their caregivers.

      h.   Staff provide needed assistance upon the conclusion of the visit.

B.   Fall Management Procedures

Clinical staff assess patient for injury and initiate necessary intervention to stabilize the injured patient.

    1.   Notify on site physician and/or lead nurse

    2.   Clinic staff who discover or witness the fall complete the Unusual Occurrence Report (UOR). The Clinic Operation Supervisor (COS) verifies the report to ensure needed material and information is presented to Risk Management.

    3.   Staff member(s) involved with the incident, with the assistance from the Provider or Lead Nurse, place a fall risk alert on the patient's electronic health record (EHR) indefinitely and document the following:

      a.   Description of the event (location, time, etc.)

      b.   Event was witnessed/unwitnessed and by whom

      c.   Related activities and patient's position

      d.   Post fall assessment which may include vital signs, neurological assessment and injury noted by a Provider

      e.   Notification of Provider

      f.   Intervention implemented post fall (e.g. imaging orders, sutures, ice, splint, etc.)

      g.   Protective measure instituted or changed after fall

    4.   Post fall huddle at the next Safety Huddle Meeting

X.   Ambulatory/Outpatient

A.   Fall Prevention Screening:

Fall Prevention Questionnaire screening tool is provided by registration staff and attached to clinic billing documents (Attachment B). (NOTE: FHCs and ancillary departments use the same form). If a patient is identified as a fall risk the following procedure is implemented:

    1.   Screening tool is reviewed by staff upon receiving patient. A yellow wristband is applied to any patient identified as a fall risk.

    2.   Staff document in the medical record Fall Prevention Questionnaire results, assistance provided, education provided, and notification of the Provider as needed.

    3.   When applicable, the Fall sign placed on door alerting staff to observe and monitor patient observation and monitoring by Staff.

B.   Post fall Management:

    1.   Upon discovery, survey the patient

    2.   Examine patient before moving

    3.   Provide immediate care as required

4. Notify the Provider as needed
5. Ask patient/family/witnesses what happened
6. Document condition of patient, assistance provided, any notification of Provider, and disposition of the patient in the EHR or written clinic note.
7. Report clinical condition of the patient to the Clinic Supervisor and/or Lead Nurse
8. Complete an UOR
9. Place an alert on patient's chart
10. Post fall huddle to include Staff and Supervisor

XI. Behavioral Health (BH) Department

A. BH implements the following fall procedures to ensure patient and staff safety
1. Patients are assessed for fall risk during the initial admission assessment in BH Triage.
2. The BH Patient Safety Fall Program is implemented for BH patients identified as "High Risk" for falls.
3. BH utilizes the Morse Scale.
4. Patient scores of 0-44 are considered "low risk".
5. Patient scores greater than or equal to 45 are considered "high risk".
    a. If the patient is in a hospital bed, the bed is kept in the lowest position.
    b. Staff reorient "fall risk" patients to the BH environment
    c. Appropriate lighting is provided to:
        1) Ensure adequate patient visualization of the room and surrounding areas
        2) Allow staff to clearly visualize and monitor patient during rounding
    d. BH does not allow furniture or personal belongings in patient rooms
    e. BH does not have call lights and/or bedside tables due to safety concerns
    f. Patient rounding is completed every 15 minutes and documented utilizing the BH Patient Locator Form (Behavioral Health Policy # 813 – Patient Locator)
B. BH implements the following fall procedures/interventions for patients identified as high fall risk:
1. During patient rounding, BH staff:
    a. Assist patients who are identified as high risk for falls with ADL's such as toileting, meals, etc.
    b. Remind patients to ask for assistance when getting up or needing toileting
2. Implementation of Fall Kit for Behavioral Health:
    a. Yellow non-skid footwear
    b. Yellow arm band
    c. Yellow "Fall Risk" stickers on patient charts
    d. Place yellow magnetized discs on the patient assignment board to communicate "Fall Risk" with BH staff
3. Keep patient doors open for safety observation purposes
4. The patient team nurse reviews medications for any with side effects that may alter patient gait, balance, etc. and address any concerns in the daily Treatment Team meeting
5. Plan of Care
    BH follows above inpatient policy and procedure guidelines

C.   Post Fall Management
      BH follows above inpatient policy and procedures except in an incident of a death of a
      patient associated with a fall. BH staff notify the Nurse Manager or House Supervisor who
      notifies the Assistant Hospital Administrator.

REFERENCES: Regulatory Agency Standards
                         Agency for Health Quality and Research, Innovations and Quality Tools,
                         www.innovations.ahrq.gov. (2010)
                         Evidence-Based Best Practices for the Prevention of Falls, www.phac-aspc.gc.ca. (2010)
                         Centers for Disease Control Fall Prevention Activities, www.cdc.gov. (2010)
                         National Guideline Clearinghouse, Fall Prevention Guidelines, www.guideline.gov. (2010)
                         Perry A., Potter P. (2014). *Clinical nursing skills & techniques,* ed 8, St. Louis, Mosby.
                         Department of Nursing Policy (DON) Policy 540.00, Safety Policy Statement: General
                         Overview
                         Administrative Policy No. 110.19 Unusual Occurrences – Reporting of
                         Administrative Policy No. 610.23, Safe Patient Handling and Movement (SPHM)
                         DON Policy 541.00, Bed Side Rails, Use Of
                         DON Policy 541.10, Patient Safety
                         DON Policy 557.01 Patient Handoff and Communication
                         Behavioral Health Policy No. 813 – Patient Locator

DEFINITIONS: NA

ATTACHMENTS: **Attachment A: Fall Assessment Check List**
                         Attachment B: Ambulatory/Outpatient Fall Prevention Questionnaire

APPROVAL DATE:

           N/A   **Policy, Procedure and Standards Committee**

           6/18/19   **William L. Gilbert, Hospital Director**
                            Applicable Administrator, Hospital or Medical Committee

           8/6/19   **Board of Supervisors**
                            Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **3/23/17**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

Fall Assessment Check List

Morse Scale:

If score > 45 or =45 implement Nursing Problem "Risk Control and Fall Prevention Strategy. Med/Surg (MED.RC)

☐ **Low risk (0-44)**

☐ **High risk (>or=45)**

Interventions: (Include a minimum of 5 interventions)

☐ **Hourly rounding**
   (4P's: pain, position, potty, & proactive measures)

☐ **Call light within reach**

☐ **Bed in low position**

☐ **Yellow non-skid footwear**

☐ **Yellow signs() (outside room)**

☐ **Yellow patient gown**

☐ **Answer call-light promptly**

☐ **Patient's door left open**

☐ **Bed Alarm Turned On (use posey elite alarm as indicated or in conjunction with the bed alarm)**

☐ **Add Nursing Problem "Risk Control and Fall Prevention"**

NOT A PART OF THE CHART: PLEASE REMOVE ON DISCHARGE

Date: _____

1. Do you use something to help you walk or keep you from falling?	YES	NO	**What do you use?** Walker Wheelchair Cane Brace Another Person
2. Do you have a health problem(s) that could raise your risk of falling?	YES	NO	If yes, please describe the health problem:
3. Have you been experiencing dizziness, lightheadedness today?	YES	NO	

Staff Use Only

Fall Intervention Provided:
☐ None
☐ Education
☐ Assistive Device

Staff Comments:

1. ¿Usa algo para apollarse al caminar o para prevenir caídas?	Sí	No	**¿Qué usas?** Nada Andadera Silla de Ruedas Bastón Abrazadera Otra Persona
2. ¿Tiene algún problema de salud que aumente el riesgo de caídas?	Sí	No	Si es así descríbalo:
3. ¿Está experimentando mareos el día de hoy?	Sí	No	

Staff Use Only

Fall Intervention Provided:
☐ None
☐ Education
☐ Assistive Device

Staff Comments:

PATIENT IDENTIFICATION

ARROWHEAD REGIONAL MEDICAL CENTER
AMBULATORY/OUTPATIENT

FALL PREVENTION QUESTIONNAIRE

USE BARCODED FORMS ONLY

22-16-582 (10/16)

SECTION:	**PATIENT CARE**	**SUB SECTION:**	**ANESTHESIA**

SUBJECT: **NON-OBSTETRIC SURGERY DURING PREGNANCY**

APPROVED BY: _____

                             Chief Executive Officer

PURPOSE

To provide guidelines for the care of pregnant patients undergoing non-obstetric surgery.

POLICY

I.   Physicians caring for pregnant patients undergoing non-obstetric surgery will obtain an obstetric consultation prior to the procedure. If the surgery is emergent in nature and consultation cannot be performed preoperatively, then a postoperative consultation will be ordered.

II.   For previable fetus (prior to 23 weeks gestation), fetal heart rate will be obtained before and after the procedure if gestational age is sufficient to detect fetal heart tones.

III.   For viable fetus (23 weeks and beyond):

     A.   Obtain obstetrical consultation prior to any sedative or anesthetic being administered.

     B.   Consent for emergency cesarean section will be obtained by the obstetrician.

     C.   If clinically indicated, the obstetrician will order steroids to be administered to aid in the fetal lung maturity prior to the procedure.

     D.   Intraoperative electronic fetal heart rate monitoring should be performed by qualified personnel when, considering surgical factors, it is possible.

     E.   If continuous intraoperative monitoring is not possible, simultaneous electronic fetal heart rate and contraction monitoring will be obtained before and after the procedure.

REFERENCES: American College of Obstetricians and Gynecologists, Committee Opinion Number 474, February 2011

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/28/15**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION:	**PATIENT CARE**	**SUB SECTION: SPECIAL PROCEDURES**

SUBJECT: **POST-PROCEDURE PRE-CLEANING OF ENDOSCOPES**

APPROVED BY: _____

                                            Chief Executive Officer

POLICY

Endoscopes are pre-cleaned immediately post-procedure at the point of use to prevent drying of organic material on the surface or in the channels of the endoscope before transport to the decontamination area.

PROCEDURES

I.   **Post-Procedure Pre-cleaning of Endoscope is done immediately after endoscopy procedure by the Procedure staff. Pre-cleaning steps are performed following the manufacturer's Instructions for Use.**

   A. Immediately after removing the endoscope from the patient, gently wipe debris from the insertion tube with enzymatic soaked sponge from proximal to the distal end.

   B. Place the distal end of the endoscope into the enzymatic solution and aspirate through the biopsy/suction channel for 5-10 seconds. Alternate aspiration of solution and air several times to create agitation for better pre-cleaning until the fluid at the Pentax Video Endoscope (PVE) connector is clear. When finished, pull the distal tip out of the solution.

   C. Set Air/Water Drain lever on the water bottle assembly to the drain position placing the lever downward. With the air pump of the video processor ON and set to the HIGHEST pressure setting, depress the air/water feeding valve of the endoscope fully until all water has been discharged from the endoscope. Alternate covering of the hole in the valve and depressing the valve until steady stream of bubbles appear to forcefully expel mucous, debris, etc. which may have entered the air and water nozzles.

   D. When using the inline irrigation system via the water jet valve, step on foot pedal until clear water runs from distal end of scope.

   E. Turn off the processor light and pump.

   F. Disconnect suction and water bottle from the video processor.

   G. When using the inline irrigation tubing, disconnect at the luerlock connector.

   H. For models with water jet channel system, attach the irrigation tube to the water jet check valve adapter. Connect a syringe filled with enzymatic solution to the irrigation tube and flush the channel with the solution. Fill the syringe with air and flush through the channel several times to force any residual solution out of the channel.

   I. Disconnect endoscope from processor and attach the soaking cap.

   J. Place endoscope into the semi-rigid bin. Place tag on bin that includes scope serial number, procedure end time, and nurse/technician initials. Transport the pre-cleaned endoscope immediately to the Sterile Processing Department (SPD) for completion of the disinfection process.

REFERENCES: **Association of peri-Operative Registered Nurses (AORN) Standards and Recommended Practices; 2013.**
                                    Society of Gastroenterology Nurses and Associates (SGNA) Standards and Practice Guidelines; 2011.

Pentax Instructions for Use; 2013.01.

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                        6/18/19   **William L. Gilbert, Hospital Director**
                                   Applicable Administrator, Hospital or Medical Committee

                        8/6/19   **Board of Supervisors**
                                   Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/8/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION:	**PATIENT CARE**	**SUB SECTION: SPECIAL PROCEDURES**

SUBJECT: **RECEIVING AND STORAGE OF ENDOSCOPES**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

Endoscopes are properly received and stored after high level disinfection to maintain safe environment for patients and staff.

PROCEDURES

I. **Receiving and Storage of Endoscope – this is in reference to the Sterile Processing Department (SPD) Policy 1100.20.03.**

   A. During regular procedure hours, the Operative Services staff visually inspects the high level disinfected endoscopes for identified structural damage, retained particles, and questionable cleanliness. After testing for any residual protein by following the manufacturer's instructions, they are hung in vertical position in the post-testing storage cabinet without touching the disposable cloths lining the bottom of the cabinet. Testing result is documented on the Scope Label that is placed on the log.

   B. After hours, weekends, and holidays, the SPD staff delivers the high level disinfected endoscopes and hangs them in the pre-testing cabinet. After the endoscopes are visually inspected and tested for any residual protein per manufacturer's instructions by the Operative Services staff, they are hung in vertical position in the post-testing storage cabinet without touching the disposable cloths lining the bottom of the cabinet. Testing result is documented on the Scope Label that is placed on the log.

II. **Reporting**

   Any identified structural damage, retained particles, or questionable cleanliness of any high level disinfected endoscopes during visual inspections and testing is reported immediately to the Manager or designee, SPD, Epidemiology, and Patient Safety Officer. Endoscopes with identified structural damage, retained particles, or questionable cleanliness are returned to SPD with written communication. An Unusual Occurrence Report is completed by the Operative Services staff.

REFERENCES: Association of peri-Operative Registered Nurses (AORN) Standards and   Recommended Practices; 2013.
Society of Gastroenterology Nurses and Associates (SGNA) Standards and Practice Guidelines; 2011.
Pentax Instructions for Use; 2013.01.

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                          6/18/19   **William L. Gilbert, Hospital Director**
                                          Applicable Administrator, Hospital or Medical Committee

                          8/6/19   **Board of Supervisors**
                                          Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/8/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION:	PATIENT CARE	SUB SECTION: SPECIAL PROCEDURES

SUBJECT: CLEANING OF ENDOSCOPE CABINETS

APPROVED BY: _____
Chief Executive Officer

POLICY

Endoscope cabinets are routinely cleaned to prevent contamination of the high level disinfected endoscopes stored in the cabinets.

PROCEDURES

I. Every first day of work week, the interior of the endoscope storage cabinets are wiped down by the designated staff with disinfectant wipes approved by the hospital. This task is documented in the Daily Checklist log being checked by the Charge Nurse.

II. Clean disposable cloths are placed at the bottom of the endoscope storage cabinets and they are changed each morning during regular working days. The disposable cloths are visually inspected for stains each time an endoscope is removed and each time they are changed. Any stains on the disposable cloths are reported immediately to the Manager or designee, Sterile Processing Department (SPD), Epidemiology, and Patient Safety Officer. If a stain is noticed on cloth, all scopes in the cabinet are removed from service and are returned to SPD for reprocessing. An Unusual Occurrence Report is completed by the Charge Nurse or designee.

REFERENCES: Association of peri-Operative Registered Nurses (AORN) Standards and Recommended Practices; 2013.
Society of Gastroenterology Nurses and Associates (SGNA) Standards and Practice Guidelines; 2011.

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

N/A   **Policy, Procedure and Standards Committee**

6/18/19   **William L. Gilbert, Hospital Director**
Applicable Administrator, Hospital or Medical Committee

8/6/19   **Board of Supervisors**
Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: 7/8/14   **REVISED:** N/A

REVIEWED: 2/07/19

| SECTION: | PATIENT CARE | SUB SECTION: | SPECIAL PROCEDURES |

SUBJECT: GUIDELINES FOR THE ADMINISTRATION OF HYPERTONIC SODIUM CHLORIDE 23.4% SOLUTION

APPROVED BY: _____

Chief Executive Officer

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) to provide guidelines for the timely and effective care of patients with refractory increases of intracranial pressures (ICP) or impending brain herniation receiving hypertonic sodium chloride 23.4% solution.

PURPOSE

To improve patient outcomes by establishing guidelines for the prompt treatment of refractory increases of intracranial pressures (ICP) or impending brain herniation, and to ensure the appropriate administration of hypertonic sodium chloride 23.4% solution.

PROCEDURES

I. Treatment

  A. Indications
    1. Intracranial hypertension (elevated ICP) refractory to conventional therapeutic modalities.
    2. Impending brain herniation.

  B. Precautions and side effects
    1. Hyperosmolarity.
    2. Hypernatremia.
    3. Hyponatremia. 23.4% saline is not intended for use in correcting hyponatremia.
    4. Hyperchloremia.
    5. Hypotension.
    6. Hypertension.
    7. Congestive heart failure (CHF).
    8. Central pontine mylinolysis.
    9. Thrombophlebitis.

  C. Notify the neurosurgery resident or attending if any of the following are present:
    1. Sustained ICP $\geq$ 25 mmHg after 23.4% saline administration.
    2. Deteriorating changes in the patient's neurological assessment after 23.4% saline administration.
    3. Serum sodium $\geq$ 160mmol/liter.
    4. Signs of fluid overload (ex.: jugular venous distention [JVD], pink-frothy sputum, etc.).
    5. Signs of hypovolemia (ex.: tachycardia, hypotension, decreased urine output, etc.).
    6. Acute onset of either hypertension or hypotension.

II. Equipment

A. Central line is preferred.
   1. Dosage is limited to 40 ml (maximum) per dose over 10 to 20 minutes as ordered.

B. A Peripheral line may be used under the following conditions:
   1. May only be used once in an emergency.
   2. A central line is unavailable.
   3. Dosage is limited to 20 ml (maximum) over 10 minutes.

C. Administration is via IV Push or mini-infuser over 10 to 20 minutes as ordered.

III. Dosing

A. 10 to 40 ml IV bolus over 10 to 20 minutes as ordered.
B. Dosage may be repeated at the physician's discretion.
C. Standing orders are not acceptable (ex.: NaCl 23.4% 30ml IV every 6 hours).

IV. Administration

A. Patient must be in the Medical or Surgical Intensive Care Units (MICU/SICU), Emergency Department (ED), Operating Room (OR), or Post Anesthesia Care Unit (PACU).
B. ICP monitoring is recommended, but not required in emergency.
C. Serum electrolytes must be drawn prior to administration.
D. Prescribing physician or authorized resident must be present at the bedside during administration or immediately available via Spectralink.
E. The Registered Nurse (RN) may administer the 23.4% saline after confirmation by a second RN and documented in Meditech electronic medical record (EMR).
F. Administration is via IV push or mini-infuser over 10-20 minutes as ordered.

V. Monitoring

A. Vitals signs every 10 minutes during administration for 1 hour, then every hour as indicated or ordered.
   1. Continuous blood pressure monitoring via arterial line is preferred.
B. ICP monitoring with cerebral perfusion pressures (CPP) every 10 minutes for 1 hour, then as ordered.
C. Obtain follow-up serum electrolytes up to 6 hours after administration or every 6 hours.
D. Monitor central line site for extravasation.

REFERENCES: Bhardwaj, A, Ulatowski, JA. (1999). Current Treatment Options in Neurology. 1:179-183.

                      Bullock, MR, et. al. (2000). Guidelines for Management of Severe Brain Trauma. New York, NY: Brain Trauma Foundation.

                      Zhong, J, et. al. (2003). "Advances in ICP Monitoring Techniques." *Neurological Research,* 25(4), 339-350.

Duke University Hospital (2006). Hypertonic (23.4%) Saline Intravenous Administration Protocol.

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/8/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	**SUB SECTION:SPECIAL PROCEDURES**

SUBJECT: **TELEMETRY: CARE OF THE PATIENT ON CENTRALIZED TELEMETRY MONITORING**

APPROVED BY: _____
                                                     Chief Executive Officer

POLICY

When ordered by a physician, a patient is provided 24 hour continuous cardiac monitoring services from a centralized location. It is the policy of Arrowhead Regional Medical Center (ARMC) that patients requiring continuous cardiac monitoring are placed on units appropriate for their clinical diagnosis and treatment. See Administrative Operations Manual (AOM) Policy 600.01 Plan – Provision of Care. Patients are admitted and cared for utilizing the guidelines of the American College of Cardiology (ACC) and American Heart Association (AHA).

PURPOSE

To provide guidelines for ARMC employees, physicians, and others involved in providing care, treatment, or services to patients requiring centralized telemetry monitoring.

To ensure patient safety by providing consistent care of the patient requiring centralized telemetry monitoring.

PROCEDURE

I. ADMISSION POLICY:

   A. Patients admitted to Intensive Care Units (ICU) receive continuous telemetry monitoring.

   B. Admission or transfer into a Medical/Surgical Telemetry Unit requires a provider order.

   C. Admission may originate:

      1. From the Critical Care Unit when the patient is hemodynamically stable.

      2. From the Medical/Surgical areas when telemetry monitoring is required and the patient condition does not warrant admission into the Intensive Care Unit (ICU).

      3. From the Emergency Department (ED), Post Anesthesia Care Unit (PACU), Outpatient clinics, or as an inter-facility transfer.

II. TELEMETRY ADMITTING CRITERIA:

The patient requiring continuous cardiac monitoring with no other need for intensive care level care, must meet any one of the following criteria:

A. Patient requires continuous pulse oximetry monitoring.

B. Experiencing chest pain syndromes or post-acute Myocardial Infarction (MI), see Level II criteria.

C. Pacemaker placement or malfunction; planned pre/post cardiac catheterization; or non-urgent, uncomplicated percutaneous coronary intervention (PCI) not due to acute MI; coronary angioplasty without stenting; routine post-coronary angiography, see Level II criteria.

D. Syncope with one of the following: Heart Failure, Ventricular tachycardia, systolic blood pressure (SBP) less than 90 mm Hg, second or third degree heart block, heart rate less than 45 beat per minute (bpm).

E. Heart blocks and bradycardia arrhythmias with SBP greater than 90 mm Hg.

F. Stable cardiorespiratory disease, such as pulmonary edema, pulmonary embolus.

G. Heart failure without cardiogenic shock.

H. Patients admitted to the unit(s) from ED or ICU that have been weaned off of vasoactive drug therapy and hemodynamic stability has been established prior to transfer.

I. Chemistries:

    1. Potassium less than 3.0 mEq/L with or without Premature Ventricular Contractions (PVCs).

    2. Potassium greater than 6.0 mEq/L with Electrocardiogram (ECG) changes indicating hyperkalemia.

    3. Sodium less than 130 mEq/L with symptoms.

J. Positive Troponin I that is returning to baseline.

K. Medications requiring telemetry during administration.

L. Arrhythmias resulting from medication toxicities after the patient has been stabilized.

M. Patients with Do-Not-Resuscitate (DNR) orders with arrhythmias that cause discomfort, palpitations, shortness of breath and/or anxiety, may be monitored as part of palliative care provisions with the goal of assisting to titrate anti-arrhythmic medications, and not to treat or prevent life-threatening arrhythmias. Telemetry monitoring is discontinued when rate control has been achieved.

N. See Class II Criteria Definitions for additional information.

O. See Class III Definitions for patients who are not appropriate for telemetry monitoring.

III. CLINICAL INDICATIONS FOR TRANSFER TO ICU:

A. The level of frequency of monitoring of vital signs on the telemetry unit is limited to four hour intervals. A patient whose condition requires a higher frequency and intensity of service is transferred to an ICU.

B. A patient whose condition requires every 1-2 hour vital sign and neurologic monitoring may remain on the telemetry unit for duration of up to 4-6 hours, if hemodynamically stable.

C. Patients requiring every 1-2 hour vital sign and neurologic monitoring for more than 4-6 hours require transfer to the ICU.

D. See Class I Definitions for additional ICU Monitoring criteria.

IV. DURATION OF CONTINUOUS CARDIAC MONITORING:

The duration of continuous cardiac monitoring is assessed daily by the provider in collaboration with the Telemetry Unit Charge Nurse, Primary Nurse, and/or the unit Manager or Assistant Manager.

V. TELEMETRY DISCHARGE CRITERIA:

In general, patients are deemed able to transfer to a lower level of care (e.g. Medical/Surgical Unit), when any of the following criteria are met:

A.   Vital signs and cardiac rhythms are stable for 24 hours:

1. Heart rate 45-100/min.

2. Respiratory rate 10-20/min.

3. SBP 90-180 mm Hg.

B. Arrhythmia controlled, hemodynamic stability achieved.

C. Chest pain resolved, acute MI ruled out or resolving.

D. Dyspnea relieved, 0_2 saturation greater than 94% on room air.

E. Lab values within acceptable ranges.

F. Nutritional route established.

G. Stable airway.

H. Patient is on anti-arrhythmic agents with a stable rhythm for a minimum of 24 hours.

I. Pacemaker/Intracardiac Device (ICD) functioning.

J. Post-surgery/procedure stability, for post-PCI procedures and uncomplicated ablation procedures, see Class II Criteria.

K. Syncope resolved (24-48 hour monitoring recommended, see Class II criteria).

L. Toxicities resolved.

REFERENCES: **Drew, B., Califf, R., Funk, M., Kaufman, E., Krucoff, M., Laks, M. (2004). Practice standards for electrocardiographic monitoring in hospital settings: executive summary and guide for implementation. Circulation; 110: 2721-2746.**
McKesson Health Solutions. (2012). InterQual Level of Care Acute Adult Criteria 2012 Clinical Revisions. McKesson Corporation-McKesson Health Solutions, LLC. http://www.mvphealthcare.com/provider/documents/McKesson/InterQual Level_of_Care_Acute_Adult_Clinical)_Revisions_2012.pdf. Accessed February 27, 2013.
Centers for Medicare and Medicaid Services Standard
Healthcare Facilities Accreditation Program Standard
The Joint Commission National Patient Safety Goals 2014
Administrative Operations Manual (AOM) Policy 690.29 Medical Device Alarm Safety
AOM Policy 600.01 Plan – Provision of Care
Department of Nursing Policy 504.01, Telemetry: Caring for the Patient Monitored on Centralized Telemetry
Infection Control (IC) Policy 308 Cleaning and Disinfection of Patient Care Items and Equipment

DEFINITIONS: **Centralized Telemetry Monitoring: Telemetry cardiac monitoring widely distributed across multiple inpatient units with 24 hour visualization from a Centralized Telemetry Monitoring Center staffed by Telemetry Monitoring Technicians.**

Class I: Cardiac monitoring is indicated in most, if not all, patients in this group. Class I includes patients at significant risk of an immediate, life-threatening arrhythmia. **These patients are generally admitted to the Intensive Care Unit.** When a patient is required to leave the monitored unit for diagnostic or therapeutic procedures, then cardiac monitoring is continued with a transport monitor/defibrillator. Class I patients are divided into 16 subcategories:
1.   Patients who have been resuscitated from cardiac arrest (high risk for recurrence).
2.   Patients in the early phase of acute coronary syndromes (ST-Elevation or Non-ST elevation myocardial infarction, unstable angina, "rule-out" MI).
3.   Patients with unstable coronary syndromes and newly diagnosed high-risk coronary lesions.
4.   Adults who have undergone cardiac surgery.
5.   Patients who have undergone non-urgent percutaneous coronary intervention with complications.
6.   Patients who have undergone implantation of an automatic defibrillator lead or a pacemaker lead and considered dependent.
7.   Patients with a temporary pacemaker or transcutaneous pacing pads.
8.   Patients with symptomatic AV Block.
9.   Patients with arrhythmias complicating Wolff-Parkinson-White Syndrome with rapid anterograde conduction over an accessory pathway.
10.   Patients who have drug induced long QT syndrome and associated ventricular arrhythmias.
11.   Patients receiving intra-aortic balloon counter pulsation.
12.   Patients with acute heart failure or pulmonary edema.
13.   Patients with indications for intensive care.

14. Patients undergoing diagnostic/therapeutic procedures requiring moderate sedation or anesthesia.
15. Patients with any other hemodynamically unstable arrhythmia.
16. Diagnosis of arrhythmias in pediatric patients, or children who have undergone cardiac surgery.
17. When symptomatic ST-Segment ischemia monitoring is required .

Class II: Cardiac monitoring may be of benefit in some patients but is not considered essential for all patients. **This level of monitoring often takes place in a telemetry unit**. These patients are divided into 10 subcategories:
1. Patients with post-acute MI, particularly in patients with previous hypertension, COPD, previous MI, ST-segment changes at presentation, and lower initial systolic blood pressure.
2. Patients with chest pain syndromes (patients admitted to the ED with chest pain but who do not have diagnostic ECG findings or elevated biomarkers—awaiting results of repeat troponins, etc.).
3. Patients who have undergone uncomplicated non-urgent percutaneous coronary intervention (Not for acute MI). These patients should be monitored for **6-8 hours** following intervention if they received a stent. Patients who undergo coronary angioplasty without stenting should be monitored for **12-24 hours** due to a higher incidence of abrupt closure.
4. Patients who are administered an antiarrhythmic drug or who require adjustment of drugs for rate control with chronic atrial tachyarrhythmias.
5. Patients who have undergone implantation of a pacemaker lead and are not pacemaker dependent.
6. Patients who have undergone uncomplicated ablation of an arrhythmia (**12-24 hours recommended**).
7. Patients who have undergone routine coronary angiography.
8. Patients with sub-acute heart failure.
9. Patients who are being evaluated for syncope with suspected arrhythmic cause (**24-48 hours recommended**).
10. Patients with DNR orders with arrhythmias that cause discomfort.

Class III: Cardiac monitoring is not indicated because a patient's risk of a serious event is so low that monitoring has no therapeutic benefit. Patients included in this class are:
1. Postoperative patients who are at low risk for cardiac arrhythmias (e.g., young patients without heart disease who undergo uncomplicated surgical procedures).
2. Obstetric patients unless heart disease or hypertension is present.
3. Patients with permanent, rate-controlled atrial fibrillation.
4. Patients undergoing hemodialysis unless patient has a Class I or Class II indication and undergo dialysis in the hospital.
5. Stable patients with chronic ventricular premature beats.

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**
_____

                      6/18/19   **William L. Gilbert, Hospital Director**
_____
                                Applicable Administrator, Hospital or Medical Committee

                      8/6/19   **Board of Supervisors**
_____
                                Approved by the Governing Body

REPLACES: **Department of Nursing Policy 504.03 Issue 1**
                          Administrative Policy No. 690.08 Issue 2

EFFECTIVE: **11/4/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	**SUB SECTION:**	**SPECIAL PROCEDURES**

SUBJECT: **PROCEDURE FOR ENDOCAVITY TRANSDUCER HIGH LEVEL DISINFECTION**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

Endocavity transducers are properly cleaned and maintained to prevent the spread of infections between patients. The following policy has been adopted as protocol for use of a hospital approved disinfection soak station for high level disinfection (HLD) of endocavity transducers between patients. Only trained staff will use the hospital approved soak solution.

PROCEDURES

I.   Ensure soak station is equipped with a carbon filter to maintain acceptable high level disinfection solution (HLD) fume exposure levels.

II.   A single use probe cover is used during procedures requiring an endocavity probes.

III.   After the exam is finished, remove the probe cover and discard. Wipe the probe with the approved disinfectant wipes to remove any gel remaining on the probe surface, taking care to avoid getting connector pins wet.

IV.   The following tasks should be performed while wearing proper Personal Protective Equipment, e.g., hand, face, eye protection, and nitrile gloves.

   A.   Test the disinfectant by dipping an approved chemical test strip prior to probe immersion. Verify the color change on the test strip and document the results on the log sheet. If the test strip fails, discard the solution in both soak stations by pouring down the sink drain, followed by copious amounts of tap water. Obtain a new gallon of solution and pour into soak stations.

   B.   Place the endocavity transducer probe in to the soak station.

   C.   Set the timer and soak the probe according to the manufacturer's instructions.

   D.   After inserting the probe into the soak station, document the date, staff initials and the start time of the probe immersion on the log.

V.   Once the soak time is completed,

    A.   Remove the probe and rinse in distilled water at the rinse station.

    B.   Perform a final rinse using tap water 2 times for 1 minute each.

    C.   Document the stop time of the probe immersion on the log.

    D.   Change the distilled water on a daily basis.

VI.   Hang the probe on the secure probe holder and storage tube to ensure cleanliness until use for the next patient.

VII. In the event qualified personnel are not available to process probes, probes will be sent to the Sterile Processing Department for HLD.

REFERENCES: **Cleaning and Disinfection Probes per Manufacturer Instruction for Use**
                         Wipe Probes per Manufacturer Instruction for Use
                         Soak Probes per Manufacturer Instruction for Use
                         Healthcare Facilities Accreditation Program Standards
                         Centers for Medicare & Medicaid Services
                         Centers for Disease Control and Prevention, Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Cleaning & High-Level Disinfection of Endocavity Probes – Competency**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                         6/18/19   **William L. Gilbert, Hospital Director**
                                        Applicable Administrator, Hospital or Medical Committee

                         8/6/19   **Board of Supervisors**
                                        Approved by the Governing Body

REPLACES: **Medical Imaging Policy No. 701.00**

EFFECTIVE: **11/4/14**   **REVISED:**   **N/A**

REVIEWED: **2/07/19**

SECTION:	**PATIENT CARE**	SUB SECTION:	**SPECIAL PROCEDURES**

SUBJECT: **CLEANING AND PREPARING TRANS-ABDOMINAL PROBES**

APPROVED BY: _____

                                       Chief Executive Officer

POLICY

Trans-abdominal transducers are properly cleaned and maintained to prevent the spread of infections between patients.

PROCEDURES

I.   After the exam is completed, wipe the probe of any remaining gel with a fine soft cloth. Do not use paper towels.

II.   Cleaning and Disinfection of Probes

    A. Use a clean alcohol based disinfectant wipe to clean any soil from the surface of the probe and cord.

    B. Obtain a clean second wipe to disinfect the probe and cord. Wipe the probe and cord, keeping them continuously visibly wet for a FULL 2 minutes. After 2 minutes, allow to air dry.

    C. If the surface dries before the 2 minutes is completed, use additional wipes as needed and continue wiping.

III. Securely hang the trans-abdominal or vascular probe on the ultrasound machine hangers until use on the next patient.

IV. See Administrative Operations Manual Policy No. 670.21, Procedure for Endocavity Transducer High Level Disinfection for cleaning and disinfecting any endocavity transducer.

REFERENCES:	**Cleaning and Disinfection of Probes per Manufacturer Instruction for Use**
	Wipe Probes per Manufacturer Instruction for Use
	Healthcare Facilities Accreditation Program Standards
	Centers for Medicare & Medicaid Services
	Centers for Disease Control and Prevention, Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:	N/A	**Policy, Procedure and Standards Committee**
	6/18/19	**William L. Gilbert, Hospital Director**
		Applicable Administrator, Hospital or Medical Committee
	8/6/19	**Board of Supervisors**
		Approved by the Governing Body

REPLACES: **Medical Imaging Policy No. 703.00**

EFFECTIVE: <u>11/4/14</u>   **REVISED:** <u>N/A</u>

REVIEWED: <u>2/07/19</u>

SECTION:	PATIENT CARE	SUB SECTION:	SPECIAL PROCEDURES

SUBJECT: OPERATIVE AND OTHER INVASIVE PROCDURES

APPROVED BY: _____
Chief Executive Officer

POLICY

The purpose of this policy is to provide Arrowhead Regional Medical Center (ARMC) with guidelines for emergent beside surgical procedures performed in Intensive Care Units (ICU) that may need Operating Room (OR) services.

PROCEDURES

I.   Procedure Requiring Operating Room Staff and Anesthesia:

When an actual or impending cardiac arrest is due to a surgically treatable condition, an immediate open bedside procedure may be life-saving. In this situation there is not time to transport the patient to the Operating Room (OR).

If this occurs, the attending surgeon will communicate with the Anesthesia attending in charge to arrange OR services, equipment and personnel necessary at the bedside. Upon determination that OR services, equipment and/or personnel are needed at the bedside, the Anesthesia attending will communicate with the OR charge nurse regarding the staffing support needed and a plan will be implemented for Operating Room support.

After the need for support has been determined, a phone call to the ICU charge will be made to the OR charge nurse communicating the plan for the bedside procedure. The attending surgeon will contact the OR charge nurse extension 02400 to communicate equipment and supplies needed.

The Operating Room Management Team or designee will provide supplies, equipment and personnel as if providing for an emergency trauma in the Operating Room. Anytime supplies or equipment are dispatched to a location outside the OR, the OR personnel will accompany the supplies and equipment. This may or may not involve delaying urgent or elective surgeries due to availability of resources.

All cases that are performed in the ICU, requiring OR supplies, equipment and personnel, will be reviewed in the Operative and Other Invasive Procedures Committee. A supply cart (Attachment A) is available for "Out of OR Procedures." The cart will be stocked and maintained in the Central Core of the Operating Room. Upon request for supplies and/or OR personnel, the cart will be transported to the bedside.

II.   Indications for Bedside Surgical Procedure:

A.   Emergent Surgical Procedures Reserved for Patients Who Have Prohibitive Risks for OR Transport

       1.   Decompressive celiotomy for abdominal compartment syndrome.

       2.   Exploratory celiotomy for acute hemodynamic decompensation due to hemorrhage.

       3.   Re-exploration of a previous open abdomen for dressing change or closure.

       4.   Peri-Mortem Emergent Cesarean Sections.

III.   Peri-operative Circulating Registered Nurses:

    A.   Assure necessary equipment and supplies are available and in working condition.

    B.   Ensures parameters of sterility are met before opening instrument or supplies (package integrity, expiration date, etc.).

    C.   Assists scrub nurse in gowning and count procedures.

    D.   Performs surgical prep.

    E.   Participate in surgical time out.

    F.   Assist in patient draping as necessary.

    G.   Anticipate needs of the attending surgeon, anesthesia team and scrub nurse during procedure.

    H.   Continuously assess and document patient status.

    I.   Account for all sponges, needles and instruments passed off the sterile field.

    J.   Completes all patient and charge records.

    K.   Disposes of specimens appropriately per Operative Services Policy No. 221.11.

IV.   Peri-operative Documentation:

    A.   Surgical Nursing documentation will be completed on the Perioperative Flow sheet and placed in the chart prior to leaving the bedside.

V.   Peri-operative scrub person Registered Nurse (RN or Surgical Tech) will:

    A.   Assure necessary equipment and supplies are available and in working condition.

    B.   Ensure parameters of sterility are met before opening instruments or supplies (packaging integrity, expiration date).

    C.   Reference procedure card and pull appropriate suture, additional to what is stocked on Emergency Bedside Procedure Cart.

    D.   Perform hand scrub according to guidelines stated in Infection Control Policy No. 176.07.

E.   Set up parameters for sterile field and prepares all sterile supplies and equipment to be used for the case.

F.   Participate in "Surgical Time Out Procedure".

G.   Participate in sponge, needle and instrument count with Circulating Registered Nurse before and during the procedure and before closure of the surgical site.

H.   Remain familiar with the preferred use and care of surgical instruments and equipment.

I.   Routinely examine all instruments for proper function and completeness.

J.   Anticipate the needs of the attending surgeon.

K.   Assist the attending surgeon by passing instruments and other equipment.

L.   Properly identify specimens received during procedure and relay any information to the circulating nurse.

M.   Maintain instruments and equipment on sterile field free of gross contaminants, rinsing frequently during the surgical procedure.

N.   At the end of the procedure, cover contaminated instrumentation for transport to dirty lift in OR or transport directly to dirty decontaminate area in Sterile Processing Department SPD.

VI.   Anesthesia Team (Anesthesiologist, Certified Registered Nurse Anesthetist CRNA, resident and/or Student Registered Nurse Anesthetist (SRNA):

A.   Administers and manages anesthesia services.

VII.   ICU Primary Nurse:

A.   Support the operating room team and anesthesia team by remaining at the bedside to help with needed information including vital signs, assessment and any additional information supporting the actual or impending emergency and or emergent need for surgical intervention. The ICU nurse will also assist the team and remain at bedside to provide any additional assistance and support if needed during the actual procedure.

1.   If anesthesia is not required then the ICU nurses will monitor the vital signs and administer the appropriate medications per Moderate Sedation Protocol including respiratory support and assistance.

VIII.   Specimen Handling:

A.   Operating Room staff will handle specimens per Operative Services Policy No. 221.11.

1.   Each specimen must be placed in the appropriate individual container. The container shall be labeled and verified at bedside with the patient name, date of birth DOB, medical record number, specimen type, physicians name and nurse's initials.

2.   All specimens must be accompanied with a "Tissue Report" form.

3.   Before closure the scrub, circulating nurse and the attending surgeon will verify the specimens that were obtained during the procedure and the location of the specimen. This must be documented by the circulating nurse in the OR charting.

4.   All routine specimens will be kept in the nurses possession and placed in the Pathology Refrigerator in the Post Anesthesia Care Unit (PACU) with formalin covering the specimen at the end of the case or can be taken to the lab immediately following the bedside procedure.

IX.   Soiled Instruments:

A.   Instrumentation and equipment used during a bedside procedure is transported via staff elevator to the Sterile Processing Decontamination area.

REFERENCES: **Operative Services Policy No. 221.11 Care of Specimens**
Sterile Processing Policy No. 1100.1 Collection of Soiled Instrumentation

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Supplies For Emergent Bedside Procedures**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

6/18/19   **William L. Gilbert, Hospital Director**
Applicable Administrator, Hospital or Medical Committee

8/6/19   **Board of Supervisors**
Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/2/15**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

Supplies For Emergent Bedside Procedures

SUPPLIES	QUANITY	*STOCKED (Y OR N)*
LAPAROTOMY PACK	1	
MAJOR INSTRUMENT TRAY	1	
SURGICEL 6X9	10	
KERLIX ROLLS	10	
WARMING DRAPE	1	
8 FR. RED ROBINSON	2	
IOBAN 6650 EZ	2	
CHORAPREP	1	
ADULT BOVIE PAD	1	
10 MM FLAT-FLUTED DRAIN	1	
SUCTION EVACUATOR	1	
2-0 VICRYL TIES 18" (L-39)	5	
2-0 VICRYL TIES 30" (L-105T)	5	
2-0 VICRYL SH (J317H)	10	
1-PDS 11 LOOPED XLH (Z881G)	2	
2-0 ETHIBOND FS (664H)	2	
WATERLESS SCRUB		
ELECTROSURGICAL UNIT		

ARROWHEAD
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Administrative Policies and Procedures

POLICY NO. 670.24 Issue 1
Page 1 of 2

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SECTION:	**PATIENT CARE**	**SUB SECTION:**	**SPECIAL PROCEDURES**

SUBJECT: **ORTHOPAEDIC GUIDELINES FOR TRAUMA ROOM FRACTURE WASHOUTS**

APPROVED BY: _____
                                 Chief Executive Officer

POLICY

Adequate wound assessment, debridement and lavage are vital adjuncts to minimize the risk of infection following open fractures. Historically it has been recommended that this should occur as soon as possible after injury, traditionally within 6 hours. However recent publications have questioned the need to rush all open injuries to the operating room when the quality of care may be compromised due to lack of experienced surgical team or when other extenuating circumstances prevail.

PROCEDURES

I. Based on the assumption that the earlier the bacterial contamination is reduced the less likely it is that an infection will supervene, the ARMC Orthopaedic Service will attempt to abide by the following general guidelines with the respect to open fracture washouts in the Trauma Room:

A. If adequate analgesia/anxiolysis can be safely achieved, the washout should be performed in the Trauma Room but ultimately in the Operating Room.

B. If adequate analgesia/anxiolysis cannot be safely achieved, the washout should not be performed in the Trauma Room but ultimately in the Operating Room.

C. Situations where the patient usually will <u>not</u> be taken to the Operating Room on an emergent basis include:

1. Gustillo grade 1 or 2 fractures
2. Absence of gross contamination
3. No operative suite available
4. Patient too unstable to go to Operating Room
5. Equipment availability issues
6. Subspecialty expertise availability

D. Circumstances where an attempt should be made to take patient to Operating Room to perform washout may include:

1. Grossly contaminated wounds
2. Neurovascular compromise/compartment syndrome

E. Decision to take patient to the Operating Room for definitive care should ultimately rest with the specific orthopaedic attending physician on call.

REFERENCES: **Skaggs, D., Friend, L., Alman, B., Chambers, H., Schmitz, M., Leake, B., Kay, R., & Flynn, J. (2005, January).** *The Effect of Surgical Delay on Acute Infection Following 554 Open Fractures in Children.* **The Journal of Bone and Joint Surgery;87(A):8-12.**

                         Srour, M., Chan, C., Schnuriger, B., Skiada, D., Inaba, K., Okoye, O., Lam, L., Demetriades, D. *Prospective Evaluation of Open Fractures – Impact of Time to Washout.* **Presented at University of Southern California, Los Angeles, CA.**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                         6/18/19   **William L. Gilbert, Hospital Director**
                                         Applicable Administrator, Hospital or Medical Committee

                         8/6/19   **Board of Supervisors**
                                         Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **9/25/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION:	PATIENT CARE	SUB SECTION:	SPECIAL PROCEDURES

SUBJECT: ALCOHOL WITHDRAWAL: MANAGEMENT OF PATIENT IN TELEMETRY UNIT AND INTENSIVE CARE UNIT (ICU)

APPROVED BY: _____
Chief Executive Officer

POLICY

Patients admitted to Arrowhead Regional Medical Center (ARMC) who exhibit signs/symptoms (S/S) of alcohol withdrawal or with known history of alcohol abuse, are evaluated for alcohol withdrawal syndrome (AWS). If AWS is confirmed, the patient receives prompt and appropriate medications to minimize the withdrawal symptoms.

Patients receiving medical care for alcohol withdrawal may be admitted to Telemetry or the Intensive Care Units (ICU). Patients with a higher acuity or who are receiving intravenous (IV) Haloperidol will be admitted or transferred to the ICU.

PROCEDURES

I.   The patient is assessed for S/S of AWS. Providers rule out other physiologic conditions for patient's presenting symptoms.

    A.   Provider orders are completed on the Physician Orders ALCOHOL WITHDRAWAL form (see Attachment A)

    B.   Haloperidol orders for ICU patients are completed on the Intravenous Haloperidol Order form (see Attachment B)

II.   Nursing Instructions

    A.   The Registered Nurse (RN) performs the alcohol withdrawal assessment using the Clinical Institute Withdrawal Assessment of Alcohol (CIWA) scale (see Attachment C for scoring guidelines) as ordered by the provider.

    B.   The RN documents assessment on the alcohol withdrawal flow sheet (see Attachment D)

    C.   The patient's Plan of Care Interventions for safety may include, but are not limited to:
      1. Seizure prevention precautions
      2. Fall prevention precautions
      3. Aspiration prevention precautions
      4. Restraints

    D.   Patient/Family Education includes:
      1. S/S of alcohol withdrawal
      2. Review of medications and side effects

        3. Incorporation of patient safety precautions i.e. seizure prevention precautions, fall prevention precautions, aspiration prevention precautions, restraints, etc.

        4. Follow up care in an alcohol rehabilitation program after discharge

    E.   The RN notifies the provider for:

        1. Respiratory rate less than 12 breaths per minute

        2. Oxygen saturation less than 92%

        3. Seizures

        4. Acute changes in sensorium, i.e., difficult to arouse

        5. CIWA score continues to increase or does not decrease after medication administration

        6. Pulse greater than 120 beat per minute or less than 50 beat per minute

        7. Systolic blood pressure greater than 180 mmHg, less than 90 mmHgTemperature greater than 101.5° F

III.   <u>The Physician considers transferring Telemetry patients to ICU if:</u>

    A.   The patient has a seizure

    B.   The sedation status requires closer or more frequent monitoring

    C.   The CIWA score is above 15 for more than 4 hours

    D.   The patient has been administered any one of the following:

        1. Chlordiazepoxide 200 mg in four hours

        2. More than or equal to lorazepam 6 mg in one hour

        3. A total of lorazepam in 12 mg in 4 hours, or

    E.   The patient requires IV Haloperidol (see attachment B)

IV.   <u>The RN notifies the physician if the CIWA assessment is below 5 and no medication has been administered in 48 hours. The physician will then discontinue the *Physician Orders ALCOHOL WITHDRAWAL.*</u>

REFERENCES: **Kattimani S, Bharadwaj B. Clinical management of alcohol withdrawal: A systematic review. *Industrial Psychiatry Journal*. 2013;22(2):100-108. doi:10.4103/0972-6748.132914.**
Hoffman RS, Winehouse GL. Management of Moderate and Severe Alcohol Withdrawal Syndromes. UpToDate 2015;
http://www.uptodate.com/contents/management-of-moderate-and-severe-alcohol-withdrawal-syndromes#H26

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Alcohol Withdrawal Order Set & Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA – Ar)**
Attachment B: Intravenous Haloperidol Order Form
Attachment : Alcohol Withdrawal Assessment Flowsheet

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **2/07/19**   **REVISED**:   **N/A**

REVIEWED: **N/A**

Admit to   ☐ **Telemetry**   ☐ **ICU**

Allergies: _____ ☐ NKDA

> Consider ICU when:
>   Patient has received 6 mg of lorazepam in one hour
>   Patient has received a total of 12 mg lorazepam in 4 hours
>   CIWA score at 15 or above for more than 4 hours
>   O2 Saturation less than 92% or airway compromise

1. Evaluate if patient is at risk for alcohol withdrawal
   - Recent drinking history including frequency, amount and time of last drink
   - Past history of withdrawal or seizures, hallucinosis, or Delirium Tremens
   - Past history of needing medications for detoxification (concurrent use of benzodiazepines or barbiturates may increase tolerance and risk of serious withdrawal phenomena, requiring higher benzodiazepine doses and a prolonged detoxification process)
2. Vital Signs: every 4 hours or   every 2 hours
3. Labs (if not already done):
   Now: Blood Alcohol Level   Urine Drug Screen (UDS)   CBC   Chem 7   Mg''   Ca   Phos
          Amylase   Lipase   LF   T   Urinalysis
   QAM: CBC   Chem 7
4. Radiology:
   Chest X-Ray: 2 View   Upright   Supine   Indication: _____
5. IV Fluids: ☐ _____ at _____ml/hour ☐ Saline Lock
6. Nursing:
   Perform Alcohol Withdrawal Assessment (Clinical Institute Withdrawal Assessment of Alcohol (CIWA) Scale on page 3) at intervals below and document on alcohol withdrawal flow sheet.
   Seizure Precautions   Fall Precautions
7. Medications:
☐ Lorazepam (Ativan)   po or   IV (ICU patients only) at dosage below according to CIWA score

CIWA Assessment Score	Lorazepam Dose	Reassessment per CIWA & Dose Frequency
5 - 7	0.5 mg	Reassess and then dose every 6 hours until CIWA Score is less than 8 for 48 hours
8 - 10	1 mg	Reassess and then dose every 4 hours
11 - 14	2 mg	Reassess and then dose every 2 hours
15 - 25	3 mg	Reassess and then dose every hour
Over 25	4 mg	Call the physician

- Discontinue the above protocol when CIWA scale less than 5 for 48 hours.
- Hold Lorazepam for any of the following reasons: Pulse less than 50, respirations less than 12, BP less than 90/60 mmHg, patient is unresponsive.
☐ Haloperidol (Haldol) 2 mg IM single dose and call physician for additional orders if agitation not relieved
☐ Haloperidol IV. Please see Intravenous Haloperidol Order Form.
☐ Normal Saline 0.9% 1 liter with additives. Run at _____ ml/hour IV daily (Yellow/Banana Bag)
   ☐ Multiple Vitamin 10ml
   ☐ Thiamine 100mg
   ☐ Folic acid 1mg
   ☐ Magnesium sulfate 2000mg
☐ Multivitamin 1 tab po daily
☐ Thiamine 100mg po daily
☐ Vitamin B12 1000 MCG po daily
☐ Ondansetron (Zofran) 4mg ___po or ___ IV every 4 hours PRN nausea/vomiting
☐ Milk of Magnesia 30 ml po bid PRN constipation
Other:

_____

Other:

_____

Physician Name (Print)	Signature	Date/Time	Pager

SUBJECT: ALCOHOL WITHDRAWAL: MANAGEMENT OF PATIENT   ARMC Policy No. 670.25
IN TELEMETRY UNIT AND INTENSIVE CARE UNIT (ICU)   Page 5 of 7
     Attachment A

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

NAUSEA AND VOMITING
Ask "Do you feel sick to your stomach? Have you vomited?"
OBSERVATION
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR
Arms extended and fingers spread apart.
OBSERVATION
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS
OBSERVATION
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY
Ask "Do you feel nervous?" Observation.
OBSERVATION
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION
OBSERVATION
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM
Ask "What day is this? Where are you? Who am I?"
OBSERVATION
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

AUDITORY DISTURBANCES
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"
OBSERVATION
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES
Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"
OBSERVATION
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD
Ask "Does your head feel different? Does it feel like there is a band around your head?"
DO NOT RATE FOR DIZZINESS OR LIGHTHEADEDNESS. OTHERWISE, RATE SEVERITY.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM
Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

TACTILE DISTURBANCES
Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

INSTRUCTIONS:
Document total CIWA-Ar Score in Meditech or ICU Flowsheet as ordered.

PATIENT IDENTIFICATION

ARROWHEAD REGIONAL MEDICAL CENTER

ALCOHOL WITHDRAWAL ORDER SET

USE APPROVED BAR CODED FORM

SUBJECT: ALCOHOL WITHDRAWAL: MANAGEMENT OF PATIENT   ARMC Policy No. 670.25
          IN TELEMETRY UNIT AND INTENSIVE CARE UNIT (ICU)   Page 6 of 7
                                                                     Attachment B

ARROWHEAD REGIONAL MEDICAL CENTER
INTRAVENOUS HALOPERIDOL ORDER FORM

Haloperidol by intravenous route may be administered in ICU and Emergency Department ONLY. Please check (√) boxes and specify the doses. A dosing range (example: 5-10mg) will not be accepted. Doses may not be repeated any sooner than 30 minutes.

MAXIMUM: 20mg per 4 hours. For patients aged 65 and older, each individual maximum dose will be REDUCED BY 50%.

Sedation-Agitation Score*	Haloperidol Dose
5	Haloperidol _____ mg (Max 2mg) IV over 5 minutes every ____ minutes / hours ☐ Alternate with Lorazepam _____ mg IV every ____ minutes / hours
6	Haloperidol ____ mg (Max 5mg) IV over 5 minutes every ___ minutes / hours ☐ Alternate with Lorazepam _____ mg IV every ____ minutes / hours
7	Haloperidol _____ mg (Max 10mg) IV over 5 minutes every ____ minutes / hours ☐ Alternate with Lorazepam _____ mg IV every ____ minutes / hours

Please call physician if maximum dose is ineffective.

MONITORING: All orders are active unless specifically discontinued.

- Baseline 12 lead EKG must be performed prior to initiation of treatment. For severely agitated patients, the baseline EKG will be deferred until the first calm opportunity.
- The patient shall be placed on continuous EKG monitoring (heart rate, QTc). A telemetry strip with QTc measurement should be documented per shift. Hold haloperidol and contact physician if QTc is greater than 450 milliseconds or arrhythmia develops.
- Serum Potassium and Magnesium levels daily. Contact physician if levels are out of the normal ranges.
- Hold haloperidol if systolic BP < 100 mmHg or MAP < 60 mmHg persistently and contact physician.
- Call physician for extrapyramidal symptoms (EPS) such as tremors, dystonic reactions, drooling, muscle spasm, jitteriness, oculogyric crisis.
- Diphenhydramine 50mg IV once for dystonic reaction. Hold haloperidol and contact physician.
- Perform Confusion Assessment Method for ICU (CAM-ICU) to evaluate for presence of delirium with each assessment of mentation/level of consciousness, no less frequently that every four hours.

_____ _____ _____ _____
Signature   Print Last Name   Pager Number   Date & Time

*ARMC Sedative-Agitation Score
7. Dangerous Agitation- Pulling at endotracheal tube and catheters, thrashing, climbing over bedrails
6. Very Agitated - Does not calm, requires restraints, bites at endotracheal tube
5. Agitated - Anxious or physically agitated, calms to verbal instructions
4 Calm and Cooperative - Calm, easily arousable, follows commands
3. Sedated - Difficult to arouse but awakens to verbal stimuli or gentle shaking, follows simple commands but drifts off again
2. Very Sedated - Arouses to physical stimuli but does not communicate or follow commands, may move spontaneously
1 Unarousable - Minimal or no response to noxious stimuli, does not communicate or follow commands

ALCOHOL WITHDRAWAL DOCUMENTATION FORM

DATE: _____

RESIDENT: _____ Pager: _____

ATTENDING: _____ Pager: _____

TIME	CIWA SCORE	INTERVENTION / MEDICATION	RN INITIALS
0700			
0800			
0900			
1000			
1100			
1200			
1300			
1400			
1500			
1600			
1700			
1800			
1900			
2000			
2100			
2200			
2300			
2400			
0100			
0200			
0300			
0400			
0500			
0600			

RN NAME	SIGNATURE	INITIAL	DATE

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	**SUB SECTION:**	**SPECIAL PROCEDURES**

SUBJECT: **ADMINISTRATION OF INFLUENZA AND PNEUMOCOCCAL VACCINES**

APPROVED BY: _____

<div align="center">Chief Executive Officer</div>

POLICY

It is the policy of Arrowhead Regional Medical Center to screen, offer and provide a pneumococcal and influenza vaccination to applicable in-patients; out-patients including those at Family Health Centers and specialty clinics; and employees and contractor staff who do not have a contraindication for the vaccine.

I.   General Instructions

    A.   Federal and State regulations authorize a RN or a Licensed Vocational Nurse (LVN) to immunize patients for Pneumococcal disease and Influenza without a physician's order.

    B.   The RN may order from the pharmacy and administer Pneumococcal vaccine and Influenza vaccine to patients that meet the criteria from the CDC.

    C.   Influenza vaccine can be administered at the same time as the Pneumococcal vaccine by a separate injection in the opposite arm.

    D.   Pneumococcal vaccine may be given year round.

    E.   Influenza vaccine is given October 1 through March 31, as available.

    F.   Anyone less than 18 years old will require a physician order prior to receiving the pneumococcal and/or the influenza vaccination(s).

II.   Criteria For Immunization

    A.   Influenza Vaccine

        1.   Persons, 6 months of age or older, who have not received the vaccination for the current season, October 1 through March 31, or as vaccine available.

        2.   Children, 6 months through 8 years of age, should get two doses the first year of vaccination. These children should receive the second dose greater than or equal to 4 weeks later.

        3.   Patients will receive the inactivated influenza vaccine.

    B.   Pneumococcal Polysaccharide Vaccine

        1.   Adults, 65 years of age or older, who have not received the vaccination.

        2.   Adults, 65 years of age or older who were vaccinated before the age of 65 and 5 years have passed since receiving the pneumococcal vaccination.

        3.   Adults, 19 to 64 years of age, who smoke or have asthma and have never been vaccinated.

        4.   Anyone, 2 through 64 years of age, that is immunocompromised (see below*) and 5 years have passed since receiving a pneumococcal vaccination.
Immunocompromised people include but are not limited to:

            a.   Kidney failure/ESRD

            b.   Lymphoma or Leukemia

            c.   Multiple Myeloma

            d.   Nephrotic Syndrome

            e.   HIV Infection or AIDS

    f. Hodgkin's Disease
    h. History of solid organ transplant
    i. Medication that affect the immune system: long term steroids, radiation therapy/cancer drugs less than 2 weeks prior to hospitalization
    j. Asplenia (sickle cell disease, malposition of the heart, anomalies of the spleen
   5. Anyone, 2 through 64 years of age, who has not received the vaccination and who has one or more of the following conditions:
    a. Heart Disease/Heart Failure/ Hypertension
    b. Lung Disease/ COPD
    c. Diabetes
    d. Alcoholism
    e. Liver Disease
    f. Cochlear Implant
    g. Cerebral Spinal Leak

III. Exceptions To Selection Criteria

  A. The Influenza Vaccine will NOT be given to patients who:
    1. Are febrile (for at least 12 hours), have unstable vital signs, or moderately/severely ill
    2. Have had a history of serious reaction from a previous influenza vaccine
    3. Have a known allergy to eggs, latex, or Thimerosal
    4. Are less than 6 months of age
    5. Have received a bone marrow transplant within the past 6 months
    6. Have a history of Guillan-Barre Syndrome within 6 weeks after a previous influenza vaccination
    7. Have received an organ transplant during the current hospitalization
    8. Patient declined
  B. The Pneumococcal Vaccine will NOT be given to patients who:
    1. Have received Pneumococcal vaccine during this hospitalization
    2. Are febrile (for at least 12 hours), have unstable vital signs, or moderately/severely ill
    3. Have had a history of serious reaction from a previous pneumococcal vaccine
    4. Are less than 2 years of age
    5. Are pregnant (Reassess the need for pneumococcal vaccination if the baby is delivered during hospitalization)
    6. Have received a bone marrow transplant within the past 12 months
    7. Are receiving chemotherapy or radiation therapy during this hospitalization or within 2 weeks
    8. Have received Zostavax, (shingles vaccine) within the last 4 weeks
    9. Had an organ transplant during the current hospitalization
    10. Patient declined

PROCEDURES

I. Screening is done using the Influenza/Pneumococcal Vaccine Consent/Order form, see Attachment A. Adult inpatients are screened by an RN at the time of admission. Rescreening is done upon unit-to-unit transfer, if the Influenza and Pneumococcal vaccine was contraindicated during the prior screening. Inpatients, previously excluded due to fever or serious condition, may be rescreened after 12 hours of afebrile status.

II.   Influenza and Pneumococcal vaccine may be administered by RNs and LVNs, according to the manufacturer and CDC guidelines. Direct physician supervision is not required.

III.   Provide patient and family education prior to administration of the vaccine.

    1.   A copy of the current Vaccine Information Sheet (VIS) from the CDC must be given to the patient and/or family and documented on the screening tool, along with the VIS issue date. Current VIS is available at http://www.cdc.gov/vaccines/hcp/vis/index.html.

    2.   Additional information from Krames on Demand or other sources may be provided as needed.

IV.   Adult inpatients not meeting the criteria, or declining to consent, are noted on a signed "Influenza / Pneumococcal Vaccine Consent / Order" form and do not receive the vaccination. The screening tool is placed in the "legal" section of the patient record.

V.   If the vaccine was given, document administration site, manufacturer lot number, expiration date on the Medication Administration Record and Discharge Instruction Sheet

VI.   Physician may cancel vaccine administration by a written order.

VII.   Transmit a copy of the screening tool to Pharmacy Services. The screening tool serves as the order to administer the appropriate vaccine.

VIII. Special Considerations

    A.   Do not combine vaccines

    B.   Site of choice: Deltoid

    C.   Method of administration: Intramuscular

    D.   Immediate Notification of Physician: Reportable Conditions and Circumstances

        1.   Redness, swelling, or severe pain at injection site

        2.   Any allergic signs and symptoms, such as:

            a.   Itching

            b.   Hives

            c.   Shortness of breath

            d.   Tachycardia, pallor, or/and dizziness

IX.   Staff Education And Competency Requirements

    A.   RNs are qualified to screen and administer Influenza and Pneumococcal vaccine upon successful completion of a post-test at hire, and on an annual basis.

    B.   LVNs are qualified to administer Influenza and Pneumococcal vaccine upon successful completion of a post-test at hire, and on an annual basis.

    C.   Post-tests are maintained in individual files and in the Education Development Department.

REFERENCES: Centers for Disease Control and Prevention, Vaccine Information Statement (VIS) Home Page Web site: http://www.cdc.gov/vaccines/hcp/vis/index.html

California Health and Safety Code Section 1288.7: Influenza Plan

California Health and Safety Code Division 1, Chap 2, Article 1, Section 1261.3

(2013) Influenza Vaccination Coverage Among Health-Care Personnel: United States, 2012-13 Influenza Season. Retrieved October 1, 2013. From Center for Disease Control. Website: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6238a2.htm?s_cid=mm6238a2_w

(2010) Updated recommendations for prevention of invasive pneumococcal disease among adults using the 23-valent pneumococcal polysaccharide vaccine (PPSV23). Retrieved September 12, 2012, from Center for Disease Control. Web site:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5934a3.htm

(2009) Prevention and control of influenza recommendations of the advisory committee on immunization practices (ACIP). Retrieved October 7, 2009, from Center for Disease Control Web site:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5510a1.htm

(2009) Prevention and control of influenza: recommendations of the advisory committee on immunization Practices (ACIP). Retrieved October 7, 2009, from Center for Disease Control Web site:
http://www.cdc.gov/flu/professionals/infectioncontrol/healthcarefacilities.htm

(2007) Influenza guidelines and recommendations: Infection control guidance and control of influenza in acute care facilities. Retrieved October 4, 2007, from Center for Disease Control Web site:
http://www.cdc.gov/flu/professionals/infectioncontrol/healthcarefacilities.htm

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Influenza/Pneumococcal Vaccine Consent/Order Form**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **Department of Nursing Policy 507.00**

EFFECTIVE: **07/28/16**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

Pneumococcal Vaccination

Administer vaccine if **ANY** of the following boxes are checked:

- ☐ I am 65 years or older and have never received the vaccine
- ☐ I was vaccinated before the age of 65 and it has been more than 5 years since I received the pneumococcal vaccine
- ☐ I am 19 to 64 years of age and smoke or have asthma and have never been vaccinated
- ☐ I am immunocompromised (**see below**) and it has been more than 5 years since I received the pneumococcal vaccine
- ☐ I am 18 to 64 years of age with any of the following conditions:

Immunocompetent persons

___ Heart disease/HF/HTN   ___ Lung disease/COPD
___ Diabetes   ___ Alcoholism
___ Liver Disease   ___ Cochlear implant
___ Cerebral Spinal Fluid leak

Immunocompromised persons

___ Kidney failure/ESRD   ___ Lymphoma or leukemia
___ Multiple myeloma   ___ Nephrotic syndrome
___ Hodgkin's disease   ___ HIV infection or AIDS
___ History of solid organ transplant
___ Medication that affects my immune system (Long-term steroid use or radiation/cancer treatment more than 2 weeks ago)
___ Asplenia (sickle cell disease, malposition of the heart, anomalies of the spleen)

Exclusion Criteria: Do not give pneumococcal vaccine if **ANY** box is checked below:

- ☐ I am less than 18 years of age **(Physician order required)**
- ☐ I am pregnant (Reassess the need for pneumococcal vaccination if the baby is delivered during this hospitalization)
- ☐ Documentation of :
  - ___ Pneumococcal vaccine given this hospitalization or in the past
  - ___ Bone marrow transplant within the past 12 months
  - ___ Receiving chemotherapy or radiation therapy **during** this hospitalization or within **2 weeks**
  - ___ Received Zostavax (Shingle's vaccine) within the last 4wks
  - ___ Patients with an organ transplant during the current hospitalization
  - ___ Allergy/sensitivity to pneumococcal vaccine
  - ___ Patient declined

Influenza Vaccination

- ☐ Influenza vaccine is out of stock at this time
- ☐ It is not influenza season (October thru March)

If neither of the above choices apply, proceed to the questions below:

Administer vaccine only if ALL boxes are checked:

- ☐ I am **NOT** allergic to eggs, Thimerosal or latex and I have not had a serious reaction/problem with the flu vaccine in the past
- ☐ I am 18 years or older
- ☐ I have not received a flu vaccine this influenza season

Exclusion Criteria: Do not give influenza vaccine if **ANY** box is checked below:

- ☐ I am less than 18 years of age **(Physician order required)**
- ☐ Received influenza vaccine during the current hospitalization or flu season
- ☐ Allergy/sensitivity to influenza vaccine or anaphylactic allergy to latex, Thimerosal, or eggs
- ☐ Bone marrow transplant within the past 6 months
- ☐ History of Guillain–Barré Syndrome within 6 weeks after a previous influenza vaccination
- ☐ Patients with an organ transplant during the current Hospitalization
- ☐ Patient declined

☐ Vaccine Information Statement given to patient/representative. **Pneumococcal VIS Date: (4/24/15) Influenza Vaccine VIS: (8/7/15)**

Screened by (Signature & Title): _____   **Date:** _____

CONSENT (Place a checkmark in the box(s) below to indicate the type of vaccine you are giving consent to receive)

I am signing this consent to verify that I am **NOT** allergic to eggs, latex, or Thimerosal, and **have not had a serious reaction or problem with the** ☐ **Pneumococcal** or ☐ **Influenza (Flu)** vaccine in the past. I have read or had explained to me the information about the vaccine and have had all of my questions answered. I understand the risks and benefits of the vaccine and authorize it to be given to me.

X_____   _____   _____
Signature of patient or authorized representative   Relationship if other than patient signature   Date

---

VACCINE(S) NOT GIVEN FOR THE FOLLOWING REASONS: ☐ Any of the exclusion criteria checked   ☐ Patient declined

I choose to **decline** the ☐ Pneumococcal vaccine   ☐ Influenza (Flu) vaccine

X_____   _____   _____
Signature of patient or authorized representative   Relationship if other than patient signature   Date

TO OBTAIN VACCINE(S) PLEASE SCAN OR SEND THIS FORM TO THE PHARMACY

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

| SECTION: | PATIENT CARE | SUB SECTION: | SPECIAL PROCEDURES |

SUBJECT: NON CHEMOTHERAPY EXTRAVASATION

APPROVED BY: _____
                                        Chief Executive Officer

_____

POLICY

Patients receiving intravenous medication infusions are monitored for signs and symptoms of extravasation.

I. Background

    A. Extravasation refers to the accidental leakage of a substance (e.g., fluid or drug) into perivascular and subcutaneous spaces and is a known risk of intravenous (IV) therapy. It is estimated that approximately 10% to 30% of patients on IV therapy may experience this complication. Depending on the type of substance that has extravasated, the degree of injury can range from local irritation to severe tissue necrosis of the skin and vasculature. Substances can be divided into three categories based on their potential for tissue damage upon extravasation: non-vesicants, irritants, and vesicants. Non-vesicants, if extravasated, rarely produce an acute reaction or result in necrosis, while extravasation of an irritant can produce pain and inflammation at the injection site and along the vein. Extravasation of a large amount of an irritant can potentially cause ulcerations. Vesicants are drugs that can cause blistering and ulceration and, if not managed promptly, tissue destruction and necrosis.

    B. Risk for extravasation is dependent on multiple factors related to the procedure, patient, equipment and materials, concomitant medications, and treatments themselves. The following is a list of the most common factors known to increase the risk for extravasation:

        1. *Patient Factors*
            a. Fragile veins (e.g., elderly)
            b. Hard, sclerosed veins
            c. Impaired circulation
            d. Inability to report stinging/discomfort (e.g., sedated, confused)
            e. Mobile veins
            f. Obesity
            g. Obstructed vena cava
            h. Pre-existing conditions (e.g., diabetes, radiation damage, Raynaud's syndrome)
            i. Small blood vessels (e.g., young children)
            j. Hypotension
            k. Peripheral vascular disease
            l. Prior extravasation injury
            m. Altered skin and subcutaneous tissue integrity
            n. Excessive patient movement around venous access site
            o. Clot formation at IV catheter site
            p. Lymphedema
            q. Peripheral neuropathy or other altered sensory perception

      r.   Variation in venous and arteriolar anatomy

  2. *Procedures*
    a. Bolus injection
    b. High flow pressure
    c. Untrained or inexperienced staff
    d. Multiple attempts at IV catheterization
    e. Unfavorable IV catheter site
    f. Catheter location in elbow, ankle, dorsum of hand, or any other point of flexion
    g. Need for IV catheter adjustments

  3. *Equipment*
    a. IV catheter size (relative to vein size) and type (steel>Teflon>polyurethane)
    b. Steel butterfly needle

  4. *Treatments*
    a. Ability to bind directly to DNA
    b. Ability to kill replicating cells
    c. Ability to cause tissue or vascular dilatation
    d. pH
    e. Osmolality
    f. Characteristics of diluent

C. Prevention is critical for minimizing the consequences of extravasation. Proper maintenance of the IV site, monitoring of the infusion rate, early identification, and education of patients and healthcare providers of risks and management strategies can prevent the occurrence of and facilitate recovery from an extravasation.

II. Extravasation Management

A. The nature of the drug and the degree of extravasation will determine the course of action required. For most extravasations, treatment aimed at minimizing the concentration of the drug at the site ("spread and dilute" approach) promotes healing and prevents further injury. The "localize and neutralize" approach is applicable only for the extravasation of cytotoxic agents. Heat with warm compresses may be used to promote vasodilatation and increase drug reabsorption and distribution. The application of moist heat may lead to maceration and necrosis of delicate tissue; therefore, regular monitoring of the site is warranted with this measure.

B. For drugs with a high risk of causing tissue damage, further treatment may be warranted to minimize the risk of permanent injury. **Saline washout** has been shown to effectively remove drug from the extravasation site and thereby reduce tissue injury. **Liposuction**, where a blunt-ended liposuction cannula is inserted into the extravasation area to aspirate fat and extravasated drug, is less effective than saline washout. The use of **steroids** (i.e., hydrocortisone and dexamethasone) by topical, subcutaneous or IV routes, has not been shown to alter outcome in managing an extravasation event. **Hyaluronidase** aids in the dispersion or flushing out of extravasated material; however, there is no clear evidence that this method is of benefit when used alone without a washout procedure. Early use of **phentolamine** may be of benefit after extravasation of vasopressors.

III. Procedure

A. Stop the infusion and/or injection immediately if there are any of these sign and symptoms:
  1. Patient complains of pain or tenderness at or above the site of infusion

    2. Redness appears above, below, or at the site of infusion
    3. If the IV site has poor of no blood return
    4. Edema or swelling present at the site or in the surrounding tissue

B. For all extravasations, initial treatment measures should include the following:
    1. Immediately stop and disconnect the infusion (not IV catheter).
    2. Call physician on call and receive Extravasation Orders
    3. Call Pharmacy for delivery of the Extravasation Kit (see appendix A).
    4. Use a 10 mL syringe to aspirate as much of the drug as possible through the IV catheter and avoid direct manual pressure to the suspected extravasation site.
    5. Leave the IV catheter in place until further treatment is determined. When no longer required, remove the IV catheter to prevent further use and injury.
    6. Initiate substance specific measures (see appendix B: Extravasation Order Set).
    7. Administer pain relief if required.
    8. Where possible, elevate the extremity and/or encourage movement to encourage lymphatic resorption of the drug.
    9. Complete extravasation documentation sheet (see appendix C).
    10. Mark the affected area and take digital images of the site.

C. Extravasation Kit
    1. An extravasation kit facilitates early management of an extravasation event. The kit contains disposable syringes and IV catheters, warm and cold compresses, gauze pads, sterile and protective gloves, and medications for extravasation treatment (e.g., hyaluronidase, dexrazoxane). A list of the kit's contents is placed within the kit, and a pharmacist conducts regular verifications of the drug contents to ensure updated expiration dates. The extravasation kit content list is provided in Appendix A.

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Phentolamine prescribing information. Available at URL: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=16573. Accessed December 29, 2010.

DEFINITIONS: Extravasation - the accidental leakage of a substance (e.g., fluid or drug) into perivascular and subcutaneous spaces

ATTACHMENTS: Appendix A: Extravasation Kit Contents
Appendix B: Extravasation Orders
Appendix C: Extravasation Documentation Sheet Antidotes

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: 4/28/16   **REVISED:**   N/A

REVIEWED: 2/07/19

Appendix A: Sample Extravasation Kit Content List

Patient Identification Stamp

Medication	Quantity in Kit	Replaced Amount	Expiration Date
*Hyaluronidase 150 unis/ml	1		
Nitroglycerin 2% Ointment 30 gm tube	1		
Phentolamine 5 mg/ml vial	2		
Terbutaline 1 mg/ml vial	2		
Normal Saline 10 ml vial	5		

Supplies	Quantity in Kit
18-gauge x/x" needle	10
25-gauge x/x" needle	30
3 mL syringe	10
5 mL syringe	10
10 mL syringe	10
Alcohol swabs	30
4x4" gauze pads	30
Instant Cold Pack	1
Instant Heat Pack	1
Indelible pen for marking the affected area	1

Documents	Quantity in Kit
Extravasation Documentation Form	1
Copy of Extravasation Management Policy	1
Patient information leaflet	1

* Stored in refrigerator

Appendix B

Date: _____   Time: _____

1. Stop IV infusion immediately. Do not remove IV catheter.
2. Notify the physician on service and retrieve the extravasation kit.
3. Slowly aspirate as much drug as possible with a 10 ml syringe. Leave the IV catheter in place until further treatment is determined. Do not apply pressure to the area.
4. After aspirating as much drug as possible and if no further treatment is required through the catheter, remove the IV catheter while aspirating to prevent further use and injury. Use of this site for further I.V access is not recommended.
5. Where possible, elevate the area for 48 hours to minimize swelling and encourage movement to facilitate lymphatic resorption of the drug.
6. Mark the affected area and take digital images of the site. Complete extravasation documentation sheet.
7. Initiate substance specific measures as follows:

Specific Substances (Circle all that apply)	Antidote Warm-Cold Therapy Indications
☐ Dobutamine Dopamine Epinephrine Norepinephrine Phenylephrine	Phentolamine: Prepare by diluting 5 mg phentolamine in 10 mL of 0.9% sodium chloride. Inject subcutaneously with a 25 gauge needle into the extravasation area within 12 hours of extravasation. Blanching should reverse immediately; additional injections may be required if blanching returns. Do not exceed 0.1-0.2 mg/kg or 5 mg total. *Warm-Cold Therapy not recommended.*
☐ Calcium Carmustine Etoposide Teniposide Vinblastine Vincristine Vindesine Vinorelbine	Hyaluronidase: Preparation—Use solution as provided (150 unit/1 mL vial); do not dilute further. Inject subcutaneously or intradermally into the extravasation site using a 25-gauge needle or smaller. Dosage: The dose is 150 units (1 mL) given as five 0.2 mL injections into the extravasation site at the leading edge; change the needle after each injection. *Apply warm packs for 15-20 minutes at least four times a day.*
☐ Cisplatin (greater than 20 ml and concentrations less than 0.5 mg / mL) Mechlorethamine	Sodium Thiosulfate: Mix 4 mL of sodium thiosulfate 10% with 6 mL sterile water for injection to prepare a 0.17 mol/L (4%) solution. Inject 3-10 mL subcutaneously with a 25 gauge needle into extravasation site; use clinical judgment and size of extravasation site to determine volume. This dosing is based on limited and varied information. *Apply cold compress for 15-20 minutes at least four times a day.*
☐ Dacarbazine Potassium Sodium Bicarbonate Phenytoin	*Apply warm packs for 15-20 minutes at least four times a day*

PHYSICIAN SIGNATURE:_____

NAME: _____   PAGER: _____

PATIENT IDENTIFICATION	ARROWHEAD REGIONAL MEDICAL CENTER **EXTRAVASATION ORDERS** **USE BARCODED FORMS ONLY**

73-100311 (6/16)

Appendix C: Sample Extravasation Documentation Sheet

Patient Identification Stamp

Extravasation recognized:

Date: ....

Time: .... □ AM □ PM

□ During administration
□ Immediately after administration
□ .... hours after administration
□ .... days after administration

Treatment:

Aspiration of drug possible:	□ Yes	□ No
Recommended general and substance specific measures taken	□ Yes	□ No

Additional measures taken – Describe: ....
....
....

Risk factors that may influence wound healing (e.g., diabetes mellitus):
....
....

Patient education provided:	□Yes	Date:..................................	□ No
Plastic surgeon consulted:	□Yes	Date:..................................	□ No

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[i] Dougherty L. Extravasation: prevention, recognition and management. Nursing Standard. 2010; 24,52, 48-55.
[ii] Non-cytotoxic drug extravasation therapy. Micromedex (2011). Thomson Reuters. Accessed November 2, 2011.
[iii] Hyaluronidase prescribing information. Available at URL: http://dailymed.nlm.nih.gov/dailymed/search.cfm?startswith=hyaluronidase. Accessed December 29, 2010.
[iv] Phentolamine prescribing information. Available at URL: http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=16573. Accessed December 29, 2010.

| SECTION: | PATIENT CARE | SUBSECTION: SPECIAL PROCEDURES |

SUBJECT: **SPINAL ORTHOTIC DEVICES AND MANAGEMENT**

APPROVED BY: _____
Chief Executive Officer

POLICY

I.   Trauma or disease of the musculoskeletal system often requires the use of devices to immobilization, stabilization, and support the affected body part(s) to enhance the healing process. When using devices, it is essential that integumentary tissues remain health and intact inside and outside of the device.

II.   Assessment of the skin includes the detection of:
A.   Pressure
B.   Inflammation
C.   Irritation
D.   Lesions

III.   Spinal Orthotic devices are removed every shift for skin assessment.

IV.   Pin sites are assessed every shift. Pin site care is performed once per shift and as needed, see Perry-Potter (2014) *Clinical Nursing Skill and Techniques* for pin site care information.

PROCEDURES

I.   <u>Types and the management of spinal orthoses (see attachment A and C)</u>

A.   Cervical Collars
1.   Should fit in such a way as the patient's neck is never hyperextended causing difficulty swallowing
2.   Foam Collars may be washed with soap and water, rinsed, squeezed, and then allowed to air dry for further use
3.   Some collars have replacement pads for the back to prevent ulcer formation
4.   When transferring or rolling the patient, keep the patient's neck immobilized and support using two hands, see photograph right.
a.   Must be kept clean and dry to protect skin
b.   Must examine pressure points to prevent pressure ulcer formation
5.   Types of cervical collars:
a.   Aspen Collar
b.   Soft Foam Collar

B.   Cervical Thoracic Orthosis (CTO)
1.   Is used to stabilize the thoracic and cervical spine
2.   Can be easily removed, unlike the Halo Vest
3.   Does not need to be worn when lying flat or less than 30 degrees to prevent pressure ulcers
4.   Ensure the CTO fit is snug, but not too tight

      5.   Should fit in such a way as the patient's neck is never hyperextended

C.   Thoracic-lumbar-sacral orthosis (TLSO)
1. Secure the top thoracic portion into place
2. DO NOT wear when lying flat or less than 30 degrees
3. Check the skin regularly and perform pressure ulcer prevention strategies
4. Should fit in such a way as the patient's neck is never hyperextended
5. Educate the patient to the importance of wearing a T-shirt or snug body shirt under the brace. The shirt must be tight and without wrinkles for skin protection.

D.   Lumbar sacral orthosis (LSO)
1. Similar to TLSO, without the thoracic spine component
2. Do NOT confuse with an abdominal binder
3. Check sacral region for ulcer formation and perform pressure ulcer prevention strategies
4. Like the TLSO, does not need to be worn when patient is lying flat in bed
5. Educate the patient on the importance of wearing a snug T-shirt or body shirt under the brace. The shirt must be tight and without wrinkles for skin protection

E.   Halo vest
1. If patient needs Cardiopulmonary Resuscitation (CPR), unbuckle the sides of the vest and lift up from the hinge to allow for chest compressions
2. No need for a backboard because the brace serves as a back board
3. Avoid catching the bars on bed-sheets when sitting patient upright as it can cause pain for the patient
4. Ensure the ends of the rods are not entangled in the bed sheets
5. Educate the patient to the importance of wearing a snug T-shirt or body shirt under the brace. The shirt must be tight and without wrinkles for skin protection
6. The emergency wrench is attached directly to the halo vest for emergency removal of the Halo
7. Provide pin care (see Attachment C)
    a.   Pin sites are assessed once per shift and as needed for:
        i.   Signs and symptoms of infection
        ii.   Pain or discomfort
        iii.   Loosening – often reported by patients as noticing a 'clicking' sound
        iv.   If patient falls, ensure pin sites are assessed by physician for migration or dislodgement.
    b.   Pin site care is performed once per shift and PRN.
        i.   Sterile technique is used in hospital. Teach patients it use clean technique once at home.
        ii.   Wet sterile cotton applicator with sterile normal saline
        iii.   Gently clean around each pin. Use new applicator for each pin site. Work in a circular pattern and do not go back over the areas with the same applicator.
        iv.   When cleaning, apply gentle pressure to move the skin at each pin to prevent skin from growing up the pin.
    c.   Dried secretions (crusts) should be gently removed. If difficult to remove or excess crusting present, wrap pin site with saline soaked gauze. Attempt to remove the crusts with a sterile applicator following. Avoid causing irritation by vigorous cleansing.
    d.   The ordering physician may choose to prescribe ointments / antiseptics / Chlorhexadine Gluconate (BioPatch) pads to the pin sites
    e.   Clip hair when it grows around the pin sites

II.   <u>Placement of orthosis</u>

A.   The device is selected and applied by the physician
B.   Physician is present to sit patient up for the first time after the brace is placed (typically for X-ray)
C.   Orthotic technician rechecks proper fit 24 hours after placement

III.   Pressure ulcer prevention

A.   Manually inspect under orthosis every shift and as needed to detect areas of pressure and or shearing
B.   Refer to manufacturer instructions on pressure relief strategies if applicable
C.   May use products recommended by wound care for prophylaxis
D.   Examples of pressure ulcers (see attachment B)

IV.   Documentation

A.   Documentation includes:
1.   Date, time, type of device, who placed the device
2.   Pressure ulcer check every shift
3.   Date and time device is applied or removed
4.   Repositioning of the patient to sitting up or lying supine and if the patient is wearing the device while in that position
B.   Documentation of patient education on brace management and care prior to discharge

V.   Staff education and collaboration

A.   Provider communicates directly with orthotic technician when ordering brace
B.   Trauma, neurosurgery, and orthopedic surgery residents receive annual spine orthoses didactic lecture
C.   Inpatient nurses receive initial training for spine orthoses. Additional training is provided with new equipment or procedure.
D.   Have designated tool box for orthotic adjustment in inpatient units
E.   Wound care evaluations weekly

REFERENCES: **Huynh, K. *Spinal Orthotic Devices* (2014) PowerPoint presentation.**
Perry-Potter (2014) *Clinical Nursing Skill and Techniques*
Department of Nursing Policy 801.00, Pressure Ulcer Prevention

DEFINITIONS: **NA**

ATTACHMENTS: **Attachment A: Types of Spinal Orthoses**
Attachment B: Examples of Pressure Ulcers from Spinal Orthoses
Attachment C: Spinal Orthoses Order Set

APPROVAL DATE:

          N/A   **Policy, Procedure and Standards Committee**

       6/18/19   **William L. Gilbert, Hospital Director**
                    Applicable Administrator, Hospital or Medical Committee

       8/6/19   **Board of Supervisors**
                    Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **2/28/18**   **REVISED: N/A**

REVIEWED: **2/07/19**

ATTACHMENT A: Types of Spinal Orthoses

Cervical Collar

### Cervical Thoracic Orthosis (CTO)

Thoracic-lumbar-sacral orthosis (TLSO)

Lumbar sacral orthosis (LSO)

Halo Vest
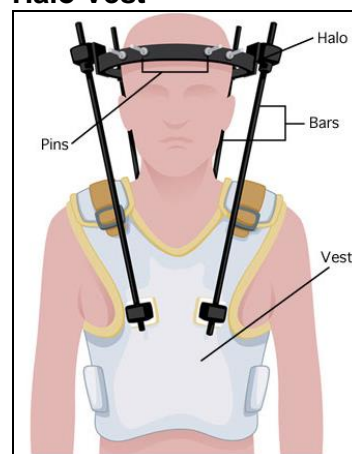
ATTACHMENT B: Examples of Pressure Ulcers from Spinal Orthoses

Occipital region

Clavicular region: Note that soft collar obstructs view of pressure ulcer

ATTACHMENT B (continued)

Under the Left Chin

SPINAL ORTHOSIS ORDER SET:
Please check all that apply.
Service: ☐ Neurosurgery   ☐ Trauma/Surgery   ☐ Ortho   ☐ Other _____

Attending:_____   Resident: _____   Pager: _____

Diagnosis: _____

DEVICE:
☐ Hard Cervical Collar
    ☐ Must be worn at all times
    ☐ FULL SPINAL PRECAUTIONS when brace is removed for skin checks every shift. Ensure the patient is in the flat
      supine position.
    ☐ Maintain C-spine precautions when the collar is removed.
    ☐ Change collar pads when soiled.
    ☐ Maintain an extra set of collar pads at the bedside.
☐ Cervical Thoracic Orthosis (CTO)
    ☐ Must be worn when sitting up greater than 30°, or up out of bed
    ☐ Remove when lying less than 30° or patient is lying flat in bed
    ☐ Spinal precautions when the brace is off.
    ☐ PLEASE FAX TO ONE OF THE ORTHOTICS COMPANIES BELOW
☐ Thoracic-Lumbar-Sacral Orthosis (TLSO)
    ☐ Must be worn when sitting up greater than 30°, or up out of bed
    ☐ Remove when lying less than 30° or patient is lying flat in bed
    ☐ Spinal precautions when the brace is off.
    ☐ PLEASE FAX TO ONE OF THE ORTHOTICS COMPANIES BELOW
☐ Lumbar Sacral Orthosis (LSO)
    ☐ Must be worn when sitting up greater than 30°, or up out of bed
    ☐ Remove when lying less than 30° or patient is lying flat in bed
    ☐ Spinal precautions when the brace is off.
    ☐ PLEASE FAX TO ONE OF THE ORTHOTICS COMPANIES BELOW
☐ Halo Vest
    ☐ Halo vest care and management per AOM Policy 670.28
    ☐ Avoid any ointments/antiseptics on pin sites after cleansing
    ☐ Place Chlorhexadine Gluconate pad (BioPatch) around each pin site after cleansing every ___ hours
    ☐ Dress pin sites with triple antibiotic ointment after cleansing every ___ hours
    ☐ Spinal precautions when the brace is off.
    ☐ PLEASE FAX TO ONE OF THE ORTHOTICS COMPANIES BELOW*

NURSING:
☐ Remove device (if applicable) while maintaining alignment, and **assess and document skin integrity every shift**
☐ During skin assessment, make sure skin is clean, moisturized, and dry and document
☐ Replace soiled/wet pads PRN
☐ Reinforce original padding with foam or elastogel as indicated
☐ Place Mepilex to pressure area and change every other day
☐ Provide second brace for bathing/showering. Dry area thoroughly before placing dry brace
☐ Provide brace information and education
☐ Document skin integrity
☐ Contact H.O. if skin breakdown is discovered
☐ Consult wound nurse if skin breakdown is discovered for r/o pressure ulcer.
☐ *Contact Hanger at 1-877-442-6437 (if skin breakdown is noted) for 24 hour inspection and PRN
☐ *Contact Redlands Prosthetic and Orthotic Group at 909-798-5853 for 24 hour inspection and PRN

_____   _____   _____   _____
         Print Name   Signature   Date   Time

PATIENT IDENTIFICATION	ARROWHEAD REGIONAL MEDICAL CENTER
	SPINAL ORTHOSIS ORDERS
	USE BAR CODED FORMS ONLY

22-17-599 (09/17)

SECTION:	**PATIENT CARE**	**SUB-SECTION:**	**SPECIAL PROCEDURES**

SUBJECT: **CODE WHITE**

APPROVED BY: _____

<div align="center">Chief Executive Officer</div>

POLICY

I. Any member of the health care team can call a code. This is done by establishing the need to summon the Code Team and communicating this need to the other care givers in the area.
II. Certified staff and ancillary personnel perform cardiopulmonary resuscitation (CPR)/ Basic Life Support (BLS) within the limits of their certification.
III. Code events are called overhead and the code team is paged.

PROCEDURE

I. THE FOLLOWING ARE THE DESIGNATED CODE TEAMS:

    A. Code White- birth to 13 years of age
    B. Code Blue – greater than 13 years of age

II. CODE ACTIVATION AREAS

    A. Clinical Areas including on-site specialty clinics and Behavioral Health
        1. The health care team member activates the Code White by notifying Security at the Code Phone Number (extension 44444). After receiving notification, Security activates the Code White Team pagers and announces the location of the Code White over the public address (PA) system (e.g. "Code White, 3 North"). The PA system announces the message throughout the facility.

    B. Non-Clinical Areas
        1. The staff member activates the Code White by notifying Security at the Code Phone Number (extension 44444). After receiving notification of the Code White, Security activates the Code White Team pagers and announces the location of the Code White over the PA system (e.g. "Code White, Orthopedic Clinic"). The PA system announces the message throughout the facility. Security calls the area back to verify that the Code White Team members have responded.

    C. Medical Office Building
        1. The staff member activates a Code White by notifying Security at the Code Phone Number (extension 44444). After receiving notification of the Code White, Security activates the Code White Team pagers and announces the location of the Code White over the PA system (e.g. "Code White, Medical Office Building"). The PA system announces the message throughout the facility. Security calls the area back to verify that the Code White Team members have responded.

D.   Arrowhead Family Health Centers and Mobile Clinics
        The staff member calls 9-1-1 to initiate the Emergency Response
        1.   Locations
                a.   McKee Family Health Center (FHC)
                b.   Westside FHC
                c.   Fontana FHC
        2.   Equipment
                The following supplies are available for emergency use:
                a.   Automated External Defibrillator (AED)
                b.   Adult, Pediatric, and newborn Bag Mask and/or 1-way valve mask

III.   CODE WHITE TEAM

A.   Code White is the designation given to a patient less than or equal to 13 years of age in
        cardio-respiratory arrest.

B.   The members of the Code White Team are an optimally trained designated group who
        manage the Code White through its entire duration.

C.   The Code White Team and Roles/Qualifications:
        1.   Attending Neonatologist
                a.   Responds to all Code Whites
                b.   Assumes overall responsibility for the performance of the members of the
                        resuscitation team
                c.   Coordinates the resuscitation efforts of the team members (for neonates 30
                        days of life or less and may assist as requested for patients greater than 30
                        days)
        2.   Emergency Department Senior Resident and/or Attending
                a.   Responds to all Code Whites
                b.   Coordinates the resuscitation efforts of the team members in the absence
                        of the neonatologist.
                c.   Demonstrates competency by:
                d.   Maintaining a current BLS card, and
                e.   Bi-ennial attendance at Pediatric Resuscitation Seminar
        3.   Resident/Intern – Family Medicine and Emergency Department
                a.   Coordinates the resuscitation efforts of the team members in the absence
                        of the neonatologist **and the ED Senior Resident or Attending.**
                b.   Demonstrates competency by:
                        1)   Maintaining a current Basic Life Support (BLS) card.
                        2)   PALS and NRP
        4.   Neonatal Intensive Care Unit (NICU) Registered Nurse (RN) (for neonates 30 days
                of life or less and may assist as requested for patients greater than 30 days)
                a.   A charge nurse or designee from the NICU
                b.   Demonstrates competency by maintaining current BLS and NRP cards.

        5.   Medical ICU (MICU) RN
                a.   A charge nurse or designee from the MICU
                b.   Demonstrates competency by maintaining current BLS and PALS cards.

        6.   Neonatal Respiratory Care Practitioner (RCP) or Respiratory Care Supervisor
                a.   Must be a designated NICU RCP and/or Respiratory Care Supervisor
                b.   Demonstrates competency by maintaining current BLS and NRP cards

    c. Must be competent in the intubation of neonates

   7. Primary RN caring for the patient
    a. Initiates and/or delegates BLS interventions until Code White Team arrives
    b. Remains at the bedside throughout the code to provide history and pertinent information
    c. Acts as recorder and may delegate other staff members to bring up the electronic medical record (EMR), and monitors/equipment (if available).
    d. Demonstrates competency by maintaining current BLS and NRP/PALS cards as required by the unit
    e. Family Advocate – Designates staff to support parents/family

   8. House Supervisor—assists with crowd control
    a. Facilitates any procedures needed during the code.
    b. Completes the Code White Evaluation.
    c. Facilitates transfer to appropriate area post code.
    d. Assigns staff to contact the patient's family.
    e. Obtains copy of code white record upon completion of event, attaches completed code white evaluation form and forwards to Code Blue Committee.

   9. Security
    a. Responds to all code white events: provides location, direction and bystander management.
    b. Assists in reducing non-essential traffic in the area.

   10. Pharmacist/Pharmacy Resident attends (when available)
    a. Provides clinical pharmacy consultation if needed.
    b. Facilitates securing of additional medications if needed.

   11. Hospital Chaplain (when available)
    a. Addresses spiritual needs of the family.
    b. Assists in obtaining additional spiritual resources, as needed.

IV.   EQUIPMENT

  A. Crash Cart
   1. Types and Locations
    a. A Neonatal crash cart is located in Newborn Nursery, 3 South, and NICU.
    b. A Pediatric crash cart is located in Pediatrics 3 North, the Emergency Room (ER), Burn unit, and Medical ICU
    c. A defibrillator with pediatric paddles is available in NICU and Pediatrics
    d. A transport monitor is available from the NICU and Pediatrics
   2. Crash carts that have been opened are replaced by Sterile Processing. A new (locked) crash cart is brought to the unit and the opened cart returned to the Sterile Processing department. The RN is responsible for completing a crash cart check upon the new cart's arrival to the unit.
   3. Replacement of opened medication trays
    a. On nursing units, medication trays are placed in the medication room for pharmacy pick-up. Medication trays that are opened in isolation rooms are left inside the patient's room or in the anteroom for pharmacy pick-up.
    b. In the Outpatient Center areas, opened medication trays are placed in a secure area by licensed personnel for prompt return to Pharmacy.

B.   Code Records
   1.   Code White Neonatal Record (for patients less than 30 days old)
   2.   Code Blue Event Record (for patients greater than 30 days old)

V.   Code White Pager Assignments

Code White	
Neonatologist	NICU RN
ED Attending	MICU RN
ED Senior Resident	Respiratory Care Supervisor and /or designee
Pediatrics (Family Medicine) Resident/Intern	House Supervisor

VI.   MAINTAINING STAFF COMPETENCY

   A.   Orientation
      1.   Nursing department employees receive department-specific orientation in the use
              and location of crash carts, the procedure to follow for calling a Code White, and
              are oriented in the proper procedure for responding to a code. This orientation
              takes place during unit orientation.
      2.   The code team is oriented in the proper procedure and response during a Code
              White event.

   B.   CPR Re-certification (BLS / PALS / NRP)
           All direct caregivers are required to possess a current BLS card.

   C.   Special Consideration for Critical Care Areas (NRP/PALS)
           Code White personnel are required to maintain competency in BLS / PALS / NRP as
           required by the patient care area. Nurses working in these areas participate as part of the
           Code White Team.

   D.   Mock Code Whites
      1.   Mock Code Whites are carried out in areas based on identified learning needs.
      2.   A simulation lab may be used to conduct mock codes.

VII.   Quality Management

   A.   Code White activities are monitored for appropriateness and accuracy, according to the
           guidelines established by the American Heart Association, the American Academy of
           Pediatrics (AAP) and members of the Critical Care Committee.

   B.   Code White Review After Codes
      1. The Code White evaluation form is completed at the time of the event by the Nursing
          Supervisor.
           Debriefing of Code White occurs immediately after the event with all participants.
      2. Code White evaluations are reviewed by the Code Blue Committee and reported to
          the Critical Care Committee.

**REFERENCES: Administrative Policy No. 220.01, Licenses, Certificates, Registration –
                    Verification of
                    Administrative Policy No. 670.03, CPR – Code Team Role**

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Code White Newborn Record**
                     Attachment B: Code White Review/Evaluation

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                      6/18/19   **William L. Gilbert, Hospital Director**
                                    Applicable Administrator, Hospital or Medical Committee

                      8/6/19   **Board of Supervisors**
                                    Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **10/27/16**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

Date: _____
Time of Onset: _____
Time Team Arrived: _____

Area of Resuscitation: ☐ Labor and Delivery ☐ 3-South ☐ Emergency Department
☐ NICU ☐ Newborn ☐ Postpartum ☐ Other _____

CIRCULATION CPR Initiated at: _____ ☐ Monitoring in Place ☐ Monitor Attached

AIRWAY/BREATHING
Breathing: ☐ Spontaneous ☐ Apneic ☐ Assisted ☐ Bag-Valve-Mask
☐ Assisted Ventilation ☐ Mask/Bag ☐ T-Piece ☐ Oral Airway ☐ LMA _____ ☐ Pulseoximeter Attached
☐ ETT ETT Size: _____ Position at lip: _____ Intubated By: _____ Time: _____
☐ Breath Sounds Bilaterally ☐ ETT Capnography Confirmed ☐ CXR ☐ OGT Placed _____

IV Access ☐ Yes ☐ No ☐ UVC ☐ PIV ☐ Intraosseous ☐ PICC
IV Insertion Site: _____ Location: _____ Time: _____

Neonatologist/ED Attending:
Present ☐ Yes ☐ No Called ☐ Yes ☐ No Time: _____
Historian: ☐ RN ☐ Family

MD Print Name/Signature _____
RN Print Name/Signature _____
RN Print Name/Signature _____
RT Print Name/Signature _____
Recorder Print Name/Signature _____
Other Print Name & Title/Signature _____

OUTCOME
Code Terminated at: _____
Family Notified (name): _____
Relationship: _____
Survived ☐ Yes ☐ No
Transferred to: _____
Expired / Time of Death: _____

OTHER INTERVENTIONS / COMMENTS

VITALS					RESPIRATORY							MEDICATIONS				
Time	BP	Pulse Rate	Compressions	O2 Saturation	Ventilation Rate Spontaneous	Ventilation Rate Assisted	FiO₂	PIP	PEEP	CPAP	Epinephrine (0.1mg/ml) 1:10,000 IV Dose 0.1-0.3 ml/Kg/dose (0.01 - 0.03mg/Kg/dose)	Epinephrine (0.1mg/ml) 1:10,000 ET Dose 0.5-1 ml/Kg/dose (0.05 - 0.1 mg/Kg/dose)	Naloxone (1mg/ml) IV/IM 0.1 mg/Kg/dose	0.9% Normal Saline IV 10 ml/Kg/dose	Defibrillation 2 Joules / Kg

PATIENT IDENTIFICATION

ARROWHEAD REGIONAL MEDICAL CENTER
CODE WHITE NEWBORN RECORD
—PILOT—
DISTRIBUTION: White–Chart Canary–Pharmacy Pink–Nurse Manager
USE APPROVED BAR CODED FORMS ONLY

73-100328 (10/16)

Code White Review/Evaluation

Name: _____   MR# _____   Date of Event: _____

Time: _____   Location: _____   Inpatient   Outpatient

Patient Outcome: No Change   Pt transferred to higher level of care:

                                             ICU   NICU   ED

Comments:

CODE WHITE

There was one designated physician leader	Yes	No
Crash Cart immediately available	Yes	No
• Equipment functioned properly	Yes	No
• Medication immediately available	Yes	No

NRP Guidelines followed?	Yes	No	All clear before each shock?	Yes	No
PALS Guidelines followed?	Yes	No	Complications of resuscitation?	Yes	No
Aiway established?	Yes	No	Parent(s) supported throughout?	Yes	No
Initial rhythm identified and documeted?	Yes	No	Compressions began after ventilation established?	Yes	No
AED in place @ Team Arrival	Yes	No			

Comments and Improvements (All "No" comments must be explained)

Patient outcome: EXPIRED   SURVIVED / TRANSFERRED TO: _____

REVIEWER: _____   Date: _____

Please attach this form to a copy of the original ARMC CARDIOPULMONARY RESUSCITATION FORM and
FAX to: ICU NURSE MANAGER at x 02319
DO NOT SEND TO MEDICAL RECORDS
Revised 2/7/2016

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONS

SUBJECT: **PATIENT'S HOME MEDICATIONS**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

Generally, medications administered to Arrowhead Regional Medical Center (ARMC) patients are distributed from the ARMC pharmacy. Home medications are not to be used during hospitalization, except when approved by the pharmacist and ordered by the practitioner. When medications are not on formulary, patients may bring their home medications into ARMC to be self-administered, or to be administered by a licensed professional.

PURPOSE

To describe the process for handling patient's home medications for administration by a licensed professional or self-administration. Self-administration may include either hospital-acquired or a patient's home medications.

PROCEDURES

I. Patient's Home Medications

   A. Prior to a patient using their home medication(s), the prescribing practitioner consults with a pharmacist to determine if the medication is in the formulary or if an alternative is available. In instances when a practitioner feels it is imperative that the patient take their home medication, an order must be written to that effect. The pharmacist reviews the order. If deemed appropriate, the medication will be sent to the pharmacy for proper identification and re-labeling to insure proper dispensing and administration.

      1. Patient's home medications, which are not formulary and are compounded by an outside pharmacy, may not be administered without verification of the quality of the process for preparation and the quality of the ingredients. If the process and ingredients cannot be verified and/or the outside pharmacy is unable to ensure the quality of the product, then alternative therapy is prescribed.

      2. A patient's own injectable medication to be administered must be unopened prior to the initial administration and stored under controlled conditions for future administration to the patient. Proper temperature storage is validated with the patient. Use of multiple dose vials is discouraged whenever possible.

   B. The prescribing practitioner writes an order authorizing the patient to take their home medication. The order specifies the medication is to be self-administered by the patient/family/significant other or administered by a licensed professional. No verbal orders are accepted.

C. Patient's home medication(s) are verified by an ARMC pharmacist prior to administration. The medication is identified and labeled by a pharmacist. If the medication appears to be altered in any way or unidentifiable or if proper storage conditions cannot be verified, the medication will not be administered.

D. Once verified by the pharmacist, the patient's home medication(s) is stored in the pharmacy and daily doses are dispensed to the patient's medication cassette in the medication room. Medications are not stored at the bedside.

E. The use of a patient's home medication(s) in ambulatory areas is prohibited.

F. A patient's home injectable medication to be administered must be unopened prior to the initial administration and stored under controlled conditions for future administration to the patient. Proper temperature storage is validated with the patient. Use of multiple dose vials is discouraged whenever possible.

G. Medications brought to ARMC by patients that are not to be administered during the hospital stay are returned to the patient's family or representative upon admission. Medications (except controlled substances) that cannot be sent home with the patient's family are secured in a tamper evident bag and sent to the pharmacy for storage.

H. A patient's home controlled substance is not administered to the patient during the hospital visit. Controlled substances that cannot be sent home with the patient's family or representative are brought to the pharmacy and secured.

   1. When securing the patient's home controlled substance(s), the nurse determines the quantity of the medication with the patient/patient's family or proxy. If the patient's family or proxy is not available, a Nurse Manager, Nursing Supervisor or designee may act as a witness.

   2. The controlled substance(s) is then brought to the Pharmacy where the pharmacist receives the medication for storage and records the date, time and quantity of controlled substance in the presence of the nurse.

 I. The controlled substance(s) is then brought to the Pharmacy where the pharmacist receives the medication for storage and records the date, time and quantity of controlled substance, in the presence of the nurse.

J. Upon discharge, the patient's own medication is returned to the patient. For controlled substances, the nurse or designee retrieves the medication from the pharmacy. The nurse verifies the quantity of the medication as recorded on the Patient Property Sheet with the patient/patient's family or proxy.

K. Medications not retrieved within 30 days after the patient is discharged are destroyed.

REFERENCES: **The Joint Commission**
                         Centers for Medicare and Medicaid Services Standards
                         Pharmacy Policy 5.2 Self-administration (Bedside Medications)
                         Pharmacy Policy 5.21 Medications Brought In By The Patient

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL   DATE: **N/A**   **Policy, Procedure and Standards Committee**
_____

                          6/18/19   **William L. Gilbert, Hospital Director**
                                          Applicable Administrator, Hospital or Medical Committee
_____

                          8/6/19   **Board of Supervisors**
                                          Approved by the Governing Body
_____

REPLACES: **N/A**

EFFECTIVE: **11/4/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**PATIENT CARE**	SUB SECTION:	**OPERATIONAL**

SUBJECT: **MEDICAL DEVICE ALARM SAFETY**

APPROVED BY: _____

<div align="center">Interim Chief Executive Officer</div>

_____

POLICY

Arrowhead Regional Medical Center (ARMC) staff ensure effective alarm coverage, appropriate alarm use, and adequate annunciation of alarms. Staff follow a process for safe medical device alarm management and response in high-risk areas. This policy applies to medical devices that contain alarms designed to alert staff to high risk clinical conditions.

PURPOSE

To guide staff in the safe operation of alarms on medical equipment and monitoring systems in high risk areas and improve the effectiveness of staff response to critical alarms.

PROCEDURE

I. GENERAL ALARM GUIDELINES

    A.   Medical device alarms must be:
        1.   Activated whenever the medical device is in use
        2.   Verified at the start of each shift
        3.   Verified if the patient is transported between clinical areas

    B.   When clinical alarms sound, staff personally check the patient and evaluate the reason for the alarm before resetting it. The alarms may be muted or suspended for the brief period of time only when the staff member is monitoring, evaluating, and/or treating the patient. Before turning attention away from the patient, the alarm must be reactivated.

    C.   Volume level of clinical alarms must be sufficiently audible with respect to distances and competing noise to be heard by the responsible clinicians in the immediate patient care area. This may require that alarm volume be adjusted upward at certain times of the day based upon the noise level and activity in the patient care area. Patient's room and physical location in the patient care area may need to be moved to improve audibility of the alarm.

    D.   In circumstances where the patient room door must be closed and clinical staff cannot readily hear clinical alarms, care providers maintain regular assessments of the room to evaluate alarm status.

II. CRITICAL ALARM SETTINGS

    A.   Critical alarms should not be disabled. Alarms may be suspended:

1. By staff trained and qualified to operate the equipment and understand the clinical implications of such action.
2. While the patient is off the equipment, or staff is working directly with the patient. The alarm must be returned to the "on" position when the equipment is placed back on the patient or when care is completed.

B. Patient care staff check equipment with clinical alarms to ensure that:
1. Settings are appropriate for each patient
2. Alarm is active
3. Alarm is not impaired in any manner
4. Alarm volumes are set at a level so that staff can hear them.

C. Alarm parameters are set by clinically trained personnel in such a manner that they are consistent with the patient's clinical presentation and care needs.

III. NON-CRITICAL ALARM SETTINGS

Non-critical alarm parameters are set either to the default settings established by the manufacturer or as clinically warranted based on the patient's condition. Parameters may be set and/or adjusted by the patient's provider or by staff trained and qualified to operate the equipment and understand the clinical implications of such action. Non-critical alarms are not turned off, but the volume may be set so that it is not disruptive to the therapeutic milieu or contribute to alarm fatigue.

IV. VERIFYING ALARM FUNCTIONALITY AND SETTINGS

Operational functionality of medical device alarms is checked in accordance with manufacturer instructions as part of the equipment(s) biomedical preventive maintenance and repair program. In addition, users of medical devices verify – as appropriate – that critical alarms are in the "on" position and sufficiently audible;

A. Prior to using the device on a patient
B. When assuming care of a patient (i.e. at the start of shift)
C. Following removal and subsequent reapplication of the device on a patient due to patient care needs
D. Prior to transferring a patient with the device to another care area

V. STAFF TRAINING

A. Upon hire, new staff receive training on clinical alarms as part of their department specific orientation on the equipment they will be using in their assigned department(s). Training may include:
1. Proper use and settings of user selectable alarm setting
2. Review of differing alarm sounds and actions required by staff
3. Prioritization of alarm response

B. Ongoing training is provided when new medical devices are introduced into the organization and as necessary.

C. Patient care staff response to clinical alarms on units or within a department is assessed during rounds by charge nurse, assistant nurse manager, and/or nurse manager. Inattentiveness is brought to the staff member's attention as needed.

VI. INSPECTION, TESTING AND MAINTENANCE

The Biomedical Engineering Department provides inspection; testing and maintenance for medical equipment (refer to Safety Manual Section 6).

REFERENCES: **Joint Commission Sentinel Event Alert. Medical device alarm safety in hospitals. Issue 50, April 8, 2013**
2014 National Patient Safety Goal on Alarm Management
American Association of Critical-Care Nurses Practice Alert, Alarm Management Practice Alert
ARMC Safety Manual, Section 6

DEFINITIONS: **MEDICAL DEVICE: A piece of equipment designated by the Food & Drug Administration as a medical device.**

HIGH RISK CLINICAL CONDITION: A medical condition that is considered life threatening to a patient.

NON-CRITICAL ALARMS: Alarms on medical equipment designed to alert staff to the presence of a non-life threatening condition.

HIGH RISK AREAS:
 Intensive care units
 Monitored care units
 Labor and Delivery
 Emergency Department
 Operative and Invasive procedure suites
 Areas where anesthesia is administered
 Post-anesthesia recovery areas
 Hemodialysis
 Hyperbaric Therapy

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director** Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors** Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **2/19/14**   **REVISED:**   **N/A**

REVIEWED: **2/07/19**

SECTION: **PATIENT CARE**   SUB SECTION: **OPERATIONAL**

SUBJECT: **WOUND CARE REFERRAL PROCESS**

APPROVED BY: _____
                                          Chief Executive Officer

_____

POLICY

Arrowhead Regional Medical Center (ARMC) provider services have a process for initiating a wound consult which is routed by the provider to the appropriate department to ensure inpatient and outpatient continuity (see Attachment A).   Wound Care Consultation is provided by a variety of wound care experts from multiple disciplines.

PROCEDURES:

I.   MAKING A REFERRAL BASED UPON ETIOLOGY AND SEVERITY OF WOUND

A.   A referral may be initiated by primary physician team, consultants, or bedside nurses for pressure ulcers.

B.   A referral for a wound care requiring treatment recommendations requires a licensed provider's order. The wound expert contacts the licensed provider for specific orders upon referral.

C.   An order for a wound consultation is placed by the provider which includes the requested wound department and the reason for the referral, according to the following criteria:

1.   Wound Care Nurse (WCN) Consultation For Community Acquired and Hospital Acquired Pressure Ulcers:

a.   This is a regulatory requirement due to the need to accurately assess, track and treat ulcers with pressure etiology.

b.   WCN makes recommendations for wound assessment and care of uncomplicated wounds not requiring follow-up under the supervision of the primary physician.

2.   Physical Therapy (PT) Wound Consultation:

a.   PT wound care consultation for lower extremity wounds.

b.   PT wound care consultation for complex wounds requiring close monitoring and/or for maggot placement, Vacuum Assisted Closure (VAC) placement, and sharp bedside debridement.

3. Vascular Surgery/Hyperbaric Oxygen (HBO) For Arterial or Perfusion Wound Etiology:

   a. An order for Transcutaneous Cutaneous Partial Oxygenation (TCPO$_2$) test notifies Vascular Surgery for the need for evaluation.

4. General Surgery for Surgical Debridement and Incision and Drainage (I&D) Procedures:

   a. An order for General Surgery Consult for surgical debridement or I&D notifies General Surgery for need for evaluation.

II. ROLE OF WOUND EXPERT AFTER REFERRAL

A. Wound Nurse Consultant:

1. Coordination of pressure ulcer prevention and pressure ulcer care with primary physician, unit Wound Resource Nurse, unit administration and nursing staff.

2. Tracking and reporting pressure ulcers as they occur and progress with recommendations for care to primary physician; unit nurse manager, assistant nurse manager, or change nurse; regulatory administration; and Wound Nursing Program Coordinator.

3. Coordination of pressure ulcer care with Unit Wound Resource Nurses.

4. Validation of etiology of pressure ulcers and staging of pressure ulcers.

5. Collaboration during hand-off transfers of service to ensure continuity of care.

B. PT Wound Consultant:

1. Recommendation for care of complex wounds to primary physician, and follow-up per clinical judgment.

2. Ensure continuity of care during transfers from PT to bedside nursing staff when follow-up is no longer needed per clinical judgment of clinician.

3. Reporting of new pressure ulcers to primary physician for WCN.

4. Collaboration during hand-off transfers of service to ensure continuity of care. Nursing requires a physician signed order for resumption of nursing administered care.

DEFINITIONS: **Wound Resource Nurse: Trained unit based nurse responsible for weekly skin
                     checks.**

                    **Wound Care Nurse: Certified Wound Nurse responsible for Pressure Ulcer staging
                    and tracking.**

ATTACHMENTS: **Attachment A: Provider Wound Referral Process Algorithm**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **1/23/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

PROVIDER WOUND REFERRAL PROCESS
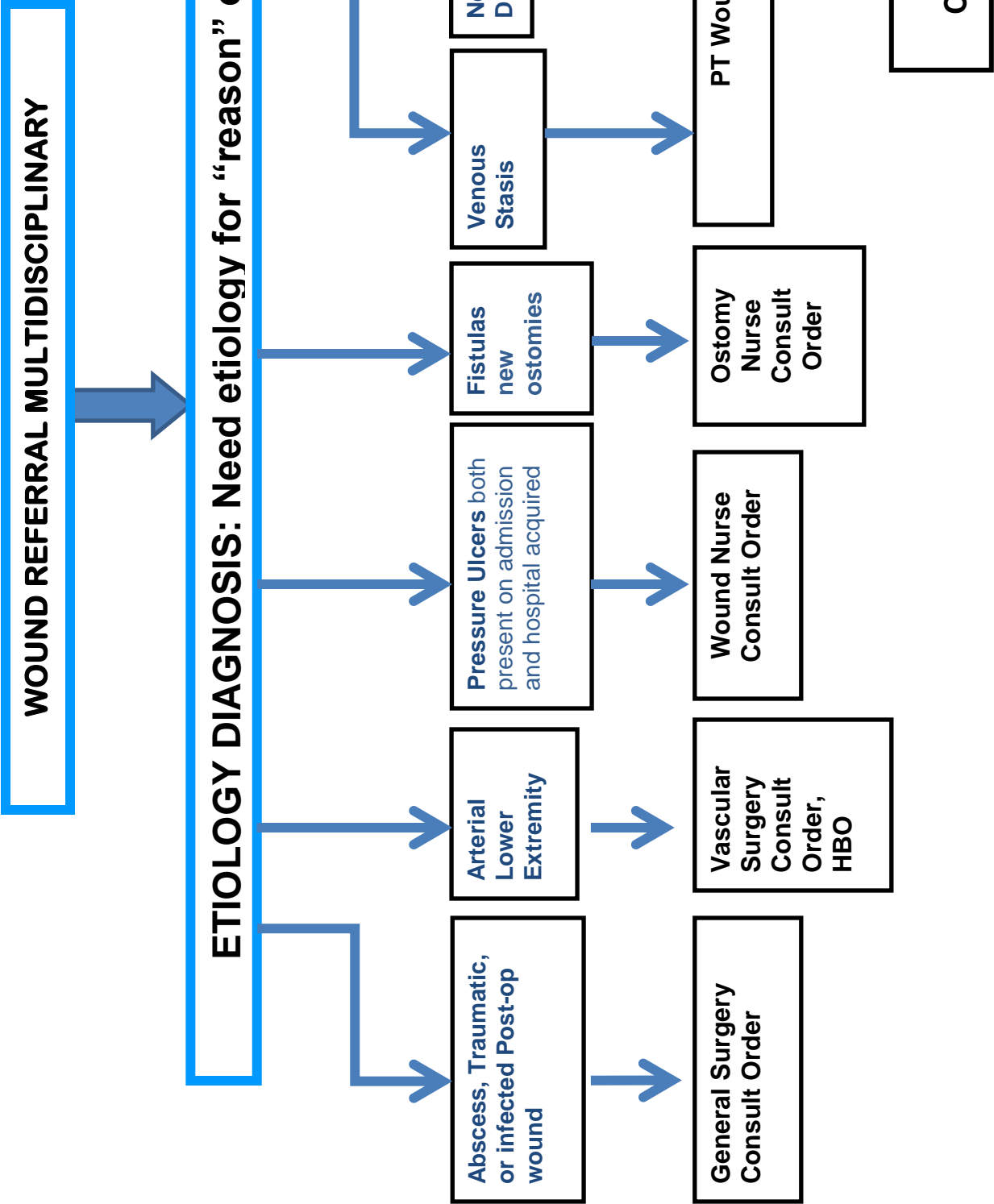
WOUND REFERRAL MULTIDISCIPLINARY

ETIOLOGY DIAGNOSIS: Need etiology for "reason" on order!

- **VAC placement Maggot Treatment, Sharp Debridement** → **PT Wound Consult Order** → **HBO Consult**
- **Neuropathic Diabetic Foot** → **PT Wound Consult Order**
- **Venous Stasis** → **PT Wound Consult Order**
- **Fistulas new ostomies** → **Ostomy Nurse Consult Order**
- **Pressure Ulcers** both present on admission and hospital acquired → **Wound Nurse Consult Order**
- **Arterial Lower Extremity** → **Vascular Surgery Consult Order, HBO**
- **Abscess, Traumatic, or infected Post-op wound** → **General Surgery Consult Order**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONAL

SUBJECT: CHAIN OF COMMAND: DUTY TO INTERVENE AND/OR CONFLICT RESOLUTION

APPROVED BY: _____
Chief Executive Officer

POLICY

I.   Arrowhead Regional Medical Center (ARMC) supports staff in utilizing the Chain of Command related to a duty to intervene and conflict resolution.

II.   Implementation of the Chain of Command requires voice-to-voice communication. Methods such as paging, text messages, voice mail or email do not constitute "notification" and are not acceptable.

III. Examples of situations where implementation of the Chain of Command may be necessary include:

A.   Inability to reach a physician or a physician fails to accept patient care responsibilities or the possible need for a consultation.

B.   Clarification of physician orders when the dietitian/nurse/therapists/pharmacist/ technologist has substantial reason to believe that carrying out of the order would not be deemed reasonable and prudent conduct, or the order is felt to be inappropriate or inadequate.

C.   The patient is in need of immediate medical attention and the attending or consulting physicians are unable to provide that treatment due to distance from hospital or unavailability.

D.   An unexpected and/or adverse event impacting patient care, or the ability of the hospital to provide a safe environment.

IV.   The Hospital Chain of Command is as follows:

A.   The Charge Nurse or designated lead of the unit/department.

B.   House Supervisor

C.   The unit/department Manager

D.   The unit/department Assistant Hospital Administrator

E.   The Administrator on call

     F.   Medical Director

     G.   The Chief Executive Officer

V.   The House Staff Chain of Command for patient care is as follows:

     A.   Attending/supervising physician

     B.   Program Director

     C.   Designated Institutional Official (DIO) for residents from Allopathic Programs or Director of Medical Education (DME) for residents from Osteopathic Programs

VI.   The Medical Staff Chain of Command for patient care is as follows:

     A.   Attending/supervising physician

     B.   Department Chairman

     C.   Department Vice Chairman

     D.   Section Directors, if applicable

VII.   The Medical Staff Chain of Command for patient care involving allied health professionals (AHP) or other disciplines, such as Podiatrists, Dentists, etc., is as follows:

     A.   Attending/supervising physician

     B.   Department Chairman

     C.   Department Vice Chairman

     D.   Section Directors, if applicable

VIII. After hours and on weekends and holidays, the House Supervisor is the on-duty administrative representative for the hospital. Any staff member may contact the House Supervisor for assistance. In addition, there is an Administrator on-call; the schedule is posted and available through the hospital operator.

PURPOSE

I.   To establish guidelines and provide a formal process to ensure that staff at all levels can carry out their independent duty to intervene in situations where they have knowledge of actions or inaction which may cause harm to patients.

II.   To establish guidelines and a formal process to ensure that conflict is resolved to the benefit of patient safety and quality of care. This process is to be used to resolve conflicts that have the potential to affect the safety or quality of care, treatment, services, or the orderly operation of the hospital.

PROCEDURE

I.   Issues Relating to the Medical Staff:

   A.   The nurse caring for the patient, or the therapist/pharmacist/technologist if applicable, contacts the physician involved and attempts to resolve the issue.

   B.   If unable to resolve the issue with the physician involved, the nurse/pharmacist/ therapist/technologist notifies his/her Manager or in the Manager's absence, the House Supervisor on duty.

   C.   The Manager/Supervisor contacts the physician involved and attempts to resolve the issue.

   D.   If no resolution is achieved, the Manager/Supervisor initiates the Medical Staff Chain of Command to facilitate resolution.

   E.   Special Considerations:

      1.   Delayed Response – Women's Services: For newborns in the Nursery or Post-Partum unit, the on-call pediatrician is contacted and the Pediatric Department Chair apprised. For anticipated deliveries in Labor and Delivery, the on-call obstetrician is contacted and the Obstetrics Department Chair apprised.

      2.   For patients in the Intensive Care Unit (ICU), the ICU Medical Director is contacted to resolve conflict/treatment issues.

      3.   Respiratory Therapy contacts their Medical Director.

II.   Patient Needing Immediate Medical Attention:

   A.   The nurse caring for the patient assesses the need for immediate medical attention and, after validating the need, calls a Rapid Response Team response or a Code Blue.

   B.   The Rapid Response Team responds and renders any necessary treatment, including utilizing any consultants necessary to meet the patient's needs.

   C.   Immediate medical attention is not limited to "code" situations, but may include any situation of an emergent nature in which the patient's care or outcome may be affected by a delay in treatment.

III. Responsibilities of Hospital Staff:

   A.   When a physician is called, it is the responsibility of the nursing staff to make certain that the necessary information is available to be reported to the physician.

      1.   Includes vital signs, medications, and appropriate chart information.

      2.   Hand-off communication is done if the patient's primary nurse is not readily available to speak to the physician when the call is returned.

      B.   No information is transmitted to a staff member by a physician who cannot take appropriate orders.

      C.   Hospital staff members with a concern regarding patient safety or quality of care are encouraged to bring those concerns forward and to utilize the hospital chain of command to seek a patient-focused solution.

IV.   Documentation:

      A.   Documentation in the medical record includes timed entries stating efforts and responses made to contact the attending or consulting physicians, notification of management, Medical Directors, Medical Staff Department Chairs, Vice Chairs, and Section Directors.

      B.   An Unusual Occurrence Report is completed and forwarded to Risk Management when:

          1.   The Chain of Command is implemented and is pursued further than the first three levels. For example, the issue makes its way to the Medical Director or to the Administrator on call.

          2.   There is failure in executing the Chain of Command process. For example, if there is a lack of response from medical and/or administrative leadership pursuant to attempted contact related to a Chain of Command issue.

V.   Medical Staff Leadership:

      A.   The Medical Staff Office ensures that the current listing of Medical Staff Officers and Department Chairs is posted on ARMC Tools in the Medical Staff Tools folder, and available to the hospital leadership team, including the House Supervisors.

REFERENCES: **Comprehensive Accreditation Manual, Leadership (LD.02.04.01), The Joint Commission**
Conditions of Participation, §482.12

DEFINITIONS: <u>**N/A**</u>

ATTACHMENTS: <u>**N/A**</u>

APPROVAL DATE: __N/A__   **Policy, Procedure and Standards Committee**

                        __6/18/19__   **William L. Gilbert, Hospital Director**
                                       Applicable Administrator, Hospital or Medical Committee

   __8/6/19__   **Board of Supervisors**
                                       Approved by the Governing Body

REPLACES: __N/A__

EFFECTIVE: __3/3/15__   **REVISED**:   __N/A__

REVIEWED: __2/07/19__

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONAL

SUBJECT: SELF-ADMINISTRATION OF MEDICATIONS

APPROVED BY: _____
Chief Executive Officer

POLICY

Patients may self-administer medications when supervised by a licensed professional to ensure safety and proper documentation of medication administration.

PURPOSE

To guide staff in the procedure for patient's self-administration of either hospital-acquired or a patient's own personal medication.

PROCEDURE

I.   Prior to self-administration of a medication, the patient/family/significant other receives patient education by a licensed professional regarding the purpose of the medication, frequency, route, dose, expected outcomes, side effects and how to monitor for side effects. Education is documented in the patient's medical record. The patient must be deemed competent at medication administration before he/she is permitted to administer the medication. The licensed professional documents education received and verifies competence via return demonstration.

II. Self-administration of a medication is supervised by a licensed professional. (i.e., an individual authorized to administer medications as defined by his/her scope of practice).

III. Medication administered by the patient/family/significant other is documented on the Medication Administration Record by the nurse caring for the patient.

REFERENCES: HealthCare Facilities Accreditation Program Standards
               Centers for Medicare and Medicaid Services Standards
               Pharmacy Policy 5.2 Self-administration (Bedside Medications)
               Pharmacy Policy 5.21 Medications Brought In By The Patient

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **11/4/14**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARMC Security Command Center Action Sequence:

CODE GREEN
Missing Patient

CALL RECEIVED

Ask Location and Extension and patient description and hold status

Patient on hold (5150), deemed danger to self by medacal staff (get name) or inmate/custody patient

—Yes→ Dispatch Officers and Colton PD as needed to search for patient At Ext. 03245 or (909) 825-2211 giving information

→ Patient found —Yes→ Escort patient back to room and follow staff instructions

No (from Patient found) ↓ Turn search over to Colton PD and gather information for IRIMS Report

No (from Patient on hold) ↓

DISPATCH OFFICERS by radio to location and to search for described individual

Patient found —Yes→ Offficers provide voluntary escort back to unit or Contact unit and request further instructions

No ↓

Call back department extension to advise

Advise officers by radio , "Code Green Location... is All Clear"

RECORD ALL INFORMATION on SAR and Event Tracking Log. (Incl. Time, Location & Ext.)

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONAL

SUBJECT: CODE GREEN—MISSING/ELOPED PATIENT

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

The Security Department is called in the event that a patient is missing or has eloped. The patient may be deemed a danger to himself/herself or others.

The Security Department is primarily responsible for searching the interior and exterior of Arrowhead Regional Medical Center (ARMC) and coordinating efforts with law enforcement and medical staff as needed.

PROCEDURES

I. SECURITY COMMUNICATIONS CENTER TECHNICIAN:

    A. Receives call reporting missing/eloped patient.

    B. Asks location where patient was last seen, direction patient was going, patient description and **hold status**. Requests the name and department extension of the caller.

    C. If the patient is on a hold (5150) or deemed a danger to self or others by responsible practitioner (request the name of the staff member), dispatch ARMC security officers and the Colton Police by radio to the location and throughout hospital to search for described individual.

        1. If the hold patient is found, escort patient back to room and follow practitioner's instructions (i.e. standby, restraints, etc.).

        2. If the hold patient is not found on premises, turn the search over to Colton Police Department for external search and gather information for the Incident Report.

    D. If patient is not on a hold or deemed a danger to self or others, dispatch ARMC security officers by radio to location and throughout hospital to search for described individual.

        1. If the patient who is not on a hold is found, ARMC security officers will ask the patient to return and provide voluntary escort back to unit, or

        2. Contact unit and request further instructions if patient declines.

    E. If patient is not found, call the reporting staff person at the department extension to advise.

F.   If patient is found/returned, advise ARMC security officers by radio, "Code Green (Location). All Clear".

G.   Record information on Shift Activity Record (SAR) and Event Tracking Log including time, location and extension.

Note: <u>There is no overhead page for Code Green, radio communication only</u>.

II.   SECURITY SHIFT LEAD/SUPERVISOR

The security shift lead/supervisor coordinates the search for the patient and dispatches officers as needed.

REFERENCES:	**Healthcare Facilities Accreditation Program (HFAP)** **Security Department Policy No. 101.662, Code Green—Missing/Eloped Patient**
DEFINITIONS:	**N/A**
ATTACHMENTS:	**Attachment A: ARMC Security Command Center Action Sequence: CODE GREEN – Missing Patient**

APPROVAL DATE:

    N/A   **Policy, Procedure and Standards Committee**

    6/18/19   **William L. Gilbert, Hospital Director**
                Applicable Administrator, Hospital or Medical Committee

    8/6/19   **Board of Supervisors**
                Approved by the Governing Body

REPLACES:	**<u>N/A</u>**		
EFFECTIVE:	**<u>9/9/14</u>**	**REVISED**:	**<u>6/25/14</u>**
REVIEWED:	**<u>2/07/19</u>**		

ARMC Security Command Center Action Sequence:
CODE GREEN
Missing Patient

CALL RECEIVED

Ask Location and Extension and patient description and hold status

Patient on hold (5150), deemed danger to self by medacal staff (get name) or inmate/custody patient

— Yes → Dispatch Officers and Colton PD as needed to search for patient At Ext. 03245 or (909) 825-2211 giving information → Patient found — Yes → Escort patient back to room and follow staff instructions

No (from Patient found) → Turn search over to Colton PD and gather information for IRIMS Report

No → DISPATCH OFFICERS by radio to location and to search for described individual

Patient found — Yes → Offficers provide voluntary escort back to unit or Contact unit and request further instructions

No → Call back department extension to advise

Advise officers by radio , "Code Green Location... is All Clear"

RECORD ALL INFORMATION on SAR and Event Tracking Log, (Incl. Time, Location & Ext.)

ARMC Security Command Center Action Sequence:

CODE GREEN

Missing Patient

1. CALL RECEIVED reporting missing/eloped patient.
2. Ask Location/Extension and patient description <u>and</u> **hold status**.
3. If patient <u>is</u> on a hold (5150) or deemed danger to self by responsible medical staff (get name of staff member) or an inmate/custody patient, DISPATCH OFFICERS <u>and</u> Colton Police <u>by radio</u> to location and throughout hospital to search for described individual.
   a. If hold patient is found, escort patient back to room and follow medical staff's instructions. (i.e. standby, restraints, etc.)
   b. If hold patient is not found on premises, turn search over to Colton PD for external search and gather information for IRIMS Report.
4. If patient is <u>not</u> on a hold or deemed a danger to self, DISPATCH OFFICERS by radio to location and throughout hospital to search for described individual
   a. If patient who is <u>not on a hold</u> is found, Officers shall request patient's return and provide <u>voluntary</u> escort back to unit, or
   b. Contact unit and request further instructions if patient declines.
5. If patient is not found, call back department extension to <u>advise</u>.
6. If patient is found/returned, advise officers <u>by radio</u>, "Code Green Location… is All Clear"
7. RECORD ALL INFORMATION on SAR <u>and</u> Event Tracking Log. (Incl. Time, Location & Ext.)

Note: There is <u>no overhead page</u> for Code Green, <u>radio communication only</u>.

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONAL

SUBJECT: **MULTI-DOSE AND SINGLE-DOSE MEDICATION CONTAINERS**

APPROVED BY: _____
                                              Chief Executive Officer

POLICY

I.   Arrowhead Regional Medical Center (ARMC) staff who administer injections to patients follow patient safety guidelines when handling multi-dose and single-dose medication containers.

II. Multiple Dose Vials

   A. Only vials clearly labeled by the manufacturer for multiple dose use can be used more than once.
   B. Multi-dose vials of injectable medications are utilized only when single dose containers are not available or do not meet the needs in the provision of patient care.
   C. To reduce the risk of contamination:
      1. Multi-dose vials are dedicated to a single patient whenever possible.
      2. Never leave needles or other objects in vial entry diaphragms between uses.
   D. If a multi-dose vial is used for more than one patient, the vial is not kept or accessed in the immediate patient treatment area. If a multi-dose vial enters the immediate patient treatment area, it is dedicated to that patient only or discarded after use.
   E. When used, multi-dose vials are controlled in a manner that assures their sterility, chemical stability, and quality.
   F. Open multi-dose vials may be used up to the Beyond Use Date (BUD)/discard date provided the container appears to be undamaged and contents are of appropriate clarity and color.
   G. Vaccines are an exception. Vaccines may be used up to the manufacturer's expiration date provided the vaccines are stored and handled appropriately (correct temperature is maintained, frequency of temperature checks, etc.). Follow the manufacturer's guidelines to assure product integrity.
   H. Nursing Unit medication rooms are inspected regularly on clinical units for BUD date labels on bottles and expired medications. See Department of Nursing Policy 571.00, Medication Administration: General Guidelines and Safe Practices.

III. Single Dose Containers

   A. Single dose containers (vials and ampoules) used outside the inpatient Pharmacy's International Organization for Standardization (IOS) Class 5 environment are only entered and used one time.
   B. Ampules are single dose containers and must be used immediately after opening. Drugs removed from ampules must be removed using a filtered needle. Any remaining solution is discarded.
   C. Opened single dose vials are discarded after use and **never** stored for future use.
   D. Never combine or pool leftover contents of single-dose/single-use vials.
   E. Under certain conditions single dose containers may have additional BUD. See procedures for special circumstances for BUD of single dose containers below.
   F. When it is necessary to enter a single dose container more than once, e.g., to achieve safe and accurate dose titration, a new needle and syringe is used for each entry.

G. Unopened single-dose containers may be repackaged into multiple single-dose containers only by qualified staff in an ISO Class 5 environment. The manufacturer's recommendations pertaining to safe storage of the medications outside the original container are followed. See Administrative Policy No. 690.36, Intravenous Admixture and Administration.

PROCEDURE

I.   Single and multi-dose containers of sterile medications:
   A. Are examined prior to use for any evidence of contamination, particulate matter, precipitates, turbidity, discoloration, and/or mislabeling.
   B. Are never used if there is evidence of contamination, particulate matter, precipitates, turbidity, discoloration, and/or mislabeling.
   C. Are discarded whenever sterility is compromised or questionable.

II. Use aseptic technique including disinfection of the vial's rubber septum before piercing by wiping (and using friction) with a hospital approved swab to prepare the dose. Allow the rubber septum to dry before inserting a needle or other device into the vial.

III. Once a multiple-dose vial is punctured, the BUD and the initials of person opening are written on the vial or a label affixed to the vial.
   A. The BUD for an opened or entered (i.e. needle-punctured) multiple dose vial with antimicrobial preservatives is 28 days, unless otherwise specified by the manufacturer.
   B. If the drug in the multi-dose vial is in powder form, it is reconstituted prior to use. Consult the package insert to determine correct storage and beyond use dating once reconstituted with the appropriate diluent.

IV. Labeling Open Multi-dose Vials

   A. Open multi-dose vials are labeled at the time of opening with a beyond use date or discard date, **not the date the vial is opened.**
   B. Attach an auxiliary label stating : "Expiration Date_____ ____ "
   C. Label the container with the BUD on 28 days from the date the vial is opened, see Attachment A; the manufacturer's expiration date; or the BUD determined after reconstitution, whichever is shorter.
   D. The initials of person opening and labeling the vial are included on the label.
   E. Expired, contaminated or potentially contaminated medications and open multi-dose vials that have reached the BUD are discarded in accordance with hospital policy (i.e. returned to the pharmacy or to the appropriate designated waste container). See Infection Control Policy 323, Medical Waste Management Plan.
   F. Single and multi-dose containers of sterile medications are stored in locked locations. Medications may be stored in patient care areas if they are secured from unauthorized use.
   G. Special Circumstances for Beyond Use Dating of Single Dose Containers
      1.   Single dose vials maintained in an ISO Class 5 environment may be labeled with a beyond use date of 6 hours if maintained in that environment the entire time.
      2.   When a single-dose or single-use vial is opened or accessed (i.e., needle-punctured) outside of an ISO Class 5 environment, the vial is discarded immediately or according to the time the manufacturer specifies. In the absence of such information the product is discarded no longer than 1 hour after opening.
      3.   When the pharmacy withdraws medications in a syringe in an ISO Class 5 environment, the BUD is 48 hours unrefrigerated and 7 days refrigerated.
      4.   Open single dose vials are **not** stored for future use.

REFERENCES: **The Joint Commission Standards**

                         CMS Conditions of Participation §482.25(b)

                         Healthcare Facilities Accreditation Program Standards

                         CDC Injection Safety FAQ: Questions about Multi-dose vials and Single dose vials
                         http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html (Updated Feb. 9, 2011)

                         The Joint Commission Standards FAQ Medication Management – Multi-dose vials
                         http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=143&StandardsFAQChapterId=76 (Current July 20, 2010)

                         USP/NF- United States Pharmacopeia 32 National Formulary 27; Official May 2009; General Notices and Requirements, Containers for Injections under Injections <1>; Antimicrobial Effectiveness Testing <51>; Sterile Preparations <797>

                         American Journal Infection Control – special article; APIC position paper: Safe Injection, infusion, and medication vial practices in health care – Dolan et al (AMJ Infection Control 2010;38:167-72)

                         Department of Nursing Policy 571.00, Medication Administration: General Guidelines and Safe Practices

                         Department of Nursing Policy 577.00, Storage of Drugs and Biologicals

                         Pharmacy Policy 6.1 Intravenous Admixture Service

DEFINITIONS: **Antimicrobial Preservatives** are substances added to sterile multi-dose containers to inhibit the growth of microorganisms that may be introduced from repeated withdrawing of individual doses from the container.

                         Beyond Use Dating refers to the date or time after which an opened sterile container cannot be used. The date is determined from the date or time the container is opened or entered. The beyond use date may not exceed the manufacturer's original expiration date.

                         Expiration Date reflects the shelf-life of a product when stored according to FDA-approved labeling, in its original unopened container. The manufacturer's expiration date refers to the date after which an unopened multi-dose vial or single dose container cannot be used.

                         ISO Class 5 Environment is an environment in which the particulate matter is filtered to a particle size of 0.5 microns or smaller and does not exceed a quantity of 3,520 particles per cubic meter of air, equal to 100 particles per cubic foot. At this air quality, it is considered an environment for maintaining sterility.

                         Multiple- Dose Vials are vials of medication intended for parenteral administration that contain more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The beyond use date (BUD) for an opened or entered (i.e., needle-punctured) multiple dose container with antimicrobial preservatives is 28 days (USP Chapter <51>: Antimicrobial Effectiveness Testing), unless otherwise specified by the manufacturer.

                         Single- Dose or Single-Use containers (vials/ampoules) are intended for parenteral administration to a single patient for a single case/procedure/injection. They are designed for one time use and one time entry. Single-dose or single-use containers are labeled as such by the manufacturer and typically lack an antimicrobial preservative.*
                         See section: Special Circumstances for Beyond Use Dating of Single Dose Containers

ATTACHMENTS: **ATTACHMENT A: Calculation of Discard Date for Medications Discarded 28 days After Opening.**

APPROVAL   DATE: <u>**N/A**</u>   **Policy, Procedure and Standards Committee**

                              <u>**6/18/19**</u>   **William L. Gilbert, Hospital Director**
                                          Applicable Administrator, Hospital or Medical Committee

                              <u>**8/6/19**</u>   **Board of Supervisors**
                                          Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**04/28/16**</u>   **REVISED**:   **N/A**

REVIEWED: <u>**2/07/19**</u>

Calculation of Discard Date for Medications Discarded 28 Days After Opening

31 Day Months
January, March, May, July, August, October, December

Date Opened	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Discard Date	28	29	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

30 Day Months
April, June, September, November

Date Opened	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Discard Date	28	29	30	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

February
Discard In March on Same Date as Opened

Leap Years
2008, 2012, 2016, 2020

Date Opened	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Discard Date	28	29	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Numbers in Grey represent Discard Date the Next Month

SECTION: **PATIENT CARE**   **SUBSECTION: OPERATIONAL**

SUBJECT: **INTRAVENOUS ADMIXTURE AND ADMINISTRATION**

APPROVED BY: _____
                                              Chief Operating Officer

_____

PURPOSE

To define standard operating and quality assurance procedures that are evidence based and designed to ensure the sterility and integrity of compounded sterile preparations (CSP) prepared in the facility.

To define how medications area administered by registered nurses following scope of practice regulations, infection control, and patient safety guidelines.

POLICY

A.   Sterile compounding services meet state and federal requirements, professional practice standards and are in compliance with United States Pharmacopeia Chapter <797> standards.

B.   A pharmacist, or pharmacy staff under the supervision of a pharmacist, prepares all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product's stability is short.

C.   When CSPs are prepared in the pharmacy or in patient care areas in urgent situations (i.e. Emergency Department, ICU, etc.), staff use aseptic techniques and maintain a clean, uncluttered and designated work space (separate from other functions) for medication preparation to avoid contamination.

D.   During product preparation, staff visually inspects the medication for particulates, discoloration, or other loss of integrity.

E.   USP defined Immediate Use; Low-Risk Level or Medium-Risk Level compounded sterile preparations are prepared in this facility. High-Risk Level compounding from non-sterile ingredients or containers is *not* performed. The pharmacy prepares Low-Risk Level and Medium-Risk Level CSPs in a laminar airflow hood or other ISO Class 5 environment that has been properly maintained and certified.

F.   The pharmacy prepares hazardous medications (i.e. Chemotherapy) in a Biological Safety Cabinet (BSC) or a Compounding Aseptic Containment Isolator (CACI) that has been properly maintained and certified.

G.   A master formula record is maintained for compounded sterile preparations that are routinely prepared. The master formula includes a list of all equipment and supplies used in compounding process including disposables

H.   CSPs are labeled with expiration dates or beyond-use-dates, and times when indicated, consistent with the product's stability **and** sterility data.

I.   A compounding log containing the manufacturer's name and lot number is maintained to facilitate drug recall procedures.

J.   Records of sterile compounding, including personnel training and competency are retained for 3 years, or as defined by the State and/or hospital policy.

K.   The Pharmacy provides education and training to pharmacy staff and assists with providing education and training to non-pharmacy (including nursing) staff that prepare CSPs.

L.   A quality assurance program is maintained to monitor, evaluate, correct, and improve activities and processes as defined in current USP standards and is reported to the hospital-wide quality program.

I.   Affected Areas/Departments:

All disciplines involved in the preparation of compounded sterile preparations (CSPs).

A.   Pharmacy
B.   Nursing
C.   Medical Staff
D.   Other healthcare professionals handling and administering CSPs

II.   Procedure:

A.   Responsibility of Compounding Personnel

All compounding personnel are responsible for understanding the fundamental practices and precautions of safe sterile compounding, for following sterile compounding procedures, and for continually evaluating the quality of final CSPs to prevent harm.

B.   Compounding Personnel are responsible for:

1.   Ensuring CSPs are accurately identified, measured, diluted, and mixed   and correctly packaged, sealed, labeled, stored, dispensed, and distributed.

2.   Maintaining appropriate cleanliness conditions and providing labeling and supplementary instructions for proper clinical administration.

C.   Compounding Supervisors are responsible for ensuring:

1.   Compounding personnel are adequately trained and have demonstrated documented competencies in aseptic technique manipulation and sterile compounding procedures.
Note: See section below *Personnel Training and Evaluation in Aseptic Manipulation Skills.*

2.   CSPs maintain their labeled strength within USP/NF standards until their beyond-use-dates (BUDs) by using either direct measurement or appropriate information sources.

3.   CSPs are prepared in a manner that maintains sterility and minimizes the introduction of particulate matter.

4.   Standard operating procedures and quality assurance procedures are followed.

D.   Personnel Training and Evaluation in Aseptic Manipulation Skills

1.   Pharmacy Personnel Orientation, Education and Evaluation

a.   Pharmacists and technicians are oriented to sterile compounding procedures and receive training in aseptic manipulations and in achieving and maintaining ISO Class 5 environmental conditions *before* they begin to prepare CSPs.

b.   Compounding personnel perform didactic review and pass written and media-fill validation testing of aseptic manipulation skills *initially* and at least *annually* for Low- and Medium-Risk Level compounding.

c.   Compounding personnel who fail written tests or whose media-fill test vials result in gross microbial colonization are re-instructed and re-evaluated to ensure correction of all aseptic practice deficiencies.

d.   Compounding personnel are adequately skilled, educated, instructed, and trained to:

1)   Perform antiseptic hand cleansing and disinfection of nonsterile compounding surfaces;

2)   Select and appropriately don protective garb;

3)   Maintain or achieve sterility of CSPs in ISO Class 5 Primary Engineering Controls (PEC) devices and protect personnel and compounding environments from contamination by radioactive, cytotoxic, and chemotoxic drugs

4)   Identify, weigh, and measure ingredients; and

5)   Manipulate sterile products aseptically, label and inspect CSPs for quality, integrity and accuracy.

e.   Competency evaluations of all pharmacists and technicians who prepare and dispense CSPs are completed on an annual basis. Competency evaluations include, but are not be limited to:

1)   Garbing and gloving

2)   Gloved fingertip sampling (garbing competency for LAFWs and BSCs)

3)   Cleaning and disinfecting

4)   Aseptic Technique

f.   Records of orientation, training, education, and competency evaluations are maintained in pharmacy personnel files for 3 years or as defined by the State and/or hospital policy.

g.   Pharmacy staff receives ongoing training to maintain and update knowledge skills and information relevant to medication related events and/or quality improvement activities.

2.   Nursing Personnel Orientation & Education

a.   Nursing personnel are oriented to the Pharmacy's IV Admixture Service.

b.   The Director of Pharmacy in collaboration with Nursing leadership determine procedures for providing training, education and competency assessment of nursing staff preparing compounded sterile products.

c.   Nursing services receive training and information relevant to medication related events and/or quality improvement activities.

E.   Single-Dose and Multiple-Dose Containers

1.   Single-dose containers of sterile products, such as IV bags, bottles, syringes and vials that are opened or accessed (i.e. needle punctured) and exposed to ISO Class 5 or cleaner air may be used (if appropriately labeled) for up to 6 hours after initial needle puncture or according to the time frame specified by the manufacturer.

2.   Single-dose containers of sterile products opened or accessed (i.e., needle-punctured) *outside* of an ISO Class 5 environment, should be discarded immediately or according to the time frame specified by the manufacturer; or in procedural areas at the end of the case /procedure.

3.   Opened single-dose ampules may <u>not</u> be stored for any time period.

4.   Open multiple-dose containers controlled in a manner that assures their sterility, chemical stability, and quality may be used up to a beyond-use-date (BUD) of 28 days unless otherwise specified by the manufacturer.

5.   Unopened single-dose containers may be repackaged into multiple single-dose containers only by qualified staff in an ISO Class 5 environment. The manufacturer's recommendations pertaining to safe storage of the medications outside the original container are followed.

F.   Equipment

Equipment used in the production of CSPs are cleaned, calibrated, and maintained in accordance with the manufacturers' recommendations and USP standards.

   1.   Primary Engineering Control (PEC)

   a.   The primary engineering control (PEC) operates continuously except for filter changes and other required maintenance. If PECs are turned off, they must operate for at least 30 minutes prior to initiating cleaning and compounding.

   b.   Pre-filters of the PEC are changed monthly or per PEC manufacturer's recommendation to ensure optimum life of the PEC's HEPA filter. This maintenance is documented.

   2.   Verification of Automated Compounding Devices (ACDs)

   a.   ACDs are verified for accuracy and precision per the manufacturers' recommended standard operation procedures.

   b.   Compounding personnel document the verification process daily. Results are reviewed to avoid potentially clinically significant cumulative errors over time.

G.   Environmental Quality and Control

   1.   Engineering Control Requirements

   a.   Controlled Environment Testing Association (CETA) Flow Chart of Engineering Control Requirements for Non-Hazardous Drugs- See Attachment

   b.   CETA Flow Chart of Engineering Control Requirements for Hazardous Drugs – See Attachment

   2.   Environmental Monitoring

   a.   Viable and Non-viable Environmental Sampling

           Viable and non-viable environmental sampling occurs when:

           1)   Commissioning and certifying new facilities and/or equipment

           2)   Servicing of the facilities or equipment

           3)   Re-certification of the facilities and equipment every 6 months

           4)   Whenever problems are identified with end products or compounding personnel technique

5) In response to patient infections where the CSP is being considered as a potential source of the infection.

b. Engineering Control Performance Verification

Primary Engineering Controls (PECs) including laminar airflow work benches (LAFWs), biological safety cabinets (BSCs), compounding aseptic isolators (CAIs), and compounding aseptic containment isolators (CACIs) and secondary engineering controls (buffer and ante-areas) are certified by a qualified individual no less than every 6 months and whenever the device or room is relocated or altered or major service to the facility is performed.

c. Pressure Differential Monitoring

The pressure differential or airflow between the buffer area and the ante-area and between the ante-area and the general environment outside the compounding area are logged at least daily or monitored by a continuous recording device.

d. Viable Air Sampling
Air sampling of the LAFWs, CAIs, clean room or buffer areas, and ante-areas using volumetric collection methods is performed by properly trained individuals at least every 6 months as part of the re-certification process.

e. Surface Sampling

1) Surface sampling is performed in all ISO classified areas on a periodic basis. Sampling is done at the conclusion of compounding using contact plates or swabs.

2) Selected sampling sites include locations within each ISO Class 5 environment and in the ISO Class 7 and 8 areas and in the segregated compounding areas at greatest risk of contamination (e.g., work areas near the ISO Class 5 environment, counters near doors, pass-through boxes).

3) A general microbiological growth medium such as Soybean–Casein Digest Medium is used. Media used for surface sampling must be supplemented with additives to neutralize the effects of disinfecting agents (e.g., trypticase soy agar (TSA) with lecithin and polysorbate 80).

4) TSA is incubated at 30° to 35° for 48 to 72 hours. The number of discrete colonies of microorganisms are counted and reported as colony-forming units (CFU), documented on an environmental sampling form and evaluated for adverse trends.

f. Action Levels, Documentation and Evaluation

See section below *Action Levels, Documentation, and Data Evaluation*

3.   Cleaning and Disinfecting the Compounding Area

See CLEANING AND SANITIZING THE IV ROOM Policy No. 6.8

4.   Personnel Cleansing and Garbing

See IV ROOM ATTIRE Policy No. 6.9

5.   Competency Evaluation of Garbing and Aseptic Work Practices, and Cleaning and Disinfecting Procedures

a.   Compounding personnel must demonstrate competency in proper hand hygiene and garbing procedures and in aseptic work practices (e.g., disinfection of component surfaces, routine disinfection of gloved hands).

b.   Competency evaluation is performed and documented *initially* and whenever media fill testing is performed; at least *annually* for compounding of Low and Medium-Risk Level CSPs .

c.   The evaluation is documented and retained on file as a record of personnel competency for 3 years or as defined by the State and/or hospital policy.

6.   Garbing and Gloving Competency Evaluation

Garbing and gloving competency evaluation includes direct observations of compounding personnel during hand hygiene and garbing procedures and gloved fingertip sampling.

7.   Gloved Fingertip Sampling

a.   Gloved fingertip sampling is performed for all CSP risk levels and is used to evaluate the competency of compounding personnel in performing hand hygiene and garbing procedures.

b.   Gloved fingertip/thumb sampling must successfully be completed with zero CFUs no less than three times during separate compounding operations.

c.   Immediately after completing the hand hygiene and garbing procedure a gloved fingertip and thumb sample is collected from both hands by lightly pressing each fingertip into an agar plate. Note: Gloves must not be disinfected with sterile 70% isopropyl alcohol (IPA). Disinfecting gloves immediately before sampling will provide false negative results.

d.   Nutrient agar with neutralizing agents such as lecithin and polysorbate 80 are used and incubated at 30° to 35° for 48 to 72 hours.

e.   Results are reported separately as number of CFU per employee per hand (left hand, right hand). The CFU action level for gloved hands is based on the total number of CFU on both gloves, not per hand. See Recommended Action Levels Table in Attachment: *USP Microbial Contamination Risk Levels, Beyond-Use-Dating and Recommended Action Levels for Microbial Contamination*

8. Aseptic Manipulation Competency Evaluation

After successfully completing the *Hand Hygiene and Garbing Competency Evaluation*, the skill of compounding personnel to aseptically prepare CSPs is evaluated using sterile fluid bacterial culture media-fill verification, (i.e., sterile bacterial culture medium transfer via a sterile syringe and needle).

9. Media-Fill Test Procedure

a. Media-fill testing is used to assess the quality of the aseptic skill of compounding personnel. Media-fill challenge tests are also used to verify the capability of the compounding environment and processes to produce sterile preparations.

b. Commercially available sterile fluid culture media, such as Soybean–Casein Digest Medium are used per the manufacturer's instructions.

c. Media-filled vials are incubated per the manufacturer's instructions.

d. Failure is indicated by visible turbidity in any one of the media-fill units on or before 14 days.

10. Cleaning and Disinfecting Competency Evaluation

Compounding personnel and other personnel responsible for cleaning are visually observed during the process of performing cleaning and disinfecting procedures. Observations are documented as stated above.

11. Surface Sampling

See segment on *Surface Sampling* in the *Environmental Quality and Control* section.

12. Action Levels, Documentation, and Data Evaluation

a. Sampling data is collected and reviewed on a routine basis as a means of evaluating the overall control of the compounding environment. The data is used to identify and correct an unacceptable work practice.

b. Action levels are determined on the basis of CFU data gathered at each sampling location and trended over time. See Recommended Action Levels Table in Attachment: *USP Microbial Contamination Risk Levels, Beyond-Use-Dating and Recommended Action Levels for Microbial Contamination*

c. If sampling data consistently shows increased levels of microbial growth:

1) Competent microbiology personnel are consulted.

2) An investigation into the source of the contaminant is conducted.

3) Any CFU count that exceeds its action level prompts a re-evaluation of personnel work practices, cleaning procedures, operating procedures, and air filtration efficiency within the aseptic compounding location.

13. General Sterile Compounding Area Workflow Procedures

See ASEPTIC TECHNIQUE Policy No. 6.7

14. Finished Preparation Release Checks and Tests

Before a CSP is dispensed or administered:

a. CSP solutions are visually examined for the presence of particulate matter. If present the product is discarded.

b. A copy of the order, written compounding procedure (master formula), preparation records, and expended materials used to make CSPs are inspected for accuracy of correct identities and amounts of ingredients, aseptic mixing , packaging, labeling, and expected physical appearance.

c. CSP labels include at minimum the correct names and amounts or concentrations of ingredients, the total volume (when indicated), the beyond-use-date (BUD), the appropriate route(s) of administration, the storage conditions, and other information for safe use.

15. Pharmacist Check

a. A pharmacist checks and signs off on all products prepared by pharmacy technicians in accordance with state regulation including label accuracy, visual confirmation of additives, and their volumes or quantities.

b. See segment of this policy *Guidelines for Safe Preparation of Sterile Compounds* for additional safety and quality control measures.

H. Storage and Beyond-Use- Dating (BUD)

In the absence of direct chemical assay results, appropriate information sources are used to determine conservative and safe beyond-use-dates (BUD).

1. Determining Beyond- Use-Dates (BUD)

a. Both end product *stability* and *sterility* are considered when determining beyond-use-dates for CSPs.

b. To determine product *stability*, compounding personnel consult and apply drug-specific and general *stability* documentation and literature, consider the nature of the drug and its degradation mechanism, the container in which it is packaged, and the expected storage conditions.

c. In the absence of *sterility testing* or published *sterility data*, the USP <797> default beyond use dating based on Risk-Level and storage environment apply.

USP<797> Default Beyond Use Dating

Risk Level	# Manipulations	Controlled Room Temperature	Refrigerated Temperature	Frozen Temperature
Low	3 or less	48 hours	14 days	45 days
Medium	Greater than 3	30 hours	9 days	45 days
High*	-	24 hrs	3 days	45 days

* after confirmation of stability, but in the absence of sterility testing completed

      d.   The beyond-use-date assigned to the end product <u>cannot</u> exceed the product *stability* or *sterility* dating.

2.   Proprietary Bag and Vial Systems

The sterility, storage and stability beyond-use-dates for attached non-activated container pairs of drug products (e.g., ADDVantage, Mini Bag Plus, Add A Vial, Add-Ease, etc.) are assigned based on the manufacturers' recommendations.

3.   Protective Outer Wrappers

Commercially available intravenous products removed from protective outer wrappers are assigned beyond-use- dates based on the manufacturers' recommendations.

4.   Changes in Storage Environment

When commercially available products such as pre-mixed IV's or irrigation solutions are moved in or out of a refrigerator, freezer, or warmer a beyond-use date based on the manufacturer's recommendations is assigned.

I.   Monitoring Controlled Storage Areas

1.   Temperatures of the compounding area and drug storage areas are monitored and recorded at least daily.

2.   If the compounding facility uses a continuous temperature recording device, the functionality of the recording device is verified at least once daily.

J.   Hazardous Drugs as CSPs

1.   Hazardous drugs are prepared for administration only under conditions that protect the healthcare workers and other personnel in the preparation and storage areas.

2.   Hazardous drugs are stored separately from other inventory in a manner to prevent contamination and personnel exposure.

3.   Hazardous drugs are handled with caution at all times using appropriate chemo compatible gloves during receiving, distribution, stocking, inventory, administration preparation, and disposal.

4.   Hazardous drugs are prepared in an ISO Class 5 biological safety cabinet (BSC) placed in an ISO Class 7 environment, or a CACI that meets the specified requirements, that is physically separated and optimally has not less than 0.01-

inch water column negative pressure to adjacent positive pressure ISO Class 7 or better ante-areas, thus providing inward airflow to contain any airborne drug.

5.   When closed-system vial transfer devices (CSTD) are used, they are used within the ISO Class 5 environment of a BSC or CACI.

6.   Personal Protective Equipment (PPE) is worn when compounding in a BSC or CACI and when using CSTD devices. PPE include:

   a.   Gown

   b.   Face mask

   c.   Eye protection

   d.   Hair covers

   e.   Shoe covers

   f.   Double gloves with sterile chemo-type gloves

7.   Personnel who compound hazardous drugs receive training in the storage, handling, and disposal of these drugs. Training is documented annually and includes:

   a.   Didactic overview of hazardous drugs

   b.   Safe aseptic manipulation practices

   c.   Negative pressure techniques

   d.   Correct use of CSTD

   e.   Containment, cleanup, and disposal procedures for breakages and spills

   f.   Treatment of personnel contact and inhalation exposures

8.   Confirmation in writing of an understanding of the risks of handling   sample form: *Hazardous Substances Training Acknowledgement Form*

9.   Hazardous drug wastes disposal complies with all applicable federal and state regulations.

10.   Personnel who perform routine custodial waste removal and cleaning activities in storage and preparation areas for hazardous drugs are trained in appropriate procedures to protect themselves and prevent contamination.

K.   Allergen Extracts as CSPs

Allergen extracts as CSPs are *not* subject to the personnel, environmental, and storage requirements for all CSP Microbial Contamination Risk Levels when USP defined criteria are met.

L.   Safe Preparation of Sterile Compounds [1]

    1.   Order Entry and Verification

        a.   Orders entered into the computerized prescriber order entry (CPOE) system, into a pharmacy information system or transcribed onto pharmacy patient profiles by a non-pharmacist are verified by a pharmacist in accordance with state rules and regulations.

        b.   Order entry of specific types of CSPs and/or selected individual medications identified as high-alert medications, are verified by a second qualified individual. The second level review is required for chemotherapy, complex CSPs, pediatric/neonatal CSPs and other CSPs as defined by the organization and includes a comparison of the order to the pharmacy generated label.

    2.   Drug Storage in Sterile Compounding Areas

        a.   Storage of concentrated bulk solutions, particularly concentrated electrolytes, amino acids, and dextrose, are separated from all other products that are directly dispensed to a patient care unit.

        b.   Sterile water for injection is sequestered to reduce the risk of inadvertent use.

        c.   Single use vials of concentrated electrolytes are employed for manual IV additives so that bulk bottles cannot be inadvertently used as base solutions or introduced back in to the production line.

        d.   A vial size closest to the dose required is used to prepare the CSP.

        e.   CSPs that have been compounded, and are waiting to be checked are placed in a clearly identified and designated storage location until the checking process is complete.

    3.   Assembling Products and Supplies for Preparation

        a.   Medications, diluents, base solutions and other supplies are gathered and placed in a separate container, (e.g., a basket or bin) for _each_ preparation or _each_ batch to be prepared.

        b.   When possible, the person gathering products should be different than the person preparing the CSPs.

        c.   The person preparing the CSPs verifies the ingredients match the production label.

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[1] Proceedings from the ISMP Sterile Preparation Compounding Safety Summit: *Guidelines for SAFE Preparation of Sterile Compounds*; ISMP 2013
http://www.ismp.org/Tools/guidelines/IVSummit/IVCGuidelines.pdf (Accessed January 2013)

4.   Compounding

a.   To the extent possible, commercially-prepared, premixed IV products that meet the patient's needs are used over manually compounded sterile preparations.

b.   Standard base solutions (e.g., dextrose 5%) are used when available to prevent the error prone process of preparing unique/unusual base solutions.

c.   Outsourcing the production of CSPs may be _considered_ as an alternative to in-house compounding when:

1)   The volume of certain CSPs is very low, thus making it difficult to maintain staff competency for preparing the CSP.

2)   The volume for certain CSPs is high and staff resources are limited or unavailable to prepare this quantity.

3)   The organization does not possess the technological resources to prepare certain CSPs according to USP <797>.

4)   Commercially-prepared, premixed product is not available, including product shortages.

d.   Standard operating procedures (SOPs) for compounding CSPs are among practitioners.

e.   Master formulas (ingredients and the process to prepare) are established and standardized to guide the compounding of complex CSPs, (e.g., dialysis solutions, cardioplegia solutions, dilutions, aliquots).

f.   SOPs and formulas are supported by current literature and periodically revised as new information becomes available.

g.   Pharmacy staff compounding CSPs follow the sequence of steps and processes specified in the formulas and SOPs.

h.   Only essential materials are placed in the direct compounding area.

i.   A preparation label, master formulation record, or worksheet is used for compounding chemotherapy, complex, and pediatric/neonatal CSPs. This document includes the medication name, base solution, patient-specific dose, preparation calculations, final volume of the preparation and identifies the appropriate dosage form to be used (e.g., concentration and size of the container).

j.   Only one staff member is permitted to work in the direct compounding area at a time. _Exception:_ Two staff members may be permitted to work in the compounding area simultaneously <u>only</u> if necessary, provided that the hood is 6 feet in length and a physical divide can be maintained between

staff members, and the preparations being compounded are not chemotherapy, high alert or complex CSPs.

k.   Only one CSP is prepared at a time.
Exception: One person can prepare multiple CSPs safely in the hood at one time only if preparing the same doses of the same drug with the same route of administration for one or multiple patients. It is <u>not</u> safe to prepare multiple CSPs at the same time in the hood for different doses or routes of administration, or multiple preparations for the same patient.

5.   Pediatric and Neonatal CSPs

a.   Computerized label runs for pediatric and neonatal CSPs are generated or printed separately from adult CSPs.

b.   Preparation of pediatric and neonatal CSPs is separated by time or location.

6.   Chemotherapy and Complex CSPs

Preparation of chemotherapy and complex CSPs is only performed based on the availability of qualified staff resources.

7.   Volume of Base Solutions

Standard work practices address and document in the master formula:

a.   If and when there is a need to remove base solution in amounts equivalent to drug additive(s).

b.   If and when there is a need to eliminate the manufacturer overfill from the base solution and the method used to accomplish removal (e.g., direct removal of overfill volume or pumping the amount of base solution from a commercial container into an empty bag).

8.   Drug Conservation Safety Measures

a.   Partially used multi-dose vials, bulk containers or single dose containers are not left in the hood or direct compounding area.

b.   Single dose containers of drugs in short supply that are covered by an organization-specific, Drug Conservation Policy may be left in the hood for use up to 6 hours after initial needle puncture in accordance with USP <797> guidelines.

c.   The Drug Conservation Policy includes safe practices that address:

d.   Maintaining the integrity and sterility of these medications.

e.   Methods used to segregate the drug from the direct compounding area.

    f.   A pharmacist must perform a regular assessment of medications stored in the hood for compliance with the policy.

    g.   ***Heparin*** and ***insulin*** vials are ***never*** **i**n the hood at the same time.

9.   Preparation of Source/Bulk Containers

    a.   A pharmacist conducts an independent double check of all diluents and drugs *before* the preparation of source/bulk containers used to prepare multiple doses or batches.

    b.   Source/bulk containers prepared for use during compounding are labeled with the following information:

          1)   Drug name

          2)   Concentration

          3)   Diluent

          4)   Date of preparation

          5)   Name or initials of preparer

          6)   Name or initials of pharmacist performing the independent double check

          7)   Beyond use date (and time if applicable)

10.   Batch Compounding Records

    a.   Batch processing formulas are developed and used for all batch sizes, document theoretical yield versus actual yield and account for all waste.

    b.   When preparing CSPs intended for storage for anticipated needs, batch records include:

          1)   Date of production

          2)   Individual components, manufacturer's name, lot numbers and expiration dates

          3)   Expected and actual yield of the batch

          4)   Example of label

          5)   Calculations

          6)   Beyond use date

          7)   Person preparing batch

8)   Person checking batch

9)   Label count

11.   Technology / Automation Used for Compounding CSPs

a.   Technology and automation such as bar code verification or IV robotics are utilized as much as possible for preparing and verifying CSPs.

b.   Routine preventive maintenance is performed, and calibration and certification are current and documented, for equipment used during the compounding of CSPs.

12.   Quality Control/Final Verification of Manually Prepared CSPs

a.   All personnel are able to "stop the line" and question any concerns about any order or any sterile preparation to be compounded.

b.   A visual check is performed to verify the accuracy of all diluents and drugs (including volumes and concentrations).

c.   When IV workflow software is not utilized, pre-production visual confirmation of the amount of each ingredient *prior* to being added to the final container is required when compounding:

1)   Chemotherapy

2)   PN admixtures

3)   Pediatric and neonatal preparations

4)   Pharmacy prepared source/bulk containers

5)   Preparations requiring the use of multi-dose vials of high-alert medications (e.g., insulin, concentrated electrolytes, heparin)

6)   CSPs administered via high-risk routes of administration (e.g., intrathecal, epidural, and intraocular)

d.   Proxy methods of verification such as the 'syringe pull-back method' of verification are not used in the preparation of chemotherapy, complex, pediatric/neonatal or high-alert CSPs and are not used without the presence of the actual, original source containers, medication and diluent.

e.   Handwriting the amount of an additive on the final preparation label is not used as the sole method of verification of any CSP.

f.   Errors that occur during the compounding of CSPs and are identified by either the pharmacist or technician prior to dispensing are documented.

g. Serious incidents are reported to the ISMP Medication Error Reporting Program (ISMP forwards reports to FDA MedWatch) for learning purposes and dissemination of prevention measures.

h. Proactive risk assessments, such as failure modes and effects analysis (FMEA) are used prior to the implementation of process changes.

i. Internal as well as external information about medication errors are reviewed and used to modify practices and procedures as needed.

13. Labeling CSPs

a. Label formats are standardized.

b. Labels are applied immediately *after* manual preparation of CSPs. Note: Certain technology may require the application of the preparation label prior to compounding.

c. Labels are affixed to the containers so that the pre-printed material on the container is on the same side as the CSP label. To the extent possible, the label should not cover the pre-printed material.

d. For chemotherapy and other CSPs identified by the organization, the final volume (e.g., bag volume + manufacturer's overfill + additive volume) to be infused is present on the label.

e. Information on the final label matches the format and units of measure of the prescriber's order and the medication administration record. The preparation label does not contain unnecessary information (e.g., vial size used to prepare the CSP).

14. Maintaining Sterility, Purity, and Stability of Dispensed and Distributed CSPs

a. Tamper evident closures and seals are used on the additive ports   of CSPs dispensed by the pharmacy as an additional security measure to ensure CSP integrity.

b. Storage conditions in the patient care setting are suitable for the CSP specific storage requirements.

c. The label on the CSP container clearly and prominently displays the requirements for proper storage and the expiration date or beyond-use-date.

d. Delivery and patient care setting personnel are trained to deliver the CSP to the appropriate storage location.

e. Outdated and unused CSPs are returned to the pharmacy for disposition.

15.   **Re-Dispensing CSPs**

a.   Pharmacy Services has the sole authority for determining whether a CSP not administered as originally intended can be used for an alternate patient or under alternate conditions.

b.   CSPs that are not used must be returned to the pharmacy for appropriate disposition.

c.   CSP's may be re-dispensed only if there is adequate assurance that quality and packaging integrity were continuously maintained between the times the CSP left the pharmacy and the time the CSP returned to the pharmacy.

1)   The CSP was maintained under continuous refrigeration and protected from light, if required.

2)   There is no evidence of tampering or readying for use.

3)   The originally assigned beyond-use time and date is sufficient to support re-dispensing.

4)   A compounding log with the manufacturer's name and lot number is maintained.

d.   CSPs are not re-dispensed if there is not adequate assurance of all of the above.

16.   **Packaging Handling and Transporting CSP**

a.   When CSPs are distributed to locations off the premise, they are packaged in containers that will maintain physical integrity, sterility, and stability during transit.

b.   When CSPs are transported outside the facilities, the mode of transportation utilized will deliver the properly packaged CSPs in an undamaged, sterile, and stable condition to the recipient

M.   Patient or Caregiver Training

Patients and caregivers responsible for home care receive training on the storage, handling and administration of CSPs. The instructional objectives for the training program include all home care responsibilities expected of the patient or caregiver and are specified in terms of patient or caregiver competencies.

N.   Patient Monitoring and Adverse Events Reporting

Reports of adverse events related to CSPs and CSP devices are reported and reviewed following the organization's event reporting program.

O.   Quality Assurance (QA) Program

1.   A formal QA program provides a mechanism for monitoring, evaluating, correcting, and improving the activities and processes described in this policy.

2.   The QA program includes follow-up on corrective actions taken to evaluate effectiveness and sustainability.

3.   The Sterile Compounding QA program is part of the Pharmacy Department QAPI process and is reported accordingly.

4.   The selection of indicators and the effectiveness of the overall QA program is reassessed on an annual basis.

III.   Administration of Intravenous Medications

A.   IV's with medications are ordered in standard concentration.

Examples of standard concentrations are as follows:

Drug	Amount	Diluent	Volume Final	Conc.	Rate
Aminophylline	1000mg	D5W	1000ml	1 mg/ml	0.5 mg/kg/hr
Amiodarone	900 mg	D5W	500ml	1.8 mg/ml	0.5-1 mg/min
Diltiazem	125mg	D5W	125ml	1 mg/ml	5-15 mg/hr
DOBUTamine	500mg	D5W	250ml	2000 mcg/ml	1-20 mcg/kg/min
DOBUTamine DS	1000mg	D5W	250ml	4000 mcg/ml	1-20 mcg/kg/min
DOPamine	400mg	D5W	250ml	1600 mcg/ml	1-20 mcg/kg/min
DOPamine DS	800mg	D5W	250ml	3200 mcg/ml	1-20 mcg/kg/min
EPINEPHrine	1mg	D5W	250ml	4 mcg/ml	2-10 mcg/min
Esmolol (pre-mix)	2.5gm	NS	250ml	10 mg/ml	50-200 mcg/kg/min
FentaNYL	1000mcg	D5W	250ml	4 mcg/ml	1-3 mcg/kg/hr
FentaNYL	2000mcg	D5W	250ml	8 mcg/ml	1-3 mcg/kg/hr
Heparin (pre-mix)	25,000 units	NS	250ml	100 units/ml	Per protocol up to 2500 units/hr
HYDROmorphone (PCA)	10mg	NS	20ml	0.5 mg/ml	PCA
HYDROmorphone (drip)	30mg	NS	60ml	0.5 mg/ml	0.1-10 mg/hr
Inamrinone (Inocor)	500mg	NS	200ml	2.5 mg/ml	5-10 mcg/kg/min
Insulin	150 units	NS	150ml	1 unit/ml	0.5-10 units/hr
Insulin (L&D)	25 units	NS	250 ml	0.1 unit/ml	Titrated per unit policy
Isoproterenol	1 mg	D5W	500ml	2 mcg/ml	0.5-5 mcg/min
Labetalol	125mg	D5W	125ml	1 mg/ml	5-20 mg/hr
Labetalol DS	500mg	D5W	250ml	2 mg/ml	5-20 mg/hr
Lidocaine	2gm	D5W	500ml	4 mg/ml	1-4 mg/min
Lidocaine DS	2gm	D5W	250ml	8 mg/ml	1-4 mg/min
LORazepam	100mg	D5W	100ml	1 mg/ml	1-10 mg/hr
Magnesium sulfate	40gm	D5W	1000ml	40 mg/ml	1-4 gm/hr
Midazolam	50mg	D5W	50ml	1 mg/ml	1-10 mg/hr
Milrinone (pre-mix)	20mg	D5W	200ml	100 mcg/ml	0.375-0.75 mcg/kg/min.
Morphine (drip)	100mg	D5W	100ml	1 mg/ml	1-10 mg/hr
Nitroglycerin(pre-mix)	50mg	D5W	250ml	200 mcg/ml	5-20 up to 200 mcg/min
Nitroprusside	50mg	D5W	250ml	200 mcg/ml	0.5-10 mcg/kg/min

Norepinephrine	8mg	D5W	1000ml	8 mcg/ml	1-12 mcg/min
Phenylephrine	50mg	D5W	250ml	200 mcg/ml	40-60 mcg/min
Phytonadione	2.5-10 mg	NS or D5W	50ml	0.05-0.2 mg/ml	Infuse over 30 min
Procainamide	1gm	D5W	250ml	4 mg/ml	1-4 mg/min
Propofol (pre-mix)	1000mg		100ml	10 mg/ml	5-100 mcg/kg/min
Vasopressin	50 units	NS or D5W	250ml	0.2 units/ml	0.01-0.04 units/min
Vecuronium	100mg	D5W	100ml	1 mg/ml	0.4-10 mg/hr

B.   The following drip concentrations are standard for NICU patients:

Drug	Concentration	Double Concentration
Alprostadil	10 mcg/ml	
DOPamine	1600 mcg/ml	3200 mcg/ml
DOBUTamine	2000 mcg/ml	4000 mcg/ml
Epinephrine	40 mcg/ml	
FentaNYL	5 mcg/ml	10 mcg/ml
Midazolam	1000 mcg/ml	
Morphine	0.1 mg/ml	
Insulin	0.1 unit/ml	0.2 units/ml
Vercuronium	1000 mcg/ml	2000 mcg/ml

C.   Upon receipt of the physician's order, Pharmacy Services prepares the IV with medication and send it to the unit. Subsequent IV's are sent to each nursing station approximately one-half hour prior to administration. The balance of the 24 hours supply is sent to each nurse station prior to 2400.

D.   Premixed KCL is available in 1000 ml sizes on nurse stations, in D5W, D5 0.45 NaCL, D5 0.9 NaCL, D5 0.2 NaCL and NaCl in 20, 30, and 40 mEq concentrations. Other sizes and concentrations are prepared by Pharmacy Services.

E.   Immediate-Use CSPs

1.   Immediate-Use CSPs are only used to meet emergency or immediate patient care needs where a delay in therapy may subject the patient to additional risks and/or harm (i.e. cardiopulmonary resuscitation, emergency room treatment, preparation of diagnostic agents, or critical therapy) or limited stability.

2.   When preparing CSPs for immediate use in patient care areas, staff use aseptic techniques and maintain a clean, uncluttered and designated work space (separate from other functions) for medication preparation to avoid contamination.

3.   Immediate-Use CSPs are not stored for anticipated needs or batch compounding.

4.   Medium-Risk Level are not prepared as Immediate-Use CSPs.

5.   Hazardous medications are not prepared as Immediate-Use CSP's

6.   Immediate-Use CSPs must meet the following criteria:

a.   The compounding process involves only a simple transfer of commercially manufactured sterile non-hazardous products.

b.   The compounding procedure is a continuous process and administration begins no later than 1 hour following preparation.

       c.   If the staff preparing the drug is different from the staff administering the drug, the CSP is labeled as follows: patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the CSP and the exact 1-hour beyond-use-date (BUD) and time.

       d.   If administration has not begun with in 1 hour of preparation, the CSP is properly discarded.

F.   The following exceptions are allowed due to the limited stability of the drug or the urgent nature of the medication needed:

    1.   CARDIOVASCULAR AND VASOACTIVE DRUGS:

        In the Critical Care Units, the Emergency Department, and Post Anesthesia Care Unit

       a.   DOPamine

       b.   DOBUTamine

       c.   Norepinephrine

       d.   Phenylephrine

       e.   Amiodarone

       f.   Diltiazem

       g.   EPINEPHrine

       h.   Nitroprusside

       i.   Nitroglycerine

       j.   Alteplase (in the ED only)

    2.   LABOR AND DELIVERY (L&D) AND POSTPARTUM DRUGS:

       a.   Oxytocin (Pitocin) 20 units (if premixed bags are not available) 1 liter bags

       b.   Magnesium sulfate 40 gm (if premixed bags are not available) 1 liter bags

    3.   ADDITIONAL MEDICATIONS:

       a.   Penicillin 5 million unit vials is available in L&D and Mother/Baby Units

       b.   Azithromycin 500 mg vials is available in L&D

       c.   *Note medications in the Operating Room are prepared and Administered by Anesthesia.

IV.   GENERAL INFORMATION:

A.   IVPB's are refrigerated unless otherwise specified.

B.   IV's expire in 24 hour expiration date unless otherwise specified.

C.   NOTIFY PHARMACY SERVICES "STAT" BY FAX IF AN IV IS DISCONTINUED OR CHANGED.

D.   IVPB Antibiotics for children younger than 15 years will be compounded by the Pharmacy and double-checked following the double check process outlined in Department of Nursing policy 571.00, Medication Administration: General Guidelines and Safe Practices.

E.   High risk intravenous drips such as DOPamine, Insulin, Heparin, Aminophylline, etc., are double-checked with another nurse and/or pharmacist to include the original order, concentration of solution, dosage calculation, and pump infusion rate. (excluding maintenance IV's) This calculation is done independently after each nurse reviews the original Physician's order. Both nurses sign and initial the MAR or eMAR for the specific medication checked.

F.   A pharmacist is available for consultation 24 hours a day.

V.   APPROVED DRUG LIST FOR IV ADMINISTRATION:

Attached is the Approved Drug List for Nursing Intravenous Administration of Drugs including patient care areas where the drug can be administered, dosing guidelines, and adverse reactions. *This list is not all inclusive as medication formularies change.*

ABBREVIATIONS AND ACRONYMS:

ACD	automated compounding device
BI	biological indicator
BSC	biological safety cabinet
BUD	beyond-use date
CACI	compounding aseptic containment isolator
CAI	compounding aseptic isolator
CDC	Centers for Disease Control and Prevention
CETA	Controlled Environment Testing Association
cfu	colony-forming unit(s)
CSP	compounded sterile preparation
CSTD	closed-system vial-transfer device
DCA	direct compounding area
FDA	Food and Drug Administration
HEPA	high efficiency particulate air
HICPAC	Healthcare Infection Control Practices Advisory Committee
HVAC	heating, ventilation, and air conditioning
IPA	isopropyl alcohol
ISO	International Organization for Standardization
LAFW	laminar airflow workbench
MDVs	multiple-dose vials
NIOSH	National Institute for Occupational Safety and Health
NIST	National Institute of Standards and Technology

PEC	primary engineering control
PPE	personnel protective equipment
psi	pounds per square inch
QA	quality assurance
SOP	standard operating procedure
SVI	sterile vial for injection
TSA	trypticase soy agar
USP	United States Pharmacopeia

REFERENCES:

- *2013 USP on Compounding: A Guide for Compounding Practitioners; c*urrent with USP 36- NF 31 (includes USP Chapters <795> and <797>)
- ISMP Sterile Preparation Compounding Safety Summit: *Guidelines for SAFE Preparation of Sterile Compounds*; ISMP 2013 (Accessed January 2013) http://www.ismp.org/Tools/guidelines/IVSummit/IVCGuidelines.pdf
- The Joint Commission Standards MM.05.01.07 EP 1-6
- CMS Conditions of Participation § 482.25(b)(1), 482.23(c)
- Healthcare Facilities Accreditation Program (HFAP) 25.01.03; 25.01.13
- DNV National Integrated Accreditation for Healthcare Organization MM.8
- Department of Pharmacy Policy # 6.2
- Department of Pharmacy Policy #5.35
- Centers of Medicare and Medicaid Services (CMS) Standards
- Healthcare Facilities Accreditation Program Standards
- Department of Nursing Policy 571.00 Medication Administration: General Guidelines and Safe Practices

DEFINITIONS:

Ante-Area—An ISO Class 8 or better area where personnel hand hygiene and garbing procedures, staging of components, order entry, CSP labeling, and other high-particulate-generating activities are performed. It is also a transition area that (1) provides assurance that pressure relationships are constantly maintained so that air flows from clean to dirty areas and (2) reduces the need for the heating, ventilating, and air· conditioning (HVAC) control system to respond to large disturbances.

Beyond-Use Date (BUD)—For the purpose of this chapter, the date or time after which a CSP shall not be stored or transported. The date is determined from the date or time the preparation is compounded.

Biological Safety Cabinet (BSC)—A ventilated cabinet for CSPs, personnel, product, and environmental protection having an open front with inward airflow for personnel protection, downward high-efficiency particulate air (HEPA)-filtered laminar airflow for product protection, and HEPA- filtered exhausted air for environmental protection.

Buffer Area—An area where the primary engineering control (PEC) is physically located. Activities that occur in this area include the preparation and staging of components and supplies used when compounding CSPs.

Clean Room—A room in which the concentration of airborne particles is controlled to meet a specified airborne particulate cleanliness class. Microorganisms in the environment are monitored so that a microbial level for air, surface, and personnel gear are not exceeded for a specified cleanliness class.

Compounding Aseptic Containment Isolator (CACI)—A compounding aseptic isolator (CAI) designed to provide worker protection from exposure to undesirable levels of airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. Air exchange with the surrounding environment should not occur unless the air is first passed through a microbial retentive filter (HEPA minimum) system capable of containing airborne concentrations of the physical size and state of the drug being compounded. Where volatile hazardous drugs are prepared, the exhaust air from the isolator should be appropriately removed by properly designed building ventilation.

Compounding Aseptic Isolator (CAI)—A form of isolator specifically designed for compounding pharmaceutical ingredients or preparations. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbially retentive filter (HEPA minimum).

Critical Area—An ISO Class 5 environment.

Critical Site—A location that includes any component or fluid pathway surfaces (e.g., vial septa, injection ports, beakers) or openings (e.g., opened ampules, needle hubs) exposed and at risk of direct contact with air (e.g., ambient room or HEPA filtered), moisture (e.g., oral and mucosal secretions), or touch contamination. Risk of microbial particulate contamination of the critical site increases with the size of the openings and exposure time.

Direct Compounding Area (DCA)—A critical area within the ISO Class 5 primary engineering control (PEC) where critical sites are exposed to unidirectional HEPA-filtered air, also known as first air.

Disinfectant—An agent that frees from infection, usually a chemical agent but sometimes a physical one, and that destroys disease-causing pathogens or other harmful microorganisms but may not kill bacterial and fungal spores. It refers to substances applied to inanimate objects.

First Air—The air exiting the HEPA filter in a unidirectional air stream that is essentially particle free.

Hazardous Drugs—Drugs are classified as hazardous if studies in animals or humans indicate that exposures to them have a potential for causing cancer, development or reproductive toxicity, or harm to organs. (See current NIOSH publication.)

ISO Class 5 – An environment certified to provide not more than 3,520 particles 0.5 micometer or larger per cubic meter. This is the environment where sterile products are prepared.

ISO Class 7 – An environment certified to provide not more than 352,000 particles 0.5 micometer or larger per cubic meter. Also referred to as the buffer area. This is the environment where the PEC is located for compounding.

ISO Class 8 – An environment certified to provide not more than 3,520,000 particles 0.5 micometer or larger per cubic meter. Also referred to as the ante-area. This is the environment where garbing, product entry, and product exiting occurs.

Labeling—A term that designates all labels and other written, printed, or graphic matter on an immediate container of an article or preparation or on, or in, any package or wrapper in which it is enclosed except any outer shipping container. The term "label" designates that part of the labeling on the immediate container.

Media-Fill Test—A test used to qualify aseptic technique of compounding personnel or processes and to ensure that the processes used are able to produce sterile product without microbial contamination. During this test, a microbiological growth medium such as Soybean–Casein Digest Medium is substituted for the actual drug product to simulate admixture compounding. The issues to consider in the development of a media-fill test are media-fill procedures, media selection, fill volume,
 incubation, time and temperature, inspection of filled units, documentation, interpretation of results, and possible corrective actions required.

Multiple-Dose Container—A multiple-unit container for articles or preparations intended for parenteral administration only and usually containing antimicrobial preservatives. The beyond-use date (BUD) for an opened or entered (e.g., needle-punctured) multiple-dose container with antimicrobial preservatives is 28 days, unless otherwise specified by the manufacturer.

Negative Pressure Room—A room that is at a lower pressure than the adjacent spaces and, therefore, the net flow of air is into the room.

Pharmacy Bulk Package—A container of a sterile preparation for parenteral use that contains many single doses. The contents are intended for use in a pharmacy admixture program and are restricted to the preparation of admixtures for infusion or, through a sterile transfer device, for the filling of empty sterile syringes. The closure shall be penetrated only one time after constitution with a suitable sterile transfer device or dispensing set, which allows measured dispensing of the contents. The pharmacy bulk package is to be used only in a suitable work area such as a laminar flow hood (or an equivalent clean air compounding area). Where a container is offered as a pharmacy bulk package, the label shall (a) state prominently "Pharmacy Bulk Package—Not for Direct Infusion," (b) contain or refer to information on proper techniques to help ensure safe use of the product, and (c) bear a statement limiting the time frame in which the container may be used once it has been entered, provided it is held under the labeled storage conditions.

Primary Engineering Control (PEC)—A device or room that provides an ISO Class 5 environment for the exposure of critical sites when compounding CSPs. Such devices include, but may not be limited to, laminar airflow workbenches (LAFWs), biological safety cabinets (BSCs), compounding aseptic isolators (CAIs), and compounding aseptic containment isolators (CACIs).

Preparation—A preparation, or a CSP, that is a sterile drug or nutrient compounded in a licensed pharmacy or other healthcare-related facility pursuant to the order of a licensed prescriber; the article may or may not contain sterile products.

Product—A commercially manufactured sterile drug or nutrient that has been evaluated for safety and efficacy by the FDA. Products are accompanied by full prescribing information, which is commonly known as the FDA-approved manufacturer's labeling or product package insert.

Positive Pressure Room—A room that is at a higher pressure than the adjacent spaces and, therefore, the net airflow is out of the room.

Single-Dose Container- A single-dose container is a single-unit container for articles or preparations intended for parenteral administration only. It is intended for a single use. A single-dose container is labeled as such. Examples of single-dose containers include prefilled syringes, cartridges, fusion-sealed containers, and closure-sealed containers when so labeled.

Segregated Compounding Area—A designated space, either a demarcated area or room, that is restricted to preparing low-risk level CSPs with 12-hour or less BUD. Such area shall contain a device that provides unidirectional airflow of ISO Class 5 air quality for preparation of CSPs and shall be void of activities and materials that are extraneous to sterile compounding.

Unidirectional Flow—An airflow moving in a single direction in a robust and uniform manner and at sufficient speed to reproducibly sweep particles away from the critical processing or testing area.

ATTACHMENTS: **Attachment A: USP Microbial Contamination Risk Levels, Beyond-Use-Dating and Recommended Action Levels for Microbial Contamination**

Attachment B: Approved Drug List for Nursing Intravenous Administration of Drugs

APPROVAL   DATE:

3/9/15	**Policy, Procedure and Standards Committee**	
4/23/15	**Nursing Executive Committee**	
	Applicable Administrator, Hospital or Medical Committee	
3/19/15	**Pharmacy and Therapeutics Committee**	
	Applicable Administrator, Hospital or Medical Committee	
4/23/15	**Michelle Sayre, Chief Nursing Officer**	
	Applicable Administrator, Hospital or Medical Committee	
4/9/15	**Quality Management Committee**	
	Applicable Administrator, Hospital or Medical Committee	
4/23/15	**Medical Executive Committee**	
	Applicable Administrator, Hospital or Medical Committee	
6/2/15	**Board of Supervisors**	
	Approved by the Governing Body	

REPLACES: **N/A**

EFFECTIVE: **2/26/15**   **REVISED**: **N/A**

REVIEWED: **2/26/15**

ATTACHMENT: USP Microbial Contamination Risk Levels, Beyond-Use-Dating and Recommended Action Levels for Microbial Contamination

Low-Risk Level Compounding

For a compounded sterile preparation to be considered Low-Risk, all of the following conditions must be met:

- The CSPs are compounded with aseptic manipulations entirely within ISO Class 5 or better air quality using only sterile ingredients, products, components, and devices.
- Compounding involved only transfers, measuring, and mixing of not more than three commercially manufactured packages and not more than two entries into any one container.

Low-Risk Level with 12-Hour or Less BUD Compounding

For a compounded sterile preparation to be considered Low-Risk with a 12-Hour or Less BUD, all of the following conditions must be met:

- Compounding occurs in a PEC which maintains at a minimum an ISO Class 5 environment.
- The PEC is not located within and ISO Class 7 environment.
- The PEC is in a segregated compounding area restricted to sterile compounding and located away from unsealed windows or doors, warehouses, food preparation, or immediately adjacent to a sink.

Medium-Risk Level Compounding

For a compounded sterile preparation to be considered Medium-Risk, the CSP meets Low-Risk conditions and one or more of the following conditions exist:

- Multiple individual small doses or sterile products are combined or pooled to prepare a CSP that will either be administered to multiple patients or one patient on multiple occasions.
- The compounding process includes complex aseptic manipulations other than single volume transfers.
- Compounding process requires an unusually long duration.

High-Risk Level Compounding

For a compounded sterile preparation to be considered High-Risk, any of the following conditions may be present:

- The preparation is compounded from non-sterile ingredients or placed in non-sterile containers.
- Sterile products, surfaces of devices or containers, and/or CSPs that lack effective antimicrobial preservatives and exposed to air quality worse than ISO Class 5 for longer than 1 hour.
- Compounding personnel are improperly garbed or gloved.
- Non-sterile water containing preparations are stored for longer than 6 hours before being sterilized.
- Chemical purity and strength is not verified in unopened or opened packages of bulk ingredients.

USP<797> Default Beyond Use Dating

Risk Level	# Manipulations	Controlled Room Temperature	Refrigerated Temperature	Frozen Temperature
Low	3 or less	48 hours	14 days	45 days
Medium	Greater than 3	30 hours	9 days	45 days
High*	-	24 hours	3 days	45 days

*after sterilizing and confirmation of stability, but in the absence of sterility testing completed

I.   Recommended Action Levels for Microbial Contamination*

Classification	Air Sample cfu per cubic meter [1000 liters] of air per plate
ISO Class 5	> 1
ISO Class 7	> 10
ISO Class 8 or worse	> 100

* Guidance for Industry–Sterile Drug Products Produced by Aseptic Processing–Current Good Manufacturing Practice–US HHS, FDA September 2004

II.   Recommended Action Levels for Microbial Contamination*

Classification	Fingertip Sample	Surface Sample (Contact Plate) (cfu per plate)
ISO Class 5	> 3	> 3
ISO Class 7	N/A	> 5
ISO Class 8 or worse	N/A	> 100

* Pharmaceutical Inspection Co-operation Scheme (PIC/S) Guide to Good Manufacturing Practice for Medicinal Products Annexes PE 009-6, 5 April 2007

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references

X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

DRUG	IVP ED	IVP ICU/PACU	IVP TELE	IVP MS	IVP PED	IVP NICU	IVP OR	IVP L&D	IVP MB	IVPB ED	IVPB ICU/PACU	IVPB TELE	IVPB MS	IVPB PED	IVPB NICU	IVPB OR	IVPB L&D	IVPB MB	Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
Acetazolamide (Diamox)	X	X	X	X	X	X	X	X	X										Initially 500 mg; may be repeated in 2-4 hours. Max: 100mg/ml	Other units
Adenosine (Adenocard)	X	X	X			X	X												IVP 6 mg over 1-2 sec. May repeat with 12 mg. Repeat 12 mg second time if required.	ACLS RN , NICU RN only
Albumin, serum	X	X	X	X		X	X			X	X	X	X		X	X	X	X	Normal maintenance therapy: 250gm/48 hrs.	
Aminocaproic acid (Amicar)												X	X						Initial priming dose:4-5gm over 1 hour followed by 1gm/hr.	MS-Tele only.
Aminophylline											X	X	X		X				Dosage: 250-500mg IV in D5W or NS. Infuse over 30-40 minutes (max rate: 25mg/min) Maintenance infusions: 0.5-0.9mg/kg/hr.	
Amiodarone (Cordarone)										X	X	X				X			Dose Regimen: 1st Dose (loading dose)- 15 mg/min. (150mg in D5W 100 ml) over 10 mins. 2nd Dose: 360mg over 6 hours 3rd Dose: 540mg over 18 hours (mix 900mg in D5W 500ml) After first 24 hours, a maintenance infusion may be given at 0.5mg/min (720mg / day). Hard plastic or glass only). 2mg/ml given via central line.	When used during a Code Blue, drug is administered IVP by ACLS RN only. Administer through an IV line located as centrally as possible. For continuous infusions, an in-line filter has been recommended during administration to reduce the incidence of phlebitis.
Antibiotics	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	IVPB over 15-60 minutes.	RN only
Atropine	X	X	X			X	X	X											SC, IM, or IV administration 0.5 mg/dose, repeated every 3-5 minutes, max. 3mg. Ped. dose 0.01 mg/kg/dose for sinus bradycardia	ACLS RN, NICU RN only
Bretylium (Bretylol)	X	X								X	X	X				X			IVP, undiluted 5mg/kg, may increase to 10mg/kg repeat as needed. Maintenance IV: 1-2mg/min.	ACLS RN Only. ECG monitoring required.
Buprenorphine (Buprenex)							X												Usual dose: 0.3mg every 6 hours prn. Ped. Dose: 2-6mcg/kg every 4-8 hours.	Monitor respirations/BP. May give IM.
Butorphanol (Stadol)	X	X	X	X			X	X	X	X	X	X				X	X	X	0.5 – 2mg every 3-4 hours for pain.	Potential adverse reactions: sedation, N/V, Vertigo, lethargy, confusion, respiratory depression, bradycardia, hypotension. Contraindicated in patients physically dependent on opioids who have not been detoxified. (may precipitate withdrawal)

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

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DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Caffeine citrate (Cafcit)	X	X				X			X	X	X				X			X	NICU: Apnea Loading dose: 10-20 mg/kg as caffeine citrate (5-10 mg/kg as caffeine base). Maintenance dose: 5 mg/kg/day as caffeine citrate (2.5 mg/kg/day as caffeine base) once daily starting 24 hours after the loading dose.	Tachycardia, hypotension If theophylline has been administered to the patient within the previous 3 days, a full or modified loading dose (50% to 75% of a loading dose) may be given.
Caffeine and sodium benzoate	X	X								X	X								**Adult:** **Electroconvulsive therapy:** IV: 300-2000 mg **Respiratory depression:** I.M., IV: 250 mg as a single dose; may repeat as needed. Maximum single dose: 500 mg; maximum amount in any 24-hour: 2500 mg. **Spinal puncture headache (unlabeled use):** IV: 500 mg in 1000 mL NS infused over 1 hour, followed by 1000 mL NS infused over 1 hour; Can be repeat in 4hour x1 **Stimulant/diuretic (unlabeled use):** I.M., IV: 500 mg, maximum single dose: 1 g	Tachycardia, hypotension
Calcium Chloride	X	X	X	X	X	X	X	X	X	X	X	X*			X	X		X	5-10 ml (1gm/10ml) in D5W or NS 50ml, over 30-60 minutes.	IVP administration for Code Blue only - ACLS RN Only * Monitor vital signs every 15 minutes x 4 (MS-Tele only)
Calcium Gluconate	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	5-20ml (1gm/10ml) in 50ml D5W or NS over 30-60 minutes.	IVP administration for Code Blue only - ACLS RN Only.
Chemotherapy Agents		X	X	X							X	X	X							Chemotherapy Certified RNs only.
Colchicine	X	X	X	X	X		X	X	X										IV use only. Extravasation may cause severe local irritation. 2mg initial dose and 0.5 mg every 6 hours as required. Max: 4mg/first 24 hours or course of treatment.	
Cosyntropin (Cortrosyn)	X	X	X	X	X	X													IVP 0.25mg IV or IM for standard Endocrine assessment test.	

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB		NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
Dantrolene (Dantrium)	X	X	X				X												1mg/kg initially and repeat as necessary to a maximum of 10 mg/kg. Administration of drug should be continuous until symptoms subside. If signs reappear, repeat the regimen. To reconstitute, add 60ml of sterile water to each 20mg vial. Final concentration=0.32mg/ml. Administer by rapid IVP.	Use within 6 hours after reconstitution. Protect from light. Precautions: pulmonary edema, thrombophlebitis.
Deferoxamine (Desferal)										X	X	X	X			X			IVPB recommended 15mg/kg/hr.	Protect from light. May cause urine discoloration
Dexamethasone (Decadron)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	IVPB orders will be administered IVP 0.5-9 mg/day. IM or IV in 2-4 divided doses. IVP: over 1 to several minutes.	
Dexmedetomidine (Precedex)										X	X				X				See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. Load: 1mcg/kg over 10 min. Then 0.2 mcg/kg/hr. Titrate 0.1 mcg/kg/hr every 10-15 min. to maintain SAS Procedure Sedation: Load 1mcg/kg. Then 0.6mcg/kg/hr.	Hypotensive side effect.
Dextran										X	X	X	X	X		X	X	X	Solutions should not be administered unless clear. Dextran 40 should not exceed 2gm/kg (20 mg/kg) for first 24 hours. 24 hour dosages should be decreased by 50%.	Observe closely for first few minutes for signs of hypotension. Monitor closely for anaphylactic reaction. Have resuscitation equipment available.
Dextrose 50%	X	X	X	X			X	X	X										For hypoglycemic treatment: 25gm/dose.	
Dextrose 25%	X	X	X	X			X	X	X											
Diazepam (Valium)	X	X	X	X	X		X	X	X										IM or direct IVP. Recommended dose: 2-20mg repeated in 3-4 hours. IVP not to exceed 5mg/min.	Too rapid administration can cause cardiac arrest and/or respiratory depression. Monitor respirations and blood pressure.

3

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	INTRAVENOUS PUSH (IVP) ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB	INTRAVENOUS PIGGYBACK (IVPB) ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB	Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring (NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references)
Diazoxide (Hyperstat)	X	X	X				X	X											Administer undiluted 150-300 mg/dose. Give over 10-30 seconds. Dose may be repeated in 30 min. if needed. Ped or small adults: 5mg/kg (0.3mg/kg) Do not use darkened solution.	
Digoxin (Lanoxin)	X	X	X	X*	X	X	X	X											0.125mg – 0.5mg slow IVP over 5 minutes undiluted or with D5W or NS at 4-fold dilution or greater. For example, dilute digoxin 0.25mg (1ml) with NS 4 ml. Dilute digoxin 0.125 mg (0.5ml) with NS 4 ml Exp: 1 hour [ECG should be maintained and monitored.]	*MS (Med-Surg) maintenance dose only—dose limit is 0.25 mg Monitor ECG for loading dose and doses over 250mcg (0.25mg)
Diltiazem (Cardizem)	X	X	X				X			X	X					X			0.25mg/kg IVP over 2 min. If inadequate, second dose of 0.35mg/kg. May be given after 15 minutes. IV infusion: 5-15mg/hr. Titrate per physician order.	ACLS RN only.
Diphenhydramine (Benadryl)	X	X	X	X	X	X	X	X	X										10-100mg/dose. Max: 400mg/day Ped. Dose 5mg/kg/day, Max: 300mg/day. Slow push in 10ml NS over 1 minute.	
Dobutamine											X				X	X			Titrate per physician order to max of 20mcg/kg/min.	ACLS RN Only. ECG monitoring required.
Dopamine											X				X	X			Do not use if solution discolored. If premixed is not available and situation is urgent: Dilute 400 mg in 250 ml (conc: 1600 mcg/ml). Titrate per physician order to max of 20 mcg/kg/min.	ACLS RN Only. ECG monitoring required. NICU RN only
Droperidol (Inapsine)		X*																	0.625-1.25mg IVP. Maximum 1.25mg IVP Every 4 hours. *Administered only after documented attempts to use alternative medication(s) unsuccessful.	* Use in PACU only Given only after documented other medication is ineffective. Obtain baseline 12-lead EKG. EKG monitoring required for 3-4 hrs post administration. Do not give if QT>450milli seconds. Potential adverse reactions: hypotension, EPS, respiratory depression. If hypotension occurs, do not use epinephrine as pressor agent.

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	IVP ED	IVP ICU/PACU	IVP TELE	IVP MS	IVP PED	IVP NICU	IVP OR	IVP L&D	IVP MB	IVPB ED	IVPB ICU/PACU	IVPB TELE	IVPB MS	IVPB PED	IVPB NICU	IVPB OR	IVPB L&D	IVPB MB	Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
Enalaprilat (Vasotec)	X	X	X			X	X	X											IVP: 1.25mg over 5 min. Dose range 0.625-2.5mg per dose.	ACLS RN, NICU RN and/or Dr. Only. ECG monitoring required.
Ephedrine	X	X					X												10-25mg over 2 min. Maximum dose: 50mg. Additional doses may be given after 5-10 min. Do not exceed 150 mg in 24 hours.	Potential Adverse Reactions: palpitations, tremor, tachycardia, arrhythmias.
Epinephrine	X	X				X	X	X	X	X	X	X			X	X			Anaphylactic shock: 0.1 mg IVP over 5 min. Cardiac arrest: 1mg IVP; may be repeated every 5 minutes as required. IV infusion: 1-4 10 mcg/min, titrate per physician order.	ACLS RN, NICU RN only. Potential adverse reactions: hypertension, tachycardia, arrhythmias, nervousness. Use phentolamine as antidote for extravasation.
Epoetin alpha (Epogen)	X	X	X	X		X	X	X	X										May be given subcutaneous. Range: 15-500 units/kg/dose.	
Eptifibatide (Integrilin)	X	X	X				X			X	X	X			X				Acute coronary Syndrome: Bolus 180 mcg/kg (max 22.6mg). Then 2mcg/kg/min (max 15mg/hr). Duration up to 72 hrs or discharge PCI: Bolus 180 mcg/kg (Max 22.6mg). Then 2 mcg/kg/min. A second bolus dose 180mcg/kg should be administered 10 min after the first bolus. Duration up to 24hr or discharge.	• Bleeding precaution • Concurrent ASA and heparin therapies are recommended. • Do not shake vials. • The 100ml vial should be spiked with a vented infusion set.
Estrogens, Conjugated (Premarin)	X	X	X	X	X		X	X	X										25mg/dose every 6-12 hours for rapid cessation of uterine bleeding. IVP: 5mg/min.	
Famotidine (Pepcid)	X	X	X	X			X	X	X	X	X	X	X	*		X	X	X	Usual Dosage: 20 mg IV Push every 12 hours Dose (Children): 1—2 mg/kg/day IV (divided every 8-12 hours) **Dose in NICU: 0.4 mg/kg/day in the TPN Dilute 20 mg of famotidine injection to a total of 10 ml with NS to give concentrations of 2 mg/ml. Inject over 2 minutes (max 10 mg/minute)	In renal failure, if doses are not adjusted, QTc prolongation may occur.

NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references

5

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring — NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Fentanyl (Sublimaze)	X	X				X	X			X**	X**	* **	* **	* **	**	**	* **		See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. 2–25mcg per dose. Maximum dose: 25mcg. May dilute in NS 5 ml prior to administration. Pediatric patients in PACU: dilute 100mcg (2ml) with NS 8ml to make a 10mcg/ml concentration. Exp:1 hour. Infuse at 0.5–5mcg/kg/hr. Titrate rate every 20 min.to maintain SAS. Moderate Sedation: refer to policy	*Peds/L&D/MS/Tele: epidural only. Potential Adverse Reactions: respiratory depression, hypotension, visual disturbances, coma, seizures, N/V, pruritis. Do not give to patients who have received MAO-inhibitors within 4 days. ** Fentanyl PCA
Filgastrim (Neupogen)	X	X	X	X	X	X	X	X	X										May be given as a bolus, subcutaneous, a or IVPB over 30 minutes (diluted w/D5W 50-100ml by the Pharmacy). Infusion over 4 or 24 hours. If concentration is 5-15mcg/ml albumin needs to be added to avoid absorption to plastic containers.	
Flumazenil (Romazicon)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	0.2mg over 15 sec. May repeat 0.2mg every minute to a cumulative dose of 1mg.[Reversal of Benzodiazepine overdose: 0.2mg over 30 sec. May need repeated doses if Versed used for moderate sedation: 0.5mg every min. to a cumulative dose of 3mg.] Max. single dose 0.5mg.	Precautions: patient with history of BZD dependence may precipitate seizures.
Fosphenytoin (Cerebyx)	X	X	X							X	X	X							IVP 100-150 mg PE/min., May be diluted with D5W or NS to 1.5mg -25 mg PE/ml. May be given IM (IM not recommended for tx of SE).	Monitor ECG, BP, and respirations.
Furosemide (Lasix)	X	X	X	X	X	X	X	X	X	X	X				X	X			Dosage: Usual dose 20-40mg. (max dose of 400mg) IM or slow IV infusion at max rate: 4mg/min. Continuous Infusion: 120 mg/hour maximum Concentrations (prepared by Pharmacy): 1mg/ml, 2 mg/ml, 10 mg/ml Initial Pediatric Dose 1mg/kg max: 6mg/kg.	Do not use yellow colored solution. Protect from light. Monitor electrolytes twice/day with infusions

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring — NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Glucagon	X	X	X	X		X	X	X	X	X	X				X				Hypoglycemia: Usual dose is 0.5 – 1mg. If response is delayed, give 1 or 2 additional doses. Diagnostic aid for GI tract: Usual dose is 0.25 – 2mg. When used as beta-blocker antidote, usual dose is 1-5mg/hr.	Give at a rate not to exceed 1mg/min. Reconstitute with 1ml of diluent. Potential adverse reactions: N/V with higher doses. 1mg glucagons = 1unit.
Haloperidol (Haldol)	X	X*																	Adults 18-64 years • Max 2mg IV Q30 min for SAS=5 • Max 5mg IV Q30 min for SAS=6 • Max 10mg IV Q30 min for SAS=7 • Max 20mg IV per 4 hours • For patients aged 65 years and older, each individual maximum dose will be REDUCED BY 50%. • Must use Haloperidol IV order form. • Refer to Department of Pharmacy Services, Policy 5.35	* Use in ICU and ED only • A baseline ECG must be performed prior to initiation of treatment. For severely agitated patients, the baseline ECG will be deferred until the first calm opportunity. • Continuous ECG monitoring; monitor for Torsades de Pointes • Monitor Potassium and Magnesium QD • QTc every shift. • Hold if QT>450 milliseconds, arrhythmias, hypotension (SBP<100 or MAP<60 persistently) or extrapyramidal side effects and contact physician.
Heparin	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		Monitor anticoagulants per protocol
Hetastarch (Hespan)										X	X	X	X		X	X	X		Max rate: 20ml/kg/hr	
Hydralazine (Apresoline)	X	X	X			X	X	X	X										20-40 mg/dose IM or IVP every 4-6 hours as necessary. 10 mg via IVP can be administered on L&D or MB units every 20 minutes x2 for hypertensive crisis. Dilute in NS prior to administration to make a 1:1 ratio: Exp: 1 hour. Add 1ml hydralazine (20 mg/ml) to NS 19ml. Add 0.5ml hydralazine (20mg/ml) to NS 9.5ml	ACLS RN, NICU RN and/or doctor only. ECG monitoring required. ACLS and ECG monitoring is not required for L&D and MB RNs to IVP Hydralazine.
Hydrocortisone (Solu-Cortef)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Dosage: 100-250mg at interval of 1-10 hours. Children: 0.16-1mg/kg. Dose may be given in D5W 100ml IVPB: over several minutes.	

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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	ED	ICU/PACU	TELE	MS	PED/PACU	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED/PACU	NICU	OR	L&D	MB		
Hydromorphone (Dilaudid)	X	X	X*	X*		X	X	X	X	X	X	X*	X*		X*	X	X	X*	*	IVP 0.5 - 4 mg over 3-5min. Dilute with NS prior to administration: Add 1 ml hydromorphone (2 mg/ml) to NS 9 ml: 0.2 mg/ml. Add 1 ml hydromorphone (2 mg/ml) to NS 1ml : 1 mg/ml. Exp: 1 hour for all dilutions	*Infusion PCA only, except ICU, ER and NICU, & OR. IVP must be given slowly over 3-5 min to prevent side effects. Potential adverse reactions: N/V, hypotension.
Immune Globulin (IVIG)										X	X	X	X		X	X	X		Dose: usual for ITP: 400 mg/kg once a day for 2-5 days. Infusion rate depends on the manufacturer and final concentration. Call the pharmacy for the rate.	Monitor for infusion related reactions (rate related): fever, chills, nausea, and vomiting
Indomethacin	X	X						X	X	X	X				X*				Neonates: IV: Initial: 0.2 mg/kg, followed by 2 doses depending on postnatal age (PNA): • PNA at time of FIRST dose less than 48 hours: 0.1 mg/kg at 12- to 24-hour intervals • PNA at time of FIRST dose 2-7 days: 0.2 mg/kg at 12- to 24-hour intervals • PNA at time of FIRST dose greater than 7 days: 0.25 mg/kg at 12- to 24-hour intervals	*Infuse over 30 min
Insulin - Regular	X	X	X*	X*		X	X	X	X	X	X				X	X	X		Only regular insulin can be added to IV solutions, IV route generally only in patients with circulatory collapse, DKA, hyperkalemia, to evaluate growth reserve. See ICU insulin infusion physician orders for IV Infusion.	* On Med Surg/Telemetry units, IVP Insulin is to be given for instances of hyperkalemia not in instances of hyperglycemia. Monitor Bedside Glucose as ordered and/or as indicated.
Iron	X	X	X	X		X	X	X	X	X	X	X	X		X	X		X	IV test dose 0.5ml of less than or equal to 50mg/min before 1st dose.	Watch for anaphylactic reaction. Observe for 1 hour. May dilute with NS.
Isoproterenol (Isuprel)										X	X				X				IV infusion for treatment of shock: 2mg dilute in 500 ml D5W or NS Rate: 0.5-5mcg/min.	ACLS RN, NICU RN and/or Dr. only. ECG monitoring required.
Ketorolac (Toradol)	X	X	X	X		X	X	X	X	X	X	X	X		X	X		X	May be given IM also. Max IV 30mg/dose.	Monitor renal function.

APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
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	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
Labetalol (Trandate)	X	X	X			X	X	X	X	X	X					X			0.25 mg/kg over 2 min. May repeat in 10 min. Maximum dose: 80mg Do not exceed 300mg in 24 hours. Infusion: titrate per physician order to max of 20 mg/min.	ACLS RN, NICU RN and/or doctor only. ECG monitoring required. ACLS and ECG monitoring is not required for L&D and MB RNs to IVP labetalol. Precautions: hypotension/CHF/bronchospasm
Levothyroxine (Synthroid)	X	X	X	X*		X	X	X	X		X #								IVP: up to 0.5mg given over 1 minute. Reconstitute with NS 5 mL . Give immediately.	* MS maintenance only. # Organ donor
Lidocaine (Xylocaine)	X	X	X			X	X	X		X	X				X	X			For perfusing arrhythmia: 0.5 – 0.75 mg/kg up to 1.5 mg/kg may be used. Continuous infusion at usually 1-4mg/min	ACLS RN, NICU RN Only. ECG monitoring required.
Lorazepam (Ativan)	X	X	X	X	X	X	X	X	X	X	X				X	X			See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. IVP dilute with equal volume of NS. IVP: 0.044 mg/kg; max. 2mg/dose Infusion: 0.01 – 0.1mg/kg/hr.	Monitor BP. Potential adverse reactions: muscular paralysis, respiratory failure, heart block, hypotension. Do not exceed 2 mg/minute or 0.05 mg/kg over 2-5 minutes. Continuous infusion solutions should have an in-line filter and the solution should be checked frequently for possible precipitation
Magnesium sulfate	X	X								X	X	X*	X*	X*	X	X	X	X	1-4gm IVP or IVPB, for IVP a concentration of 20% or less should be used. When giving IVP, must dilute in NS to a concentration of 0.2 mg/ml or less t and administer no faster than 150 mg/minute. May administer over 1-2 minutes in patients with persistent pulseless VT or VF with known hypomagnesemia	* Post-partum patients must remain in the mother-baby unit or L&D for continuous infusion, and should not be transferred to overflow Med-Surg or Peds units. Give calcium gluconate 1-2 gm IVP over 5 min. to reverse toxicity.
Mannitol	X	X	X			X	X	X	X	X	X				X	X			12.5-25Gm IV over 3-5 min., Repeat in 1 hr. Reduce intracranial pressure: 1.5 gm/kg over 30-60 min.	Administer through 0.2 micron filter only
Meperidine (Demerol)	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	50-100 mg/dose IM preferred but also given subcut or slow IVP in a diluted solution. Dilute in NS prior to administration to a concentration of 10mg/ml. Exp: 1 hour Ped. Dose: 1-1.8mg/kg every 3-4 hours	Monitor respiration and blood pressure. Dizziness N.V.

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Methlprednisone (Solu-Medrol)	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	Dosage: 10-250mg up to 6 times a day by IM or IV (over several minutes). Children: 0.5-1.7 mg/kg/day.	For infants and children, verify dosing with resources and/or pharmacist
Methocarbamol (Robaxin)	X	X	X				X			X	X	X	X			X		X	IV 300mg/min. IVP max 300mg/min (3ml of 100mg/ml)	
Methyldopa (Aldomet)										X	X	X	X		X	X			250-500mg every 6 hrs. Max=1gm every 6 hours. Ped. Dosage: 20-40mg/kg per day in divided doses over 6 hours. For IVPB dilute with at least 100 ml IV fluid and give over 30-60 minutes.	
Methylergon-vine (Methergine)								X											Infuse at 0.2 mg/min.	Monitor BP
Metoclopramide (Reglan)	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	IVP 10mg over 1-2 min IVPB: 10-100mg in D5W or NS.	A feeling of anxiety/restlessness and drowsiness may occur with rapid administration.
Metoprolol (Lopressor)	X	X	X			X	X												5-10mg IV over 1 minute or diluted in 50 mL of IV NS or D5W and given over 30 minutes.	Monitor BP, HR
Midazolam (Versed)	X	X	X				X	X	X	X	X			X	X	X			See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. Give initial dose no faster than 1.5mg over 2 min. Do not exceed 5mg total dose. Dilute with NS to make up to a 1:1 ratio prior to administration. For example, Add 1 ml midazolam (5mg/ml) to NS 4 ml Exp: 1 hour. Infusion: 1-5mg/hr. Titrate rate every 20 min to maintain SAS.	Precautions: respiratory depression, somnolence, confusion.

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	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Morphine	X	X	X	X	X	X	X	X	X	X	X	X*	X*	X	X	X	PCA	PCA	See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. IVP 2-15mg. Max: 30mg Dilute with NS to make up to a 1:1 ratio prior to administration for slow IVP. The following are 1:1 ratio dilutions for different morphine strengths: Add 1 ml morphine (5 mg/ml) to NS 4 ml Add 1 ml morphine (8 mg/ml) to NS 7ml Add 1 ml morphine (10mg/ml) to NS 9ml Exp: 1 hour Infusion: 0.5-2mg/hr. Titrate rate every 10 min to maintain SAS. Pediatric dose: 0.05 - 0.1mg/kg.	Monitor respirations and BP. *IV drip (infusion) for comfort measures only – not titratable
Multivitamin										X	X	X	X		X	X	X	X	Usual dose is 10ml in 1000ml of solution daily.	MVI recommended for administration is not less than 500ml commonly used solutions.
Nalbuphine (Nubain)	X	X	X	X		X	X	X	X										10mg every 3-6 hours, Max dose: 160mg/day	Contraindicated in pts who are physically dependent on opioids and have not been detoxified (may precipitate withdrawal).
Naloxone (Narcan)	X	X	X	X	X	X	X	X	X	X	X					X			IV (preferred), subcutaneous. Give IVP dose over 1 minute. Initial dose 0.4 mg. Dilute to NS 10mL prior to administration. Exp: 1 hour Give 1mL over 1 minute. Observe 1 minute. May repeat 2-3 minutes for 2-3 doses, if necessary.	Potential adverse reactions: pulmonary edema, hypotension, ventricular arrhythmias. Protect from light. Caution: Administration to narcotic dependent person (including neonate of dependent mother may cause withdrawal symptoms).
Nesiritide (Natrecor)										X	X					X	X		2 mcg/kg bolus then 0.01 mcg/kg/min. Titrate by 0.005 mcg/kg/min. Max 0.03 mcg/kg/min.	Do not administer through a heparin-coated catheter. Monitor closely during administration (can cause severe hypotension and V-tach).
Nitroglycerin										X	X					X			Titrate per physician order to max of 200 mcg/min.	ACLS RN Only. ECG monitoring required.
Nitroprusside (Nipride)										X	X				X	X			Titrate per physician order to max of 10 mcg/kg/min. Reconstitute only with D5W.	ACLS RN, NICU RN Only. ECG monitoring required. Protect from light. Potential adverse reactions: hypotension, cyanide toxicity, methemoglobinemia.

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

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DRUG	IVP ED	IVP ICU/PACU	IVP TELE	IVP MS	IVP PED	IVP NICU	IVP OR	IVP L&D	IVP MB	IVPB ED	IVPB ICU/PACU	IVPB TELE	IVPB MS	IVPB PED	IVPB NICU	IVPB OR	IVPB L&D	IVPB MB	Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
Norepinephrine (Levophed)										X	X				X	X			Infusion only. Titrate per physician order to max of 30 mcg/min.	ACLS RN, NICU RN Only. ECG monitoring required. Potential adverse reactions: bradycardia, headache, hypertension, necrosis and sloughing with extravasation.
Octreotide (Sandostatin)	X	X	X	X		X				X	X				X				**Acromegaly:** Subcut, IV: Initial: 50 mcg 3 times/day; titrate. Usual effective dose; range 300-1500 mcg/day. **Carcinoid tumors and VIPomas:** Subcut, IV: 100-750 mcg/day. **Diarrhea (unlabeled use):** IV: Initial: 50-100 mcg every 8 hours; increase by 100 mcg/dose at 48-hour intervals; maximum dose: 500 mcg. **Esophageal varices bleeding (unlabeled use):** IV bolus: 25-50 mcg followed by continuous IV infusion of 25-50 mcg/hour	Tele is required for continuous infusions.
Ondansetron (Zofran)	X	X	X	X			X	X	X	X	X	X	X	X		X		X	Single doses may be administered IV injection over 2-5 minutes as undiluted solution. Immediately before induction of anesthesia or post-op for nausea and/or vomiting.	Potential adverse reactions: diarrhea/headache. Monitor for prolonged QT interval.
Oxytocin (Pitocin)										X	X	X*	X*	X*		X	X	X	IV infusion: 10-20 units in 1000ml IV solution.	Never given IVP. * For mothers in overflow Med-Surg and Peds areas in emergent situations only. The Pitocin drip should be completed prior to transfer from L&D to the Med-Surg/Peds areas.

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	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Pancuronium (Pavulon)	X	X				X	X		X		X				X	X			**Neuromuscular blockade:** Initial: 0.06-0.1 mg/kg or 0.05 mg/kg after initial dose of succinylcholine for intubation; maintenance dose: 0.01 mg/kg 60-100 minutes after initial dose and then 0.01 mg/kg every 25-60 minutes **Neuromuscular blockade in the ICU:** 0.05-0.1 mg/kg bolus followed by 0.8-1.7 mcg/kg/minute once initial recovery from bolus observed or 0.1-0.2 mg/kg every 1-3 hours	Patient MUST be intubated, on ventilator and placed on assist control. Patient MUST receive sedation.
Pantoprazole (Protonix)	X	X	X	X	X	X	X		X	X	X	X	X		X	X		X	40mg to 80mg Daily or BID Drip: 80mg Bolus, then 8mg/hr	Flush IV line before and after administration. **2-minute infusion:** The volume of reconstituted solution (4 mg/mL) to be injected may be administered intravenously over at least 2 minutes. **15-minute infusion:** Infuse over 15 minutes at a rate not to exceed 7 mL/minute (3 mg/minute).
Pentobarbital (Nembutal)	X	X				X	X			X	X				X	X			**Hypnotic:** IV: Initial: 100 mg, may repeat every 1-3 minutes up to 200-500 mg total dose **Barbiturate coma in head injury patients or status epilepticus:** IV: Loading dose: 5-10 mg/kg given slowly over 1-2 hours; maintenance: initial: 1 mg/kg/hour; may increase to 2-3 mg/kg/hour; maintain burst suppression on EEG **Note:** Intubation required	Administer at a rate less than 50mg/min. May be used as an infusion in brain injury cases. Potential adverse reactions: respiratory depression, hypotension, somnolence. • Do not confuse with **Phenobarbital**

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Administration/Adverse Reactions/Monitoring — NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references

DRUG	IVP ED	IVP ICU/PACU	IVP NICU	IVP PED	IVP MS	IVP TELE	IVP OR	IVP L&D	IVP MB	IVPB ED	IVPB ICU/PACU	IVPB NICU	IVPB PED	IVPB MS	IVPB TELE	IVPB OR	IVPB L&D	IVPB MB	Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
Phenobarbital	X	X	X	X	X	X	X	X	X										**Hypnotic:** 100-320 mg at bedtime. **Anticonvulsant/status epilepticus:** *Loading dose:* IV: 300-800 mg initially followed by 120-240 mg/dose at 20-minute intervals until seizures are controlled or a total dose of 1-2 g. *Maintenance dose:* Oral, IV: 1-3 mg/kg/day in divided doses or 50-100 mg 2-3 times/day	Rate no greater then 30mg/min. • Do not confuse with **PENTO**barbital
Phentolamine (Regitine)	X	X					X	X		X	X	X				X			IVP by physician for diagnosis of pheochromocytoma. *For extravasation with levophed, dopamine, 5-10mg in 10ml NS infiltrated into affected areas.	Administer in circular or starburst pattern
Phenylephrine (Neo-Synephrine)										X	X	X				X			Titrate per physician order to max of 200 mcg/min.	ACLS RN & NICU RN Only. Potential adverse reactions: headache, reflex bradycardia, excitability, necrosis and sloughing with extravasation.
Phenytoin (Dilantin)	X	X								X	X	X	X	X	X	X	X	X	IVP: not to exceed a rate of 50mg/min. Follow IV injection with NS to reduce irritation. For IV infusions: Mix in NS only. **Loading Doses** (e.g.500-1000mg) are prepared on the nursing units. **Maintenance doses** (e.g.100-200mg) are sent from pharmacy (actual dose is mixed on the nursing unit immediately prior to administration). ***Dilution guidelines:*** 100mg - NS 50ml; 101-500mg - NS 100ml; Greater than 500 mg - NS 250ml. Max infusion 50mg/min. Infuse doses over 30 -60 min.	Use filtered needle to withdraw med from glass ampule. Use 0.22 micron filter when infusing. Compatible with NS only. If the dose crystallizes, stop the infusion immediately and notify the prescriber (for additional dose orders) and the pharmacy (for consultation on compatibility). Monitor cardiac function and BP during injection/infusion during loading dose
Physostigmine (Antilirium)	X	X					X												0.5-1mg over 1 minute, repeat at 10-30 minute intervals.	Potential adverse reactions: N/V, bradycardia, convulsion.

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DRUG	INTRAVENOUS PUSH (IVP)							INTRAVENOUS PIGGYBACK (IVPB)							Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Phytonadione (Vitamin K)										X	X								Up to 10mg in 50 ml NS infused over 30 minutes (prepared by Pharmacy). **DOSING:** ~ Hypoprothrombinemia due to drugs (other than coumarin derivatives) or factors limiting absorption or synthesis: 2.5 – 10 mg ~ Vitamin K deficiency (supratherapeutic INR) secondary to coumarin derivative: ➢ If serious bleeding at any INR elevation: Hold warfarin, administer vitamin K 10 mg by slow IV infusion. IV vitamin K may be repeated every 12 hours. ➢ If life-threatening bleeding: Hold warfarin, give FFP, PCC, or rFVIIa supplemented with vitamin K 10 mg slow IV infusion; repeat if necessary, depending on INR.	**The injectable route should be used only if the oral route is not feasible or there is a greater urgency to reverse anticoagulation.** ~ **Monitor** for rare but fatal anaphylactoid reactions during and immediately after IV administration. Anaphylactoid reactions have occurred even with proper dilution and rate of administration. *Protect infusion from light and freezing at all times.*
Potassium Chloride										X	X	X*	X	X	X	X	X	X*	Usual concentration is 40 meq/L with 80 meq/L as the maximum desired. As much as 40meq/hr may be administered in urgent cases.	* Non-monitored and Peripheral line: 10 mEq/100 mL for maximum of four doses. Peds 40 mEq/1 liter. Adults 80 mEq/1 liter. Central line: 20 mEq/50 mL.
Potassium Phosphate										X	X	X	X	X	X	X	X	X	IV: Doses listed as mmol of phosphate. **Caution: With orders for IV phosphate, there is considerable confusion associated with the use of millimoles (mmol) versus milliequivalents (mEq) to express the phosphate requirement.** 3mmol of potassium phosphate gives 4.4 mEq of potassium. Adult IV dose range from 5-60mmol.	Given over 4-6 hours or longer.

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INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		
Procainamide (Pronestyl)	X	X				X				X	X				X	X			IVP at 20mg/min up to 100mg/5 min. to a maximum of 1 gm. IV infusion: 1.5-5mg/min (20-80mcg/kg/min.)	ACLS RN, NICU RN Only. ECG monitoring required.
Prochloperazine (Compazine)	X	X	X	X			X	X	X	X	X	X	X			X			5-10mg/dose. IVP: Max: 40mg/day. Dilute to 1mg/ml with NS infuse at rate of 1mg/minute.	
Propofol (Diprovan)							X*			X	X					X			*General anesthesia:* IV infusion: Initial: 100-200 mcg/kg/minute for 10-15 minutes; usual infusion rate: 50-100 mcg/kg/minute. IV intermittent bolus: 25-50 mg increments as needed. **ICU sedation in intubated mechanically-ventilated patients:** Avoid rapid bolus injection. See Dept. of Nursing Policy 586.00 for ICU Sedation Guidelines. *Continuous infusion:* Initial: 5 mcg/kg/minute; Titrate every 5 minutes to maintain SAS, Notify physician if dose >75 mcg/kg/min.	* PHYSICIAN ONLY Change tubing q12 hours. Infusion not to hang more than 12 hours. Monitor for respiratory and cardiac depression. Hypotension. Lactic acidosis.
Propranolol (Inderal)	X	X	X			X	X												IVP:1mg every 2 min. for 5 doses if needed.	
Protamine	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	Usual dose: 25mg max dose: 50mg in equal volume NS. 50mg/min Infusion may be given over 2-3 hours. Dose calculated on the amount of heparin to be neutralized. Each 10mg neutralizes 1,000 units of heparin.	Give IVP slowly over 3 min. May give undiluted or diluted to 10ml with NS. Potential adverse reactions: Rapid administration may result in hypotension, bradycardia, and anaphylaxis.
Quinidine gluconate										X	X					X			Dosage: 800mg dilute with at least 50ml D5W or NS. Concentration 16mg/ml. Infuse at a rate not to exceed 1ml/min.	ECG monitoring required. Potential adverse reactions: hypotension, slow conduction arrhythmias.
Ranitidine (Zantac)	X	X	X	X						X	X	X	X	X	X	X	X	X	Usual dose: 50mg every 6-8 hours. Ped. Dose: 1-2mg/kg/24 hr equally divided every 6-8 hours. IV infusion: 150mg over 24 hours.	Potential adverse reactions: transient local burning or itching at IV site.
Sodium Bicarbonate	X	X*	X	X	X	X*		X	X	X	X	X	X	X*	X	X	X	X	IVP: 0.5meq to maximum of 2meq/kg/dose. Infusion: 2-5meq/kg may be administered.	*Administer slowly over 20 min. for neonates

NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	PED	NICU	OR	L&D	MB		NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references
Sodium Chloride 2.6%										X	X	X				X			IV infusion through peripheral or central line	**High Alert Medication-requires independent double check prior to administration** Irritant solution
Sodium Chloride 3%										X	X	X				X			IV Infusion through a central line due to high osmolarity and tonicity	**High Alert Medication-requires independent double check prior to administration** Irritant solution
Sodium Chloride 23.4%	X	X					X												IVP: Sodium Chloride 23.4%: 30-60 mL *Per neurosurgery order only -to treat refractory elevated intracranial pressure (ICP) refractory to conventional modalities. See AOM Policy: Guidelines for the Administration of Hypertonic Sodium Chloride 23.4% Solution.	**High Alert Medication-requires independent double check prior to administration** Review GUIDELINES FOR THE ADMINISTRATION OF HYPERTONIC SODIUM CHLORIDE 23.4% SOLUTION *Administer 10-40ml IV bolus over at least 10-20 minutes - central line preferred. If peripheral line is used, dose is limited to 20ml (max) over 10 minutes. Patient must have continuous ICP monitoring, Requires ICP monitoring with Cerebral Perfusion Pressures every 10 minutes for 1 hour, then as ordered. Monitor vital signs every 10 minutes during administration for 1 hour, then every hour as indicated or ordered. Continuous blood pressure monitoring via arterial line is preferred. Obtain follow-up serum electrolytes up to 6 hours after administration or every 6 hours. -Physician must be present at bedside or immediately available via Spectralink.

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

DRUG	INTRAVENOUS PUSH (IVP)							INTRAVENOUS PIGGYBACK (IVPB)							Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring (NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references)
	ED	ICU/PACU	TELE	MS	NICU	OR	L&D	MB	ED	ICU/PACU	TELE	MS	NICU	OR	L&D	MB		
Tolazoline (Priscoline)					X								X				IVP: 1mg/kg/hr. Infusion: 1-2mg/kg/hr	Watch for severe BP drop; monitor ECG
Valproic Acid (Depacon)									X	X	X	X		X	X		IV infusion: 10-15 mg/kg/day (divided every 6 hours) (Infuse over 60 minutes) Prepared from pharmacy in D5W 100ml or NS 100ml	Monitor valproic acid levels (50-125 mcg/ml) Contraindications: hepatic disease, mitochondrial disease, pregnancy
Vasopressin (Pitressin)	X	X				X			X	X			X				**Diabetes insipidus::** Dosage is highly variable. *IM, Subcut:* 5-10 units 2-3 times/day as needed *Continuous IV infusion (unlabeled route):* 0.0005 unit/kg/hour; double dosage as needed every 30 minutes to a maximum of 0.01 unit/kg/hour **Variceal hemorrhage (unlabeled use):** Continuous IV infusion: Initial: 0.2-0.4 units/minute, may titrate. Maximum dose of 0.8 units/minute; maximum recommended duration: 24 hours at highest effective dose continuously. **Vasodilatory shock/septic shock (unlabeled use):***IV:* 0.01-0.04 units/minute.	ECG monitoring required. Monitor BP, circulation, urinary output. ACLS RN only High dose infusion (variceal hemorrhage): Monitor closely for signs/symptoms of ischemia Patient should also receive IV nitroglycerin concurrently to prevent myocardial ischemic complications.
Vecuronium (Norcuron)	X	X			X	X			X	X		X	X	X			Initial dose is 0.1mg/kg. Subsequent doses are 0.01mg/kg. Patient MUST be intubated on ventilator placed on assist control and MUST receive sedation.	Must be on ventilator. RN and/or physician only. Hypotension, bradycardia. ECG monitoring.
Verapamil (Calan/ISoptin)	X	X	X		X	X	X										IVP: Give slowly over 2 minutes. 3 minutes in geriatric patients. 5-10mg/dose. May repeat in 30 minutes. Maintain continuous monitoring (ECG, BP).	ACLS RN, NICU RN and/or MD only. ECG and BP monitoring required. Potential adverse reactions: hypotension, rapid ventricular rate, bradycardia MS –Tele only.
Zoledronic Acid (Zometa)									X	X	X	X		X	X		Dose: 4 mg infuse over at least 15 minutes every 3-4 weeks. Prepared from pharmacy in NS or D5W 100ml.	DDo not allow to come in contact with any calcium or divalent cation-containing solutions. Contraindications: renal failure (ClCr less than 35 ml/min.

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APPROVED DRUG LIST FOR NURSING IN ROUTINE (NON-EMERGENT) SITUATIONS
INTRAVENOUS ADMINISTRATION OF DRUGS

NOTE: THIS LIST IS NOT ALL INCLUSIVE. REFER TO LEXICOMP ONLINE FOR MOST UPDATE TO DATE MEDICATION INFORMATION

DRUG	INTRAVENOUS PUSH (IVP)									INTRAVENOUS PIGGYBACK (IVPB)									Adult Dosing Guidelines (for pediatric patients consult appropriate reference)	Administration/Adverse Reactions/Monitoring
	ED	ICU	TELE PACU	MEDS	PED	NICU	OR	L&D	MB	ED	ICU	TELE PACU	MEDS	PED	NICU	OR	L&D	MB		NOTE: This policy is not intended to be a substitute for verification of dosing and administration recommendations through pharmaceutical references

X=Medication can be given in the designated patient care area intravenous push or intravenous infusion as listed.

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SECTION:	PATIENT CARE	SUB SECTION:	GENERAL

SUBJECT: DRUG SHORTAGES

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

Arrowhead Regional Medical Center defines a process for identifying and assessing the criticality of medication shortages and how that information is communicated to licensed independent practitioners and staff who participate in the medication management process.

GENERAL

I.   A multidisciplinary approach is used to manage *critical* medication shortages.

II.   Pharmacy conducts an operational assessment when a medication shortage is identified to validate details of the shortage, utilization history and inventory on hand.

III.   Patient population(s) affected by the shortage and potential therapeutic alternatives are identified.

IV.   The impact of the shortage is analyzed to estimate the influence on patient care.

V.   Strategies are identified and implemented to reduce the impact on patient care.

VI.   Drug conservation strategies that include restricted use or patient prioritization require approval by Chairman of the Pharmacy and Therapeutics (P&T) Committee.

VII.   Information about the medication shortage and any identified strategies implemented to reduce the impact of the shortage are communicated to key stakeholders including nursing, medical staff, and pharmacy.

PROCEDURE

I.   **Pharmacy Leadership**

    A.   The Director of Pharmacy or assigned designee:

        1.   Maintains a *Medication Shortage List.*

        2.   Communicates medication shortages and outages to independent licensed practitioners and staff who participate in the medication management process.

        3.   Collaborates with the medical and nursing staff and the P&T Committee to develop and recommend strategies for alternative regimens and/or substitution protocols when necessary.

        4.   Reports actual and potential medication shortages to the P&T Committee.

5.   Communicates with the Chairman of the P&T Committee when all options to obtain a medication or an acceptable alternative have been exhausted.

II.   **Identification of Medication Shortages**

Pharmacy staff monitors internal and external sources such as manufacturers, consumer groups, wholesalers, the lay press, group purchasing organizations, and Food and Drug Administration (FDA) or American Society of Health-System Pharmacists (ASHP) websites to identify actual or potential medication shortages or outages.

III.   **Medication Shortage List**

A.   A current *Medication Shortage List* specific to the facility is maintained.

B.   This information is distributed/communicated throughout the organization (medical staff, pharmacy staff, nursing staff, clinics, etc.)

IV.   **Operational Assessment**

The status of the medication shortage is assessed by the Pharmacy staff by determining:

A.   The accuracy of the information. This is verified by contacting the manufacturer directly and/or a Comprehensive Pharmacy Services (CPS) Corporate Purchasing Analyst.

B.   If there is a projected release date for the product.

C.   If the shortage is from one manufacturer or several manufacturers.

D.   The total quantity of the product on hand and if there is potential for the supply to be exhausted.

E.   The utilization volume for the facility and whether the lack of availability could negatively impact patient care.

V.   **Criteria for Critical Medication Shortages**

If any of the following criteria are met, the shortage is termed *critical*.

A.   There is no known release date and stock levels are at or below a one-week supply.

B.   There is a known release date, but stock levels are at or below a one-week supply.

C.   There is no known release date and no supplies have been received from any sources for 7 or more days.

VI.   **Critical Medication Shortage Management Strategies**

If a shortage is termed critical, the Director of Pharmacy, or assigned designee, collaborates, as appropriate, with hospital leadership, medical staff, nursing staff, the Chairperson of the P&T Committee, and the Patient Safety Officer to evaluate and initiate any of the following:

A.   Purchasing

1.   Initiate attempts to obtain medication(s) from legitimate sources that are appropriately licensed and can provide product pedigrees.

a)   Utilize direct vendor accounts for backorders from the manufacturer.

b)   Utilize the backorder procedure with the wholesaler.

c)   Use both the manufacturer and the wholesaler backorder procedures.

d)   Maintain a backorder log.

e)   Purchasing from secondary source/wholesalers is <u>not</u> recommended, however if unavoidable:

  (1)   Validate with the state's Board of Pharmacy that the vendor is licensed.

  (2)   The vendor must be able to provide a pedigree.

  (3)   Verify the product by National Drug Code (NDC) number, not just product name.

  (4)   Attach a copy of both of these documents to the product invoice.

2.   If there is still product available on the market consider purchasing an additional week or two of inventory and/or enrolling in a manufacturer's allocation program, if available. Before increasing inventory, discuss any significant financial impact with hospital administration to quantify the financial commitment involved.

3.   Purchasing large quantities of an item in anticipation of a shortage is discouraged due to the overall negative impact on the market.

4.   Consider outsourcing preparation to an appropriately licensed and vetted contracted vendor

B.   <u>Stock Reallocation and Restricted Use</u>

1.   Pull Inventory from automated dispensing machines or floor stock and hold in Pharmacy for patient specific dispensing.

2.   Locate and isolate all remaining supplies and begin allocation to each location based on short term need.

3.   Develop plans to restrict use and reduce waste of the product in short supply.

4.   Obtain P&T Committee approval to implement specific restrictive use guidelines, if applicable.

C.   <u>Ethical Considerations</u>

1.   The allocation of medications in short supply must be fair, in that clinically similar patients are treated similarly with no special considerations or exceptions.

2.   Restricted use with ethical implications are reviewed and approved by the P&T Committee and the Patient Safety Officer.

D. <u>Patient Prioritization</u>

When a limited supply of a drug remains available and alternatives for specific patient groups are undesirable, the organization may need to prioritize use for specific patient groups. National organizations such as the Center for Disease Control (CDC), or other medical organizations, may provide guidance on setting patient priorities.

1. To limit product use for select patients or services, a multidisciplinary team including but not limited to pharmacy, nursing, medical staff, patient safety, risk management develop drug specific utilization criteria and clear guidelines for patient prioritization.

2. Guidelines for prioritization include:

a) Reviewed and approved by the P&T Committee and the Patient Safety Officer

b) Communicated to the medical staff and affected patients, as appropriate

c) Provided to pharmacy to assist pharmacists in evaluating the appropriateness of medication orders

VII. **Planning for Product Alternatives and/or Substitution Protocols**

The Director of Pharmacy or assigned designee:

A. Identify possible alternate products, including recommended dosages.

B. Collaborate with medical staff for recommendations on alternative therapy and/or substitution protocols, if necessary.

C. Anticipate possible safety issues involved with the use of an alternative product and develop steps to prevent adverse patient effects/outcomes.

D. Obtain P&T Committee approval for alternative products and/or substitution protocols.

E. Implement information system changes, technology changes (i.e. bar-code), inventory system changes and/or new procedures.

VIII. **Communication**

A. The Director of Pharmacy or assigned designee notify the independent licensed practitioners and staff who participate in medication management of the shortage.

B. Notification may be verbal (i.e. department meeting or telephone) but must also be documented by written communication (i.e. newsletter, posters, e-mail).

C. Communication(s) include but are not limited to:

1. Product(s) affected by the shortage

2. Reason for the shortage (if known)

3. Expected timeframe or duration of the shortage

4. Data to support utilization (when indicated)

5. Recommendations for alternatives and/or substitution protocols including product information (i.e. pharmacology, drug interactions, usual and maximum dosage, administration technique and other relative drug information as appropriate)

6. Rationing or restriction strategies

7. Patient prioritization guidelines, when appropriate,

8. Temporary management procedures such as removing product from automated dispensing cabinets and centralizing distribution, or drawing up doses in the pharmacy to conserve product.

D. Regular updates are provided to keep staff apprised of the status of the medication shortage.

E. Staff are notified by the most expeditious means available once the shortage is resolved.

IX. **Documentation**

Pharmacy staff maintains a Medication Shortage File including:

A. The *Medication Shortage List*

B. Notifications of medication shortages

C. Documentation of communications to patient care staff related to the medication shortage, i.e. memos, newsletters, substitution protocols.

D. The information (notebook/file) is readily available and retrievable.

X. **Follow-up Evaluation/Action**

A. <u>Purchasing</u>

If the shortage was for a multi-source generic product on contract, and alternative generic products were available for purchase, file claims with the contracted manufacturer for the difference in cost between the contracted product and that which was purchased.

REFERENCES

- The Joint Commission Standards MM.02.01.01 EP 10 -15

- Center for Medicare and Medicaid Services (CMS) §482.25(a)

- Healthcare Facility Accreditation Program (HFAP) 25.01.11

- DNV National Integrated Accreditation for Healthcare Organizations (NIAHO –DNV) MM.2

- FDA Current Drug Shortages

- ASHP Drug Shortages Resource Center

DEFINITIONS: N/A

ATTACHMENTS: **N/A**

APPROVAL   DATE: __**N/A**__   **Policy, Procedure and Standards Committee**
                                   _____

                                  __**6/18/19**__   **William L. Gilbert, Hospital Director**
                                   _____
                                   Applicable Administrator, Hospital or Medical Committee

                                  __**8/6/19**__   **Board of Supervisors**
                                   _____
                                   Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: __**9/15/15**__   **REVISED**   **N/A**

REVIEWED: __**2/07/19**__

SECTION:	PATIENT CARE	SUB SECTION:	OPERATIONAL

SUBJECT: **INTENSIVIST POLICY**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

PURPOSE

To improve patient outcomes and the appropriate uses of Hospital resources for our critical care patients through a contracted Intensivist Service at Arrowhead Regional Medical Center ("Hospital"). The Intensivist Service is available to provide continuous and timely care for our critical care patients.

DEFINITIONS

I.   "Intensive Care Unit" or "ICU" means the Medical/Surgical, Burn Intensive Care Units, and other location where critical care patients may be placed pending transfer to a designated ICU bed.

II.   "Critical Care Medicine Physician" or "Intensivist" means a physician who has completed a Critical Care Medicine ("CCM") fellowship and is either board certified in CCM by the American Board of Medical Specialties (ABMS)/American Osteopathic Association (AOA) or is an active candidate in the CCM board certification process.

III. "Intensivist Service" means a group holding an administrative contract to provide continuous and timely CCM coverage in the ICU.

IV.   "Admitting Physician" means a physician holding ICU admitting privileges.

V.   "Attending Physician" or "Attending" means the physician assuming primary responsibility for an ICU patient. The attending physician directs and coordinates all critical care services for their patients while in the ICU. The Attending physician may also be referred to as the managing *physician.*

VI.   "Co-managing Physician" means a physician holding ICU admitting privileges who is actively involved in the management of a critical care patient. ICU Co-managing physicians may make daily patient rounds and enter daily progress notes and write orders. Collaboration with the Attending physician regarding the patient's care plan and orders is available on a 24/7 day basis.

VII. "Consultants" mean other physicians providing care to an ICU patient in their area if specialty. Consultants are expected to see an ICU patient in a timely manner when requested by the Attending or Co-managing physician, make patient rounds as clinically indicated, enter daily progress notes following each patient visit and collaborate with the Attending and Co-managing physician(s) regarding the patient's care plan and orders.

POLICY

I.   The ICU will be staffed by the Intensivist Service who will act as the Attending or Co-managing physician for each ICU patient.

II.   Every patient in the ICU will be either managed or Co-managed by a CCM physician.

III.   Managing and Co-managing CCM physicians are authorized to diagnosis, treat, and write orders for a patient in the ICU on his/her own authority.

IV.   The Intensivist Service will be headed by an ICU Medical Director. The designee of the ICU Medical Director is the Intensivist Service physician assigned to the ICU on a given day.

V.   The ICU Medical Director has the authority to relocate a patient from an ICU bed to a different level of care. Decisions in these matters will be based on the acuity and needs of the patient and ICU bed availability. The ICU Medical Director or designee will discuss patient relocation with the patient's Attending prior to relocation.

VI.   The ICU is not a closed unit and any physician with ICU admitting privileges can admit to the ICU.

VII.   All physicians holding privileges at the Hospital may consult in an ICU in their area of specialty.

VIII.   Any member of the Medical Staff may visit and review the medical record when one of his/her patients is admitted to an ICU. Unless the physician is the attending or consulting in his/her area of specialty on an ICU patient, he/she may not write orders or make entries in the medical record.

PROCEDURE

I.   All patients admitted to a critical level of care, regardless of location in the hospital, will receive a bedside consultation by an Intensivist.

II.   It is the responsibility of the Admitting or ED physician to notify either the Intensivist Service or other CCM physician of an ICU admission.

III.   Following their consultation, the Intensivist will discuss the findings directly with the patient's Admitting physician and collaboratively determine the appropriate care plan for the patient based on the patient's needs/acuity. Following this discussion, the Admitting physician may either:

   A.   Turn management of the patient over to the Intensivist Service or other CCM physician, or;
   B.   Remain involved in care of the patient in Co-management with an Intensivist.

IV.   The name of the patient's Attending and Co-managing Intensivist will be entered into the medical record by the Intensivist or by Nursing staff.

V.   The Intensivist Service will conduct daily bedside rounds on all ICU patients.

VI.   The Intensivist Service will conduct bedside multi-disciplinary team rounds daily on all ICU patients.

VII.   The Intensivist Service physician on duty has the authority to assess and treat any ICU patient experiencing clinical instability/deterioration requiring emergent intervention if the Attending or appropriate Consultant is not immediately available.

VIII. The Intensivist Service remains as a care provider for any patient requiring a critical care level of care.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

　　　　　　　　　　　N/A　　　**Policy, Procedure and Standards Committee**

　　　　　　　　　　　6/18/19　**William L. Gilbert, Hospital Director**
　　　　　　　　　　　　　　　　Applicable Administrator, Hospital or Medical Committee

　　　　　　　　　　　8/6/19　　**Board of Supervisors**
　　　　　　　　　　　　　　　　Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/22/17**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION: **INFORMATION MANAGEMENT** SUB SECTION: **INFORMATION SECURITY**

SUBJECT: **LAPTOP COMPUTER USE AND SECURITY**

APPROVED BY: _____

<div align="center">Chief Executive Officer</div>

_____

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) that all ARMC-owned laptop computers assigned to staff will be used, stored and transported in a secure manner in compliance with all hospital policies and state and federal laws. All personnel assigned the use of a laptop computer must comply with this policy.

Note: This policy is not applicable to ARMC-owned laptop and tablet computers configured with alternative security controls, which prevent local storage of data on the computer hard drive. These laptops and tablets (e.g. Workstation on Wheels (WOW's), etc.) are used only at the Hospital and Family Health Centers and are not taken offsite. These devices are labeled accordingly and include an ARMC property tag.

PURPOSE

Employees must understand and adhere to strict security standards in the use, storage and transportation of assigned computers. Use of such technology devices poses a risk of theft or loss of data and equipment which may be reportable to the state Department of Public Health and to the patient. Employees must protect the confidentiality and security of patient identifiable information and the systems used to process, store or transmit such data at all times.

PROCEDURES

I. Security Configuration Requirements

A. Information Management will configure assigned computers to allow functionality while providing for secure configuration and use of prior to assigning them to authorized staff. Computers will be configured according to the security standards as prescribed by this policy.

B. Before any Medical Center-owned laptop or tablet computer is issued, the following security will be configured:

1. Computer will be assigned to an individual who will be responsible for the laptop.
2. Computer will be tagged with an Medical Center property tag and an encryption tag.
3. Laptops/Tablets will use full disk encryption of at least 128-bit strength.
4. Account will require a user name and complex password in order to log on to the device. The account will have standard user privileges (no administrator accounts) in order to prevent users from modifying the computer's configuration.
5. Updated antivirus and anti-malware software will be installed.
6. Devices will time-out after 15 minutes of inactivity and require a password to unlock.
7. Audit logging will be enabled and successful and failed logons will be recorded.
8. Services which are not required will be disabled.

9. Updated patches will be applied on a scheduled basis or configured to automatically update.
10. Disable or delete any other accounts. No guest accounts (or accounts that do not require a password) will be allowed.
11. Accounts will be configured to prevent users from being able to modify the computer or install or change programs or settings.

II. Computer Security Awareness Training

A. Users are given appropriate training and instruction in the use of the laptop/tablet and its security functionality. This will include their responsibility for safeguarding the device and their obligation to comply with relevant information governance security procedures of the Medical Center.

B. Staff must read, understand and sign an acknowledgement of receipt of this policy (ATTACHMENT A) and the security agreement (ATTACHMENT B) prior to being assigned or allowed to use a Medical Center-owned laptop or tablet computer. Policy acknowledgements will be placed in the employee personnel file.

C. Computer users must take personal responsibility for the security of the equipment, software and data in their care and abide by the following:

1. Staff are authorized to use the computer for business purposes only.
2. Do not download, install or modify computer settings or attempt to update the software manually.
3. Do not store personal information, pictures or other data on the device.
4. Do not use the computer for any illegal or inappropriate purposes.
5. Unauthorized or unlicensed software must not be loaded on the device.
6. Ensure the computer is not used by unauthorized persons.
7. Do NOT store any passwords for the computer in the bag or with the device.
8. Take reasonable steps to ensure that the laptop is not damaged through misuse.
9. Computers must never be left unattended in public or unsecured places.
10. When traveling by car, computers must be stored securely in the trunk or completely out of site.
11. Computers must not be left in the vehicle overnight. Store in a secure location at the residence or at the Medical Center.
12. Report any possible security breaches (e.g. computer stolen or misplaced) in line with the Security Incident Reporting policy 700.06 and advise the Department Manager immediately.
13. Users are personally accountable for all network and systems accessed under their user ID. Keep passwords absolutely secret. Never share it with anyone, not even family members, friends or IT staff.

III. Disciplinary Action

A. Department Managers/Medical Staff Department Chairpersons are ultimately responsible to ensure laptops/tablets are assigned and accounted for appropriately. Employees will be held responsible for the proper use, storage and security of the computer. Any inappropriate use, loss or theft of the computer through negligence or failure to follow this policy may subject the assigned user to disciplinary action up to and including revocation of use and/or termination of employment in accordance with Medical Center policy 700.06 - Security Incident Procedures and Sanctions.

REFERENCES: **N/A**

DEFINITIONS: **N/A**

ATTACHMENTS: **ATTACHMENT A - LAPTOP/TABLET COMPUTER USE AND SECURITY POLICY ACKNOWLEDGMENT FORM**
                                        ATTACHMENT B - ARMC Laptop Use and Security Agreement

APPROVAL   DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**7/18/15**</u>   **REVISED:**   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

**LAPTOP/TABLET COMPUTER USE AND SECURITY POLICY
ACKNOWLEDGEMENT FORM**

I, _____, acknowledge that I

Employee Name

have received, read, and understood ARMC Policy #700.20 regarding Laptop and Tablet Computer Use and Security and I agree to comply with the policy requirements. I take full responsibility for the security and appropriate use of the computer. I understand that failure to secure the computer or to use it appropriately for only business purposes may result in disciplinary action against me up to and including termination of employment. I will report the theft or loss of the computer to my supervisor and to Information Management immediately.

_____   _____
Employee Signature   Date

_____   _____
Supervisor Signature   Date

This acknowledgment form is to be retained by the department with a copy to be placed in official personnel file.

ARMC Laptop/Tablet Use and Security Agreement

Employees and staff authorized to use a Medical Center-owned laptop or tablet computer must take personal responsibility for the safekeeping of such devices and agree to the following terms as part of their responsibilities to safeguard both the computer and the data stored on the device. (This agreement must be read, understood and signed prior to the issuance of an assigned computer by the supervisor/manager and the employee. A copy must be provided to the employee and Information Management.)

Encryption

Medical Center-owned laptop or tablet computers are protected by the use of "Whole Disk Encryption" software which scrambles the data on the device making it unreadable or accessible to unauthorized persons.

Users will enter a unique user ID and password after turning on the computer. Upon entering the correct ID and password the computer will be decrypted (unscrambled) and function normally.

__Important__ **- After each use the computer must be turned off.** Your computer is only encrypted when it's turned off. As soon as you log in, the hard drive is decrypted. If your computer is lost or stolen while it's in hibernation mode or turned on, the data may not be encrypted.

Additional Security Measures

- Do NOT leave your computer unattended, even for a few minutes. Laptops/tablets should be stored in locked desks, offices or cabinets when not in use.
- Never leave your laptop/tablet in an unsecured office or classroom or out in the open, unattended.
- Never leave your laptop/tablet inside a vehicle where it is an easy target for theft. Store computers in the case and only in the trunk of the car. **Do not store computers in the trunk overnight.**
- Keep the amount of data stored on your computer to a minimum.
- Report the loss or theft of your computer immediately by phone to your 1) supervisor or manager, 2) Information Management (909-580-2600), and 3) the Security Department (580-4444).
- Return computer immediately upon request or termination of employment/contract.

I have read and understand that I must abide by the terms of this agreement and that I am responsible for the appropriate use and care of the laptop/tablet computer assigned to me. I understand that failure to comply with Medical Center policies concerning information security and this agreement may be cause for disciplinary action up to and including termination of employment.

_____   _____
                  Employee Name   Title

_____   _____
               Employee Signature   Date

Laptop Name: _____ Serial #: _____ Issue Date: _____

_____   _____
               Supervisor Signature   Date

This agreement is to be retained by the department with a copy to be placed in the official personnel file, with Information Management, and a copy given to the responsible employee.

SECTION:	INFORMATION MANAGEMENT	SUB SECTION:	INFORMATION SECURITY

SUBJECT: DATA STORAGE

APPROVED BY: _____
Chief Executive Officer

PRELUDE

Personal data stores (V Drives) are provided for each user to save their work. Each is accessible only by the assigned user. It is regularly backed up to provide protection from loss. They are intended to provide protected storage for unique, user-specific, work-related data only.

Shared data stores (department "Tools" folders) are provided for protected storage of data that is intended to be shared among all members of their assigned department. It is regularly backed up to provide protection from loss.

POLICY

Users are expected to save their user-specific, unique, work related data to their personal data store (V Drive).

Users are expected to save any and only unique work related data, that is intended to be saved and shared amongst their department, to their shared department "Tools" folder.

Any data not stored in these locations, cannot be expected to be safe from loss.

AMPLIFICATION

Data that is available on a shared (department "Tools" folder) is not considered to be unique to the user and must not be copied to the user's V Drive.

Non-compliant data may be removed from users' V Drive or "Tools" folder at the discretion of Information Management without notification of the user(s).

REFERENCES: Information Management Policy No. 600.05

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: <u>**06/28/16**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

| SECTION: | INFORMATION MANAGEMENT | SUB SECTION: | INFORMATION SECURITY |

SUBJECT: DATA INTEGRITY AND INTERNAL DATA VALIDATION

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) maintains a data integrity process ensuring metric specifications are thoroughly validated. It includes and not limited to:

1. Produce customized data validation reports.
2. Review data and ensure the accuracy of the data collected and reported.
3. Undertake improvement initiatives to enhance internal data reporting systems.

RESPONSIBILITY

The responsibility of data integrity spans across ARMC departments.

I. Information Management (See Policy No. 700.13)

A. Protect data against unauthorized alteration or deletion of data files.
B. Safeguard, prevent, deterred and rectify any issues related to the confidentiality, integrity and availability of the information collected, maintained, used or transmitted.
C. Maintains data integrity by:

1. Backing up data regularly and controlling access to data via security mechanisms
2. Designing user interfaces and/or databases that prevent the input of invalid data
3. Utilize data signatures and user access controls

II. Health Information Management Department (See Policy No. 360.00)

A. Using the accepted principles of coding practice, consistent with guidelines established for ICD-9/ ICD 10 coding, the Uniform Hospital Discharge Data Set data –element definitions, and coding clarifications issued by the Centers for Medicare and Medicaid Services (CMS).
B. Verifying the accuracy of the hospital's diagnosis and procedure code assignments that affect Diagnosis Related Group (DRG) assignment.
C. Ensuring that diagnostic and procedural information and the beneficiary's discharge status, as coded and reported by the hospital on its claim, matches both the attending physician's description and the medical-record information.
D. Validating principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

III. Compliance (See Policy No. 1000.02)

A. Maintain a compliance and ethics program consistent with federal, state and regulatory guidelines that develop a culture which promotes compliance ethics, integrity and quality service.

IV. Finance (See Policy No. 1000.05)

   A. Adhere to all the requirements and standards for participation in the health care industry,
       including but not limited to, all rules and regulations pertaining to claims submission and
       reimbursement under the Medicare and Medicaid Programs.
   B. If overpayment is received or a reporting error occurs, ARMC will report and return the
       overpayment along with a written explanation.
   C. ARMC is responsible for reporting to the Office of Inspector General (OIG) if there is credible
       evidence of fraud or abuse.

V. Project Manager

   A. Oversee collection, maintenance, and dissemination of data.
   B. Designating staff to be responsible for data entry, maintenance, and validation.
   C. Monitoring data collection for accuracy, integrity, and dependability.
   D. Ensure timeliness and completeness of data.
   E. Analyze & report the data.
   F. Coordination with departments in order to ensure necessary data elements are reported.

VI. Department Manager

   A. Oversee collection, maintenance, and dissemination of data in their designated department.
   B. Designating staff to be responsible for data entry, maintenance, and validation.
   C. Monitoring data collection for accuracy, integrity, and dependability.
   D. Ensure timeliness and completeness of data.
   E. Identifying gaps and redundancies in the data.

VII. Administrative Data Committees

   A. Provide oversight on data collection activities and internal data validation to ensure adherence to
       federal and/or State laws and regulations.

VIII.   Data Users

   A. Protecting the confidentiality and security of data for which they have been granted access.

PROCEDURES

I. Data Collection

   A. The Project Manager will review metric specifications and will serve as the main coordinator for
       data validation.

II. Data Validation

   A. Abstractors will perform random validity checks throughout the year.
   B. "Spot Checks" of a given metric will involve data analysis on a random selection of patient
       records ensuring that the data matches the metrics specifications.
   C. Each record should be complete and accurate as it is checked against the patient's EMR.
   D. When discrepancies that will affect reporting are discovered, these will be reported to the
       appropriate entity within 10 days.

E. After any discrepancies are reported these will be revised and resubmitted to the applicable entity within an equitable time frame.

II. Reporting Data
   A. For each metric being reported, staff will need to review all the metric specifications including the data elements such as population, target population, numerator, denominator, qualifying exclusions and guidance on sampling.

      1. Review of the entire population or sample size will need to be determined on the given metric adhering to sampling criteria.
      2. If metric does not contain guidance on sampling, then ARMC should follow the sampling guidance below:

         a. When reasonably feasible, submit as many cases as possible to entire population.
         b. If raw data is extracted from the EMR, ARMC should submit the entire population.
         c. Sampling cannot be used when the measure has a population size which is lower than the minimum cases of the sample size

   B. If report is available to be utilized, use the data reported and checking the elements against the database.
   C. All of the data and supporting documentation, including all patient-level data, will be keep for a period of five years after submission of the Demonstration Year reports;
   D. Project Manager and departments will review data reports to confirm accurate data
   E. Project Manager will also provide a summary report along with the data which may include methodology.

REFERENCES: **Prime Reporting Guide**
                         CMS Standard Terms and Conditions

DEFINITIONS:

Data Integrity - the qualities of validity and reliability conjoined with the accuracy of values.

Data Element - a singular item of information such as first name, last name, date of birth, etc.

Data Users – individuals who access data in order to perform their assigned duties.

Data Validation – assessing the accuracy of data.

Project Manager – the person assigned overall responsibility for reporting to internal and external entities, outcomes, and measures using the collected data as reported to them by departments.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**	
6/18/19	**William L. Gilbert, Hospital Director**	
	Applicable Administrator, Hospital or Medical Committee	
8/6/19	**Board of Supervisors**	
	Approved by the Governing Body	

REPLACES: **N/A**

EFFECTIVE: <u>**6/13/17**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

SECTION:	**HEALTH INFORMATION MANAGEMENT SUB SECTION: INFORMATION SECURITY**
SUBJECT:	**ELECTRONIC HEALTH RECORD DOCUMENTATION REQUIREMENTS**

APPROVED BY: _____
Chief Executive Officer

_____

PURPOSE

I. To define requirements related to the use of the electronic health record ("EHR") for patient care documentation by Practitioners at Arrowhead Regional Medical Center ("Hospital").

DEFINITIONS

I. The term "EHR Requirements" includes the use of computerized practitioner order entry ("CPOE"), Practitioner electronic documentation ("pDoc"), Dragon Speech Recognition ("Dragon"), associated order sets/templates/forms and other approved components of the patient's electronic record.

POLICY

I.   All Practitioners must comply with documentation and other electronic entry requirements as described in this Policy.

II.   All Practitioners must directly enter a minimum of 90% of their orders through CPOE and a minimum of 90% of their progress notes and other clinical documentation through pDoc/Dragon, with the exception of EHR downtime.

III. Clinical documentation that must be electronically completed via pDoc/Dragon includes:

    A.   H&P Examination
    B.   Progress Notes
    C.   Operative and Procedure Notes
    D.   Consultation Reports
    E.   Death Summary
    F.   Discharge/Transfer Summary

IV.   Verbal orders ("VO") may only be given to appropriate Hospital staff in emergency situations such as a Code Blue/Rapid Response and when the use of CPOE is not feasible because of multiple simultaneous Practitioner clinical demands. All VOs must be authenticated by the ordering practitioner within 48 hours.

V.   Telephonic orders ("TO") may be given to appropriate Hospital staff when the Practitioner is not in the Hospital and he/she is physically unable to access CPOE provided the Practitioner maintains his/her 90% CPOE compliance.

VI.   It is each Practitioner's responsibility to use TOs judiciously and to assure he/she maintains the required 90% CPOE use compliance rate.

A.   To minimize transcription errors, whenever reasonably possible, the TO should be entered into the patient's EHR by the staff member receiving the order.
B.   All "read-back" requirements pertain to electronically entered TOs.
C.   All TOs must be authenticated by the ordering practitioner within 48 hours.

VII.   Hand written, and/or pre-printed orders will only be accepted as described in the EHR Downtime Policy or when either the use of electronic orders is not supported by Meditech or the time delay in the Practitioner entering electronic orders could adversely affect patient safety.

VIII.   Clinical areas not supported by Meditech at this time include:

A.   Chemotherapy
B.   Restraint Orders
C.   Maternal Child – includes Labor & Delivery, Postpartum, and Newborn Nursery

IX.   All Practitioners must comply with Hospital Meditech down-time procedures.
X.   The Hospital dictation system may be used when an appropriate procedure/operative reports template is not available or, when in the opinion of the attending physician, providing a dictated report is in the best interest of quality patient care.
XI.   It is each Practitioner's responsibility to use Hospital dictation system judiciously. Clinical documentation entered via the Hospital's dictation system negatively impact the Practitioners required compliance rate.

EHR COMPLIANCE USE DATA

I.   Data will be collected regarding both Clinical Services/Department and individual Practitioners use of CPOE and pDoc/Dragon.
II.   Trends in the use of the EHR for Clinical Documentation and CPOE will be reviewed by the HIM/UR Committee
III.   Electronic feedback will be provided every month to Practitioners who have at least ten (10) orders/encounters in the last month and have not achieved at least 90% compliance with the use of CPOE and 90% compliance with the use of pDoc/Dragon electronic documentation.
IV.   Compliance information will also be provided to the appropriate Department Chairs bi-monthly. The Department Chairs will use compliance information to identify opportunities to mentor and educate department members.
V.   Practitioner and Clinical Service/Department specific compliance data will be presented to the Medical Executive Committee ("MEC") quarterly. The MEC will use compliance information to identify opportunities to mentor and educate Practitioners.
VI.   Practitioners with patterns of EHR non-compliance, who have not been responsive to feedback and collegial consulting, will be referred by the MEC for peer review pursuant to the Medical Staff Peer Review Policy.

REFERENCES: Title 22 Section 70751(g)
                         The Joint Commission
                         ARMC Medical Staff Rules and Regulations

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**

Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**

Approved by the Governing Body

REPLACES: **Health Information Management Policy 335.00**

EFFECTIVE: **4/19/18**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

SECTION:	**HEALTH INFORMATION MANAGEMENT**	**SUB SECTION:**	**MISCELLANEOUS**

SUBJECT: **MEDICAL RECORD CORRECTIONS, LATE ENTRIES AND ADDENDUMS**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

A Medical Record of a discharged patient is considered "closed" when regulatory, licensing and accreditation requirements have been met, along with specific requirements stated in the facilities' bylaws and rules and regulations. A closed document is final and authenticated. Erroneous documentation are identified and corrected in order to preserve the integrity of the record.

PROCEDURES

I.   If documentation is recorded in error, the following processes take place.

    A. **CORRECTIONS**

       1. **Paper Corrections** (if the author recognizes the erroneous documentation <u>before</u> it leaves their hands and/or <u>has not</u> been acted on)

          a. Mark a single line through incorrect information

             1) Do not white out

             2) Do not obliterate/cross out

          b. Print "error" by the incorrect information and state reason for error

          c. Sign name, credentials/title and date

          d. Enter correct information as a notation

       2. **Paper Corrections** (if the erroneous documentation <u>has</u> left the author's hands, and/or <u>has already been</u> acted on)

          a. Mark a single line through incorrect information

             1) Do not white out

             2) Do not obliterate/cross out

          b. Print "discontinue" by the incorrect information and indicate the order/action was done in error

          c. Sign name, credentials/title and date

          d. Enter correct information as a notation

       3. **Electronic Information Corrections**

          a. Original entry must have date and time stamp and identify the author

          b. Must not change or delete original information

          c. The notation with the additional or corrected information must have its own date and time stamp and author identification (see ADDENDUMS)

4. **Imaged Record Correction**

The Health Information Management (HIM) Department is notified and the following actions occur by HIM Department personnel:

a. Document on wrong patient record (retraction)

   1) Remove the incorrect document from standard view – though it is still be available if needed for any legal or audit purposes

   2) Note the date and time and circumstances under which the document is being removed in the comment/reason field

   3) Post the document to the correct record

b. Document posted to wrong episode of care for patient (reassignment)

   1) Remove the document from the incorrect episode of care

   2) Post the document in the correct episode of care

   3) Note the date and time and circumstances of the change in the comment/reason field

c. Document posted to wrong document type or in wrong location within record (re-sequencing)

   1) Re-index the document to the correct document type or move the document to the correct location within the same episode of care

   2) No notation needed

d. Errors made in the MPM system cannot be removed. The following action must be taken:

   1) Electronically or hand written, the author documents the correct information in the correct patient record

   2) A notation is made that a previous entry (specify) was erroneous

B. **LATE ENTRIES**

A late entry provides information about a patient even when the pertinent entry was not made in a timely fashion

1. **Paper Late Entry**

   a. Begin with the words 'late entry'

   b. Enter the current date and time

   c. Refer to the date and time of the event

   d. Identify the source of the information

   e. Sign the entry

2. **Electronic Late Entry**

   a. The electronic late entry is automatically dated with the new entry date and time

C. **ADDENDUMS**

Addendums are used to provide additional information for a prior entry. Addendums are used to add or correct information to closed documents. Addendums may be used for corrections.

1. Begin with the words "Addendum"

2. Enter current date and time

3. Note the reason for the addendum and refer back to the original entry

4. Sign the entry

REFERENCES: **Health and Safety Code 123111**
The Joint Commission
American Health Information Management Association (AHIMA)

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **Health Information Management Policy No. 371.00**

EFFECTIVE: <u>**2/10/15**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**2/07/19**</u>

SECTION:	HEALTH INFORMATION MANAGEMENT	SUB SECTION:	MISCELLANEOUS

SUBJECT: "DO NOT USE" ABBREVIATIONS

APPROVED BY: _____

Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) standardizes the use of abbreviations, acronyms, and symbols used in the medical record – including identifying those abbreviations, acronyms, and symbols that should not be used.

The following, because of their propensity to be misunderstood and lead to an error in care, are not used for any type of medication order or in any medication-related documentation. This includes entries handwritten, free-text generated computer entries, and any pre-printed form.

"DO NOT USE" Abbreviation	Use Instead
U, u (referring to a unit of measure)	Write "Unit"
I.U. or IU (international units)	Write "Units" or "International Units"
QD, Q.D., qd	Write "Daily"
QOD, Q.O.D, qod	Write "every other day"
Trailing zero (1.0 mg	Write "1 mg"
Lack of leading zero (.25 mg)	Write "0.25 mg"
MS	Write "morphine sulfate"
MSO4	Write "morphine sulfate"
MgSO4	Write "magnesium sulfate"
cc or CC or c.c.	Write "ml"
ug (for micrograms)	Write "mcg"
sc or sq (for subcutaneous)	Write "subcut" or "subcutaneous"

If a "Do Not Use" Abbreviation, acronym, or symbol is hand-written into the medical record the author of the order is:

I.   Notified and asked to clarify the order prior to implementation of the order

II.   Asked to re-write or re-enter the order

REFERENCES: **Regulatory Body Standards**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/10/16**   **REVISED**: **N/A**

REVIEWED: **2/07/19**

SECTION:	PATIENT RIGHTS	SUB SECTION:	GENERAL

SUBJECT: **LIMITED ENGLISH PROFICIENCY EFFECTIVE COMMUNICATION**

APPROVED BY: _____

Chief Executive Officer

POLICY

Limited English Proficiency (LEP) describes an individual who is unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP person will benefit from an interpreter who will translate to and from the person's primary language. Arrowhead Regional Medical Center (ARMC) is committed to serving all patients according to their needs. Recognizing that patients, their relatives, or companions and an obligation to meet those needs.

Pursuant to the following procedure, ARMC will provide appropriate services, including qualified interpreters, in a timely manner to patients and companions who are LEP where necessary to ensure effective communication and an equal opportunity to participate fully in the services, programs, or activities of ARMC.

All ARMC personnel are responsible for assisting in the determination of a patient or companion's language preference, or need for interpreter services.

PROCEDURE

I.   *Collecting Information.*

    A.   If a patient or companion requests an interpreter for effective communication, or if ARMC personnel recognize, or have any reason to believe, that a patient or companion is LEP, said personnel shall:

        1.   Advise the patient that ARMC utilizes in-person qualified medical interpreters and/or dual handset interpreter services free of charge, 24/7.

II.   *Making a Determination that a Qualified Medical Interpreter is required.*

    A.   In making the determination for interpreter services, ARMC personnel shall consider all relevant facts and circumstances, including without limitation the following:

        1.   The nature, length, complexity and importance of the communication at issue;
        2.   The person's communication skills and knowledge, including their normal method(s) of communication;
        3.   The patient's health status;
        4.   The reasonably foreseeable health care activities of the patient (e.g., group therapy sessions, medical tests or procedures, rehabilitation services, meetings

with health care professionals or social workers, or discussions concerning billing, insurance, self-care, prognoses, diagnoses, history, and discharge); and

5.   Any other factors relevant to determining whether the specific type of interpreter services that will be effective under the circumstances.

B.   Staff shall document in the patients' medical record the preferred language of the patient and the need for interpreter services. Once the determination has been made that an interpreter is necessary, the ARMC personnel who made the determination shall

1.   Contact ARMC's Telecommunication Department at X01020 to request an ARMC qualified medical interpreter (staff); or

2.   Contact Language Services Associates (contract interpreter services vendor 1-855-350-7540, Access Code 8001234#) using a dual handset phone or a phone with speaker capability.

III.   **Possible Services.**

A.   For patients and companions who are LEP, services which may be available for effective communication include, but are not limited to the following:

1.   In-person interpretation from an ARMC qualified medical interpreter.
2.   Phone call to Language Services Associates using dual handset phones.
3.   Assistance in completing forms.
4.   Assistance in guiding a person to an unfamiliar location or along an unfamiliar route. (Can be performed by a Hospital employee or Physician knowledgeable of the campus layout.)
5.   Written materials.

IV.   ***Interpreting services accommodation***

A.   A qualified medical interpreter, whether by way of in-person or dual handset phones, will be used in any and all situations where clear and effective communication is necessary. Situations for which a qualified medical interpreter might be necessary include, *but are not limited to:*

1.   Discussing a patient's symptoms and medical condition, medications, and medical history (including medical, psychiatric, psychosocial, nutritional);
2.   Reviewing, explaining or obtaining

     a.   Informed consent or permission for treatment,
     b.   Health Care Proxy,
     c.   Powers of attorney,
     d.   Living wills,
     e.   DNR/DNI, and
     f.   Patient Bill of Rights;

3.   Determining if a patient is conscious;
4.   Explaining a patient's diagnosis or prognosis and recommendation for treatment;
5.   Explaining medical procedures to be selected by the patient or used, including tests, treatment, treatment options or surgery;
6.   Explaining medications prescribed (such as dosage, instructions for how and when the medication is to be taken, and side effects or food or drug interactions);

7.   Determining any condition or allergy of a patient that may affect the patient's choice of medication;

8.   Explaining follow-up treatments, post-treatment activities, therapies, test results or recovery;

9.   Assisting with communication during routine nursing care (i.e. general routine care involving rapport, comfort and anxiety level of the Patient);

10.   Explaining a change in regimen, environment, condition or unfamiliar treatment;

11.   Explaining and resolving emergency situations that arise;

12.   Providing information about blood donations or apheresis (removal of blood components);

13.   Discussing discharge planning and discharge instructions;

14.   Religious services and spiritual counseling provided by ARMC;

15.   Providing   mental health services, individual or group therapy or counseling, other therapeutic activities including, but not limited to grief counseling and crisis intervention;

16.   Explaining complex billing or insurance issues that may arise;

17.   Providing educational services, such as classes concerning birthing, nutrition, CPR, and weight management.

B.   Non-Scheduled Incidents in which the patient or companion requests an **in-person interpreter.** ARMC will do the following when a patient or companion requests or is deemed to require an in-person interpreter for a non-scheduled incident:

1.   Staff shall contact ARMC Telecommunication Department at X01020 to request an ARMC medically qualified interpreter.

C.   Scheduled Incidents. ARMC will do the following when a patient or companion requests or is deemed to require an interpreter for a scheduled incident:

1.   For an in-person interpreter, the ARMC personnel who schedules the appointment for the patient shall call ARMC Telecommunication Department at X01020 to request an ARMC medically qualified interpreter.

2.   For dual handset phones, the ARMC staff member who schedules the appointment for the patient shall ensure the patient's record indicates a need for an ARMC medically qualified interpreter or dual handset phones by documenting in the patient electronic medical record or paper chart.

D.   In the event a qualified medical interpreter is not available, is delayed, or was not effective, ARMC personnel shall 1) provide the best aid available under the circumstances, 2) exert reasonable efforts to obtain another in-person interpreter, 3) keep the patient informed, and 4) document the information and efforts in the patient's medical chart.

E.   The use of family, friends, or minors as an interpreter is generally inappropriate.

1.   Family members and companions of LEP person shall not be asked to serve as interpreters.

2.   The use of family and friends to provide interpreting services is not permitted except in an emergency involving an imminent threat to the safety or welfare of an individual or the public and a qualified interpreter is not available; or:

        a.   The patient or companion specifically requests that the accompanying adult interprets or facilitates communication, the adult agrees to provide assistance, and such use is appropriate under the circumstances.

        b.   In assessing whether a family member or friend can provide effective communication, ARMC personnel shall consider, among other things, the sensitivity of the information that needs to be conveyed, the ability of the interpreter to convey the information in a neutral and unbiased manner, the interpreter's apparent ability to interpret, and the interpreter's age and maturity.

3.   The patient or companion must have been made aware of ARMC's interpreter services available free of charge.

4.   It is not appropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or has a personal stake in the outcome of a situation.

5.   A spouse shall not be relied on to interpret for the other spouse in situations alleging spousal abuse.

6.   A minor child must not be relied on to interpret or facilitate communication for a patient who is LEP, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.

V.   *Continuation* of *Provision* of *Appropriate Interpreter Services.*

A.   If a patient is admitted to ARMC, ARMC personnel shall ensure that the patient and/or companion receives the necessary interpreter service throughout the patient's stay; the patient is not required to renew requests for services deemed necessary for effective communication. The patient's medical record shall be conspicuously labeled to alert ARMC personnel to the fact that the patient or companion is LEP and that interpreter services have been identified as necessary to communicate effectively with the patient or companion. Upon discharge, if a clinic visit is scheduled, the interpreter services shall be noted at that time. If a patient returns to ARMC, ARMC personnel shall reference the patient's prior medical records, where available, as part of the communication assessment to determine if an interpreter is needed.

REFERENCES: **Regulatory Agencies**
                     Health and Safety Code

DEFINITIONS: **QUALIFIED MEDICAL INTERPRETER:** is an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any specialized vocabulary necessary for effective communication in the hospital setting.

                     ARMC MEDICALLY QUALIFIED INTERPRETER: ARMC staff that have undergone a screening process to determine their competencies in the second language, knowledge of medical terminology and understanding of hospital privacy and confidentiality requirements

                     COMPANION: In many situations, ARMC communicates with. someone other than the patient or other person who is receiving their goods or services. For example, ARMC staff often talk to a patient's spouse, other relative, or friend about the patient's condition or prognosis. These people are "companions" and ARMC must provide effective communication for companions who have communication disabilities. The term "Companion" means a person who is LEP and is a family member, friend, or associate of an individual seeking access to a service, program, or activity of ARMC, who, along with such individual, is an appropriate person with whom ARMC should communicate.

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**
                                                    _____

                               6/18/19   **William L. Gilbert, Hospital Director**
                                                    _____
                                                    Applicable Administrator, Hospital or Medical Committee

                               8/6/19   **Board of Supervisors**
                                                    _____
                                                    Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **03/03/16**   **REVISED**:   **N/A**

REVIEWED: **2/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION: **COMPLIANCE**   SUB SECTION: GENERAL

SUBJECT: **PHYSICAL REMOVAL AND TRANSPORT OF PROTECTED HEALTH INFORMATION**

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

It is the policy of Arrowhead Regional Medical Center to protect all patient identifiable information from unauthorized access use or disclosure when transporting such information in any form or medium. Workforce members shall not physically remove or transport any protected health information (PHI) from Arrowhead Regional Medical Center (ARMC) Work Locations, unless such information will be used for the performance of job duties. Workforce members shall ensure that all PHI, whether in paper or electronic format, that is physically removed is secured and transported in compliance with this policy and safeguarded from any unauthorized use, viewing, access or disclosure; including theft or loss.

PURPOSE

The purpose of this policy is to ensure appropriate safeguards against the loss; theft; and unauthorized access, use, disclosure, alteration or destruction of protected health information in paper form or stored in electronic form on laptops or USB drives by providing basic requirements for the physical removal or transport of such information from ARMC Work Locations.

PROCEDURES

I.   Original patient medical records may not be removed from the premises without the express prior approval from the Medical Records Department Manager.

II.   PHI created or used for education or research purposes shall not be removed from ARMC Work Locations.

III.   Workforce members must consider the risks to the information prior to removal and consider other ways to conduct business that will afford greater protection to the data first. In most cases secure remote access to patient information by workforce members is the preferred method since this affords greater protection to the data by eliminating or minimizing the need to remove any patient or confidential information from hospital premises.

IV.   Workforce members who seek to take non-electronic PHI from ARMC work locations to work on at home or offsite must request approval from their supervisor or the department's director. Before approving the request, the supervisor or director shall be satisfied that the workforce member will implement proper safeguards for protecting the information when physically removed from ARMC Work Locations.

V.   Workforce members will determine the best way to safeguard the information from unauthorized access, use or disclosure in accordance with this policy. Workforce members who transport PHI in any form, whether on-site or off-site, shall take reasonable precautions to safeguard and

secure the information at all times. Workforce members shall only transport the minimum information necessary to perform their job duties.

VI.   Examples of appropriate safeguards for such information include but are not limited to:

A.   For information in electronic form staff shall encrypt the data with at least 128-bit strength encryption in accordance with ARMC AOM Policy 700.19 Data Encryption.

B.   Staff will not store PHI on personally owned devices or devices which are not encrypted. If the device is not encrypted, no PHI may be stored on it.

C.   Store printed information in a lockable attaché case or file box.

D.   Place the information in the trunk of the vehicle during transport.

E.   Never place patient identifiable information in plain view where it can be seen or accessed such as in the passenger seat.

F.   Immediately remove and return the information to a secure area once transported, whether this is at the place of residence or back at the work location. Do not leave patient information in the vehicle overnight as the vehicle can be broken into.

G.   Destroy any copies no longer required by using a cross-cut shredder or returning the information to ARMC and placing in a secured shred bin.

H.   Promptly report any loss or theft of the information to supervision and the Hospital Privacy and Security Officer.

DISCIPLINARY ACTION FOR NON-COMPLIANCE

Workforce members who remove PHI from ARMC premises for non-business related purposes or who fail to properly secure patient information from unauthorized viewing, access, use or disclosure may be subject to disciplinary action up to and including termination from employment, cancellation of contract or expulsion from training programs.

REFERENCES: **HIPAA Regulations - 45 C.F.R. 164.530(c)**
                         Administrative Policy Nos. 700.01, 700.10, 700.19

DEFINITIONS: Protected Health Information – any individually identifiable information which could be used to identify a patient. Includes but is not limited to patient name, address, phone, facial photograph, medical record number, SSN, date of birth, demographic information, guarantor, payment information, etc.

Workforce Members: are defined as employees (including temporary employees), researchers, volunteers, trainees, medical staff and other persons whose conduct, in the performance of work, is under the direct control of ARMC, whether or not they are paid by ARMC.

ARMC Work Locations: is defined as any space owned, leased, or used by ARMC such as the Hospital Campus or Family Health Centers.

ATTACHMENTS: **Attachment A: Policy Acknowledgment Form**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

            6/18/19   **William L. Gilbert, Hospital Director**
                      Applicable Administrator, Hospital or Medical Committee

            8/6/19   **Board of Supervisors**
                      Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/25/14**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

POLICY ACKNOWLEDGMENT

I acknowledge that I have received policy 1000.27 **Physical Removal and Transport of Protected Health Information**. I understand and will comply with this policy in that I will only remove patient information from hospital or clinic premises for business duties and only with appropriate safeguards in place to protect the information from unauthorized viewing, theft or loss. For patient information in electronic form I will not store patient information on any device unless the information is encrypted with at least 128-bit encryption. For assistance with information privacy or security questions I can contact Information Management or the Hospital Compliance Department.

Name:_____ **Dept.** _____

Employee Number: _____ **Date:** _____

Signature:_____ **Supervisor:** _____

Copy to be placed in HR 201 file or maintained in department or with contract for auditing purposes

SECTION:	**COMPLIANCE**	**SUB SECTION:**	**GENERAL**

SUBJECT: **COMPLIANCE OFFICER/REPORTING TO THE JOINT CONFERENCE COMMITTEE (BOARD)**

APPROVED BY: _____

Chief Executive Officer

POLICY

The Compliance Officer generally reports to the Joint Conference Committee (JCC) at regularly scheduled meetings. If an issue is deemed to be of a serious nature, however, it is reported to the JCC as appropriate. During the reporting period, the Compliance Officer will inform the JCC of any current compliance issues or investigations and inform them of compliance audits performed during the reporting period.

PROCEDURES

I.   The Compliance Officer's report is intended to keep the JCC informed of how the compliance program is operating, to ensure the JCC that complaints or concerns are being addressed, and to ensure continued oversight and support from the JCC in Arrowhead Regional Medical Center's compliance program.

II.   Throughout the year, the Compliance Department performs various audits, investigations and provides education as pertinent to compliance related trends (activities).

III.   Information from these activities is reported to the JCC as informational material and for further discussion.

IV.   To ensure maximum confidentiality of the information presented to the JCC during the meetings, any written reports that the Compliance Officer deems confidential in nature and submits to the JCC are collected at the end of the meeting and returned to the Compliance Officer.

V.   The Compliance Officer's report will be reflected in the official minutes.

REFERENCES: **The Joint Commission**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                            6/18/19   **William L. Gilbert, Hospital Director**
                                              Applicable Administrator, Hospital or Medical Committee

                            8/6/19   **Board of Supervisors**
                                              Approved by the Governing Body

REPLACES: **Administrative Policy No. 1000.29 Issue 1**

EFFECTIVE: **5/14/14**   **REVISED**:   **7/24/14**

REVIEWED: **02/07/19**

SECTION: COMPLIANCE   SUB SECTION: GENERAL

SUBJECT: CONFLICT OF INTEREST – PREVENTION OF

APPROVED BY: _____
                    Interim Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) requires employees (regular, contract, volunteer, students, residents, interns, etc.) to disclose any personal interests when they present, as actual or potential conflicts, with the interests of the organization, or appear to conflict with the objectivity and integrity of professional roles and responsibilities. It is the purpose of this policy to ensure the integrity of decisions made on behalf of ARMC. Business decisions shall be free of personal bias, interest or gain. The intent of this policy will be met when decisions are made fairly and objectively, with the interests of ARMC in mind.

PROCEDURES

I.   Whenever an employee becomes aware of any interests or activities in which they are or another employee is involved that could conflict with the interests or activities of ARMC, they shall disclose such potential conflict of interest to a member of management and the Compliance Department.

II.   The Compliance Department shall review the situation and examine the facts to determine if a real or potential conflict of interest exists. Not every situation involving competing personal and professional interest will warrant action.

III.   For conflicts of interest that warrant action, such action will be taken to protect the interests of ARMC.

IV.   Examples of when conflicts of interest arise are as follows (this list is not exhaustive, only to serve as a guide):

A.   Purchasing and Contracting – Purchasing and contracting decisions shall be based on vendor quality, service, price and other factors necessary to advance the interests of ARMC. Individuals who have the ability to make or influence a purchasing or contracting decision shall be free of personal bias or gain. Personal relationships with a potential vendor or contractor, financial interests, gifts or favors received and other forms of influence must be disclosed. When a conflict of interest warrants action, there may be exclusion from the selection, negotiation, purchasing and contracting process.

B.   Staffing – Staffing decisions shall be based on academic credentials, skills, experience, professional qualifications and achievements and other factors necessary to excel in the role. Individuals who have the ability to make or influence staffing decisions should be free of personal bias or gain. Staffing decisions involving immediate family members, relatives and other individuals where a personal relationship exists must be disclosed.

When a conflict of interest warrants action, there may be exclusion from the screening, selection or hiring process, career development, advancement and other staffing decisions.

C. Gifts and Gratuities between Staff – Gifts, even between staff, are never permitted if it is prohibited by law or regulation; prohibited by an ARMC or County policy; or intended to improperly influence, or would have the appearance of improperly influencing the recipient. Gift giving between staff, or between staff and medical staff, shall be limited to a maximum of $50 cash value per calendar year. Any gift over this amount shall be reported to the Compliance Department for further consideration.

D. ARMC Property and Assets – The privilege to access and use ARMC assets are granted to advance the interests of the hospital and should not be abused for personal gain. Financial, personal and other incentives to misuse cash, property, equipment, supplies and other ARMC resources must be disclosed. ARMC expenditures for professional memberships and education must be disclosed. When such use of ARMC property and/or assets are based on personal relationships or for personal gain and do not advance the interests or ARMC or when such expenditures do not enhance the performance of professional responsibilities for ARMC, they may be considered waste and abuse of ARMC property and/or assets. Waste and abuse of ARMC assets may result in disciplinary actions, up to and including, termination.

E. Information Integrity- The management and communication of ARMC information should be free of personal bias or gain. Obtaining, disclosing or using patient or ARMC information for direct or indirect personal interest, profit or advantage without ARMC authorization is prohibited.   When a conflict of interest warrants action, there may be exclusion from access, analysis and presentation of the information.

F. Outside Activities – Outside activities that may conflict with professional roles and responsibilities shall be disclosed and include, but are not limited to, service on competitor boards, working for competitors, ownership in a competing business, investments in competitors, political activities and contributions, or activities that go against the core value of ARMC. When a conflict of interest warrants action, such action should be reviewed with management and the Compliance Department.

REFERENCES: **The Joint Commission**

DEFINITIONS: **Conflict of Interest – Competing personal and professional interests, whereby personal interests may be in conflict with professional roles and responsibilities.**

Personal Interest – Motivated by personal gain, which may involve financial interests, personal relationships or activities outside of work.

Financial Interest – Driven by the potential for personal financial gain. Financial interests may include stocks, bonds, securities and other investments in which an individual, or someone with whom they have a personal relationship, has a financial stake.

Personal Relationship – Any relationship other than a professional one. Personal relationships have the potential to impact professional objectivity. Examples are the relationship you have with a spouse, relative, friend, romantic partner, someone who lives in your household or with whom you have a financial connection.

Outside Activities – Engaging in activities outside work that appear to be in conflict with professional roles. Examples include serving on the board of a competitor, working for a competitor or having financial interest (ownership or investment) in a competitor.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/8/14**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: **ANTI-KICKBACK AND STARK LAWS**

APPROVED BY: _____
                                        Chief Executive Officer

POLICY

The purpose of this policy is to assure Arrowhead Regional Medical Center (ARMC) complies with the federal anti-kickback statute which prohibits offering, paying, soliciting, or receiving any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce referrals of or recommending or arranging for the purchase of any items or services covered under a federal health care program and the physician self-referral law (Stark Law) which prohibits a physician from referring patients for designated health services (DHS) paid for by Medicare, if the physician or physician's immediate family member has a financial relationship with the entity providing the DHS.

ARMC and its employees, contractors, vendors and volunteers (employees) must comply with the Anti-Kickback Statute by prohibiting specific categories of referral payments, including kickbacks, bribes or rebates. ARMC strictly prohibits its employees from knowingly and willfully offering, paying, soliciting or receiving remuneration in order to induce the referral of a federally-funded health care program business, including, but not limited to, Medi-Cal and Medicare. The prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration intended to include the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by a federally-funded health care program.

The Office of Inspector General (OIG) has published regulations outlining certain categories of activities referred to as "safe harbors" that are deemed not to violate the Anti-Kickback Statute. While the failure of a particular business arrangement to comply with an established safe harbor may not make the conduct or activity illegal, it does require that an analysis of the arrangement be undertaken to determine if there is a violation of the Anti-Kickback statute.

In addition, ARMC complies with the Stark Law by prohibiting a physician who has a financial relationship with an entity from making a referral to that entity for the provision of a designated health service (DHS). The Stark Law applies to entities with which a physician or the physician's immediate family member has a financial relationship.

Due to the complexity of Stark law issues, it is the policy of ARMC that all potential financial relationships of ARMC with physicians or their immediate family members be reviewed and approved by County Counsel before a financial relationship is established.

PROCEDURES

Anti-Kickback Law

I.   All items and services provided by or to, and all payments to or from ARMC pursuant to arrangements with referral sources must be pursuant to a written contract or purchase order, which has been reviewed and approved through County Counsel and the Board of Supervisors. Such arrangement must provide for payments consistent with fair market value, properly documented and must be necessary for items or services actually provided. Payments must be set in advance and must not take referrals into account and may not be conditioned on either party making referrals to the other party.

II.   Space or equipment leases between ARMC and referral sources must be set in writing, signed by both parties and reviewed and approved by County Counsel and the Board of Supervisors. Such leases must provide for rent consistent with fair market value and must be for necessary space or equipment actually provided. The aggregate rent must be set in advance and must not take referrals into account, and may not be conditioned on either parity making referrals to the other party.

III.   ARMC compensates physician pursuant to written agreements based on fair market value for their services without taking referrals into account and in compliance with applicable legal guidelines as specifically approved by County Counsel.

IV.   ARMC will not accept a discount when purchasing items or services from a referral source, including without limitation, purchasing from vendors or suppliers through Group Purchasing Organizations, unless the discount: (1) complies with the discount safe harbor set forth in 42 CFR section 1001.952(h), or (2) has been approved in advance by County Counsel.

V.   Any gift or business courtesy must comply with ARMC's Vendor Relations Policy No. 1000.24.

VI.   Compliance with this policy is a required condition of employment or continued engagement with ARMC. Violations of this policy should be reported to the Compliance Department immediately.

Stark Self-Referral Law

I.   To comply with the Stark law, compensation arrangements with referring physicians and their immediate family members must:

    A.   Be set forth in a signed, written contract specifying the item or services covered;

    B.   Specify the payment terms, which must set in advance, consistent with fair market value for items or services actually provided, not taking account of the volume or value of referrals or other business generated between the parties;

    C.   Specify the timeframe for the arrangement; and

    D.   Be reviewed and approved by County Counsel and the Board of Supervisors before proceeding with any referral type arrangement.

REFERENCES: **42 C.F.R. Section 411.351**
        42 U.S.C. Section 1320a-7b(b)

DEFINITIONS: **Designated Health Services (DHS)** – The Stark Law applies to a broad range of services, which include: all inpatient and outpatient hospital services; clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other services, including MRI, CT and ultrasound; radiation therapy services and supplies; durable medical equipment and supplies; parental and enteral nutrients, equipment and supplies; prosthetic, orthotic and prosthetic devices and supplies; home health services; and outpatient prescription drugs.

Entity – A person or legal entity that furnishes DHS.

Financial Relationship – (1) A direct or indirect ownership or investment interest by the physician (or an immediate family member) in the entity providing the DHS, or (2) A direct or indirect compensation arrangement between the physician (or immediate family member) and the entity providing the DHS.

Immediate Family Member – Includes, husband or wife; birth or adoptive parents; child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and a spouse of a grandparent or grandchild.

Physician – A doctor of medicine or osteopathy, dentist, podiatrist, optometrist and chiropractor. A physician and the professional corporation of which he or she is a sole owner are the same for Stark purposes.

Referral – A request by a physician that includes the provision of any DHS, the establishment of a plan of care by a physician that includes DHS, the certifying or recertifying of the need for DHS, or the request for a consultation with another physician and any test or procedure ordered by or to be performed by that other physician. The definition specifically excludes DHS personally performed or provided by the referring physician.

Referral Source – Any physician, health care facility, contractor, vendor or agent that is in a position to make referrals to, or receive referrals from ARMC.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: <u>**N/A**</u>

EFFECTIVE: <u>**9/9/14**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**02/07/19**</u>

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION: COMPLIANCE   SUB SECTION:

SUBJECT: **PERSONAL REPRESENTATIVES OF PATIENTS**

APPROVED BY: _____
                                                Chief Executive Officer

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PURPOSE

This policy defines who may represent the patient under the Health Insurance Portability and Accountability Act (HIPAA) patient rights requirements and California state law when the patient cannot make decisions or requests representation by an authorized individual.

POLICY

I. Definition of Personal Representative

A patient's personal representative is the person who has the authority to act on behalf of the patient in making decisions related to health care provided to the patient under California law. It should not be assumed that a family member or caregiver is a personal representative of the patient, unless such individual meets the definition set forth in this policy.

II. Authority of Personal Representative

Arrowhead Regional Medical Center (ARMC) treats a patient's personal representative as the patient with respect to the ability to authorize ARMC's use and disclosure of patients protected health information (PHI) that is relevant to the personal representation. In general, the scope of the personal representative's authority to act for the patient derives from his or her authority under state law to make health care decisions for the patient. Where the authority to act for the individual/patient is limited or specific to particular health care decisions, the personal representative is to be treated as the individual only with respect to PHI that is relevant to the representation.

III. Who May Act as a Personal Representative

A. In General

Under the laws of California, the following may act as personal representative of a patient:

1. An attorney-in-fact (also known as an agent) under a written health care power of attorney or advance directive.

   a. The power of attorney or advance directive will specify any limitations on an agent's ability to make health care decisions on behalf of the patient, e.g., only where the patient lacks capacity. A patient with capacity may revoke the designation of an agent in writing, or by personally informing the supervising health care provider. If the patient informs an ARMC employee who is not the supervising health care provider, the supervising health care provider should be contacted immediately. The supervising health care provider should

then talk to the patient about his or her expressed desire to revoke the designation of the agent.

2. A surrogate designated (orally or in writing) by the patient to make health care decisions on his or her behalf.

   a. A patient may designate a surrogate to make health care decisions on such patient's behalf by personally informing the supervising health care provider. The designation of a surrogate should be promptly recorded in the patient's medical record. Unless the patient specifies a shorter period, a surrogate decision maker is effective only during the course of treatment or illness or during the stay in the healthcare institution when the surrogate designation is made, or 60 days, whichever period is shorter. Unless otherwise stated by the patient, the surrogate has priority over the agent for purposes of making health care decisions on behalf of the patient. A patient with capacity may revoke the designation of a surrogate at any time and in any manner that communicates intent to revoke.

3. A conservator in accordance with the letters of conservatorship or other applicable California law.

   a. As a general rule, unless the patient's power of attorney for health care or advanced directive provides otherwise, the designated agent who is known to the health care provider to be reasonably available and willing to make health care decisions has priority over the conservator. However, a court can modify an advanced directive. Therefore, please contact County Counsel should a dispute arise relating to whether an agent or conservator has priority for making health care decisions on behalf of the patient.

4. For an unemancipated minor, a parent, a relative pursuant to a Caregivers authorization affidavit, or a guardian appointed by a court to make health care decisions for the minor. Please contact County Counsel if more than one of such persons claims to be the legal representative for the minor patient.

B. Personal Representative for Adults and Emancipated Minors

If the patient is an adult or emancipated minor who lacks decisional capacity as documented in the patient record, then ARMC, through the appropriate health care provider, must make a reasonable inquiry as to the availability and authority of a personal representative under state law.

C. Minors

ARMC will treat a parent or guardian as the personal representative of a minor with respect to such minor's PHI, except in the following circumstances:

1. The minor is emancipated as determined by a court of law. In this case, a copy of the minor's department of motor vehicles identification card evidencing the minor's emancipation should be placed in the patient's record.

2. The parent or legal guardian is not permitted to act on such minor's behalf with respect to the PHI under California Health and Safety Code Sections 123100 et seq.

   Note: Generally, a parent of a minor has the right of access to the minor's patient information. However, where the minor is authorized by law to consent to treatment, the right of access

with respect to that patient information rests with the minor, not the parent or guardian. Additionally, a provider may deny a parent or guardian access to the minor's patient information where the provider determines that access would have a detrimental effect on the provider's professional relationship with the minor or on the minor's physical safety or psychological wellbeing.

3. An unemancipated minor with the right to consent to treatment under state law must be given the ARMC Privacy Notice.

    Note: An unemancipated minor is a minor who is legally under the control of such minor's parents or other legal guardian.

D. Minors that may legally consent to treatment without parental consent.

If a minor may legally consent to a particular type of treatment without the consent of a responsible adult, the minor will be treated as the individual for HIPAA compliance purposes. By way of example, minors may lawfully consent to the following types of treatment among others:

1. Pregnancy-related services (Cal. Family Code 6925)
2. Treatment of reportable contagious disease (Cal. Family Code 6926)
3. Treatment related to rape, if age 12 or older
4. HIV tests, if age 12 or older (Cal Health and Safety Code 121020)

Except as permitted by California law or as authorized by the minor in writing, ARMC is prohibited from telling the minor's parents or legal guardian about medical care the minor is legally able to authorize.

E. Deceased Patient

If, under applicable state law, an executor, administrator, or other person has authority to act on behalf of a deceased patient or the patient's estate, ARMC will treat such person as the personal representative with respect to PHI relevant to such personal representation. As discussed in Section II below, ARMC must obtain written documentation of a person's authority under state law to act as the patient's personal representative before allowing the person to act as the patent's personal representative.

F. Victim of Abuse, Neglect or Endangerment

ARMC may elect not to treat a person as the personal representative of a patient if the following two elements are satisfied and the election is documented in the patient's record:

1. (a) ARMC has a reasonable belief that the patient has been or may be subjected to domestic violence, abuse, neglect by such person: or

    (b) Treating such person as the personal representative could endanger the patient: AND

2. ARMC, in the exercise of the professional judgment of the relevant health care provider, decides that it is not in the best interest of the patient to treat the person as the patient's personal representative.

PROCEDURES

I. Determine Status of the Patient

If the patient lacks decisional capacity as documented in the patient's record and is unable to give his or her authorization on an Authorization Form as required by ARMC policies, ARMC, through the appropriate staff or health care provider must first determine if the patient is (A) an adult or emancipated minor; (B) an unemancipated minor; (C) deceased; or (D) a victim of abuse, neglect or endangerment. After making this determination, then staff must follow the policy applicable to the category of the patient as set forth in Section I above.

II. Verify Authority of Personal Representative

For all categories of patients, ARMC must obtain written documentation of a person's authority under state law to act as the patient's personal representative before allowing the person to act as the patient's personal representative in connection with the use or disclosure of the patient's PHI.

III. Documentation

A. ARMC shall maintain in the patient's record the written documentation of a person's authority to act as the patient's personal representative. Examples of appropriate documentation include an "advance directive" executed by the patient, which appoints a person as the patient's "health care representative"; or documentation of the patient's verbal authorization of a particular individual to act as the patient's surrogate for health care decisions.

B. ARMC also should maintain in the patient's record the personal representative's name, address, telephone number and relationship to the patient.

IV. Out-of-State Personal Representatives

As set forth in Section II above, ARMC must obtain written documentation of the authority of any out-of-state personal representative. Thereafter, ARMC employees should use good clinical judgment in communications with that personal representative. For example, the personal representative should provide contact information (e.g. telephone numbers) on initial contact and the identity of that personal representative should be verified through call-backs if ARMC employees are not familiar with the personal representative's voice.

REFERENCES   **45 C.F.R. 164.502(g)**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A**   **Policy, Procedure and Standards Committee**

                      6/18/19   **William L. Gilbert, Hospital Director**
                                    Applicable Administrator, Hospital or Medical Committee

                      8/6/19   **Board of Supervisors**
                                    Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **9/9/14**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: HEALTH INFORMATION EXCHANGE

APPROVED BY: _____
Chief Executive Officer

POLICY

It is the policy of Arrowhead Regional Medical Center (ARMC) to participate in the exchange of limited electronic patient information for the purpose of patient treatment. ARMC utilizes the Inland Empire Health Information Exchange (IEHIE) to facilitate the sharing of patient information for such purposes. Patient information in the IEHIE will only be included after appropriate notification to ARMC patients. Uses and disclosures of patient information in the IEHIE are in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Regulations and applicable California state laws. Use of the IEHIE by ARMC staff is permitted only in accordance with this policy and IEHIE privacy and security policies.

PROCEDURES

I. **Appropriate Use**

   A. Access to the IEHIE by ARMC staff is permitted for treatment purposes only. This strict limitation is intended to help reduce privacy violations, which can easily occur when data is collected for one legitimate reason and then reused for different unauthorized purposes.

   B. The IEHIE is only accessed by ARMC staff in accordance with HIPAA and state law. Use of the exchange for curiosity, malicious intent, research, marketing or any other uses in violation of HIPAA or state laws is strictly prohibited.

II. **Access**

   The access accounts are managed by the Information Management (IM) Department in accordance with ARMC access management policies. Access requests to the IEHIE for staff or users outside of the employ of ARMC are referred to the IEHIE directly. ARMC staff must request access to the IEHIE using the ARMC centralized computer sign-on request process.

III. **Audits**

   Audits of system access are made by the IEHIE and discrepancies are reported to the ARMC Compliance Department.

IV. **Notification**

   ARMC patients are notified of their participation in the IEHIE in the ARMC Privacy Notice and on the ARMC Consent forms. An additional brochure is also provided to patients.

V. **Opt Out Model**

A. It is the policy of ARMC to opt in patients to the IEHIE by default, except for Behavioral Health patients.

B. Patients wishing to opt out of the exchange are provided the appropriate opt out form.

C. The forms may take up to 72 hours before the patient is opted out of the IEHIE.

D. Patients who have been opted out of the exchange will appear in the exchange with a lock picture next to the name to designate the opted-out status.

E. Patients opted out of the system may opt back in to the IEHIE using the same form.

VI. **IEHIE Security Policies and Procedures**

The IEHIE maintains a separate security policy document which is referred to for specific system security and access account levels.

VII. **Disciplinary Action**

Accessing the IEHIE for unauthorized or non-treatment purposes may subject the individual responsible to disciplinary action up to and including termination of employment and prosecution under applicable laws.

REFERENCES: **Administrative Policy No. 700.06 – Security Incident Procedures**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: <u>**N/A**</u>

EFFECTIVE: <u>**11/4/14**</u>   **REVISED**:   <u>**N/A**</u>

REVIEWED: <u>**02/07/19**</u>

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: USES AND DISCLOSURES OF DECEDENT INFORMATION

APPROVED BY: _____

Chief Executive Officer

PURPOSE

This policy describes the circumstances under which Arrowhead Regional Medical Center (ARMC) may use or disclose protected health information (PHI) for decedents (deceased patients) when the purpose of the use or disclosure is not for payment or health care operations or authorized by the patient's personal representative.

POLICY

I. ARMC may use or disclose PHI about a deceased patient without a written authorization for the following purposes:

   A. To a coroner or medical examiner, upon request, for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law (see ARMC Policy 690.19 – Coroner's Case: Notification of the Coroner);

   B. To ARMC personnel performing the duties of a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law;

   C. To funeral directors for the purpose of carrying out their duties (including disclosures prior to and in reasonable anticipation of the individual's death);

   D. To organizations engaged in organ procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating the donation and transplantation; (see ARMC Policy 690.16 – Death of a Patient and ARMC Policy 910.06 - Donor Guidelines);

   E. To law enforcement – PHI about a patient who has died may be disclosed to a law enforcement official for the purpose of alerting law enforcement of the patient's death if there is suspicion that the death may have resulted from criminal conduct.

   F. To family members or others involved in the care of the patient:
   PHI may be disclosed to a decedent's family members or others who were involved in the care or payment for the care of the decedent prior to death, unless doing so would be inconsistent with any prior expressed preference of the deceased patient that is known to ARMC staff. The PHI must be limited to information directly relevant to the family members or others involvement with such care or payment.

      1. A provider may describe the circumstances that led to an individual's passing with family members and other persons who s/he believes to have been involved in the care or payment for the care of that patient if in their professional

judgment they do not believe that doing so would be inconsistent with the deceased patient's prior expressed wishes. A provider that questions the relationship of the person to the decedent or otherwise believes, based on the circumstances, that disclosure of the decedent's PHI would not be appropriate, should not make the disclosure.

A provider generally should not share information about past, unrelated medical problems in disclosures made under this provision.

G. For research purposes - The use of decedents' PHI for research purposes requires Institutional Review Board (IRB) review and approval. Consult the ARMC IRB for instructions.

II. Heightened standards of confidentiality are required when using or disclosing PHI pertaining to sexually transmitted disease (STD), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), behavioral/mental health records, drug and alcohol treatment records, or sexual assault counseling. Disclosure of PHI of heightened confidentiality concerning deceased patients requires a valid written authorization or court order.

PROCEDURES

Documentation of disclosures
ARMC staff will document and retain in electronic or written format a record of all disclosures in accordance with ARMC record retention policies and procedures. See ARMC AOM Policy 1000.09 - *Procedures for Accounting for Disclosures of Protected Health Information*.

(For additional information and instructions concerning authority of personal representatives of patients, refer to ARMC Policy 1000.32 – Personal Representatives of Patients.)

REFERENCES:	45 CFR Parts 160 and 164; Section 164.512 – Uses & Disclosures for Which Consent, Authorization or Opportunity to Agree or Object is Not Required
	California Civil Code Section 56.10
DEFINITIONS:	N/A
ATTACHMENTS:	N/A

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: 6/2/15   **REVISED**:   N/A

REVIEWED: 02/07/19

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: BREACH NOTIFICATION

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) will review all relevant facts to determine if a breach of Protected Health Information (PHI) has occurred based on all available information and as determined on a case by case basis. When a breach is confirmed, ARMC will provide written notification to all appropriate parties as required by state and federal regulations.

PURPOSE

To establish a process for reporting the impermissible or unauthorized acquisition, access, use or disclosure of PHI in accordance with the requirements of the Health Information Portability and Accountability Act (HIPAA) and California state laws.

PROCEDURES

When a breach of unsecured PHI is suspected or discovered, the Hospital Privacy and Security Officer must be notified immediately.

After investigation, the Hospital Privacy and Security Officer or their designee will notify affected individuals, the U.S. Department of Health and Human Services (HHS), and the media, where required, of any breach of unsecured PHI. Notification will also be made to ARMC Administration, County Counsel and the County Office of Compliance and Ethics. Under California state law, the California Department of Public Health will also be notified as appropriate. All suspected breaches of unsecured PHI will be investigated, and all necessary notifications will be sent, in accordance with the guidelines set forth in this policy.

I. **HIPAA Breach Risk Assessment Determination**

Under HIPAA, an acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule is presumed to be a breach unless ARMC demonstrates that there is a low probability that the PHI has been compromised based on a documented risk assessment. ARMC utilizes the California Hospital Association (CHA) form, "HIPAA Breach Decision Tool and Risk Assessment Documentation Form" for this purpose. (Refer to the current CHA California Health Information Privacy Manual, Chapter 12.) Note: ARMC may choose to not complete this process and report the breach as required.

A. **Notification to individuals and the California Department of Public Health (CDPH) under California Health and Safety Code Section 1280.15**

1. Notification shall be made to individuals and the CDPH within 15 business days of the discovery of the breach. Notification shall be made to individuals by first class mail to the last

known address. Note: A single written notice may be sent to the patient which satisfies both California laws and HIPAA, as long as all required elements of Section B - *Notification to Individuals under HIPAA* are present.

2. Note: When more than 500 California residents are affected by a single breach of unencrypted Protected Health Information (PHI), notice must be made to the California State Attorney General by electronically submitting a single sample copy (which must exclude any PHI) at https://oag.ca.gov/ecrime/databreach/report-a-breach. [Civil Code Section 1798.82]

B. **Notification to Individuals under HIPAA:**

1. Notification must be made to the affected individuals without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

2. Method of Notification. Notification must be made through one of the following methods:

   a. *Written notice.*

      i. Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.

      ii. If ARMC knows the individual is deceased and has the address of the next of kin or personal representative of the individual (refer to ARMC Policy 1000.32 – Personal Representatives of Patients), written notification by first-class mail to either the next of kin or personal representative of the individual. The notification may be provided in one or more mailings as information is available.

   b. *Substitute notice.*

      i. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under paragraph (B)(2)(a)(i) of this section, a substitute form of notice reasonably calculated to reach the individual shall be provided. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under paragraph (B)(2)(a)(ii).

      ii. In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means.

      iii. In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall:

         a) Be in the form of either a conspicuous posting for a period of 90 days on the home page of the ARMC website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and

      b) Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may have been included in the breach.

    c. *Additional notice in urgent situations.*

      i. In any case deemed by ARMC to require urgency because of possible imminent misuse of unsecured protected health information, ARMC may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under paragraph (B)(2)(a) of this section.

3. Notification shall include:

    a. A brief description of what happened, including the date of breach and the date of discovery of the breach, if known;

    b. A description of the types of unsecured PHI that were involved in the breach, e.g. full name, social security number, date of birth, home address, diagnosis, or other types of information that were involved;

    c. Any steps individuals should take to protect themselves from potential harm resulting from the breach;

    d. A brief description of what ARMC is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches;

    e. Contact procedures for individuals to ask questions or learn additional information which shall include a toll-free number, an email address, website, or postal address;

    f. The notification shall be written in plain language and if necessary, translated into an alternative language if translation is required for the patient.

C. **Notification to Health and Human Services (HHS):**

1. For breaches involving less than 500 individuals, a log or other documentation of such breaches shall be maintained, and not later than 60 days after the end of each calendar year, notification shall be provided as required to HHS in the manner specified on HHS website.

2. For breaches involving 500 or more individuals, ARMC shall provide the notification required, contemporaneously, with the notice required to the individuals and in the manner specificed on the HHS website.

D. **Notification to Media:**

1. For breaches involving 500 or more individuals, ARMC will ensure that a prominent media outlet is notified without reasonable delay and in no case later than 60 calendar days after discovery of a breach. ARMC shall consult with County Counsel prior to posting notification to the media and shall inform the County Public Information Officer.

2. The notication to the media shall contain the same required elements as Notice to Individuals under HIPAA.

E. **Law Enforcement Delay:**

If a law enforcement official communicates to ARMC that a required notification, notice, or posting would impede a criminal investigation or cause damage to national security, ARMC shall:

1. If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or

2. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.

REFERENCES: 45 C.F.R. Part 164.400 et seq., Ca. Health and Safety Code Section 1280.15, Civil Code Section 1798.82

DEFINITIONS: *Access:* The ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource.

Breach: The acquistion, access, use or discloure of PHI in a manner not permitted by the HIPAA Privacy Rule.

Covered Entity: A health plan, health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA covered transaction.

Disclosure: The release, transfer, provision of, access to, or divulging in any manner of information outside the entity holding the information.

Health Insurance Portability and Accountability Act (HIPAA): A federal law designed to provide privacy and information security standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. (45 C.F.R. Parts 160 and 164)

Protected Health Information (PHI): Individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium (excludes individually identifiable health information in employment records held by the Covered Entity in its role as employer).

Unsecured PHI: PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS) in the guidance issued under 42 U.S.C. section 17932, subdivision (h)(2).

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/19/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: DISCLOSURES OF PROTECTED HEALTH INFORMATION TO LAW ENFORCEMENT

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center may disclose protected health information (PHI) to law enforcement officials, without the individual's written authorization, under specific circumstances as described below. While HIPAA allows for broad access to PHI for a variety of law enforcement purposes, California law in many cases is more stringent in protecting the patient's privacy than HIPAA. In such cases, California law must be followed where the protection to the patient is greater, unless the disclosure is required by law or is part of a legal process. In general, absent an authorization from the patient, or a law compelling the disclosure, only nonmedical information may be disclosed pursuant to a request from law enforcement. In all cases, disclosures for law enforcement purposes must be documented as part of the accounting for disclosures process and tracked in accordance with Administrative Policy No. 1000.09 - Procedures for Accounting for Disclosures of Protected Health Information.

PROCEDURES

Disclosures for law enforcement purposes are permitted as follows:

I. **Required Disclosures**

   A. ARMC may be required by a law to disclose limited PHI pursuant to legal process as follows:

   1. To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena. (The law recognizes that the legal process in obtaining a court order and the secrecy of the grand jury process provides protections for the individual's private information. (Reference Administrative Policy No. 830.03 - Subpoenas, Search Warrants, Court Orders and Summons.)
   2. To respond to an administrative subpoena. (must be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used (Reference Administrative Policy No. 830.03 - Subpoenas, Search Warrants, Court Orders and Summons.)
   3. To report PHI to law enforcement when required by law to do so. (For example, California law requires health care providers to report incidents of gunshot or stab wounds, or other violent injuries such as assaultive or abusive conduct, sexual assault or rape; and the federal law permits disclosures of PHI as necessary to comply with these laws.

      a. Child abuse or neglect may be reported to any law enforcement official authorized by law to receive such reports and authorization by the individual is not required. (Refer to Administrative Policy No. 620.01, Abuse – Children - Reporting of)
      b. Adult abuse, neglect, or domestic violence may be reported to a law enforcement official authorized by law to receive such reports:

         i. If the individual agrees; or
         ii. If the report is required by law; or

   iii. If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (Refer to Administrative Policy Nos. 620.02, 620.03 or 620.04 – Abuse and Domestic Violence Reporting)

  c. To alert law enforcement about the death of the individual, when there is a suspicion that death resulted from criminal conduct. (Refer to Administrative Policy No. 690.19 - Coroners Cases: Notification of)

II. **Permissible Disclosures of Nonmedical Information**

A. Disclosure of nonmedical information is permitted to respond to a request from law enforcement for purposes of identifying or locating a suspect, fugitive, material witness or missing person. (Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, without court order, search warrant or subpoena.

B. Nonmedical information concerning a suspected perpetrator of a criminal act may be reported to law enforcement by the victim, if the victim is a member of the ARMC workforce.

C. When an individual admits to participation in a violent crime in which ARMC staff reasonably believes serious physical harm to another has occurred, non-medical information may be reported to law enforcement, except when such admission occurs during the course mental health counseling, therapy or treatment related to the propensity to commit this type of violent crime.

D. To respond to a request for nonmedical information about a victim of a crime when the victim authorizes disclosure. (If, because of an emergency or the person's incapacity, the individual cannot agree, ARMC staff may disclose the nonmedical information if law enforcement officials represent that the information is not intended to be used against the victim, is needed to determine whether another person broke the law, the investigation would be materially and adversely affected by waiting until the victim could agree, and ARMC staff believes in its professional judgment that doing so is in the best interests of the individual whose information is requested.)

E. To report nonmedical information that ARMC staff in good faith believes to be evidence of a crime that occurred on ARMC premises.

F. When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime.

G. Nonmedical information may be provided to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.

H. To report nonmedical information to identify or apprehend an individual who appears to have escaped from lawful custody.

I. To report nonmedical information to federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act or to provide protective services to the President and others and conduct related investigations.

III. **Other Permitted Disclosures**

A. Disclosure of PHI is permitted to a correctional institution or a law enforcement official having lawful custody of an inmate or others if they represent such PHI is needed to:

  1. Provide health care to the individual (treatment purposes); or
  2. To protect the health and safety of the individual, other inmates, officers or employees of or others at a correctional institution or responsible for the transporting or transferring inmates; or

3. For the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility

IV. **Warrantless Interrogation of Patients**

A. Includes requests by law enforcement to interview, interrogate, fingerprint, photograph or otherwise collect evidence from a patient who is not under arrest or lawful custody. (Excludes warrantless searches or medical evaluation or testing pursuant to a peace officer's authority to conduct constitutionally permissible searches. Refer to Administrative Policy No. 690.10 – Emergency Medical Evaluation Requested by Law Enforcement Officers)

1. When a patient arrives from an accident or incident where law enforcement has an interest, and the patient is not in the custody of law enforcement, the patients' privacy is protected by state and federal law. In order for law enforcement to photograph, interview a patient or obtain evidence, law enforcement must:

   a. Contact the manager/administrator prior to entering the patient care area.
   b. The manager/administrator must obtain the patient's permission in order for law enforcement to enter the patient's room/exam area. The consent must be documented in the medical record.

2. When the patient is not able to provide permission, the manager/administrator using professional judgment, when appropriate, may allow law enforcement to photograph and/or obtain evidence.
3. If the patient refuses permission, inform the law enforcement officer. If the law enforcement officer insists on proceeding, do not attempt to physically prevent the officer from interrogating the patient. If an officer insists on interrogating a patient despite being warned that it is improper, staff are to:

   a. Document the incident
   b. Forward a copy to Administration and the Compliance Department immediately.
   c. The manager should contact the officer's supervisor and request assistance in resolving the matter.

V. **Minimum Necessary Applicability**

A. Except when required by law, the disclosures to law enforcement summarized above are subject to a minimum necessary determination by ARMC staff. Even in cases where the disclosure is required by law, the medical information disclosed must be limited to the required information which is relevant and necessary to meeting the legal obligation. When reasonable to do so, ARMC staff may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose.

VI. **Verification of Identity and Authority**

A. If the law enforcement official making the request for information is not known to ARMC staff, ARMC staff must verify the identity and authority of such person prior to disclosing the information.

VII. **Documentation Requirements**

A. Disclosures made to a law enforcement official as permitted by this policy must be documented in accordance with "Accounting for Disclosures of Protected Health Information" Policy No. 1000.09.

B. The disclosure should only be made at the written request of law enforcement. The form or other documentation must include at a minimum:

1. The date (or dates) of the disclosure
2. Name and address of the law enforcement agency
3. The purpose of the disclosure
4. Brief description of the information disclosed

A copy of the form must be placed in the medical record (or at a minimum, document the four required elements above in the patient chart.

REFERENCES: **45 CFR 164.502**
                       45 CFR 164.512
                       45 CFR 164.514
                       Administrative Policy No. 620.01 - Abuse-Children Reporting of
                       Administrative Policy No. 620.02 - Abuse-Elder Dependent Adult
                       Administrative Policy No. 620.03 - Abuse-Health or Community Care Facility
                       Administrative Policy No. 620.04 – Domestic Violence – Reporting of
                       Administrative Policy No. 690.10 - Emergency Medical Evaluation Requested by Law Enforcement
                       Administrative Policy No. 690.19 - Coroners Cases – Notification of
                       Administrative Policy No. 830.03 - Subpoenas, Search Warrants, Court Orders and Summons

DEFINITIONS: **Law Enforcement/Law Enforcement Official:** an officer or employee of any agency or authority of the United States, or a State, territory, political subdivision, or Indian tribe who is empowered to (1) investigate or conduct an official inquiry into a potential violation of law; or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

                       Non-medical information: includes patient name and address, date and place of birth, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics such as height, weight, hair and eye color, presence or absence of facial hair, tattoo's, etc.

ATTACHMENTS: **N/A**

APPROVAL DATE: _____N/A_____   **Policy, Procedure and Standards Committee**

                       6/18/19   **William L. Gilbert, Hospital Director**
                       _____   Applicable Administrator, Hospital or Medical Committee

                       8/6/19   **Board of Supervisors**
                       _____   Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/9/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: VERIFICATION OF IDENTITY AND AUTHORITY TO DISCLOSE PROTECTED HEALTH INFORMATION

APPROVED BY: _____
<div align="center">Chief Executive Officer</div>

POLICY

Arrowhead Regional Medical Center (ARMC) will maintain patient confidentiality by obtaining identity verification of persons requesting the use and/or disclosure of protected health information (PHI) as per state and federal law.

PURPOSE

Prior to any disclosure of PHI permitted by state or federal law, ARMC will verify the identity of a requesting party and the authority of any such party to have access. Staff will obtain proper identification of all individuals, including patients, prior to allowing access to protected health information. Verification requirements are considered met if professional judgment is used in good faith to determine appropriate authority.

PROCEDURES

I. **Verification Requirements for Disclosure of PHI**

   A. For any disclosure of PHI, ARMC staff will:

   1. Verify the identity of any person who is not known and determine their authority for access to PHI.
   2. Obtain any required documentation, statement or representations (verbal/written) from the requestor. Any information received verbally should be documented in the medical record for future reference.
   3. The general rule for verification by ARMC staff shall be as follows:

      a. Staff will establish the identity of individuals to whom they disclose PHI to limit the possibility of unauthorized disclosures. (For procedures on verifying the patient's identity see Administrative Policy No. 610.12 – Patient Identification.)
      b. Prior to disclosing PHI, staff should ask specific questions (e.g. date of birth, Social Security Number (or last four digits if appropriate), telephone number, or address) that could be answered only by the patient, the patient's personal representative, or those individuals with legitimate business need and compare the information provided with the information contained in the documentation to be disclosed to the patient or in the medical record.
      c. Prior to disclosing PHI, staff shall ensure that all documents/information being disclosed belongs to the requesting patient and does not include any documents or information belonging to another patient.

   B. If a disclosure is conditioned on particular documentation, statements or representations from the person requesting the PHI, ARMC staff may, if it is reasonable under the circumstances, rely on

documentation, statements or representations that, on their face, meet the applicable requirement (for example, an administrative subpoena or summons).

C. Where the disclosure is to a public official or someone acting on their behalf, ARMC staff may rely, if it is reasonable under the circumstances, on any of the following to verify identity:

1. An agency identification badge or other official credentials or proof of government status (if the request is in person);
2. Government letterhead (if the request is in writing);
3. A written statement on government letterhead that the person is acting under the government's authority (if the disclosure is to a person acting on behalf of a public official); or
4. Other evidence or documentation of agency (such as a contract for services, memorandum of understanding or purchase order) that establishes that the person is acting on behalf of the public official.

D. Where disclosure is to a public official or someone acting on behalf of the public official, ARMC staff may rely, if it is reasonable under the circumstances, on any of the following to verify authority:

1. A written statement of the legal authority for the request; or
2. A warrant, subpoena, order or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority. (Refer to Administrative Policy No. 830.03 Subpoenas, Search Warrants, Court Orders, Summons, or Other Requests by Legal Entities.)

E. Verification of identity and authority in connection with uses and disclosures for research purposes has special requirements. (See Administrative Policy No. 1000.26 Use and Disclosure of Protected Health Information for Research Purposes)

REFERENCES: **45 CFR 164.514(h)**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/9/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: DISCLOSURE OF PATIENT INFORMATION TO FAMILY AND FRIENDS

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) may, but is not required to, disclose limited, relevant, protected health information (PHI), without the patient's written authorization, to a family member or friend who has been specifically identified by the patient or who is directly involved in the care of the patient or the payment for care. Patients may also authorize disclosures of health information to specific family members or friends at any time, either verbally or in writing. Use or disclosure of limited PHI is also permitted to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the patient, domestic partner, or another person responsible for the care of the patient, of the patient's location, general condition, or death.

PURPOSE AND SCOPE

This policy pertains specifically to patients as they are being seen for care in ARMC medical, dental, and nursing clinics and departments, outpatient care facilities and Family Healthcare Centers. It does not apply to patients being seen as patients in ARMC Behavioral Health (Mental Health Information), patients in the custody of law enforcement (jail patients), or for confidential patients. For those circumstances, caregivers should follow department policies, which are more restrictive.

This policy pertains to limited verbal disclosures of PHI to persons directly involved in a patient's treatment, for purposes of notifying such persons of a patient's current location, general condition, or death. It also applies to limited disclosures of PHI, which may be in print or other written formats, to such persons for the purposes of making appointments, receiving appointment reminders, picking up prescriptions and making billing or payment inquiries on behalf of a patient.

This policy does not apply to disclosures of health care information unrelated to the patient's current condition, disclosures of Sensitive Information (Such as HIV/AIDS or STD's), or the provision of copies of health records; in both cases, a written authorization must be provided by the patient or the patient's legal representative. Refer requests for medical record information to the Health Information Management (Medical Records) Department.

This policy applies in situations where the patient is present and able to make decisions as well as situations where the patient is not present and/or cannot give permission. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care.

Unique identifier or password: This policy authorizes the department or area to establish a mechanism by which a patient may be asked to provide ARMC staff with a password, which will be documented in the medical record. The patient may then provide this password to whomever they wish. When the password is provided, the limited information concerning the patient may be disclosed. Departments utilizing such a process must establish the process in writing and train all staff on a regular basis.

PROCEDURES

ARMC workforce members may disclose to a family member or other relative, a close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's health care or payment related to the individual's health care. Staff will make reasonable efforts to verify the identity of any person requesting information about, or acting on behalf of the patient, prior to discussing the patient's PHI with them. Ask the person to describe their relationship to the patient and their authority or need to receive the patient's information if necessary.

I. **Uses and disclosures with the patient present:** If the patient is present for, or otherwise available, prior to a permitted use or disclosure and has the capacity to make health care decisions, ARMC workforce members may use or disclose the protected health information if the workforce member:

   A. Obtains the patient's verbal agreement; or
   B. Provides the patient with the opportunity to object to the disclosure, and the individual does not express and objection; or
   C. Reasonably infers from the circumstances, based on the exercise of professional judgment that the patient does not object to the disclosure.

II. **Limited uses and disclosures when the patient is not present:** If the patient is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the patient's incapacity or an emergency circumstance, the ARMC workforce member may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the patient and, if so disclose only the PHI that is directly relevant to the person's involvement with the patient's care or payment for care, or needed for notification purposes. ARMC workforce members may use professional judgment and their experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to act on the patient's behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar limited forms of PHI.

III. **Uses and disclosures when the patient is deceased:** If the individual is deceased, a workforce member (employee or provider) may disclose to a family member, or other persons identified above who were involved in the patient's care or payment for health care prior to a patient's death, PHI of the patient that is relevant to such person's involvement, unless doing so would be inconsistent with any prior expressed wishes of the patient that are known to ARMC. For disclosure of medical record information, PHI may only be disclosed to the authorized Personal Representative of the Patient (For further information reference ARMC AOM Policy 1000.34 – Uses and Disclosures of Decedent Information or ARMC AOM Policy 1000.32 - Personal Representatives of Patients.)

IV. **Notification:** ARMC workforce members may use or disclose limited PHI to notify, or assist in notification of (including identifying or locating), a family member, a personal representative of the patient, or another person responsible for the care of the patient, of the patient's location, general condition or death.

REFERENCES: California Hospital Association (CHA) Consent Manual Chapter 16.17
                        Civil Code Section 56.1007
                        HIPAA Privacy Rule - 45 CFR 164.510(b)

DEFINITIONS: **Mental Health Information -** HIPAA's provisions permitting disclosures to persons involved in the patient's care are not applicable for mental health patients.
Sensitive Information - Heightened standards of confidentiality are required when using or disclosing PHI pertaining to sexually transmitted disease (STD), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), behavioral/mental health records, drug and alcohol treatment records, or sexual assault counseling. Disclosure of PHI of heightened confidentiality requires a valid written authorization or court order unless required by law.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/9/16**   **REVISED**:   **N/A**

REVIEWED: **04/28/16, 02/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	**COMPLIANCE**	**SUB SECTION:**	**GENERAL**

SUBJECT: **PATIENT DIRECTORY**

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) may use limited Protected Health Information (PHI) to create a patient directory and may use or disclose the information in the directory as provided in this policy. Information on patients in ARMC Behavioral Health, Jail/Custody patients, patients who are at risk as determined by the Admissions Department or Administration, and patients who have requested confidential status will not be included in the patient directory.

PROCEDURES

I.   Upon admission, the patient shall be:

   A.   Informed of the PHI that may be included in the patient directory and the persons to whom it may be disclosed, including clergy regarding religious affiliation, and
   B.   Given the opportunity to restrict or prohibit the information from being included.

II.   Unless there is an objection, permitted uses for purposes of maintaining a directory of patients in ARMC shall include:

   A.   Patient Name
   B.   Patient's Room number or location within ARMC
   C.   Patient's religious affiliation
   D.   Patient's general condition described in general terms that do not communicate specific medical information:

      1.   Good
      2.   Fair
      3.   Serious
      4.   Critical

   Note: ARMC may elect to not include in the patient directory, the patient's religious affiliation and the patient's condition as described above.

III.   Patient Directory Information Disclosures

   A.   Unless there is an objection, permitted disclosures for patient directory purposes shall include:

      1.   To members of the clergy
      2.   To other persons who ask for the patient by name (except for information regarding religious affiliation.)

V. Emergency Circumstances

A. If the opportunity to object cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, ARMC may use or disclose some or all of the PHI permitted in the patient directory as described above if:

1. The use or disclosure is consistent with a previously known expressed preference and
2. The use or disclosure is considered in the patient's best interest and
3. The individual is given the opportunity to object to the use or disclosure when it becomes practicable.

REFERENCES: **45 CFR 164.510**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **9/13/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: PATIENT PRIVACY PROTECTIONS

APPROVED BY: _____
Chief Executive Officer

POLICY

All Arrowhead Regional Medical Center (ARMC) employees, medical staff members, volunteers, students and other workforce members shall be responsible for maintaining the confidentiality of all patient information, including Protected Health Information (PHI). This responsibility shall include personal observations, oral conversations, patient charts, the designated record set and its contents, and any other electronically stored or written patient or patient-related data. All employees, including contract employees, and all volunteers shall be required to read and sign a confidentiality agreement. The signed agreements will be maintained on file in the department, area, or program responsible for the workforce member or contract. Employee confidentiality agreements will be maintained in Human Resources.

PROCEDURES

I. Written Information

A. When possible, patient names shall be kept out of public view. If doing so will compromise patient care, the following shall be required:

   1. The patient's first name and last initial shall be used rather than the patient's full name.
   2. No other clinical or demographic information shall be posted with the name.
   3. Sign-in sheets shall only include the patient name, date and time. No other patient-related data is allowed on the sign-in sheet.

B. Only employees with job-related purposes shall have access to written PHI and those employees shall access only the minimum necessary information to perform their job functions.
C. Use or disclosure of PHI shall be done only according to the provisions of Administrative Policy No. 1000.07 – Uses and Disclosures of Protected Health Information.
D. Paper charts, copies of charts, printed patient lists and all other PHI shall, when unattended, be placed only in secure locations (e.g., not accessible to unauthorized persons.)

   1. Paper charts with patient's names on them shall be placed out of public view when possible. The names shall be in small print so as not to be easily read by unauthorized persons.
   2. When it is necessary to place charts in locations that are more visible to the public, the patient's names shall appear upside down or face away from public view. (For example: When placing a patient chart on the door in a rack where the patient is waiting to see the doctor, the chart shall face away from view towards to the door.)
   3. Unknown and not properly identified persons who attempt to read charts shall be approached in a polite manner and asked their reasons for accessing charts. Staff must be appropriately identified and the purposes for accessing patient information must be verified and appropriate prior to access being granted. Those who do not offer appropriate identification and/or reasons for accessing charts shall not be allowed access.

E. Distributed lists and reports containing PHI, (e.g. patient lists, census, medical record information) shall be delivered or distributed (including through inner-office mail) as follows:

1. Such information shall only be delivered directly to authorized persons or to secure designated receptacles or areas not open to the public or other non-authorized ARMC staff.
2. Printed information shall be placed in an envelope or with a cover sheet marked confidential or restricted as indicated to preclude viewing of contents by unauthorized persons.
3. Sensitive information (e.g. Human Immunodeficiency Virus, substance abuse or mental health information, or information related to patients who are also employees) must not be distributed if secure delivery cannot be ensured.

F. Faxed medical information shall be managed according to Administrative Policy No. 1000.10 - Facsimile Transmission and Security.

1. Fax machines and other similar communications or output devices such as printers and copiers must be located in secure areas to prevent access by unauthorized individuals or the public.

G. All PHI that is to be discarded shall be placed in a designated secure shred container or shredded using a cross-cut shredder, not placed in regular trash.

H. Staff shall implement a clean desk policy wherein paperwork containing PHI shall not be left out on desktops where the paperwork can be accessed by unauthorized staff or members of the public.

1. Papers must be removed from copiers, printers, and fax machines promptly and secured.
2. Staff will double-check printed information before handing to patients or placing in the mail, etc. to ensure that only the correct patient's information is included.
3. Patient information must not be left in plain view to unauthorized individuals. This includes protecting such information from access or viewing on desktops, counters or from being visible through door, office or other types of windows or partitions.
4. Patient information maintained in cubicles should be turned upside down or secured when left unattended and put away at the end of the shift. In areas where the public or other non-ARMC staff are allowed access, patient information must not be left out unsecured or be visible.

I. Documents containing patient identifiable information must only be stored in locked containers or secure areas. Patient information must never be accessible or left unattended without being properly secured from unauthorized access. (For example, patient information stored in cabinets must be locked when the cabinet is in an area that is accessible to the public or unauthorized staff or other workforce members.)

J. Documents containing PHI for multiple patients require additional protections

1. All patient lists, or documents containing information for more than one (1) patient shall contain a "CONFIDENTIAL" watermark and must be protected with appropriate safeguards from loss, theft, inappropriate access, use or disclosure at all times.
2. The information shall only be distributed in meetings when appropriate safeguards are implemented, such as providing training to staff on how to properly and securely handle such information.
3. Such information shall not be permitted to be left in conference rooms or other unsecured areas.
4. Patient lists and reports for multiple patients should be covered or placed in secure containers to avoid being seen by unauthorized individuals.

II.   **Transporting PHI**

A.   Business practices sometimes require that Protected Health Information (PHI) other than the patient's record be transported offsite, between ARMC facilities, etc. Transporting of medical records offsite shall only be done in compliance with Health Information Management (Medical records) Department Policies.

NOTE: For removal and transport of PHI see Administrative Policy No. 1000.27 – Physical Removal and Transport of PHI.

1.   PHI transported from one location to another or an offsite facility or location shall be based on department business purposes only.
2.   Confidential information, including PHI, is not to be removed from ARMC by members of the workforce including employees, residents, volunteers, trainees, and temporary workers, without prior approval from the department head.

B.   Only designated individuals may transport PHI on or off campus as determined by department managers or administration.
C.   Transportation of PHI should be limited to the minimum necessary to accomplish the authorized, intended purpose.
D.   PHI must be safeguarded during transportation and shall not be left unattended in vehicles in publicly-accessible locations. Containers or envelopes with PHI shall:

1.   Be kept safe from viewing through the vehicles window by unauthorized persons (including passers-by), and
2.   Be removed from vehicles immediately upon reaching the intended destination, or if the vehicle is left unattended for an extended period of time in a private or publicly-accessible location (e.g. overnight).

E.   The following shall apply to patient identifiable documents:

1.   All lists, schedules or printed census documents containing information for more than one (1) patient shall be protected with appropriate safeguards from loss, theft, inappropriate access, use or disclosure at all times.
2.   Secure containers shall be used to store and transport PHI which identifies multiple patients. The containers must be secured in the trunk of the vehicle and not left in vehicles overnight.
3.   Patient identifiable documents shall be delivered directly to the intended recipient, department, or secure location.
4.   The workforce member is responsible for maintaining the privacy and security of all PHI they may be transporting or using offsite.

NOTE: The carrying of notes, patient lists or other items that identify patients for use as personal reminders, or other similar purposes, should be avoided. If absolutely necessary to facilitate patient care, efforts should be taken to minimize identifiable information written down to prevent inadvertent or accidental disclosure that could occur from notes being lost.

F.   Transported health care items shall be managed as follows:

1.   Health care items that may be labeled or marked with patient identifiers include; but are not limited to:
a.   Specimens

        b. Slides
        c. Medication bottles and other items that have labels with patient identifiers

    2. Health care items labeled or marked with patient identifiers shall be safeguarded during transport using one or a combination of the following methods:
        a. Covered bags
        b. Cases or secure containers

    3. Health care items labeled or marked with patient identifiers shall be delivered directly to the intended recipient, department, or secure location.

G. Any loss/theft or evidence of tampering of PHI during transport shall be immediately reported to the department manager and to the Hospital Compliance Department.

H. The carrying of portable devices or removable media with PHI shall be done only in accordance with Administrative Policy No. 700.19 - Data Encryption and Administrative Policy No. 1000.27 – Removal and Transport of Protected Health Information. Portable storage media must be encrypted, labeled and accounted for prior to the allowance of any removal or transport is permitted.

III.   Management of Electronic Information

A. Computer screens used to display PHI shall, when possible, be located/positioned so they are not visible to the public.

B. When space allocation and/or patient care needs do not allow for computer screens to be placed away from public view, the following measures shall be used:

    1. A screen cover (privacy screen) or other similar device shall be used to preclude viewing of the screen from side angles.
    2. Those using the screens shall be alert to the possibility of public viewing and prevent unauthorized viewing

C. PHI shall not be left on display when the user has finished using the information

D. Electronic patient records shall be accessed only by authorized persons who have:

    1. Appropriate security clearance and passwords
    2. Job-related reasons to view such records and view the minimum information necessary to perform job functions.

E. PHI shall not be downloaded to or be stored in personally-owned or ARMC-owned computer or laptop/tablet hard drive, (i.e. c: drive), unless previously authorized and encrypted via an Information Management department approved methodology.

F. PHI contained in electronic devices, to include but not be limited to portable devices, shall be encrypted in accordance with Administrative Policy No. 1000.19 - Data Encryption.

IV.   Oral Communications

A. Employees shall provide the maximum possible privacy for conversations with patients and families and make every effort to prevent sensitive information from being overheard.

B. Employees shall not discuss PHI in public areas, e.g. cafeteria, elevators, etc.

C. PHI shall not be discussed during phone conversations unless absolutely necessary and the ARMC caregiver is certain of the identity of the person with whom he or she is speaking.

(Reference Administrative Policy No. 1000.37 – Verification of Identity and Authority to Disclose Protected Health Information.)

    1. Use of phones in public areas shall be avoided if possible.
    2. If total privacy is not possible, the person using the phone shall keep the conversation to a minimum and make every effort to avoid being overheard.

D. Messages containing PHI shall not be left on answering machines/voice mail except that which is minimally necessary to provide appointment reminders, request a call back, etc.

II. Personal Cell Phone and Camera Use Restrictions

A. Patient and staff privacy must be protected at all times when using digital communication devices. Great care must be taken to ensure that patient identifiable information is never communicated over insecure methods such as texting, social media, unencrypted email, or other similar technologies. The following restrictions must be observed with cell phones, cameras and other recording devices:

    1. Under no circumstances shall staff use their phones for the photographing, videotaping or recording of patients, their interactions, or any information pertaining to patients.
    2. Patients are prohibited from recording or videotaping staff, other patients or any patient information.
    3. Staff is prohibited from texting about patients in any way that would identify or lead to the identification of patients. (Texts cannot contain any patient identifiable information including Name, DOB, SSN, Sex, Age, etc.) Texts should be deleted routinely.
    4. Staff is prohibited from using any social media to communicate about ARMC patients or send or receive pictures, posts or any other communication about patients.
    5. Phone calls concerning patients must be protected by keeping a low voice and ensuring that no unauthorized staff or the public can overhear the conversation or identify a patient in any way from listening to the phone call.

VI. Expectations and Best Practice Guidelines

A. The following best practice guidelines are to be used to protect patient privacy and comply with this policy:

    1. Shred all paper containing confidential health information or place in closed locked shred receptacles.
    2. When faxing, verify the fax number before sending.
    3. Close doors or privacy curtains and lower your voice when having discussions of confidential health information.
    4. Do not leave medical records unattended or in open areas.
    5. Keep confidential health information you hear or see to yourself.
    6. Before looking at patient information ask yourself "Do I need to know this to do my job?" and if not, don't look at anything.
    7. Passwords selected must be strong passwords that are difficult to guess and must remain confidential.
    8. It is important to not disable the anti-virus and/or anti-spyware software on any ARMC computer system.
    9. Log off or secure your computer when you walk away from it.
    10. Staff are prohibited from transmitting and/or storing sensitive and/or confidential information on file sharing or text messaging applications such as cloud storage systems.

11. As a rule, do not store information on the C drive (local hard drive) of any computer because the information is not backed up and can be lost. Further, the information cannot be stored locally on a computer hard drive unless the drive is encrypted.
12. Hard copies that contain PHI must be disposed of in containers designated for storage of such documents prior to destruction, e.g. shred bins. Shred bins must not be overfilled.

VII.   Disciplinary Action

A. All ARMC staff, employees and workforce members are responsible to protect all ARMC patients from violations to their privacy, including the protection of patient identifiable information in all forms, including oral, paper and electronic.
B. Workforce members who violate this policy, patient privacy or other ARMC patient and patient information privacy and security protections may be subject to disciplinary action up to and including termination of employment, termination of contract or expulsion from training or volunteer programs.
C. Workforce members are expected to safeguard patient information from unauthorized access, use or disclosure and secure such PHI no matter where the information is created, stored or transmitted.
D. Workforce members are expected to report suspected or actual violations to patient privacy or information security immediately to supervision. (For example, when a fax is sent to the wrong number, a patient received information belonging to another patient, a device is lost or stolen which contains patient information, etc.)
E. Administrative Policy No. 700.06 – Security Incident Procedures and Sanctions shall be consulted for assistance with recommended disciplinary action for violations of policy.

REFERENCES: County Policy Manual 1403-SP03 – Administrative Safeguards

DEFINITIONS: **Protected Health Information:** Individually identifiable health information that includes any of the following:
1. It is maintained or transmitted in any form or medium (e.g. written, verbal or electronic);
2. It is created or received by a health care provider, health plan, public health authority, or health care clearinghouse;
3. It relates to the past present or future physical or mental health or condition of an individual;
4. It describes the past, present, or future payment for the provision of health care to an individual;
5. It identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Use: With respect to individually identifiable health information, the sharing, application, utilization, examination, or analysis of such information within an entity that maintains the information.

Disclosure: The release, transfer, provision of access to, or divulging in any manner, of information outside the entity holding the information.

Record: Any item, collection, or grouping of information that includes PHI and is maintained, collected, used or disseminated by or for ARMC.

Designated record set: Patient records (medical and billing) that are maintained by or for ARMC and used to make decisions pertaining to the patient's health care or payment for health care.

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**

6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee

8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **11/21/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	HIPAA

SUBJECT: USE AND DISCLOSURE OF PATIENT INFORMATION FOR FUNDRAISING

APPROVED BY: _____
                                    Chief Executive Officer

POLICY

All Fundraising activities at Arrowhead Regional Medical Center (ARMC) will be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The use or disclosure of any additional protected health information (PHI) for fundraising purposes beyond the PHI as set forth in this policy requires written authorization from the patient. Disclosures made to a Business Associate for fundraising purposes must only be made pursuant to a Business Associate Agreement.

PURPOSE

The purpose of this policy is to provide guidance to ARMC workforce members on the use of patient information for fundraising purposes. This policy also outlines the proper procedures to follow when a patient opts out of receiving fundraising communications.

PROCEDURES

I.   All patients are provided the Notice of Privacy Practices (NOPP) at registration. It informs patients that ARMC may use their information to contact them about fundraising activities at ARMC.

II. Patients have the right to opt out of receiving fundraising communications. ARMC may not send fundraising communications to or otherwise contact patients who have opted out of receiving such communications.

     A. ARMC departments, programs, practitioners and medical groups must consult with the ARMC Foundation before sending any correspondence to patients to verify that they have not previously communicated their right to be removed from lists related to fundraising activities.
     B. Communications by phone or electronic means for a fundraising purpose must clearly inform the individual that they have the right to opt out of receiving future communications
     C. ARMC may not condition an individual's treatment on whether or not they have opted out of receiving fundraising communications.

III. The following patient information may be used for fundraising purposes without a patient's written authorization:

     A. Demographic information, including name, address, date of birth, age and gender
     B. Health insurance status
     C. Department of service (for example, cardiology, surgery, oncology, etc.)
     D. Date of service
     E. Treating physician
     F. Outcome information (for example, death, suboptimal outcome, successfully treated)

IV. FUNDRAISING OPT OUT REQUIREMENTS

A. Prior to engaging in any fundraising efforts to ARMC patients, the ARMC Foundation will implement a process to ensure that patients who opt out of any future fundraising communications are not contacted.

1. Before contacting patients for fundraising purposes, the department, program, physician, or medical group must contact the ARMC Foundation to verify that the patients they wish to contact have not opted out.
2. Requests received from patients to opt out of receiving future fundraising communications must be referred to the ARMC Foundation to ensure the request for opt out is documented.
3. Written materials mailed to patients for the purpose of soliciting a donation must include the following required opt out language:

   a. "If you wish to be removed from future ARMC fundraising communications, please contact the ARMC Foundation by telephone at 909-580-3135."
   b. With each fundraising communication made to an individual, ARMC must provide the individual with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
   c. The method for an individual to elect not to receive further fundraising communications may not cause the individual to incur an undue burden or more than a nominal cost.

4. Verbal communications / telephone solicitations must also advise patients of the right to opt out.
5. Questions about this policy should be directed to the ARMC Foundation or Hospital Compliance Department.
6. A patient who has elected not to receive further fundraising communications can be provided with a method to opt back in to receive such communications.

REFERENCES: **45 CFR 164.514(f)**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE: **N/A** **Policy, Procedure and Standards Committee**

6/18/19 **William L. Gilbert, Hospital Director**
Applicable Administrator, Hospital or Medical Committee

8/6/19 **Board of Supervisors**
Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **6/13/16** **REVISED**: **N/A**

REVIEWED: **02/07/19**

SECTION:	COMPLIANCE	SUB SECTION:	GENERAL

SUBJECT: **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT REQUIRE AUTHORIZATION**

APPROVED BY: _____
Chief Executive Officer

POLICY

Arrowhead Regional Medical Center (ARMC) may use and disclose an individuals Protected Health Information (PHI) only pursuant to a written authorization of the patient or the patient's Personal Representative with the following exceptions:

A. For treatment or payment purposes (See Administrative Policy No. 1000.07 Uses and Disclosures of Protected Health Information)
B. For operations purposes (except for mental health information covered by the Lanterman-Petris-Short (LPS) Act (Welfare and Institutions Code 5328)
C. As mandated or permitted by law
D. For certain research purposes (See Administrative Policy No. 1000.26 Use and Disclosure or Protected Health Information for Research)
E. De-identified PHI (See Administrative Policy No. 1000.25 De-identification of Protected Health Information)
F. HIV (Human Immunodeficiency Virus) test results, which requires HIV disclosure-specific written authorization.

PROCEDURES

Generally, ARMC will obtain written patient authorization for all uses and disclosures of PHI except for purposes of treatment, payment, or health care operations. The patient shall retain the right to refuse to sign an authorization, and exercise of that right will not affect provision of treatment. Any authorization may be revoked in writing, except to the extent of action already taken pursuant to that authorization.

I. Written Patient Authorization Requirements\

A. Except as set forth above, a patient or patient's Personal Representative must sign a HIPAA authorization before ARMC may use or disclose the patient's PHI. Example of specific disclosures requiring authorization include the following:

1. Disclosure of HIV test results
2. Disclosures to a patient's attorney, private companies and vendors, except to a business associate under a business associate agreement or contract
3. Sending medical records to a health care provider or other entity outside of ARMC for purposes other than treatment, payment or operations purposes
4. Life or auto insurance company requests
5. Camp or school physical forms (if the form will be released to anyone other than the parent
6. Immunization records (if such records will be released to anyone other than the parent)
7. Workers compensation (except if the disclosure is limited to payment only)

8. Any activity that does not meet the HIPAA definition of a healthcare operation under HIPAA and is not a required/permitted disclosure
9. Company physicals (other than at the request of the employer)
10. Disclosures of PHI to an employer for employment decisions
11. Use or disclosure of PHI for marketing
12. Research proposals that do not have IRB approval or waiver
13. Sale of PHI
14. Requests from the Medical Board of California
15. Requests from a Professional Liability Insurer
16. Disclosures of PHI to the media (including photography and interviews)

II. Use of ARMC Authorization Forms

A. Both California law and HIPAA specify required elements that an authorization for the use or disclosure of patient-identifiable health information must meet. ARMC has developed a standard form which contains all the required elements. The "AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION" form can be located in ARMC Tools folder under 'Authorization Form'. The form is also available on the ARMC website at www.arrowheadmedcenter.org.

III. Non-ARMC Authorization Forms

A. ARMC staff may not disclose PHI pursuant to an authorization form without ensuring that it meets the privacy requirements. Contact Medical Records for assistance or refer to the required elements below.

IV. Elements of a Valid Patient Authorization

A. A valid non-ARMC authorization form must be in writing and printed in at least 14-point type or handwritten by the person who signs it and contain the following elements:

1. Description of health information - The authorization identifies the PHI to be used or disclosed in a specific and meaningful fashion.
2. Identification of authorized person - The authorization identifies the name or other specific identification of the person(s) authorized to make the requested use or disclosure (e.g., the patient or the patient's Personal Representative).
3. Identification of recipient - The authorization identifies by name or other specific identification the person(s), or class of persons, authorized to receive, use and/or disclose the PHI (e.g., ARMC; a third party designated by the patient).
4. Description of purpose(s) - The authorization must contain a description of each purpose for which PHI is to be used or disclosed by the recipient.

   a. This description must be specific enough to provide a patient with the facts that he/she needs to make an informed decision whether to allow release of the PHI.
   b. The statement "at the request of the individual/patient" is a sufficient description of the purpose when the patient initiates the authorization and does not (or elects not to) provide a statement of the purpose.

5. Expiration - The authorization must contain an expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure. For research authorizations, "none" or "the end of the research study" is acceptable.
6. Statement of right to revoke - The authorization must contain a statement of the patient's right to revoke the authorization in writing and the exceptions to the right to revoke, together

with either a description of how the patient may revoke the authorization or a cross-reference to a Notice of Privacy Practices.

7. Statement that treatment is not conditioned on the authorization - The authorization must contain a statement that the provision of health care to the patient is not conditioned on whether the patient signs the authorization, unless either:

   a. The health care to be provided is solely for the purpose of creating PHI to be disclosed to a third party and the patient's authorization permits ARMC to release the patient's PHI to such third party; or

   b. The health care to be provided is research-related treatment and the patient's authorization is for the use or disclosure of PHI for such research pursuant to ARMC policy.

8. Statement regarding redisclosure - The authorization must contain a statement that PHI used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.

9. Remuneration for marketing activity - If the authorization is for a marketing activity and if ARMC has received or will be receiving any remuneration in connection with such marketing activity, the authorization must state that ARMC is receiving remuneration in connection with such marketing activity.

10. Dated patient signature - The authorization must contain a signature of the patient or the patient's Personal Representative and the date of the signature.

11. Personal Representative - If the authorization is signed by a Personal Representative of the patient, a description of such Personal Representative's authority to act for the patient must be included.

V. Verification of Validity

   A. The following information must be verified to confirm that the authorization is valid:

   1. Completion - A non-ARMC authorization must contain all the elements identified in Section IV above.

   2. Not expired - The authorization must not be expired.

   3. Not revoked - The authorization must not be revoked.

   4. No material false information - The authorization must not contain any material information that is known to be false.

   5. No compound authorizations - An authorization may not be combined with any other document to create a compound authorization, except as set forth in the two exceptions below:

      a. An authorization to use or disclose PHI for a research study may be combined with the consent for research.

      b. An authorization covered under this policy may be combined with any other authorization covered under this policy, except when the provision of health care has been conditioned on the provision of one of the authorizations.

REFERENCES: **45 CFR 164.508**

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **11/21/16**   **REVISED**:   **N/A**

REVIEWED: **02/07/19**

ARROWHEAD REGIONAL MEDICAL CENTER
Administrative Policies and Procedures

SECTION:	COMPLIANCE SUB SECTION: GENERAL

SUBJECT: USE AND DISCLOSURE OF HIV TEST RESULTS

APPROVED BY: _____
Chief Executive Officer

POLICY

It is the policy of Arrowhead Regional Medical Center to protect the confidentiality of Human Immunodeficiency Virus (HIV) test results in compliance with California law, which is more stringent than the requirements of the Health Insurance Portability and Accountability Act (HIPAA). California law declares the results of HIV tests to be confidential and strictly limits the disclosure of test results in a manner that identifies the person tested. A written authorization is generally required prior to disclosing HIV test results. Exceptions to the authorization requirements will only be made in accordance with this policy.

PURPOSE

California law places special restrictions on the use or disclosure of HIV test results, which must be complied with for all patient types in California, including patients whose records are covered by the Confidentiality of Medical Information Act (CMIA) and Lanterman Petris Short (LPS) Act for mental health records. This policy outlines the authorization requirements and exceptions for use and disclosure of HIV test results.

PROCEDURES

I. **Written Authorization Requirements**

A. A valid authorization to disclose HIV test results must be in writing and include to whom the disclosure will be made. The authorization may allow disclosure of the test results only to a person who is responsible for the care and treatment of the patient. Written authorization is required for each separate disclosure of the HIV test results.

B. A general authorization by a patient to release medical records is not sufficient to disclose HIV test results. The authorization form must specifically state that the HIV test results will be released.

C. Staff will utilize the standard ARMC Authorization for Use or Disclosure of Protected Health Information form and ensure that the box is checked for HIV test results. The authorization form will be placed in the patient's medical record.

Note: An entry of HIV test results in the patient medical record is not considered to be a disclosure of the results and thus does not require authorization. (Health and Safety Code Sections 120980(l) and 120985).

D. If the results are entered in the patient's medical record, however, the portions of the medical record that contain the HIV test results must not be disclosed without a special authorization by the patient unless it falls within one of the exceptions listed below.

II. Exceptions to Written Authorization

A. HIV test results may be disclosed as follows without written authorization in the following cases:

1. Disclosures to the Patient or Legal Representative

    a. HIV test results may be disclosed to the subject of the test of the subject's legal representative, conservator, or to any person authorized to consent to the test. (Refer to CHA Consent Manual Chapter 23 and Administrative Policy No. 1000.32 Personal Representatives of Patients).

2. Disclosures to Health Care Provider for Treatment Purposes

    a. HIV test results may be disclosed to a test subject's provider of health care, except that for purposes of this policy, provider of health care does not include health care service plans (health plans or health maintenance organizations (HMO's).
    b. HIV test results may also be disclosed to an agent or employee of the test subject's provider of health care who provides direct patient care and treatment.

3. Disclosure by a Physician to Third Parties

    a. The physician who ordered the HIV test may, but is not required to, disclose confirmed positive test results of his or her patient to a person reasonably believed to be the spouse of the patient, a person reasonably believed to be a sexual partner, a person with whom the patient has shared the use of hypodermic needles, or to the county health officer or designated local or public health agency staff for HIV partner services.
    b. A physician will not be held civilly or criminally liable for doing so. Such disclosure made to a third party may not include any identifying information about the infected person (Health and Safety Code Section 121015).
    c. Prior to disclosing test results to a third party, the physician must first discuss the results with the patient, counsel the patient, and attempt to obtain the patient's voluntary consent to notify the patient's contacts. Also, when the physician discloses the information to the contact, the physician must refer that person for appropriate care.

4. Anatomical Gifts

    a. HIV test results may be disclosed to a provider of health care who procures, processes, distributes or uses a human body part donated pursuant to the Uniform Anatomical Gift Act.
    b. Disclosure may also be made to a procurement organization, a coroner or a medical examiner in conjunction with organ donation.

5. Ryan White CARE Act

    a. HIV test results may be disclosed to the designated officer of an emergency response employee only to the extent necessary to comply with the Ryan White Care Act (Health and Safety Code Section 121010(e)).

6. Workplace Exposures

a. Disclosure may be made to a health care worker who has been exposed to the potentially infectious materials of a patient, provided that strict procedures for consent and testing are followed. Disclosure of the source patient's identification is not allowed if not already known. (Refer such incidents to the Infection Control department).

7. Court Order

    a. Disclosure of HIV test results may be made pursuant to a court order.

8. Inmates

    a. California law requires medical and other personnel providing services to adult correctional or juvenile detention patients to communicate to the officer in charge of such patients that an inmate or minor has been exposed to or infected by the AIDS virus or has an AIDS-related condition or other communicable disease. Information subject to disclosure includes:

        1) A laboratory test that indicates exposure to or infection by the AIDS virus, AIDS-related condition or other communicable disease.
        2) Statements by the inmate or minor to medical personnel that he or she has AIDS or an AIDS-related condition or has been exposed to the AIDS virus or has a communicable disease.
        3) The results of a medical examination or test that indicate that the inmate or minor has tested positive for antibodies to the AIDS virus, has been exposed to the AIDS virus, has an AIDS-related condition, or is infected with AIDS or a communicable disease.

9. Communicable Disease Reporting

    a. Disclosure may be made to CDPH and the local health officer for the purpose of communicable disease reporting.

10. Subpoena or Other Discovery Request

    a. California law prohibits the disclosure of HIV test results pursuant to a subpoena or other discovery request by a party to a judicial (civil or criminal), administrative, legislative or other proceeding. Disclosure is only permitted if required by a court order or by another provision of law.

REFERENCES: Health and Safety Code Sections 120980 and 121010, California Hospital Association (CHA) Consent Manual

DEFINITIONS: **HIV Test**: means any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV. A diagnosis of AIDS is not considered an HIV test for the purposes of this law, nor is a patient's self-report of HIV status.

                         Disclosure: includes all releases, transmissions, disseminations or communications, whether they are made orally, in writing or by electronic transmission

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
6/18/19	**William L. Gilbert, Hospital Director**
	Applicable Administrator, Hospital or Medical Committee
8/6/19	**Board of Supervisors**
	Approved by the Governing Body

REPLACES: **N/A**

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