SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

Riverside University HEALTH SYSTEM Medical Center

ITEM 3.1 (ID # 8416)

MEETING DATE:
Tuesday, November 13, 2018

FROM : Riverside University Health System Medical Center Governing Board:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER: Approval of Medical Center and Clinics Policies as Required by Federal and State Regulations

RECOMMENDED MOTION: That the Governing Board:

1. Review and Approve the attached Medical center and Clinics Policies.

ACTION:

Jennifer Cruikshank, Chief Executive Officer – Health System 11/1/2018

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Tavaglione, seconded by Supervisor Perez and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Tavaglione, Washington and Perez
Nays:	None
Absent:	Ashley
Date:	November 13, 2018
xc:	RUHS-Medical Center

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A.			Budget Adjustment: No	
			For Fiscal Year: 18/19	

C.E.O. RECOMMENDATION: [CEO use]

BACKGROUND:

Summary

The Riverside University Health System Medical Center (RUHS MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. RUHS MC currently has two campuses – one in Moreno Valley and one off County Farm Road in the City of Riverside.

As an acute care hospital RUHS MC is required by the State of California to have a "governing body" separate from its administrative leaders and medical staff leadership. The "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital." 22 CCR §70035. (See also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01). The Board of Supervisors serves as the "governing body" for the hospital.

Various regulatory requirements mandate that the Governing Board participate in the leadership and decision-making of the Medical Center by reviewing and approving its policies relating to certain topics. The policies developed or updated between March 27, 2018 and October 31, 2018 relate to:

HW 139 Data Integrity
HW 146 Monitoring Hand Hygiene
HW 149 Medical Supply, Device and Service Suppliers/Vendors/Manufacturer Representatives Management
HW 151 Precleaning Instruments for Transportation to Sterilization or Disinfection
HW 403 New Employee Orientation
HW 514.2 Response to Allegations of Assault on a Patient
HW 602 Patient Informed Consent
HW 610 Reporting Never Events
HW 613 Methotrexate for Ectopic Pregnancies
HW 617 On-Q Protocol

HW 628 Moderate and Deep Sedation
HW 633 Unauthorized Leave of Patients
HW 642 Administration of Influenza Vaccine to Patients by Registered Nurses
HW 643 OB Patients in the ED
HW 645 Strangulation Evaluation
HW 646 Involuntary Holds
HW 657 Peripherally Inserted Central Catheter (PICC) Guidelines in Non-Neonate
HW 677 Alteplase for Ischemic Stroke
HW 678 Blood Transfusion
HW 689 Code Stroke
HW 692 Interdisciplinary Plan of Care
HW 693 Acquisition and Handling of Human Milk Products
HW 695 Scope of Service for Stroke Program
HW 712 Computer Access Use Security
HW 723 HIPAA Security Risk Management Evaluation and Audit
HW 724 Securing Laptop Computers and Mobile Devices
HW 726 Notification of Security Breaches
HW 729 Backup of Protected Health Information PHI
HW 815 Patient Controlled Analgesia PCA and End Tidal CO2 (EtCO2) Use and Monitoring
HW 816 Single-dose and Multiple-dose Ophthalmic, Otic and other Topical Preparations
HW 817 Guidelines for Ordering Parenteral Phosphate Solutions for Patients 18 Years of Age and Older
HW 821 Neonatal Total Parental Nutrition
HW 822 Downtime Inpatient Pharmacy Cerner
HW 824 Anesthesia Narcotics Record and Pharmacy Record Monitoring and Reconciliation
HW 828 Smart Infusion Pump System
HW 830 Administration of Parenteral Medications
HW 832 Use of Multiple and Single-Dose Vials
HW 848 Automatic Substitution for Adult Inpatient
HW 849 Automatic Substitution for Adult Outpatient
HW 859 Pediatric and Neonatal Pharmacist-based Protocol for Vancomycin and Aminoglycoside Dosing Service
HW 865 Hazardous Drug Spill Deactivation and Waste Management
HW 872 Biosimilars
HW 873 Cleaning and Disinfection of the Sterile Compounding Area
HW 874 Garbing and Hand Hygiene for Sterile Compounding
HW 876 Personal Insulin Pump Guideline

HW 903 Food from Outside
HW 1100 Dept Time off Closed Clinic Request

Impact on Residents and Businesses

In 2017 RUHS MC provided care to residents of the County and others in more than 19,000 inpatient stays and more than 230,000 emergency and outpatient encounters. As part of its operations it employs more than 3,000 individuals and contracts with over 1,000 other individuals and businesses. An efficient, well-functioning medical center providing care of high quality creates many positive benefits for Riverside County citizens and its businesses

Gregory P. Priamos, Director County Counsel 11/2/2018

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	No: 139	Page 1 of 6
Title: Data Integrity and Internal Data Validation	**Effective Date:** 6/15/2018	☒ **RUHS – Behavioral Health** ☒ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☒ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 Purpose and Application

a. This policy and Procedure standardizes the date integrity processes and provides the procedural framework for internal data validation.

b. This policy is to:

- Ensure the accuracy of data collected and reported on program activities and outcomes through a data validation process;
- Report and repay overpayments in an appropriate and timely manner;
- Produce customized data validation reports;
- Undertake improvement initiatives to enhance internal data reporting systems.

c. This policy and procedure applies to Riverside University Health System (RUHS) Behavioral Health, Care Clinics, Medical Center, Public Health and any other extended entities.

2. DEFINITIONS

2.1 **Data Element**. This is defined as a singular item of information such as a first name, last name, date of birth, etc.

2.2 **Data Integrity**. Defined as the qualities of validity and reliability conjoined with the accuracy of values.

2.3 **Data Users**. Defined as individuals who access data in order to perform their assigned duties.

2.4 **Data Validation**. Defined as assessing the accuracy of data. Data element validation id performed by reviewing data against source documentation.

2.5 **Measure-Specific Data Element**. Defined as data elements used by one specific measure or several measures in one specific measure set.

2.6 **Project manager**. Defined as 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.

2.7 **Validity**. Defined as ensuring the reported information can be substantiated or confirmed. It is either correct or incorrect.

3. RESPONSIBILITY SPECIFICATIONS

3.1 The hospital Chief Executive Officer, Chief Financial Officer, Chief Information Officer and Chief Operating Officer will ensure compliance to this procedures.

3.2 Quality management Department is responsible for:

a. Providing clinical data for selected milestones for designated State and/or federal programs.

b. Conducting a core measure orientation and competency validation process for contracted abstractors.

c. Re-abstracting 100% of fallout cases identified by the contracted abstractor to verify accuracy and to provide feedback to RUHS staff/medical staff for internal performance improvement.

d. Conducting monthly conference calls with contracted abstractors.

3.3 Fiscal Services Department is responsible for:

a. Reporting and repaying overpayments from Federal health care programs as required by the Patient Protection and Affordable Care Act (PPACA), and notify the Office of Inspector General (OIG) in accordance with the OIG's Provider Self-Disclosure Protocol when there is a material deficiency.

b. Conducting internal audits and reporting cost data.

c. Attesting to the accounting and reporting for cost data. Maintain supporting documentations as required by law and regulation.

d. Validating audit data by reviewing samples services and determining whether or not each service meets billing requirements, identified service gaps, identified other disallowed services, and confirming when disallowed services have been filled or paid.

3.4 **Information Services Department is responsible for:**

a. Protecting data against unauthorized alteration or deletion of data files.

b. Maintaining data integrity by:

- Backing up data regularly and controlling access to data via security mechanisms;
- Designing user interfaces and/or databases that percent the input of invalid data;
- Using error detection and correction software for data that is transmitted from one computer to another.

c. Producing data reports to support mandated reporting requirements for designated state and/or federal programs, per specific guidelines.

3.5 Medical Records Department Coders are responsible for:

a. Using the accepted principles of coding practice, consistent with guidelines established for ICD-10-CM 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 procedures 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 diagnosis, and procedures affecting or potentially affecting the DRG.

3.6 Project manager for designated data project is responsible for:

a. Creating a specific validation protocol for performance measure or outcome summaries required by internal and external entities such as legal or regulatory authorities;

b. Maintaining documentation to demonstrate that each summary/report is consistent with the data used to prepare the summary/report (e.g. attestations, original data, internal reports, ets.);

c. Determining the most reliable sources for data collection;

d. Determining the survey design, sample size estimation, samples selection procedures, and analytical measurements;

e. Collaborating the wit6h department manager responsible for the collection and maintenance of the data;

f. Regularly escalation the quality of the data source;

g. Establishing validation time frames and approving validation documentation.

3.7 Department manager are responsible for:

a. Overseeing collection, maintenance, and dissemination of data for a particular program/operation/activity in their department;

b. Designating staff to be responsible for data entry, maintenance, and validation;

c. Specifying data control and protection requirements to be observed by data users and processors;

d. Authorizing system access to the data under their responsibility

e. Monitoring data collection for accuracy, integrity, and dependability and where appropriate, initiating action concerning any issues;

f. Ensuring timeliness and completeness of data entries;

g. Identifying gaps and redundancies in the data

h. Interpreting the data through documentation;

i. Training staff how data is collected, validation is executing , and outcomes are crecod3ed;

j. Maintaining all appropriate training and documentation records for collectors and abstractors of data.

3.8 The California Delivery System Report Incentive program (DSRIP) Steering Committee is responsible for:

a. Providing oversight on all reporting requirements for the DSRIP program, including addressing identified data and other issues;

b. Calling upon the department/s with primary responsibility for providing the data to address issues and to present its processes for ensuring the data's integrity;

c. Maintaining its membership to include the following committee members;

- RUHS Medical Director (Chairman);
- Representation from all members of RUHS's executive management team;
- Chief of Family Medicine;
- Medical Director of Ambulatory Care;
- Assistant Hospital Administrator/DSRIP manager

3.9 Administrative Data Committee may be established:

Provide oversight data collection activities and internal data validation to ensure adherence to federal and/or State laws and regulations.

3.10 Data users are responsible for:

Protecting the confidentiality and security of data for which they have been granted access.

4. Procedures

4.1 Data Collection

The Project Manager shall develop a written protocol specific for the performance objectives or measure which includes the methods for data collection. The protocol shall be maintained in the department responsible for the collection, maintenance, and dissemination of data for the particular protocol.

4.2 Data Validity Checks

To ensure discrepancies are minimized and data is being recoded correctly, on gong regularly validity checks are completed by Department managers.

a. Random validity checks are conducted throughout the year. Values entered in the registries and databases are randomly checked to identify any unexplained outliers which fall outside of normal ranges. Information entered in error is traced back to a specific medical record and corrections are made.

b. "Spot checks," which involve data analysis on a random selection of patient records by measuring against source material, are conducted routinely to verify spot checks are resolved and relevant staff is re-trained.

4.3 Internal Data Report and Data Element Validation

Routine internal data integrity validation reviews are conducted by the Project Manager in collaboration with designed abstractor/s. The data validation includes:

a. Determining the sample size and conducting a random sampling of records;

b. Recording measure-specific data elements;

c. Manually abstracting the elements from the source and checking the elements against the entries in the database/registry to ensure that the data are accurate. Note: multiple sources may be used to increase the validity of the data.

d. Researching and resolving data issues such as outliers, discrepancies, and missing data elements by:

- Checking for valid responses and/or ranges for each data field;
- Reviewing the patient medical record information;
- Consulting their staff by tracing the documentations back to the staff person who entered the information;
- Involving clinicians when resolving issues where the data may have been entered by clinical coding staff;
- Making the appropriate changes to insert, update or delete data in the database.

e. Correcting and reproducing data reports as needed;

f. Reviewing data reports and supporting documents to confirm accurate data;

g. Additional verification's of data may include checking to ensure;

h. Producing a summary report indicating the level of error in the performance outcomes. Sample files excluded from the measure set shall by explained in the summary report such as when values are missing or not documented.

4.4 Data Validation Approval

a. At the end of each audit, the validation records and summary report must be reviewed by the Project Manager and the decision regarding the acceptability of the validation documented.

b. Records, all data documentation which may include patient-specific data reports, survey data, presentation materials, and other reports or information used to substantiate a claim, provide evidence of milestone achievement, and/or validate data shall by stored in a secured electronic file and maintained for minimum of five years and/or as required by law or regulations. Supporting documentation is subject to review and audit by internal and external entities.

5. References

5.1 Centers for Medicare and Medicaid Services (CMS) Standard Terms and Conditions of the California Section 1115 Medicaid waiver.

5.2 Office of Inspector General, Department of Health and Human Services, Update Providers Self-Disclosure protocol April 17, 2013 (https://oig.hhs.gov)

5.3 Patient Protection and Affordable Care Act (PPACA), Public Law 111-148.

5.4 Health Insurance Portability and Accountability Act, 45 CFR 160-164.

5.5 Specification Manual for Joint Commission National Quality Measure (v2013B) Discharges 07-01-13 (3Q13) through 12-31-13 (4Q13).

Document History:

Prior Release Dates: 01/12/2009	Retire Date: N/A
Document Owner: Information Services	Replaces Policy: N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/14/2018	Policy Approval Committee	No	
6/15/2018	CEO	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 146	Page 1 of 2
Title: Hand Hygiene Monitoring	**Effective Date:** 8/20/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 Hand hygiene: A general term that applies to either: handwashing, antiseptic handwashing, alcohol based hand sanitizer, or surgical hand antisepsis.

1.2 Handwashing: Washing hands with plain (i.e. non-antimicrobial) soap and water.

1.3 Antiseptic handwashing: Washing hands with warm water and soap containing a hospital approved antiseptic agent.

1.4 Alcohol based sanitizer: Applying a hospital approved alcohol based hand sanitizer product to all surfaces of the hands to reduce the number of microorganisms present.

1.5 Surgical hand antisepsis: the antiseptic surgical scrub or antiseptic hand rubs performed preoperatively by surgical personnel to eliminate transient bacteria and reduce resident hand flora.

1.6 Health Care Worker (HCW): is defined as any person working in or for the County of Riverside, Riverside University Health System – Medical Center, or its associated campuses.

2. GUIDELINES

2.1 Surveillance for hand hygiene compliance should be performed in multiple locations in the Riverside University Health System campuses each calendar month.

2.2 Unannounced surveillance should be performed in a variety of patient care locations.

2.3 Surveillance should be performed on all types of health care workers performing a variety of tasks during the course of the month.

2.4 Surveillance should be performed when the health care worker has contact with patients or their surrounding environment.

2.5 Data reporting conventions:

a. Hand Hygiene Percent Adherence = Numerator/ Denominator X 100

b. Numerator: Hand hygiene performed = Total number of observed contacts during which a healthcare worker touched either the patient or inanimate objects in the immediate vicinity of the patient and appropriate hand hygiene was performed.

c. Denominator: Hand hygiene indicated = Total number of observed contacts during which a health care worker touched either the patient or inanimate objects in the immediate vicinity of the patient and therefore, appropriate hand hygiene was indicated.

d. Data Analysis: Data are stratified by time (e.g., month, quarter, etc.) and patient care location.

2.5 Hand Hygiene Compliance Goal: 70%

3. REFERENCES

3.1 World Health Organization Guidelines on Hand Hygiene in Health Care, First Global Patient Safety Challenge Clean Care is Safer Care, ISBN 978 92 4 159790 6, Geneva, Switzerland, 2009.

Document History:

Prior Release Dates: Released as Infection Control policy IC 9-7 on 11-1988; 11-2005; 04-2009; 06-2010; 7-2011; 08-2014, 9-2015, and then as a housewide policy 9/17/2015	**Retire Date:** N/A
Document Owner: Hand Hygiene Compliance Team Quality Mgmt	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/7/2018	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Housewide

	Document No: 149	Page 1 of 4
Title: Medical Supply, Device and Service Suppliers/Vendors/Manufacturer Representatives Management	**Effective Date:** 6/15/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. SCOPE

1.1 Vendors, suppliers, healthcare industry representatives who call on/provide sales and/or services to the Riverside University Health System Medical Center.

2. DEFINITIONS

2.1 Cold Call: A sales technique whereby a salesperson contacts individuals with whom they do not have an existing business relationship and who have not previously expressed an interest in the products or services that are being offered whether in person or via other communication methods.

2.2 Warm call: The solicitation of a potential customer with whom a sales representative or business has had prior contact. Warm calling refers to a sales call, visit or email that is preceded by some sort of contact with the potential customer or prospect, such as a direct mail campaign, an introduction at a business event or a referral.

2.3 Vendor(s): A person employed by a company or self-employed that provides any product or service to the Medical Center. This includes, but is not limited to persons that sell supplies, pharmaceuticals, equipment and/or services. Vendors may also be referred to as health care industry representatives (HCIR).

2.4 Vendor management System: An electronic system that houses required vendor credentials and information, relevant Riverside University Health System (RUHS) policies and procedures, and provides for the printing of visitor badges. The approved vendor management system is IntelliCentrics SEC^{3}URE.

2.5 Loitering: The act of standing or waiting around idly or without an apparent purpose in a public or non-public area.

3. POLICY

3.1 VENDORS

A. All vendors must register with IntelliCentrics SEC^{3}URE at www.intellicentrics.com.

i. The cost of vendor management systems, such as IntelliCentrics, is the burden of the vendor and/or his/her employer. IntelliCentrics will bill the

individual vendor.
Subscription to the system is controlled by IntelliCentrics and is not the responsibility of RUHS.

ii. Vendors must upload and maintain all required documentation and documentation updates in the IntelliCentrics system.

   a. Any required expired document will prevent a vendor from servicing their RUHS account.

   b. Vendors must comply with all immunization and policy requirements as designated by their specific sales and service category and area of the Medical Center visited. These requirements are revealed during the registration into the vendor management system.

iii. Vendors must read and attest to having read all policies, procedures, notifications and orientation materials prior to entering the Medical Center. Vendors will not be provided account access until all required forms and attestations are completed/submitted.

B. Vendors must sign in at one of the designated kiosks located in the purchasing office, storeroom or staffing office and print a badge.

   i. Printed badges must be displayed visibly on the vendor's left or right upper quadrant.

   ii. If a badge fails to stick over the visit, the vendor must go procure another badge by checking out and checking in in again at one of the kiosks.

   iii. Vendor/Visitor badges are only good on the day issued.

C. Vendors may not wander or conduct business in hallways, or loiter on the Medical Center premises or any adjunct buildings at any time. Vendors may have up to one hour for purchasing and consuming food in the Medical Center cafeteria or café.

D. Vendors may not "cold call" or "warm call" medical staff/providers, Medical Center management or other employees.

   i. Vendors who have established business relationships with department managers may reach out via email or phone to support currently utilized products or service for update purposes.

E. Vendors must refrain from any up-selling, recommendation of any unapproved device/product substitute or new technology.

   i. Vendors may only support current approved products in use at the Medical Center.

F. Failure to comply with any aspect of the vendor management policy may result in a vendor being permanently or temporarily dismissed from the Medical Center.

G. Gifts and meals provided by vendors are prohibited, including for inservice/training. NOTE: Items are considered gifts if a county employee is reimbursed by a vendor or contractor for purchasing food or goods to give away to County employees.

   i. Vendors are to adhere to county board policy # C-35

H. Trial of Equipment of Products

iv. Trial of equipment must be requested first by the department manager. The purchasing department is the only approved County entity that may approve an equipment trial. It is important to note that the County will not take responsibility for any loss, breakage or damage to trial equipment. Equipment left at the Medical Center for trial is at the risk of the vendor/sponsoring company.

v. Trial of medical supplies may only be approved by the Value Analysis Program. Managers must first gain approval for the trial of any supply item(s) prior to accepting the supplies by the vendor. As a rule, the Medical Center does not maintain a budget for the trial of supplies and the cost of trial supplies are borne by the sponsoring manufacturer.

vi. RUHS will not pay for any unapproved, devices or implants used for patient care or trial.

I. Exceptions: Contractors and construction workers providing services under the auspices of the County Economic Development Agency (EDA) or an approved vendor turnkey project are generally excluded from this policy. These vendors must check-in to plant operations at the start of every shift for a new vendor badge that will be provided by plant operations staff. Vendors will be notified if they are exempt by Plant Operations management.

3.2 STAFF

A. All vendors are to present to Medical Center areas of business with a valid, visible printed badge. For vendors who present without a printed badge, Medical Center office staff and employees are to direct vendors to the purchasing office in the Cactus Professional Center (CPC) to receive additional information about our vendor-related policies and vendor registration.

B. RUHS administration will evaluate compliance with this policy based on compliance scores generated in the vendor management system. Those vendors not meeting compliance requirements will be terminated.

C. Medical Center physicians, managers and staff are to refer all vendors to the purchasing department if they are found speaking to staff -- selling/representing products.

D. Medical Center physicians, managers and staff are to report vendors who fail to follow this policy to the Medical Center purchasing department for corrective action. This includes loitering and conducting business that is unscheduled on county property.

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Value Analysis	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
2/7/2017	Policy Approval Committee	Yes	Needs more review
2/15/2017	Ad Hoc 147 Committee	Yes	Clarifications and definitions
3/1/2017	Purchasing Manager	No	
3/7/2017	Policy Approval Committee	Yes	
6/14/2018	Policy Approval	No	
6/15/2018	CEO	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 151	Page 1 of 2
Title: Pre-Cleaning Instruments for Transporting for Sterilization/Disinfection	**Effective Date:** 5/2/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. SCOPE

1.1 This policy is Housewide for Riverside University Health System- Medical Center, excluding departments that conduct operative procedures.

2. PROCEDURE

2.1 RUHS – Medical Center departments will pre-soak dirty instruments immediately after use and place disposable sharps in the sharps container.

2.2 Each department will designate a pre-soaking station equipped with easily accessible gloves, face shield/goggle, protective gown and eye wash kit.

2.3 Staff member pre-soaking the instruments will:

a. Don the gloves, face shield/goggles, and apron before beginning.

b. Place the dirty instruments in a container labeled: "Soiled instruments with enzymatic humectant" or "Biohazard", arranging them to permit contact of cleaning solutions with all surfaces of the instruments.

c. Open and spray the instruments directly with the enzymatic humectant, covering all surfaces.

d. Place a lid on the container and set it aside to soak. As long as all surfaces have been completely covered with the enzymatic humectant it is not necessary to reapply, as moisture is retained for 72 hours.

e. Remove the personal protective equipment and wash hands thoroughly in compliance with RUHS – Medical Center policy HW 407.10 Hand and Nail Hygiene.

2.4 Transport the container with the soaking instruments for cleaning and sterilization to the Central Processing Department (CPD) prior to the end of shift

2.5 The CPD will exchange the container with dirty instruments soaked in enzymatic humectant for a clean and labeled container.

3. REFERENCES

3.1 Infection Control Policies: # IC 9-03, at Infection Prevention and Control Manual on-line, 2014, RUHS-MEDICAL CENTER Portal.

3.2 Guideline for Cleaning and Care of Surgical Instruments. In: *Guidelines for Perioperative Practices*. Denver, CO: AORN, Inc; 2015:615-650.

3.3 *Prepzyme material safety data sheet* (Ruhof corporation Jan. 1, 2012) http://www.ruhof.com

3.4 *Prepzyme instructions for use* (Ruhof corporation Jan. 1, 2012) http://www.ruhof.com

3.5 RUHS – Medical Center policy HW 407.10 Hand and Nail Hygiene

3.6 Central Processing Policy C-23 on Decontamination of Trays and Instruments

Document History:

Prior Release Dates: N/A		**Retire Date:** N/A	
Document Owner: Perioperative - Central Processing		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
3/14/2018	Nursing, Infection Control, Compliance, Education	Y	update

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 403	Page 1 of 2
Title: New Employee Orientation	**Effective Date:** 8/20/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank Hospital Director/CEO		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 **Hospital Orientation**: is conducted by the Department of Human Resources (HR) which provides the new employee with key administrative policies as well as other hospital-wide information.

1.2 **Patient Care Orientation (PCO):** is conducted by the Department of Education Services which provides an overview of clinical policies and procedures as well as completion of any hospital required certifications and validations. PCO includes use of the Electronic Health Record for that employee's specific job classification.

1.3 **Electronic Health Record (EHR) Training:** is conducted by the Information Services (IS) department. This hands-on training provides the foundation for the proper use, purpose and documentation of patient's observations in the EHR. Unit specific orientation: is conducted by the Nursing Director and /or designee which provides an overview of the unit specific policy, procedure and workflow process.

1.4 **Department Specific Orientation:** is conducted by the hiring department or unit and provides an overview of specific job duties, department-specific relevant policies and procedures as well as any department or unit-specific required certifications and validations. Each department or unit establishes its own content to meet the level of care and patient clinical services provided to maintain quality outcome and a safe environment of care.

1.5 **Preceptor:** An employee assisting and serving as a resource for a new or transferred employee through a planned orientation to a specific clinical area.

2. POLICY

2.1 **All Hospital Personnel:**

a. The hospital requires all personnel to complete Hospital Orientation at the time of hire. Hospital Orientation includes, but is not limited to:

- Key safety content.
- Relevant hospital-wide policies and procedures.
- General infection prevention and control practices.
- Sensitivity to cultural diversity and responsibilities.

- Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities.

b. Hospital Orientation and competency validation shall be documented and maintained in the employee's file.

2.2 **Patient Care Personnel**

a. All patient care personnel, including temporary staff, shall receive and complete Patient Care Orientation and Department-Specific Orientation before receiving patient care assignments.

b. All patient care personnel, including temporary staff, shall be subject to the process of competency validation for their assigned department or unit.

c. Patient care personnel shall not be assigned total responsibility for patient care until all the standards of competency for that department or unit have been validated.

- Patient care assignments shall include only those duties and responsibilities for which competency has been validated.
- Patient care personnel who have demonstrated competency for the patient care department or unit shall be responsible for patient care, and shall be assigned as a preceptor for those with the same license or scope who have not yet completed competency validation for that unit

d. Patient Care Orientation and Department-Specific Orientation competency validation shall be documented and maintained in the employee's file.

3. REFERENCES

3.1 Title 22, Division 5, Chapter 1, Article 3, Section 70214
3.2 The Joint Commission, Human Resources, HR.01.04.01
3.3 RUHS – Medical Center policy HW 404.2 Certified Competency and Competency Assessment.

Document History:

Prior Release Dates: 3/1991, 7/2008	**Retire Date:** N/A
Document Owner: Nursing Administration	**Replaces Policy:** NURS 180 Orientation

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
2/2018	Director, Nursing Education	Y	Minor wording and clarification
2/2018	Human Resources	N	
3/2018	Nursing P&P	Y	Deletion of elements in nursing section.
7/3/2018	Policy Approval Committee	Y	Confirm that language is consistent with Title 22.
8/7/2018	Policy Approval Committee	Y	Delete overlapping information. Streamline.
8/20/2018	Policy Approval Committee, evote	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 514.2	Page 1 of 3
Title: Response to Allegations of Assault on a Patient	**Effective Date:** 8/20/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. SCOPE

1.1 This policy addresses allegations of patient assault within the Medical Center including Arlington Campus. For abuse, neglect and/or domestic violence outside the Medical Center and Arlington Campus refer to policy HW 626 titled "Abuse, Neglect, and/or Domestic Violence Assessment and Reporting".

2. POLICY

2.1 All patients have the right to receive care in a safe environment including freedom from assault of any nature. All allegations of assault will be promptly investigated with follow-up action(s) taken as warranted. All employees have an obligation to report any allegation of assault against a patient.

3. DEFINITIONS

3.1 Assault – An attempt to cause or intentionally, knowingly, or recklessly causing bodily injury to another person or to putting another in fear of imminent serious bodily injury. Assault may take different forms including: emotional or verbal assault, physical assault or sexual assault.

3.2 Patient Representative - Someone with legal authority to health care decisions on behalf of a patient.

3.3 Law Enforcement – Local Police or Sheriff's department.

4. PROCEDURE

4.1 An allegation of patient assault may come from employees, patients, family members and visitors and may be received in writing, via electronic communications or orally. An allegation of assault will result in the initiation of a process for taking action to protect patients, collect information and determine the facts of the occurrence.

4.2 **Care of Alleged Victim (s) of Assault**

a. Employees becoming aware or witnessing patient assault shall immediately report it to Department Manager/Charge Nurse or designee.

b. If the ***alleged assailant is a staff member***, the Department Manager/Charge Nurse or designee will immediately remove the alleged

perpetrator (if known) from patient care. If alleged staff perpetrator is not immediately known, a complete and thorough attempt will be made to identify them. The identified staff member may not work in any area with patient contact until the full investigation into the allegation is complete.

c. ***If the alleged assailant is a patient***, the Department Manager/Charge Nurse or designee will immediately take steps to ensure the safety of the victim patient.

d. The Charge Nurse or designee will notify the attending physician. A care provider should assess the patient and document the assessment in a progress note.

e. ***If the alleged victim is a minor or has a patient representative*** notify the parent or patient representative of the situation.

f. Should any evidence related to the event be discovered, it will be preserved, and the Chain of Command notified.

4.3 **Initial Investigation**

a. An incident report should be completed by the person initially receiving the allegation of assault or witnessing an assault.

b. The Department Manager/Charge Nurse or designee will immediately report the allegation to the House Supervisor, Department Executive Director and/or Administrator on Call (AOC).

c. The Department Manager/Charge Nurse or designee will offer the patient the opportunity to report the alleged assault to law enforcement and assist with the notification process if the patient so chooses. Law enforcement will be notified for all allegations of sexual assault and/or if patient lacks decision making capacity. Hospital staff may elect to call law enforcement with any type of allegation they deem warrants law enforcement involvement.

d. The Department Manager/Charge Nurse or designee will offer the patient the opportunity to meet with the Patient Advocate and file a grievance if desired.

e. The Department Manager/Charge Nurse or designee will initiate investigation by interviewing the patient, alleged assailant, staff members present or with knowledge of the event and family or visitors present or with knowledge of the event.

f. The Department Manager or designee will prepare an investigation report into the allegation with a timeline of events/actions taken and submit the report to the Department Executive Director.

g. The Department Executive Director will use a comprehensive and systematic approach to review the patient safety event, the investigation and associated timeline and improvement actions to reduce the risk of harm to future patients. The documents shall be submitted to the Regulatory Compliance department for further investigation and follow up action(s) as warranted.

5. DOCUMENTATION

5.1 The allegation of patient assault, assessment, physician and related notifications, updated plan of care, interventions, and patient's response will be documented in the patient's medical record.

6. REFERENCES

6.1 RUHS – Medical Center policy HW 122, Incident Reporting/Risk Management.

6.2 RUHS – Medical Center policy HW 631 Code Green: Assault by a Patient or Other Individual in the Hospital Environment.

6.3 RUHS – Medical Center policy HW 626 Abuse, Neglect, and/or Domestic Violence Assessment and Reporting

6.4 County of Riverside Board of Supervisors policy C-27 Workplace Violence, Threats, and Securities.

6.5 Handbook of conservators 2016. Revised edition, Judicial Council of California. Retrieved on 4/10/2018 from http://www.scscourt.org/self_help/probate/conservatorship/conservatorship_overview.shtml

6.6 State of California Penal Code Section 240. CHAPTER 9. Assault and Battery, Retrieved on 4/11/2018 from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=PEN&sectionNum=240

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Executive Director Quality and Service Excellence	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
2/28/2018	Executive Director Quality & Service Excellence	Yes	New Policy Written
3/16/2018	Regulatory Compliance	Yes	Grievance process, minor word change,
4/11/2018	Arlington Campus	Yes	Definitions added
6/29/2018	Nursing	Yes	Minor verbiage
7/3/2018	Policy Approval Committee	Yes	Revise and return. Add scope. Delete references to conservatee and add definition for patient representative. Clarify that staff may call law enforcement independently. Delete ACNO. Add law enforcement definition. Add opportunity to meet with patient advocate. Add county assault policy and abuse reporting in reference section.
8/7/2018	Policy Approval Committee	Yes	Clarify 4.2 C and 4.2 D

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 602	Page 1 of 5
Title: Patient Informed Consent	**Effective Date:** 9/13/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 **Informed Consent** – A process of obtaining and documenting permission before conducting a healthcare intervention on a person. It involves discussion between a physician and the patient or patient's legal representative about the nature of the procedure, the potential risks, benefits and alternatives to the treatment.

1.2 **Medical Emergency**. A medical emergency exists when:

a. Immediate services are required for the alleviation of severe pain

OR

b. The procedure is required for immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

AND EITHER

a. The patient is unconscious or incapable of giving consent and there is insufficient time to obtain informed consent from the patient's legal representative

OR

b. The procedure has to be undertaken immediately and there is insufficient time to fully inform the patient or a legal representative of possible consequences.

2. POLICY

2.1 RUHS – Medical Center honors each patient's right to give or withhold consent for medical treatment.

2.2 No treatments, other than treatments needed to address a medical emergency, will be permitted unless the patient, or a person legally authorized to consent on the patient's behalf, has consented to treatment.

2.3 **Emergencies -** In the case of a medical emergency:

a. Only the emergency condition may be treated.

b. The medical determination that an emergency exists must be documented by the physician and placed in the medical record.

c. Treatment that exceeds what is necessary for the emergency condition may not be rendered without consent from someone authorized to consent to treatment on a nonemergency basis.

d. The medical emergency treatment exception is not applicable when a patient has validly refused medical treatment, and the emergency arises from the fact that treatment was not given.

e. If evidence exists to indicate that the patient (or the patient's legal representative) would refuse the treatment, legal counsel shall be consulted.

f. The following types of procedures will require documentation of informed consent before they are performed on a non-emergency basis:

g. Operative procedures

h. Invasive procedures that have the potential for serious risks and / or adverse reactions

i. Blood transfusions or other use of blood products

j. Planned use of all forms of anesthesia and moderate sedation

k. Electroconvulsive therapy

2.4 It is the treating physician's responsibility to obtain informed consent prior to beginning medical treatment.

a. The physician who performs the treatment is responsible for obtaining the patient's consent. This responsibility may not be delegated to a non-physician, or to a physician who does not have privileges to perform the treatment.

b. If a Physician's Assistant (PA) or a Nurse Practitioner (NP) has been granted privileges to perform a procedure independently, the PA or NP is responsible for obtaining the patient's consent prior to beginning the procedure.

c. If a non-physician other than a PA or NP will perform the procedure, then the ordering physician is responsible for securing the consent.

d. If more than one physician is providing the treatment, they can determine together which physician will obtain consent.

2.5 The physician will provide the information to the patient or legal representative, answer any questions about the procedure, sign and then have the patient sign and date the informed consent form. A copy of the signed informed consent form may be provided to the patient and the original copy will be placed in the patient's chart/medical record.

2.6 Informed Consent must include:

a. Assessment of the patient's capacity to understand the discussion or location of an appropriate substitute decision maker if the patient is incapable by age, mental state or medical condition of understanding the decision under discussion.

b. A discussion about the patient's proposed care, treatment, and services.

c. Potential risks, benefits, and alternatives to the proposed care, treatment, and services.

d. Any potentially conflicting interests the physician may have such as research or financial interests.

2.7 **Consent by telephone -** Consent for medical or surgical procedures should be obtained by telephone only if the person having the legal ability to consent for the patient is not otherwise available. The telephone discussion between the physician and the patient's legal representative and a responsible hospital employee should be confirmed by either (a) the physician and one hospital employee or (b) by two hospital employees and documented in the telephone consent section of the informed consent with name, signature, title, date and time.

2.8 **Interpreters -** If a patient or his/her legal representative cannot communicate with the physician due to a language or communication barrier, the physician will arrange for an interpreter according to the instruction in RUHS – Medical Center policy *HW 142 Access to Language Services for Non or Limited English Proficient, Deaf, and Hearing Impaired Persons.* If an interpreter is used in person, the interpreter will sign, date, and time on the informed consent form. If an interpreter is used on line or on phone, the required information will be documented along with the Interpreter's telephone ID on the informed consent form.

2.9 **Nursing role -** The nurse will ensure that the appropriate informed consent form has been signed and is in the medical record prior to the procedure being done.

2.10 **Abbreviations -** Abbreviations should not be used in the informed consent form.

2.11 **Corrections -** When discussing the informed consent form with the patient prior to the procedure and an error is made on the form, either prepare a new form or use a single line through the material to be deleted. The physician and patient must initial, date, and time each correction made to the form.

2.12 **Names of practitioners -** The names of the practitioner(s) performing the procedure(s) must be included in the form. Use of medical group practice name or use of a surgeon's name followed by "and associates" is not acceptable. Also, the name(s) of other practitioners who will conduct specific, significant surgical tasks not being done by the primary surgeon/practitioner, should be included on the informed consent.

2.13 **Refusal to Consent** – Patient and those giving consent on their behalf are entitled to refuse any and all recommended care and treatments. The physician's duty is to make every effort to explain the risks, benefits and likely consequences of refusing the recommended treatment so that such refusals are informed by that information.

a. Refusals of recommended care or treatments should be documented in the patient's chart;

b. Consultation by psychiatry or with the RUHS Bioethics Committee may be indicated if there are questions about the patient's capacity to appreciate the consequences of such a refusal, whether refusal by a substitute decision-maker is in the patient's best interest or the refusal could have consequences for another individual, such as a fetus in utero.

2.14 **Special Consent Requirements** – The following procedures have specialized consent requirements under California land or Federal law:

a. **Blood transfusions** – Patients must be given (1) "A Patient's Guide to Blood Transfusion" whenever there is a reasonable possibility that an autologous transfusion may be needed and (2) allowed adequate time for pre-donation unless there are medical contraindications to pre-donation or the patient waives that right.

b. **HIV testing** – If a patient does not independently request an HIV test, prior to ordering one a medical care provider must make certain disclosures to the patient. The provider also must provide certain information and counseling when the test result is released to the patient. If a patient declines an HIV test that fact must be documented in the patient's medical record.

c. **Sterilization** - The Obstetric Gynecology Department, Family Medicine Department, and the Urology Division each have a policy regarding sterilization that includes appropriate informed consent in compliance with state and federal laws.

d. Silicone Implants and Collagen Injections - State law requires provision of specified information to patients prior to undergoing procedures that include the use of these materials.

e. Vaccines – Federal law requires the furnishing of written information before the administration of most vaccines. These statements can be found at www.immunize.org/vis

f. Procedures related to research - All research at RUHS is governed by the RUHS Institutional Review Board which may require completion of a specific informed consent form before a procedure relating to research is performed.

3. REFERENCES

3.1 The Joint Commission Comprehensive Accreditation Manual for Hospitals Standard RI.01.03.01.

3.2 California Hospital Association Consent Manual

3.3 Medical Informed Consent: General Considerations for Physicians, Paterick et al., Mayo Clin Proc. 2008;83(3):313-319

3.4 42 CFR Sec. 482.51(b)(2); Interpretive Guideline A-0392

Prior Release Dates: 7/1986, 10/2008, 7/2009, 8/2014	**Retire Date:** N/A
Document Owner: Regulatory Compliance	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/13/2017	Policy Program Administrator	Y	Created new policy from CHA Consent Manual and the CAHM Manual
9/13/2017	Marty Knutson, Sunder Nambiar	Y	Revised and updated
9/2017	Chief Nursing Officer	Y	
9/2017	Director HIM	Y	
9/2017	Program Director, Surgery	Y	
9/2017	Chair, MEC	Y	
10/3/2017	Policy Approval Committee	Y	Minor wording
6/2018	Marty Knutson	Y	Add the provision: b. If a Physician's Assistant (PA) or a Nurse Practitioner (NP) has been granted privileges to perform a procedure independently, the PA or NP is responsible for obtaining the patient's consent prior beginning the procedure.
6/2018	Dr. Garrison	N	
6/2018	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 610	Page 1 of 4
Title: Reporting Never Events	**Effective Date:** 10/12/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 Serious Disability: Serious Disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient healthcare facility, or the loss of a body part.

1.2 Never Event: A Never Event is defined as one of the "Adverse Event" occurrences as listed by California Health and Safety Code Section 1279.1 and one of the 29 "Serious Reportable Events In Healthcare" as listed by the National Quality Forum's (NQF) that could negatively impact patient care and safety. Those events are:

a. Surgical Events, including any of the following:

- Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subsection does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
- Surgery performed on the wrong patient.
- The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subsection does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
- Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
- Death during or up to 24 hours after induction of anesthesia after surgery on a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

b. Product or device events, including the following:
   - Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by RUHS – Medical Center when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
   - Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of the subsection, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
   - Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in RUHS – Medical Center, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

c. Patient protection events, including the following:
   - An infant discharged to the wrong person.
   - Discharge or release of a patient/resident of any age who is unable to make decisions, to someone other than an authorized individual.
   - Patient death or serious disability associated with patient disappearance for more than four (4) hours, excluding events involving adults who have competency or decision-making capacity.
   - A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to RUHS – Medical Center , excluding deaths resulting from self-inflicted injuries that were the reason for the admission to RUHS – Medical Center.

d. Care management events, including the following:
   - A patient death or serious disability associated with a medication error, including but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
   - A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
   - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in RUHS – Medical Center, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
   - Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in RUHS – Medical Center.
   - Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subsection, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
   - A Stage 3 or 4 ulcer, acquired after admission to RUHS – Medical Center, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

- A patient death or serious disability due to spinal manipulative therapy performed at RUHS – Medical Center.
- Patient death or serious injury associated with a fall while being cared for in RUHS- Medical Center.
- Artificial insemination with the wrong donor sperm or wrong egg while being cared for in RUHS- Medical Center.
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.

e. Environmental events, including the following:
- A patient death or serious disability associated with an electric shock while being cared for in RUHS – Medical Center, excluding events involving planned treatments, such as electric countershock.
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
- A patient death or serious disability associated with a burn incurred from any source while being cared for in RUHS – Medical Center.
- A patient death associated with a fall while being cared for in RUHS- Medical Center.
- A patient death or serious disability associated with the use of restraints or bedrails while being cared for in RUHS – Medical Center.

f. Radiologic events
- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

g. Potential Criminal events, including the following:
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- The abduction of a patient of any age.
- The sexual abuse/ assault on a patient or staff member within or on the grounds of RUHS – Medical Center.
- The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of RUHS – Medical Center.

2. PROCEDURES

2.1 Staff will immediately provide a verbal report of the occurrence of a Never Event to the department director or designee either by phone or in person.

2.2 Reporting staff will complete an Incident Report within 48 hours of the Never Event and submit it to the Quality Management Department.

2.3 Upon receiving a verbal report from staff, department director or designee will immediately report the Never Event by phone or in person to the relevant RUHS-Medical Center Administration without waiting for the Incident Report to be completed.

2.4 The Executive Director of Quality and Service Excellence and/or the Compliance Officer will coordinate with the Chief Operating Officer (COO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and Chief Executive Officer (CEO) to ensure that the California Department of Public Health (CDPH) receives the report within:

a. Five (5) days of the detection of the Never Event if the event is NOT an ongoing threat to the welfare, health or safety of other patients, personnel, or visitors.

b. Twenty-four (24) hours of detection if the Never Event IS an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors.

2.5 RUHS – Medical Center Administration will ensure that the patient or the party responsible for the patient is informed about the Never Event at the time of reporting to CDPH.

2.6 The patient and/or family affected by the never event will be provided with an apology if warranted.

2.7 RUHS- Medical Center will waive any costs directly related to the Never Event.

a. An evaluation of the cost associated with the Never Event will conducted on an individual basis.

2.8 A copy of this policy will be made available to patients, patients' family members, and payers upon request.

2.9 The Quality Management Department will conduct a root cause analysis, which at a minimum, includes the elements required by the Joint Commission.

2.10 The RUHS- Medical Center Administration or medical representative will interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.

2.11 The RUHS- Medical Center Administration or medical representative will inform the patient and/or his/her family of the action (s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis.

2.12 The supervisor of the caregivers involved in the Never Event will offer the contact information for counseling support through the Employee Assistance Services.

2.13 The Quality Management Department will perform an annual review to ensure compliance with the procedure section of this policy for each Never Event that occurs at RUHS- Medical Center.

Document History:

Release Dates: 7/01/07, 10/2015		**Retire Date:** N/A	
Sponsored by: Quality Management Department		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
8/2018	Quality Management Department		
8/2018	Executive Director, Quality and Process Improvement		
	Nursing Evote		
9/27/2018	PAC Evote	Yes	Minor wording edits
10/11/2018	MEC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
HOUSEWIDE

	Document No: 613	Page 1 of 4
Title: Methotrexate Administration and Management for Treatment of an Ectopic Pregnancy	**Effective Date:** 5/2/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS:

1.1 Methotrexate: Methotrexate is a chemotherapeutic agent for use as a medical therapy for unruptured ectopic pregnancies. Its mechanism of action is competitive inhibition of folate-dependent steps in nucleic acid synthesis, which effectively kills the rapidly dividing ectopic trophoblast.

1.2 Dosage and route of administration of methotrexate: 50mg/m2 to be administered intramuscularly using the patient's actual body weight. Methotrexate is cleared through the kidneys.

1.3 Ectopic pregnancy: A fertilized egg that implants in any location other than the inner lining of the uterus. The majority (95%) of ectopic pregnancies occur in the fallopian tube. However, they can occur in other locations, such as the ovary, cervix, and abdominal cavity.

1.4 Chemo Certified RN (Chemo Nurse): An RUHS-MC Registered Nurse who has a current Oncology Nursing Society (ONS) Chemotherapy Provider card and current competencies to administer chemotherapy.

2. EXCLUSION CRITERIA:

2.1 Viable intrauterine pregnancy.

2.2 Clinically significant abnormalities of hematologic, renal or hepatic laboratory values. Blood dyscrasias, chronic liver disease, chronic renal disease (dialysis).

2.3 Breastfeeding (discontinue for 72 hours-methotrexate will not be given if patient refuses to stop breastfeeding).

2.4 Hypersensitivity to methotrexate.

2.5 Immunodeficiency, active pulmonary disease or peptic ulcer disease.

2.6 Hemodynamically unstable.

2.7 Patient is not able to participate in follow-up.

2.8 Concurrent intrauterine pregnancy (heterotopic pregnancy).

2.9 No signed informed consent by patient for the use of methotrexate in the treatment of ectopic pregnancy.

3. INCLUSION CRITERIA:

3.1 Hemodynamically stable.

3.2 No contraindications to methotrexate therapy.

3.3 Serum beta-human chorionic gonadotropin (hCG) ≤ 5000mIU/ml.

3.4 Lack of fetal cardiac motion detected on transvaginal ultrasound.

3.5 Ectopic mass < 4 cm.

3.6 Willing and able to comply with post-treatment follow-up with access to emergency medical services.

a. Failure of the hCG level to decrease by at least 15% from day 4 to day 7 after methotrexate administration will require a repeat dose on day 7.

3.7 Informed consent is signed by the patient or her legal surrogate (must be checked before prescribing).

4. CLINICAL PROTOCOL:

4.1 Obtain serum beta-human chorionic gonadotropin (hCG).

4.2 Complete transvaginal ultrasound.

4.3 Blood type and RH.

4.4 Complete blood count and renal and liver function tests.

4.5 Once ectopic pregnancy has been diagnosed and patient meets criteria for methotrexate administration, the risks, benefits and alternatives to treatment will be discussed with patient and an informed consent will be obtained by the OB GYN physician and an order for the medication will be placed in the medical record.

4.6 The ED charge nurse or designee will notify the house supervisor to assign a chemo nurse to come to the ED to administer the medication. The assigned chemo nurse will call the main pharmacy to verify order was received and approximate time to pick up medication. The chemo nurse will notify the ED of the approximate time they will come to administer the medication.

4.7 Chemo nurse to obtain medication from the main pharmacy and verify right patient, medication, dose, route, expiration date and time.

4.8 The chemo nurse will bring the medication and chemo administration PPE's, the ED will supply the chemo disposal container.

4.9 Patient teaching should be given prior to methotrexate administration.

4.10 The ED and chemo nurse will follow the administration checklist (Attachment A) and sign and date when completed.

4.11 The chemo nurse will administer the IM injection of methotrexate as per physician order.

4.12 The ED and chemo nurse will document the care provided in the medical record. Once the chemo nurse has completed the administration, monitoring and documentation, the ED nurse will conclude the visit and provide the discharge instructions and follow up care.

5. FOLLOW UP CARE & COUNSELING

5.1 Discharge Instructions to include:

a. Follow up physician consultations (in office or via phone) and lab testing must be made prior to discharge with OB GYN to repeat serum hCG on days 4 and 7 then weekly until zero. (***Note that 15-20 percent will require a second dose of methotrexate at 7 days. If the decrease in hCG between days 4 and 7 is < 15% a second dose of methotrexate 50 mg/m^2 is*** *administered. Repeat pretreatment laboratory testing is not indicated).*

b. Adverse reactions are usually mild and self-limited including stomatitis, conjunctivitis and (rarely) gastritis, enteritis, dermatitis, pneumonitis, alopecia, elevated liver enzymes and bone marrow suppression.

c. Breastfeeding, if applicable, is contraindicated for 72 hours after Methotrexate administration.

d. Discontinue use of vitamins containing folate for one week after administration of methotrexate

e. Avoid alcohol, penicillin and NSAIDs (nonsteroidal anti-inflammatory drugs) during treatment

f. Discontinue breastfeeding for 72 hours after administration of methotrexate

g. Pain and bleeding may occur around day 6 or 7 of treatment.

h. Return to the ED for severe abdominal pain, bleeding greater than 1 pad per hour, fever greater than 100.4.

6. ATTACHMENT:

6.1 Methotrexate Administration Checklist for Ectopic Pregnancy

7. REFERENCES:

7.1 Kurt T. Barnhart, MD; MSCE; and Jason M. Franasiak. MD, TS (ABB). Tubal Ectopic Pregnancy. *Am J Obstet Gynecol* ACOG Practice Bulletin Number 193, March 2018.

7.2 Vicken P Sepilian, MD MSc; Chief Editor Michel E Rivlin, MD. Ectopic Pregnancy treatment and management. Medscape Jul 05, 2016.

7.3 Elsevier Performance manager Clinical Skills; Elsevier, INC. 2018 Methotrexate for Ectopic Pregnancy.

Document History:

Prior Release Dates: N/A		**Retire Date:** N/A	
Document Owner: ED		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
05/30/2017	ED, Pharmacy, Nursing Admin, OB	Yes	
07/12/2017	ED, Pharmacy, Nursing Admin, OB	Yes	
08/02/2017	ED, Pharmacy, Nursing Admin, OB	Yes	
09/26/2017	ED Committee	Yes	
10/10/2017	ED, Pharmacy, Nursing Admin, OB	Yes	
02/21/2018	ED, Pharmacy, Nursing Admin, OB	Yes	Minor changes made throughout the policy.
03/01/2018	ED, Pharmacy, Nursing Admin, OB	Yes	
03/21/2018	Nursing Policy & Procedure Committee	Yes	Checklist to be used as a tool only for QA, not part of record.
03/22/2018	Cancer Quality of Care Committee	No	
04/02/2018	P&T	No	
3/12/2018	PAC	No	
3/8/2018	MEC	No	Approved concurrently for patient care urgency.
4/25/2018	HEC	No	

METHOTREXATE ADMINISTRATION CHECKLIST FOR ECTOPIC PREGNANCY

DATE: _____

TIME	VERIFICATION, VALIDATION, AND ADMINISTRATION	VALIDATOR INITIALS	
	The Chemotherapy RN & ED RN will verify/validate the following prior to medicating patient:	Chemo RN	ED RN
	ED to notify HS of need for Chemo Nurse to administer Methotrexate in ED.		
	HS to assign Chemo Nurse.		
	Chemo Nurse to call main pharmacy to confirm order in computer and time for pick-up. Chemo Nurse to call ED with ETA.		
	Chemo Nurse to go to main pharmacy to pick up medication and verify with Pharmacist the right medication, dose, route, and expiration date & time. (Pharmacist to initial here and sign on signature section of form)		
	Chemo Nurse to bring Methotrexate to ED to administer to patient.		
	Verify the correct patient using two identifiers.		
	Verify that the physicians' history includes: last menstrual period (LMP) and symptoms of pregnancy & is present in medical record (MR).		
	Assess the patient for specific contraindications to receiving Methotrexate and advise the practitioner accordingly. (See policy)		
	Verify the informed consent is signed and complete.		
	Verify correct patient's weight in kilograms and height in centimeters are documented in MR. Stated weights are not acceptable. Wt:_____ Ht:_____		
	Verify that a baseline quantitative beta-hCG, liver and kidney function tests, and a CBC are in the MR if this is the first dose. (Does not need repeating if second dose being administered.) Validate if a baseline chest radiograph for a patient with a history of pulmonary disease was completed. If any abnormalities above are identified, notify physician for approval to administer Methotrexate.		
	Validate a transvaginal ultrasound was completed, and an ectopic mass is not > than 4cm.		
	Inspect the medication, checking that it does not have particulates, discoloration, or other loss of integrity. Do not use any medication that is cloudy or precipitated unless manufacturer information states that this is acceptable.		

Patient Label

METHOTREXATE ADMINISTRATION CHECKLIST FOR ECTOPIC PREGNANCY

DATE: _____

TIME	VERIFICATION, VALIDATION, AND ADMINISTRATION	VALIDATOR INITIALS	
	The Chemotherapy RN & ED RN will verify/validate the following prior to medicating patient:	Chemo RN	ED RN
	Perform hand hygiene using proper PPE for hazardous drug handling, double chemo gloves, protective gown, mask, and eye protection as indicated.		
	Explain the procedure to the patient and verify patient agreement for treatment.		
	Verify the six rights of medication safety: right medication, right dose, right time, right route, right patient, and right documentation. Use bar code scanning of patient ID and medication at the bedside.		
	Administer the medication intramuscularly into the right or left ventrogluteal site using a 22g 11/2" needle. (The dorsogluteal site is not recommended for IM injections because of risk of sciatic nerve damage.)		
	Dispose of the syringe and vial, discard supplies, remove & discard PPE, into the chemo disposable container & perform hand hygiene per RUHS policy		
	The ED and Chemo RN will monitor the patient for adverse and allergic reactions to methotrexate. Recognize and notify physician immediately for dyspnea, wheezing, and circulatory collapse. Follow the RUHS practice for emergency response.		
	Documentation of the procedure completed by the ED RN and the Chemo certified RN in the patient's MR.		
	Assess and treat patient's pain as needed.		
	Educate patient on DC instructions, including follow up MD consultation (in office or via phone), lab appointment and symptoms to return to the Emergency Department immediately.		
	Provide a copy of patient face sheet to the ED Charge Nurse for auditing purposes after the patient is discharged.		

Chemotherapy Registered Nurse: _____
(Print/sign/date)

Pharmacist: _____
(Print/sign/date)

Emergency Department Registered Nurse: _____
(Print/sign/date)

Patient Label

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 617	Page 1 of 4
Title: On – Q Protocol	**Effective Date:** 10/12/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. PURPOSE
   1.1 To establish guidelines for the safe ordering, implementation and maintenance of continuous nerve block therapy.

2. DEFINITIONS
   2.1 On-Q (Peripheral Nerve Block) consists of a multilayer chamber filled with a local anesthetic near the nerve for regional anesthesia and postoperative pain management.
      a. Continuous nerve block therapy is a continuous infusion of local anesthetic at the operative site to optimize postoperative pain control and minimize the use of supplemental analgesics
   2.2 Post Anesthesia Care Unit (PACU)
      a. A short-term care unit where patients are recovered after anesthesia

3. GUIDELINES
   3.1 General
      a. On-Q is used to deliver continuous peripheral nerve block therapy.
         i. The pre-filled pump is connected to a catheter that has been placed by the anesthesiologist next to a nerve near the operative site.
         ii. The flow rate is determined by turning the dial on the control until the disk clicks into place and the flow rate setting is aligned with the mL/hr mark.
         iii. The flow rate can be changed only with the rate-changing key to unlock the device and manual change of the flow rate.
         iv. The rate-changing key is held by Anesthesiology.
      b. Local anesthetic will be used in the On-Q.
      c. Patients may have multiple nerve block catheters as long as the total amount of local anesthetic infusing does not exceed the maximum dose, which is 0.4mg/kg/hr per patient.
      d. On-Q can be ordered for inpatient and outpatient use.
      e. Patient with On-Q MAY undergo MRI Testing.
      f. On-Q CAN be used in patients with Latex allergy.
      g. On-Q is contraindicated in patients with an allergy to local anesthetics.
   3.2 Anesthesia Responsibilities
      a. Ordering the medication, placement, care and discontinuation of the continuous peripheral nerve block therapy.

b. Connecting and disconnecting the continuous peripheral nerve block therapy to the patient while inpatient.
c. Monitoring and following all patients with the continuous peripheral nerve block therapy.
d. Ordering the continuous peripheral nerve block therapy using the EPIC system.
e. Appling a dressing over the insertion site and labeling the site of the catheter placement after insertion.
f. Connecting On-Q to the peripheral nerve catheter, setting and locking the flow rate chamber.
g. Discontinuing of On-Q. Anesthesia will use the following guidelines for removal of the On-Q:
    i. Wash hands with soap and warm water.
    ii. Remove the dressing over the catheter by lifting a corner edge and then peel the entire dressing off.
    iii. With one hand, hold tubing and gently pull tubing straight out until catheter is completely removed.
    iv. The catheter and pump will be thrown in the pharmaceutical waste container.
h. Documenting
    i. Document in EPIC the concentration and volume of medication used, and the initial flow rate set on the continuous peripheral nerve block therapy.
    ii. Complete a Peripheral Nerve Block note.

3.3 Nursing Responsibilities

a. The PACU RN will check the medication filled On-Q against the order in EPIC.
b. Monitor the patient with the continuous peripheral nerve block therapy during the postoperative inpatient course.
c. The PACU RN will double check the continuous peripheral nerve block medication and flow rate at the bedside.
d. Assess the patient upon arrival and discharge from the PACU, upon arrival to the unit and with each shift assessment and PRN until discontinuation of the device.
    i. Assess for dizziness, palpitations, seizures, blurred vision, agitation, anxiety, metal taste, ringing/buzzing in ears, hypotension, difficulty breathing, anxiety, metallic taste and tinnitus. These may be signs of local anesthetic toxicity. If present, immediately clamp the catheter and call Anesthesia x18315.
    ii. Ensure dressing site is clean and dry. Notify Anesthesia of excessive drainage at the catheter site, redness, swelling, tenderness, discharge, or leakage of local anesthetic from the On-Q.
    iii. Do not attempt to change the dressing. If loose, reinforce with tape. Call Anesthesia for any concerns.
    iv. Ensure the tubing clamp is open.
    v. Check for kinks in the tubing. If the tubing appears crimped, massage the area on the tubing to facilitate flow.
    vi. Assess and document pain intensity using the pain scale appropriate to the patient's age and development upon patient's arrival to the floor and every four hours. Notify Anesthesia if the patient is experiencing inadequate pain relief.

e. Do not allow the patient to get out of bed or ambulate alone when the continuous peripheral nerve block therapy is placed in the lower extremities. The affected leg may be weak. These patients should be helped and escorted out of bed.
f. Do not squeeze, inject anything, or adjust the flow rate the On-Q.
g. The continuous peripheral nerve block therapy is complete when the On-Q is empty/flat.
h. Nursing Documentation
    i. This is not an intake and is not recorded in the Intake and Output section of the flow sheet.
    ii. The initial flow rate and subsequent flow rate changes will be documented Q4hrs in the appropriate section of the MAR.
    iii. Site observation will be documented with wound dressing site, including medication verification every shift change.

3.4 Pharmacy Responsibilities
a. Pharmacy is responsible for verifying order, preparation of medication (local anesthetic), and delivery of the On-Q to PACU.
b. Pharmacy will deliver the On-Q to PACU with a clearly printed medication label, which will be placed on the pump tubing.

3.5 Patient Education
a. Inform the patient (and family) that the extremity will be numb.
b. The dressing must be kept dry. No showers or baths until the continuous peripheral nerve block therapy is discontinued.
c. Do not expose the On-Q to extreme hot or cold temperatures i.e. electric heated blankets, heating pads, or ice packs.
d. The medication being delivered should allow the patient to have minimal pain at the operative site. Notify the nurse if pain is present.

3.6 Precautions
a. Immediately clamp the catheter and call Anesthesia if the patient is experiencing:
    i. Redness, swelling, tenderness or discharge at the catheter site
    ii. Leakage of local anesthetic from the system
    iii. Seizure activity
    iv. Restlessness
    v. Anxiety
    vi. Itching
    vii. Nausea and Vomiting
    viii. Difficult breathing
b. On-Q hotline
    i. 1-800-444-2728
    ii. RN available 24/7 if patient has additional questions/comments/concerns
c. For patients with local anesthetic toxicity, physicians will order Intralipid 20% and it will be given immediately. An initial bolus of Intralipid 20% 1.5mL/kg IV every 3- 5 minutes (maximum 3 times) will be administered IV, followed by a continuous IV infusion at 0.25mL/kg/min.

3.7 Discharge to home with On-Q
a. The patient will be provided with Care Instructions for On-Q by Anesthesia prior to discharge home.
b. Provide patient with complete discharge instructions and information including:
    i. The name and concentration of the medication that is infiltrating around the nerve.

ii. Statement that the area around the surgical wound will be numb.
iii. The dressing must be kept dry. No showers or baths until On-Q is discontinued.
iv. The medication being delivered should allow the patient to have minimal pain at the surgical site.
v. Reminder to ensure the dressing site is clean and dry. Do not attempt to change the dressing. If loose, reinforce with tape. Call Anesthesia for any concerns.
vi. Be sure the tubing clamp is open.
vii. Do not squeeze, inject anything, or adjust the flow rate the On-Q.
viii. The continuous peripheral nerve block therapy is complete when the On-Q is empty and the delivery time has passed.
ix. The On-Q should be discarded in the wastebasket.
x. Immediately clamp the catheter and call Anesthesia if the patient is experiencing:
- Redness, swelling, tenderness or discharge at the catheter site
- Leakage of local anesthetic from the system
- Seizure activity
- Restlessness
- Anxiety
- Itching
- Nausea and Vomiting
- Difficult breathing, call 911.

xi. If instructed by Anesthesia, the patient may remove the catheter using instructions listed above for removal of catheter.

4. REFERENCES

4.1 On-Q post-op pain relief. http://www.iflo.com/prod_cbloc.php

5. ATTACHMENTS

5.1 Information for Patients taking home an On-Q

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Anesthesiology	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
4/18/2018	Nursing P&P	Yes	
5/7/2018	P&T	Yes	Revisions and return requested
			Changed 3.6C to Bullet under 3.6B. 3.6D reflects physician to order Intralipid. 5.1 Attachments, pain service removed and changed to HotLine. Next to last bullet in policy change Pain Service to On Call Anesthesiologist.
9/27/2018	PAC	Yes	Minor formatting, change 'should' to 'will'.
10/11/2018	MEC	No	

Information for Patients Going Home with an On-Q Pump

You are being sent home with a Nerve Block System that will provide pain relief after your surgery. This pain relief system decreases the use of narcotic pain mediation by providing a continuous flow of local anesthetic (numbing medicine) near the area where you had surgery.

The Nerve Block System has a pre-filled, locked pump that is connected to a catheter. The catheter is placed under the skin. Pain Service will instruct you on when you can remove the catheter at home.

Important Things to Know:

Bathing

- No showers or baths until the pump is removed.

Dressing/Wound Care

- The dressing must be kept dry.
- Do not try to change the dressing. This may pull out the catheter.

If the dressing becomes loose or wet, call On-Q Hotline or call RUHS hospital for further instructions.

Activity

- As directed by your doctor Medication
- The medication in the pump is a local anesthetic (numbing medicine) called Ropivacaine
- Continue to take gabapentin, acetaminophen, and more or less ibuprofen, as directed by your doctor

How to Remove the Catheter

- Wash hands with soap and warm water.
- Remove the dressing over the catheter: lift up from a corner edge of the bandage and then peel the entire dressing off.
- With one hand, hold the tubing and gently pull the tubing straight out until the catheter is completely removed.
- The catheter and pump can be thrown out in the regular trash.
- If the catheter does not come out easily, do not force it. Stop and call your doctor.

Call the doctor if:

- Your pain does not go away after taking the pain medication.
- The skin near the catheter is red, swollen, or painful to touch, or if the catheter starts to leak.
- You have ringing of the ears or a metallic taste in the mouth

How to Call for Questions/Concerns/Help:

- On-Q hotline: 1-800-444-2728. A Nurse is available 24/7
- Call RUHS Medical Center at 951-486-4000 and ask the operator to page the senior Anesthesia residents on call.
- In case of an emergency, call 911

Información para pacientes con una bomba On-Q

A usted se lo envía a su casa con un sistema de bloqueo nervioso. Dicho dispositivo le proporcionará alivio del dolor que pudiera sentir después de la cirugía. Este sistema para aliviar el dolor disminuye el uso de medicamentos narcóticos al proveer una infusión continua de un anestésico local (medicamento para insensibilizar) al área de su cirugía.

El sistema de bloqueo nervioso contiene una bomba fija de infusión conectada a una sonda. La sonda se coloca debajo de la piel. El personal de Servicio para la Atención del Dolor le instruirá acerca de cuándo podrá quitarse la sonda en su casa.

Tenga presente lo siguiente:

Bañarse

- No se duche con regadera ni tome baños de inmersión hasta que le hayan quitado la bomba

Cuidado de la herida/vendaje

- El vendaje debe permanecer seco.
- No intente cambiar el vendaje; hacerlo podría desprender la sonda.
- Si el vendaje se moja o se despega, llame a la línea directa On-Q o llame a la RUHS hospital para que le indiquen qué hacer.

Actividades

- Según las indicaciones de su médico.

Medicamentos

- El medicamente de la bomba es un anestésico local (medicamento para insensibilizar) de nombre Ropivacaine.
- Continúe tomando gabapentina, paracetamol (acetaminofén) y más o menos ibuprofeno, según las indicaciones de su médico

Cómo quitarse la sonda

- Lávese las manos con agua tibia y jabón.
- Para quitar el vendaje sobre la sonda, levante una orilla del apósito y luego despegue el resto.
- Con una mano, sostenga el tubo y, con cuidado, jale el tubo hacia afuera hasta retirar la sonda completamente.
- Puede desechar la bomba y la sonda en la basura normal
- Si la sonda no sale con facilidad, no debe forzarla. Deténgase y llame a su médico.

Llame a su médico en caso de lo siguiente:

- Si el dolor no desvanece después de tomar el medicamento para el dolor.
- Si la piel cerca de la sonda se vuelve roja, se ve hinchada, le duele al tocar o si la sonda gotea.
- Si siente un zumbido en los oídos o un sabor metálico en la boca.

Cómo conseguir respuestas a sus preguntas o inquietudes o si necesita ayuda:

- Linea directa On-Q: 1-800-444-2728. Una enfermera está disponible las 24 horas del día, los 7 días de la semana.
- Llame al número telefónico 951-486-4000 y pídale a la operadora que localice al residentes senior de anestesia de turno.
- En casos de emergencias, llame al 911.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 628	Page 1 of 13
Title: Moderate and Deep Sedation/Analgesia	**Effective Date:** 10/12/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS.

1.1 Anesthesia: The administration of a medication to produce a blunting or loss of pain perception (analgesia), voluntary and involuntary movements, autonomic function, memory and/or consciousness, depending on where the medication is delivered.

1.2 Analgesia: The use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the same extent that he or she may without the medication.

1.3 Levels of Sedation: The distinctions among levels of sedation are made for the purpose of describing appropriate levels of training for personnel, the level of physiologic monitoring, and anticipated risk.

a. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a. patent air way and spontaneous ventilation may be inadequate; cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner who has been determined to be qualified to manage such progression.

b. General Anesthesia: A drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

c. Moderate (Conscious) Sedation/Analgesia: A drug-induced depression of consciousness during which patients respond purposefully to verbal command, either alone or accomplished by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

d. Minimal Sedation (Anxiolysis): A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Although care should be individualized for each patient and circumstance, the following patients may be considered inappropriate candidates for minimal sedation:
   i. Known or suspected abnormal airway anatomy.
   ii. Suspected or known oral or neck mass that may impede necessary airway management.
   iii. Prior history of failing minimal sedation.

e. Regional Anesthesia. The delivery of anesthetic medication at a specific level of the spinal cord and/or to the peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks. It is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional anesthesia to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered or supervised by a practitioner qualified to manage such progression.

f. Monitored Anesthesia Care. Anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by regulations. Indications for monitored anesthesia depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic.

g. Rescue Capacity: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Further, no clear boundary exists between some of these services. Procedures must be in place to rescue patients whose level of sedation becomes deeper than initially intended, for example, patients who inadvertently enter a state of Deep Sedation/Analgesia when moderate sedation was intended. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects the adverse physiologic consequences of the deeper-than-intended level of sedation and returns the patient to the originally intended level of sedation.

2. EXCLUSIONS – This policy applies to all hospital areas that administer Moderate Sedation. Areas and conditions *not* included are:

2.1 Low risk patients receiving single dose anxiolysis (minimal sedation) at doses lower than the usual recommended for moderate sedation (e.g., oral midazolam up to or less than 0.5 mg/kg with a maximum of 20 mg oral).

2.2 Patients not undergoing a diagnostic or therapeutic procedure.

2.3 Patients receiving general, spinal, or epidural anesthesia or monitored anesthesia care by an anesthesiologist in the operating room.

2.4 Patients receiving diagnostic or procedural sedation outside the operating room by an anesthesiologist where documentation occurs on an approved hospital anesthesia record.

2.5 The sedation of mechanically ventilated patients.

2.6 Patients receiving medications to alleviate post-operative pain or as part of a pain management protocol.

2.7 Patients receiving medications to promote sleep/alleviate insomnia.

2.8 Patients receiving medications to perform urgent tracheal intubation.

3. POLICY

3.1 **Oversight**

a. Oversight for moderate and deep sedation will be provided by the RUHS - MEDICAL CENTER Chair of Anesthesia.
b. The moderate and deep sedation standards of care are not intended to address situations that require the services of a qualified, hospital-credentialed anesthesia provider.
c. Staffing requirements will be based on the patient's acuity, route of medication administration and the potential response of the patient to the procedure.

3.2 **Informed Consent**: Informed Consent must be obtained for both moderate and deep sedation. Please refer to RUHS – Medical Center policy HW 601 Patient Informed Consent.

3.3 **Credentials and Privileges**

a. If provisional approval is given, the physician must be proctored for at least one case for moderate sedation and two for deep sedation. The proctoring physician must be either an attending anesthesiologist or an active staff physician fully credentialed to administer moderate or deep sedation.
b. The proctoring report must be submitted to the Credentials. Committee for approval and then to the Medical Executive Committee (MEC). Once approved by MEC, the Medical Center Governing Board will decide on final approval for sedation privileges.
c. Moderate Sedation Privileging Requirements
    i. M.D. or D.O. licensed independent practitioner.
    ii. Current knowledge of airway management demonstrated by residency/fellowship training or RUHS - MEDICAL CENTER Airway Management for Sedation course.
    iii. Completion of RUHS - MEDICAL CENTER Moderate/Deep Sedation On-line Course
    iv. Successful passing grade (85%) on the moderate sedation written exam.*
    v. Successful completion of one (1) moderate sedation case under the direct supervision or a RUHS - MEDICAL CENTER practitioner holding appropriate clinical privileges in moderate sedation.
    vi. At the time of reappointment, if the practitioner wishes to maintain this privilege, he/she will be required to have:
        - Have completed a minimum of two sedation cases during his/her appointment period
          OR
        - Completion of RUHS - MEDICAL CENTER On-line training for moderate/deep sedation.
    vii. Moderate sedation for patients 14years and younger requires training in the care of pediatric patients demonstrated by residency/fellowship training.

d. Deep Sedation Privileging Requirements
   i. RUHS - MEDICAL CENTER medical staff anesthesiologist, intensivists, or appropriately credentialed Emergency Department physicians will provide deep sedation analgesia.
   ii. Successful completion of Moderate/Deep Sedation examination.
   iii. Current knowledge of airway management. As demonstrated by residency/fellowship training, ACLS/PALS, or RUHS - MEDICAL CENTER Airway Management for Sedation course.
   iv. Successful completion of two (2) deep sedation cases under the direct supervision of an RUHS - MEDICAL CENTER practitioner holding appropriate clinical privileges in deep sedation.
   v. At the time of reappointment, if the practitioner wishes to maintain this privilege, he/she will be required to either:
      - Have completed a minimum of two sedation cases during his/her appointment period.
        OR
      - Complete the RUHS - MEDICAL CENTER On-Line Training for moderate/deep sedation.
   vi. Deep sedation for patients 14 years and younger requires training in the care of pediatric patients demonstrated by residency/fellowship training.
   vii. If a passing grade is not attained by the practitioner in the first attempt, the practitioner will be required to take a second exam. If a passing grade is not attained on the second attempt, the practitioner will be required to attend a CME-sponsored sedation training course and submit evidence of successful completion of said course.

3.4 **Competencies:**

a. Qualified physicians shall be trained in professional standards and techniques as follows:
   i. To administer pharmacologic agents to achieve a desired level of sedation. (See Attachment 5.1 for moderate sedation Dosing Guide.)
   ii. To monitor carefully the individuals served in order to maintain them at the desired level of sedation.
   iii. Competency for resident/fellow physicians to perform the moderate sedation procedure will be established by the RUHS - MEDICAL CENTER Graduate Medical Education Committee and verified and approved by the Director of Medical Education or designee. If any questions arise regarding the authority for a resident to perform a moderate sedation procedure, the Attending
   iv. Physician will be called for verification. Residents credentialed to perform moderate sedation, may not perform a moderate sedation procedure unless their supervising attending physician has also been credentialed to perform moderate sedation.
   v. The RUHS - MEDICAL CENTER Department of Anesthesiology provides an on-line (computerized) course on moderate/deep sedation that provides the opportunity for physicians to take a test following completion of the on-line course. Anyone who fails the moderate/deep sedation test after completing the course must take another test to certify competency.
b. Registered Nurses (RN) deemed competent for administering age appropriate moderate sedation may only do so under the direct supervision of a physician who has moderate sedation privileges.

3.5 **The RN shall have age-specific education in the following:**

a. Current Basic Life Support (BLS) Certification and Advanced Cardiovascular Life Support (ACLS), Pediatric Advanced Life Service (PALS) or NRP (Neonatal Resuscitation Program (NRP) Certification as appropriate.
b. Equipment employed to monitor the patient.
c. Basic pharmacology of the sedative and analgesic agents employed.
d. Completion of Moderate Sedation Online course and successfully passing the competency class.
e. Competency will be assessed, demonstrated, documented and maintained annually for nursing staff.

3.6 **Orders:** Orders for sedation shall include the following provisions:

a. They shall be written only by licensed independent practitioners who are privileged for procedure related moderate (conscious) sedation or residents who have completed the necessary competency training for moderate sedation.
b. They shall specify the name of the medication, dose, route, frequency of administration and clinical parameters to achieve effective sedation.

3.7 **Pre-procedures requirements.**

a. Each patient's moderate/deep sedation care shall be planned. A plan for the operative or invasive procedure, pre- and post-sedation assessment, need for blood products, and post procedure care needs must be documented in the patient's, electronic medical record.
b. For non-emergent cases, the decision of NPO (nil' per os = nothing by mouth) status should be made by a privileged practitioner weighing the risks and benefits of the procedure on a case by case basis. The suggested NPO period is as follows:
    i. 2 hours if ingested clear liquids
    ii. 4 hours if ingested breast milk
    iii. 6-8 hours if ingested solids, non-human milk, infant formula
    iv. Longer time periods (at least 8 hours, for example) may be deemed appropriate if fatty or solid foods have been ingested.
    v. For non-elective cases where the NPO period is deemed inadequate by the licensed independent practitioner, airway protection (e.g., endotracheal intubation) should be considered.
c. When appropriate fasting has not been ensured, or in the case of a valid emergency, the increased risks of sedation shall be weighed against its benefits and the lightest level of effective sedation employed. An emergency procedure may require protection of the patient's airway against aspiration (intubation) before sedation.

3.8 **Facilities.** Procedures requiring procedure related sedation or anesthesia covered by this policy shall be performed in locations with:

a. Adequate lighting to observe patient and monitors.
b. Adequate power outlets and clearly labeled outlets connected to the hospital emergency power supply.
c. Emergency numbers readily accessible for immediate access to the appropriate Code Team.

3.9 **Equipment.** Age and size appropriate equipment for care and resuscitation shall be available for monitoring vital signs including heart and respiratory rates and oxygenation. The following equipment/supplies will be available:

a. Pulse oximeter.
b. Capnography
c. Cardiac monitor.
d. Automatic Blood Pressure Monitor, or Sphygmomanometer and Stethoscope.
e. Oxygen, E cylinder, or wall access, and self-inflating positive-pressure oxygen delivery system (ambu-bag) that is the appropriate size for the patient undergoing the sedation.
f. Airway management equipment/supplies (suction and its required apparatus).
g. Suitable age appropriate emergency equipment (adult/peds) including crash cart with defibrillator shall be in the immediate area at all times.
h. Equipment for administering intravenous fluids and medications, and blood and blood components.

3.10 **Qualified Staffing: Sufficient Numbers**

a. Sufficient numbers of qualified personnel (in addition to the physician performing the procedure) shall be present during the procedures using moderate sedation to:
    i. Appropriately evaluate the patient prior to beginning the moderate sedation.
    ii. Provide the sedation.
    iii. Monitor the individual patient.
    iv. Recover and discharge the patient from the post-sedation recovery area.
b. There should always be a minimum of one sedation trained provider to monitor the patient at all times.
c. If the sedation is for a procedure, there needs to be a minimum of two personnel: The practitioner privileged to perform the procedure and an assistant competent to monitor designated physiologic variables.
d. A qualified provider for deep sedation (see 3.3d) must be contacted for any patient exhibiting loss of protective reflexes, ability to maintain a patent airway, appropriate response to physical stimulation or verbal command.

3.11 **Reversal Agents**

a. Appropriate antagonists shall be readily available. One vial of flumazenil and one vial of naloxone will be kept with the monitoring equipment, and their location will be verified prior to medication administration.
b. Flumazenil should effectively reverse the sedative and respiratory depressant effects of benzodiazepines when administered in an initial dose of 0.2 mg. If the desired effect is not achieved, this dose may be repeated at 60-second intervals up to a maximum dose of 1.0 mg.
c. Naloxone should effectively reverse opioid-induced respiratory depression in patients. However, analgesia also is antagonized, and the abrupt sensation of pain may be associated with hypertension, tachycardia, and pulmonary edema.
    i. Adults: in increments of 0.02-0.2mg in two (2) to three (3) minute intervals to the desired degree of reversal
    ii. Pediatrics: in increments of 0.01mg/kg to 0.015 mg/kg in two (2) to three (3) minute intervals to the desired degree of reversal. In case slower titration is necessary, titration may start at a lower dose of 0.001 mg/kg.

d. Both flumazenil and naloxone have shorter durations of action than the benzodiazepines and opioids that they antagonize. Therefore, patients must be observed for an appropriate period of time (up to 2 hours) after the last does of the antagonist to ensure that respiratory depression does not reoccur.

3.12 **Pre-Procedure Assessment**:

a. Pre-Sedation Assessment. Pre-sedation assessment shall consider data from other assessments and collect information needed to:
   i. Select and plan sedation.
   ii. Safely administer sedation.
   iii. Interpret findings of the individual monitoring.

b. Additionally, the patient assessment shall be documented in the medical record by the licensed independent practitioner or resident who has completed competency training in moderate sedation and shall include:
   i. History and physical (H&P), including current medications and dosages, over the-counter medications, herbal supplements, and all past medication reactions
   ii. Procedure indication
   iii. ASA (American Society of Anesthesiologists) physical status classification
   iv. NPO status
   v. History of allergy
   vi. History of prior adverse events during sedation, if any
   vii. Current orders for diagnostic tests, if the H&P suggest the necessity for them Note: Test results must appear on the patient's medical record.
   viii. Plan for sedation
   ix. Discussion of risks, benefits, and options of sedation with patient and/or the family as appropriate
   x. NOTE: The resident may NOT perform the pre-sedation assessment unless the attending is privileged.

c. The following requirements will be established prior to medication administration:
   i. A licensed independent practitioner has planned or concurred with the sedation plan.
   ii. Confirmation that the H&P has been documented and informed consent for the procedure and for sedation has been obtained by the physician and signed by the patient or guardian.
   iii. Confirmation that orders for sedation have been written by the physician.
   iv. Pre-sedation assessment will be performed before beginning sedation and will be documented in the electronic medical record (EMR).
   v. Each patient's moderate sedation care shall be planned and documented in the EMR.
   vi. Baseline for vital signs (blood pressure, pulse, respiration, oxygen Saturation, level of consciousness, weight, Pain Scale, and previous sedation history including complications will be established and documented in the EMR).

d. The following monitoring devices will be initiated:
   i. Continuous pulse oximetry
   ii. Continuous capnography
   iii. Continuous cardiac monitoring
   iv. Intravenous access will be obtained for all patients requiring sedation monitoring. Use of a saline lock IV for this purpose is acceptable.

3.13 **Re-Assessment**

a. The patient will be re-evaluated immediately before moderate or deep sedation use and this re-assessment will be documented in the EMR.

3.14 **Assessment During the Procedure**

a. Each patient's physiological status shall be monitored continuously during sedation administration. All of the following shall be documented:
   i. Physiological data from continuous monitoring will be documented at 5-minute intervals and at any significant event and recorded in the EMR.
   ii. Vital Signs (including heart and respiratory rates,)
   iii. Respiratory frequency and adequacy of pulmonary ventilation
   iv. Capnography - if sedation is to be administered unless precluded or invalidated by the nature of the patient or procedure.
   v. Blood pressure (optional in Pediatrics)
   vi. EKG, when significant cardiovascular disease or dysrhythmias are anticipated or detected
   vii. Pain Scale when the patient has a RASS (Richmond Agitation-Sedation Scale) score of -2 or higher. (-1, 0, +1 etc.)
   viii. Oxygen saturation (using pulse oximetry) prior to administration of medications and supplemental oxygen (if administered). This documentation shall serve as a baseline for comparison at the end of the procedure. Note: Patients with room air oxygen saturation of less than 90 percent shall be transported with oxygen (exception: patients with congenital cyanotic heart disease).
   ix. All medications, IV solutions, and blood components administered including name, dose, route, date and time administered.
   x. Complications and the management of those events.
   xi. All personnel involved with the sedation procedure.

3.15 **Post procedure Transport.** The patient may need to be transported to another location for post-procedure observation/recovery. If transported they will be monitored with the following equipment/supplies by a qualified RN:

a. Continuous pulse oximetry
b. Continuous capnography
c. Continuous cardiac monitoring
d. Oxygen and appropriate airway management equipment/supplies

3.16 **Post Procedure Assessments/Monitoring:**

a. Post-procedure assessment documentation shall begin within five minutes after completion of the procedure. The patient's post-procedure status shall be assessed and documented on admission to and before discharge from the post-sedation recovery area.
b. The patient's physiological status, mental status, and pain level will be monitored at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or sedation or analgesia administered.

c. Patients who have received moderate sedation will be monitored continuously post procedure for vital signs (BP, pulse, respiration, CO2) and documented every 15 minutes and those who have received deep sedation will be monitored continuously until:
    i. The patient scores a minimum of 8 on the post-anesthesia recovery (Modified Aldrete Score) scoring guidelines or the patient's pre-sedation score is reached. Exceptions: Critical care patients, paraplegics, quadriplegics, or other hospital patients with conditions which preclude use of such a scoring system.
    ii. At least 30 minutes after the last intravenous administration of any drug, or 60 minutes after the last intramuscular or oral drug administration for moderate sedation.

3.17 **Discharge Criteria.**

a. Discharge Criteria for direct discharge from procedural or recovery area are as follows:
    i. Is easily awakened and is oriented to person and place; or has a mental status consistent with pre-procedure condition
    ii. Can cough and swallow
    iii. Has not received naloxone or flumazenil for 45 minutes
    iv. Has not received flumazenil for two (2) hours after sedation with parenteral diazepam or lorazepam, or greater than 10 milligrams of midazolam.
    v. Has pulse oximeter saturation of greater than 92% after breathing room air 10 minutes, or has orders for supplemental oxygen.
    vi. Has not received IV narcotics within the previous 30 minutes.
    vii. Has been observed at least 30 minutes.
    viii. Has a Modified Aldrete score of eight (8) or greater.
    ix. The qualified licensed physician discharges the patient from continuous monitoring status.
b. Discharge Criteria for direct discharge for outpatients, in addition are as follows:
    i. Able to dress and ambulate consistent with developmental age.
    ii. Received and indicate understanding of discharge instructions.
    iii. Has a responsible person to transport them home and care for them at home.
    iv. Infants and patients whose mental status was initially abnormal should have returned to their baseline status

3.18 **Discharge Instructions:**

a. Discharge instructions to the patient and responsible adult who will be caring for patient at home will include:
    i. Diet
    ii. Medications
    iii. Activity level
    iv. Signs and symptoms of complications

b. Parents must be aware that pediatric patients are at risk for airway obstruction should the head fall forward while the child is secured in a car seat. Parents will be educated that children in car seats should not ride alone in the backseat.
c. Patients will be discharged into the care of a responsible adult.

3.19 **Performance Improvement**

a. Based on The Joint Commission Standards, the outcomes of patients undergoing moderate sedation and deep sedation shall be collected and analyzed in the aggregate using QI tools in order to identify opportunities to improve care.

4. REFERENCES

4.1 Statement of granting privileges for administration of moderate sedation to practitioners who are not anesthesia professionals, American Society of Anesthesiologists 2006

4.2 The Joint Commission Standards, Provision of Care, PC.03.01.01 through PC.03.01.07, Effective date July 1, 2018

4.3 Moderate Sedation/Analgesia, Perioperative Standards and Recommended Practices, 2012

4.4 Guideline Summary: Moderate Sedation/Analgesia, AORN 2016

4.5 Centers for Medicare & Medicaid Services §482.52 Conditions of Participation: Anesthesia Services. Rev. 176, 12-29-17.

5. ATTACHMENTS

5.1 Dosing Guides for Sedation/Analgesia Moderate Sedation for Patients Less Than 60 yo.and Weighing Fewer than 100kg

5.2 Dosing Guides for Sedation/Analgesia Moderate Sedation for Patients More Than 60yo or Chronically Ill.

5.3 5.2 Dosing Guides for Sedation/Analgesia Moderate Sedation for Pediatric Patients.

Document History:

Prior Release Dates: 01/17/03, 11/15/08, 12/15//11, 1/15/12, 1/29/2015, 5/7/18	**Retire Date:** N/A
Document Owner: Anesthesia	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
9.19.2018	Nursing Administration & Legal Counsel	Y	Changes throughout the policy – largely to correspond with practice change and documentation in the electronic Health Record. Updated references. Added numbers to Attachments.
10/1/2018	Pharmacy & Therapeutics Committee	N	
10/2/2018	Hospital Wide – Policy Advisory Committee	N	
10/11/2018	MEC	N	

5.1 DOSING GUIDES for "SEDATION/ANALGESIA" MODERATE SEDATION

1. Medications labeled for general anesthesia, monitored anesthesia care and deep sedation only, or those that have specific CMS guidelines that interpret the same, will require the LIP to undergo separate credentialing for deep sedation for utilization. The following medications require credentialing for deep sedation for use: methohexital and propofol.

ATTACHMENT 5.1 FOR PATIENTS LESS THAN 60 Y.O. AND LESS THAN 100KG

Any doses above what is stated below is considered deep sedation

	IV Midazolam	IV Diazepam	IV Lorazepam	IV Morphine	IV Hydromorphone	IV Fentanyl
Within *15 min of IV opiates*	0.03 to 0.05 mg/kg	0.1 to 0.15 mg/kg	0.02 to 0.04 mg/kg	-	-	-
If no opiates	0.05 to 0.075 mg/kg	0.15 to 0.225 mg/kg	0.02 to 0.06 mg/kg	-	-	-
Within *15 min benzodiazepines*	-	-	-	Up to 0.1 mg/kg	Up to 0.015mg/kg	Up to 1 mcg/kg*

Intravenous if no other opioid or sedative-hypnotic medications are administered within 15 minutes.

USE OF REVERSAL AGENTS

1. Naloxone: the reversal agent for opioids, is administered IV in 0.2 mg increments at 2 to 3 minute intervals. Then repeat at 1 to 2 hour intervals if necessary.
2. Flumazenil: the reversal agent for benzodiazepines, is administered IV of 0.2 mg given over 15 seconds. If desired effect not reached an additional 0.2 mg may be given after a 60 second wait. This may be repeated up to a maximum total dose of 1 mg.

ATTACHMENT 5.2 FOR PATIENTS MORE THAN 60 Y.O. OR CHRONICALLY ILL

Any doses above what is stated below is considered deep sedation

	IV Midazolam	IV Diazepam	IV Lorazepam	IV Morphine	IV Hydromorphone	IV Fentanyl
Within *15 min IV opiates*	0.01 to 0.035 mg/kg	0.05 to 0.1 mg/kg	0.01 to 0.028 mg/kg	-	-	-
If no opiates	0.02 to 0.05 mg/kg	0.07 to 0.15 mg/kg	0.015 to 0.04 mg/kg	-	-	-
Within *15 min benzodiazepin*	-	-	-	Up to 0.75 ·mg/kg	Up to 0.01 mg/kg	Up to 0.75 mcg/kg

Intravenous fentanyl in doses up to (one) 1 micrograms per kilogram may be used in patients 18-to- 60 years old, if and only if no other opioid or sedative-hypnotic medications are administered within 15 minutes.

USE OF REVERSAL AGENTS

1. Naloxone: the reversal agent for opioids, is administered IV in 0.2 mg increments at 2 to 3 minute intervals. Then repeat at 1 to 2 hour intervals if necessary.
2. Flumazenil: the reversal agent for benzodiazepines, is administered IV of 0.2 mg given over 15 seconds. If desired effect not reached an additional 0.2 mg may be given after a 60 second wait. This may be repeated up to a maximum total dose of 1 mg.

ATTACHMENT 3. FOR PEDIATRIC PATIENTS

Any doses above what is stated below is considered deep sedation

	IV Midazolam	PO Midazolam	IV Lorazepam	IV Morphine	IV Fentanyl	IV hydromorphone
Within 15 min of *Opiates*	0.05 mg/kg	1 mg/kg	0.1 mg/kg			
Within 15 min of *benzodiazepines*				0.1 mg/kg to 4mg	2 mcg/kg to 50mcg	0.015 mg/kg to 1 mg

USE OF REVERSAL AGENTS

1. Naloxone: start at 0.01 mg/kg/dose in non-arrest situations. In arrest situations use 0.1 mg/kg/dose to maximum of 2 mg for children under 20 kg.
2. Flumazenil: 0.01 mg/kg to a maximum of 0.2 mg, then 0.005-0.01 mg/kg every minute to a maximum of 1 mg total cumulative dose.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 633	Page 1 of 4
Title: AMA, Missing, and Eloped Patients	**Effective Date:** 10/1/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS:

1.1 **Elopement:** When a patient is missing from their assigned hospital room and common unit areas for more than 4 hours.

1.2 **Against Medical Advice (AMA):** When a patient leaves or is planning to leave against the advice of their doctor.

2. POLICY:

2.1 **Missing Patient.** When a patient is missing, the Nursing Director, Nurse Manager or designee will:

a. Attempt to contact the patient on their cellular phone, if applicable.

b. Assign personnel to initiate a search for the patient. The search will be within the unit the patient was assigned and expanded hospital-wide including common areas outside of the facility.

c. Attempt to contact the patient's family, emergency contact or next of kin, if applicable.

2.2 **Patients Located after Search.** A four (4) hour time line will be used to make determinations regarding a patient's status. If the patient is located:

a. Within four (4) hours:

- The patient shall be escorted back to his/her hospital room and given instructions about remaining there.
- The patient shall be reassessed.
- The treatment plan shall be updated, as needed.
- The entire episode shall be documented in the medical record.

b. After four (4) hours:

- The patient shall be sent to the Emergency Department for assessment and re-admittance, as appropriate.

2.3 **Eloped Patient.** If the patient is not located within four (4) hours, the patient's absence is considered an elopement. The following steps should occur.

a. The assigned unit will contact the patient's family, emergency contact, or next of kin to inform them of the patient's status.

- Conservators and legal guardians such as CPS, shall be notified when a patient is under conservatorship/guardianship.

b. The patient's status will be documented by the physician in the medical record.

c. Notify:

- Attending Physician/Psychiatrist.
- House Supervisor, Administrator-on-Call, Executive Director, and the Nursing Director / Nurse Manager of the unit involved.

2.4 **Documentation**

a. Complete appropriate reports.

b. Document all pertinent information about the patient's absence/elopement in the patient's medical record e.g. phone calls to patient/family, areas searched, number of search attempts, etc.

2.5 **Patient with Intent to Leave Against Medical Advice (AMA).** When a patient or Patient Representative tells any staff member of his/her intent to leave AMA, the staff member will immediately notify the primary nurse and the charge nurse.

The primary nurse will:

a. Immediately notify primary physician.

b. Assess reasons for leaving and attempt to resolve concerns.

c. Notify social worker.

d. Involve the family, if appropriate and available, only after consultation with social worker.

e. Notify Nursing House Supervisor.

f. Advise the patient / patient representative to make his/her own arrangements for transportation, equipment, and supplies to leave the hospital.

2.6 **Minors / Patients lacking capacity**

a. Special urgency should be given to locating minors and patients with impaired decision-making capacity unless it is known that they have been removed from the facility by a custodial parent or a guardian with authority to make medical decisions after discussion with the primary physician.

b. Parents with custody over a minor also have authority to remove the minor against medical advice. If the primary nurse or primary physician believes that such removal poses an immediate danger to the health or safety of the minor, law enforcement should be called to take temporary custody of the minor on behalf of the Juvenile Court.

2.7 **Physician Responsibility to AMA Patients.** Physicians must attempt to provide information and education on reasons for continued medical care, alternatives to leaving AMA, and specific safety/health risks including death or disability so that the patient will be in a position to make an informed decision on whether or not to leave the hospital. Physicians shall:

a. Encourage questions and discussion.

b. Assess the patient's understanding of condition and risks/possible consequences associated with leaving.

c. Notify Psychiatry Consultation and Liaison Services (PCLS) if patient appears to lack capacity to make an informed decision to leave AMA.

d. Request that the patient sign the Release for Patient Leaving Hospital Against Medical Advice of Doctor. The original is placed in the medical record, and a copy is provided to the patient. If the patient refuses to sign, this is documented on the form, then witnessed and signed by two hospital employees.

e. Complete discharge summary, list of medically necessary medications, and discharge note documenting capacity determination, all recommendations, and patient's refusal(s).

2.8 **Patients Leaving without Speaking to Physician.** If the patient refuses to wait for the physician, the nurse shall:

a. Confirm that all steps in section *2.5 a* through *f* above have been completed.

b. Provide the patient with instructions necessary for life or ability to function; clinic follow up instructions, including advisement that he/she may return to the emergency department at any time; and signs and symptoms requiring immediate medical attention.

c. Attempt to provide a copy of the discharge summary or after visit summary and medication list to the patient if the patient leaves AMA.

d. Complete appropriate reports.

3. Patients on Involuntary Holds (5150 / 5250 / 5270)

3.1 **Missing Patients who are on Holds.** If a patient who is on an involuntary-hold is noted missing from their room, the patient is immediately considered to be an eloped patient. The following steps shall be immediately put into place:

a. Notify:

- Law enforcement.
- Attending Physician/Psychiatrist.
- House Supervisor, Administrator-on-Call, Executive Director, and the Nursing Director / Nurse Manager of the unit involved.

b. The assigned unit will contact the patient's family, emergency contact, or next of kin to inform them of the patient's status.

- Conservators and legal guardians (CPS), shall be notified when a patient is under conservatorship/guardianship.

c. The patient's status will be documented by the physician in the medical record.

4. REFERENCES

1. California Health and Safety Code §1279.1
2. Welfare and Institutions Code §305

Document History:

Release Dates: 10/03/86, 3/16/00, 3/25/03, 5/22/2016	**Retire Date:** N/A
Document Owner: Nursing	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
7/6/2018	Compliance and Legal	Yes	Edits re: providing medical records post elopement and actions relating to minors
9/4/2018	Nursing P&P by evote quorum achieved 9/4/2018		Edits: clarify language on missing vs. eloped vs. ama. Add requirement to notify provider on eloped patient.
9/4/2018	Policy Approval Committee	Yes	Change language of 'incident' to 'episode'. Change notification of 'intent to leave' from Nursing Admin to Nursing House Supervisor In 2.8, update the section number referred to.
9/13/2018	Medical Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
HOUSE WIDE

	Document No: 642	Page 1 of 3
Title: **Administering Seasonal Influenza Vaccine to Patients by a Registered Nurse**	**Effective Date:** 5/2/2018	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By and Date Approved: Jennifer Cruikshank Chief Executive Officer		☒ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 This policy and procedure applies to RUHS – Medical Center patients within the Emergency Department and inpatient units. It does not apply to clinics within the Medical Center (refer to clinic-specific policy).

2. POLICY

2.1 A Registered Nurse (RN) may administer the Inactivated Influenza Vaccine as follows:

a. Influenza vaccine season is October 1st through March 31st. If vaccine is available, patient screening and administering may begin in September, and continue beyond March 31st if the virus are circulating, the vaccine is available, and has not expired.

b. Screen all patients to see if they qualify for the influenza vaccine upon admission or prior to discharge during influenza vaccine season.

c. When indicated and appropriate, the influenza vaccine may be given any time prior to discharge

d. Inpatients may only receive inactivated or recombinant seasonal influenza vaccine. Live attenuated influenza vaccine is not administered to inpatients.

e. Age appropriate seasonal influenza vaccine will be available. Product specific guidelines will be followed per the manufacturer label.

f. Influenza vaccine may be administered concurrently or sequentially with other inactivated vaccines or with live vaccines.

2.2 IF UNSURE whether to administer the influenza vaccine, contact the attending physician for clarification and document the physician's instructions.

3. PROCEDURE

3.1 Assess for vaccination need

a. INCLUSION criteria, as follows when there is an absence of any contraindication:

- Patients aged greater than or equal to 6 months of age

- Women who are pregnant or who might be pregnant in the influenza season are recommended to receive influenza vaccine. Influenza vaccine can be administered at any time during pregnancy.
- People who do not recall whether they received influenza vaccine this year

3.2 Screen patient for potential contraindications. If unsure about whether a condition is a contraindication to receiving the vaccine, discuss with primary medical team and clarify. If the patient refuses vaccination, document "Refused" in the electronic health record.

a. Potential EXCLUSION criteria:

- Patient already immunized this flu season
- Severe allergy to eggs (CDC no longer views this as an absolute contraindication)
- Previous severe allergic reaction to influenza vaccine
- History of Guillian-Barre Syndrome
- Patient refusal/declination

3.3 **PRECAUTIONS:**

a. The RN will consult with the physician prior to administering the vaccine to persons with moderate-to-severe acute febrile illness as they usually should not be vaccinated until their symptoms have abated. However, minor illnesses with or without fever do not contraindicate use of influenza vaccine.

3.4 **Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS)**. You must document in the patient's medical record the publication date of the VIS and the date it was given to the patient.

a. Provide non-English speaking patients with a copy of the VIS in their native language, if available. These can be found at www.immunize.org/vis or at **www.cdc.gov**

3.5 **Prepare to administer vaccine**.

a. Place order in electronic health record for age appropriate influenza vaccine. To complete the order, accept and sign "per protocol".

3.6 **Administer the vaccine**

a. **Age greater than or equal to 36 months.** Administer 0.5 mL of injectable seasonal influenza vaccine intramuscularly in the deltoid muscle.

b. **Age greater than or equal to 6 months up to 35 months.** Administer 0.25 mL of injectable seasonal influenza vaccine intramuscularly in the anterior thigh muscle.

3.7 **Document** each vaccine administration in the designated location in the medical record. Documentation must include:

a. The date the vaccine was administered

b. The Manufacturer

c. A lot number and expiration date

d. The vaccination site and route

e. The name and title of the person administering the vaccine.

3.8 Adverse Event Reporting

a. Report all adverse reactions to influenza vaccine via hospital incident report system.
b. Refer to Hospital Wide Policy on Medication Errors and Adverse Drug Reactions 805.

4. REFERENCES

4.1 Grohskpf LA, Sokolow LZ, Broder KR, et al. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2017-18 Influenza Season. MMWR Recomm Rep 2017:66(No. RR-2):1-20.
4.2 CMS Conditions of Participation §482.23 (*Rev. 176, 12-29-17)*
4.3 RUHS Medical Center: Housewide Policy 805: Medication Errors and Adverse Drug Reactions (eff. 10/26/2016)
4.4 Immunization Action Coalition. Standing orders for Administering Influenza Vaccine to Adults (2016). www.immunize.org/catg.d/p3066.pdf

Document History:

Release Dates: 2/2007, 9/2014		**Replaces Policy:** Nursing Standardized Procedure 431	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
1/25/2018	Nursing Department Infection Control IDPC	yes	Updated template. Changed title to "seasonal". Removed Trivalent. Added all patients (not just adults). Updated Procedure order of operations. Updated references. Removed reference to employees. Clarified scope.
1/26/2018	Pharmacy Review Committee – e-vote	Yes	Clarified Contraindications 3.2.1.2 & 3.2.1.3 - separated egg from vaccine, added CDC comment re egg allergy
2/5/2018	Pharmacy & Therapeutics Committee	No	
2/21/2018	Nursing Policies and Procedures Committee	Yes	Addition of 3.5 place order
3/7/18	PAC	No	
4/12/18	Medical Executive Committee	No	
4/25/2018	HEC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 643	Page 1 of 5
Title: Care of the Obstetrical Patient in the Emergency Department	**Effective Date:** 10/5/1028	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ Policy ☐ Procedure ☐ Guideline

1. DEFINITIONS

1.1 **Medical Screening Examination (MSE):** a required examination of a patient to rule in or rule out if a patient has an emergency medical condition.

1.2 **Emergency Medical Condition: An emergency medical condition is either**

a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could result in:
   i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   ii. Serious impairment to bodily functions; or
   iii. Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions –
   i. That there is inadequate time to effect a safe transfer to another hospital for delivery; or
   ii. That transfer may pose a threat to the safety of the woman or unborn child.
   iii. NOTE: In the case of a pregnant woman, the health of the fetus must be considered in determining whether an "emergency medical condition" exists.

2. PROCEDURES

2.1 All pregnant patients presenting to RUHS Medical Center Emergency Department (ED) will be assessed by an Emergency Department Registered Nurse (RN) and an approximate gestational age will be determined using the mother's recollection of her last menstrual period and a gestational calculator ("the wheel").

2.2 In cases of uncertainty, confirmatory ultrasound may be appropriate. Specific additional procedures depend on the patient's stage of pregnancy, condition upon arrival and presenting complaint.

2.3 Delivery in the field:

a. Paramedics will initiate care in the field with advice from Mobile Intensive Care Nurse and transfer mother and baby(ies) to base hospital.

b. ED Physician will perform MSEs on mother and baby(ies) upon arrival.

c. ED physician will contact OB resident or OB attending on call for admission of mother.

d. ED Physician will contact NICU physician or Nurse Practitioner on call for admission of the baby(ies).

e. All care provided in the ED will be documented in the patients' medical record.

2.4 **Pregnant patient, delivery imminent:** If a pregnant patient arrives and delivery is imminent or meets trauma criteria:

a. The ED/Trauma physician will coordinate the maternal and fetal care.

b. The ED RN will:
   i. Ensure that key personnel have been notified to come to the ED to assist with maternal and fetal care. (i.e. L&D, Respiratory Therapy, house supervisor, etc.).
   ii. Ensure all necessary equipment and supplies are available at the bedside.
   iii. All care provided will be documented in the medical record

2.5 Critical, Unstable or meets Trauma Activation Criteria Patients:

a. ≥ 20 0/7 weeks gestation - If a critical, unstable or meets trauma activation criteria pregnant patient is determined to be greater than 20 weeks gestation:

   i. Initial assessment and treatment will be completed in the emergency department.
   ii. Activate OB-GYN response team (Prior to arrival if known)
   iii. Obstetric US to be completed by OB-GYN Attending /Resident
   iv. Activate Trauma Team (if applicable) (Prior to arrival if known)
   v. Time Target: Priority response from both teams when each are activated.

b. < 19 6/7 weeks gestation – If the patient is determined to be less than 20 weeks gestation:
   i. Critical Care to be provided in the ED as needed including activation of trauma team if indicated.
   ii. ED staff to document fetal heart rate (FHR).
   iii. Consult OB-GYN as needed. Physician to Physician.
   iv. Consult L and D Charge as needed. RN to RN.

2.6 **High risk patient – any gestational age.** If a pregnant patient presents with abdominal pain, injury from MVA, Hypertension > 135/85, or other serious medical conditions such as sepsis, seizure, hypotension, respiratory difficulty the MSE will be performed in ED:

a. The ED RN will triage the patient as ESI level 1 or 2

b. Patient will be moved to a treatment room immediately

c. ED physician will be notified immediately and see patient ASAP.

d. ED Physician will initiate the OB consult process with OB-GYN On call. OB-GYN physician will consult within 30 minutes.

e. All staff will assess FHR if gestation is > 16 weeks

f. L&D RN will monitor patients with > or = 20 weeks gestation

2.7 Stable patient, > 20 0/7 weeks with pregnancy related complaint:

a. If it is determined that the patient has a pregnancy related complaint and is greater than or equal to 20 0/7 weeks gestation:
   i. The ED RN will escort the patient immediately up to the L & D department if safe to do so. The charge nurse should call ahead to inform L & D that they are coming. These patients do not need to be registered or triaged in the ED. They may be transported directly by an ED RN on a gurney or by wheelchair to the Labor and Delivery (L&D) Unit for assessment of maternal and fetal well-being by an obstetric provider.
   ii. If the triage RN is unsure of the appropriateness of transport to L&D, a triage assessment will be completed and the patient will be registered as an ED patient. The ED Physician or ED nurse can call the OB attending or L&D charge nurse for any questions or to have them come to the ED to access the maternal and fetal well-being as needed.
   iii.
   iv. If a pregnant patient > 20 0/7 weeks is being admitted to another service, the ED attending should communicate with the OB attending.

2.8 Stable patient, > 20 0/7 weeks with non-pregnancy related complaint:

a. Pregnant patients presenting at ≥20 0/7 weeks with a non-pregnancy related complaint will be triaged and registered in the ED and have an assessment that includes but is not limited to:
   i. A brief assessment by the nurse and vital signs documented upon arrival and as indicated based on the patient's clinical status.
   ii. L&D will monitor fetal heart rate in the ED.
   iii. The ED Physician or PA will initiate a timely MSE to assess maternal and fetal well-being and treatment. The ED Physician or ED nurse can call the OB attending or L&D charge nurse for any questions or to have them come to the ED to access the maternal and fetal well-being as needed.

iv. Care for the non-related pregnancy complaint will be completed in the ED and documented in the medical record.

2.9 **G. Stable patient, < 19 6/7 weeks with pregnancy related complaint:** Pregnant patients presenting to the Emergency Department at < 19 6/7 weeks gestation and a pregnancy related complaint will be assessed and triaged by an ED RN and registered in the Emergency Department.

a. At a minimum the assessment will include date of last menstrual period (LMP), Gravidity and Parity status and the presence or absence of vaginal bleeding.

b. Vital signs will be documented upon arrival, and as indicated based on the patient's clinical status. FHT's will be assessed for all patients > 16 0/7 weeks.

c. The ED Physician or PA will initiate a timely MSE to assess maternal and fetal well- being and provide treatment as required for the presenting symptoms.

d. Clinical examination and testing will be provided in the ED to determine maternal and fetal well-being and will provide treatment as required by condition.

2.10 **H. Stable patient, < 19 6/7 weeks with non-pregnancy related condition:**

a. Pregnant patients presenting to the Emergency Department at ≤ 19 6/7 weeks EGA with a non-pregnancy related complaint will be assessed and triaged by an ED RN and registered in the Emergency Department.

b. Vital signs will be documented upon arrival, and as indicated based on the patient's clinical status.

c. Fetal heart tones (FHT) will be assessed and the rate documented in the medical record for those patients that are > 16 0/7 weeks.

2.11 **Up to 6 weeks postpartum:**

a. Postpartum patients should be triaged in the ED.

b. For complaints that are not related to postpartum or postsurgical state, care should be provided in the ED.

c. The ED RN should contact the L&D RN for any postpartum patient:

i. With blood pressures >140/90
ii. With fever
iii. Within 30 days of an obstetric-related surgery
iv. Being admitted to another service

2.12 **Discharge:**

a. If maternal and fetal status is stable and true labor and/or a medical emergency can be excluded, the ED physician may elect to discharge the patient.

b. The physician will document their assessment and findings that demonstrate that no medical emergency condition exists prior to discharge.

c. The RN will discuss with the patient the discharge orders, as provided by the physician and provide written instructions as appropriate (e.g. next prenatal visit, signs/symptoms of labor, how to care for their non-pregnancy related complaint etc.).

3. ATTACHMENTS.

3.1 Algorithm: Management of Pregnant Patients in the ED

4. REFERENCES

4.1 American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care, (eighth edition). Elk Grove Village, IL, and Washington D.C. Authors.

4.2 Emergency Nurses Association. (2013 seventh edition) Sheehy's Emergency Nursing: Principles and Practices.

4.3 Emergency Medical Treatment and Active Labor Act, 42 U.S.C., Section 1395.

4.4 Gilboy N, Tanabe T, Travers D, Rosenau AM. Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4. Implementation Handbook 2012 Edition. AHRQ Publication No. 12 – 0014. Rockville, MD. Agency for Healthcare Research and Quality. November 2011.

Document History:

Release Dates: New	**Retire Date:** N/A
Document Owner: Emergency Department	**Replaces Policy:** Departmental Policy

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
07/12/2018	Approved at ED Committee	New	
07/20/2018	Approved at OB GYN Committee	New	
9/19/2018	Approved at Nursing P&P	No	
10/02/2018	Approved at PAC Committee	Yes	Minor wording consistency with age of fetus.
10/5/2018	Approved at MEC	No	Revision of trauma section

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 645	Page 1 of 2
Title: Strangulation Evaluation	**Effective Date:** 10/1/2018	☐ **RUHS – Behavioral Health** ☐ **RUHS – Care Clinics** ☐ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. DEFINITIONS

1.1 Strangulation. A form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck by external pressure on the neck. [3.1]

1.2 Suffocation. External prevention of respiration via occlusion of the nose and mouth with an object.[3.1]

1.3 CTA. Computed Tomography Angiography.[3.3]

1.4 Neurological signs and symptoms. Loss of consciousness, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symptoms.[3.2]

1.5 Petechial hemorrhage. Minute hemorrhagic spots of pinpoint to pinhead size, in skin.[3.3]

1.6 Dysphagia. Difficulty in swallowing.[3.3]

1.7 Dysphonia. Difficulty or pain in speaking.[3.3]

1.8 Subcutaneous Emphysema. The presence of air or gas in the subcutaneous tissue.[3.3]

1.9 Dyspnea. Shortness of breath, a subjective difficulty or distress in breathing.[3.3]

1.10 Forensic Medical Examination. Examination conducted by a SANE with the purpose of discovering and preserving evidence of assault.[3.4]

1.11 SANE. Sexual Assault Nurse Examiner.

2. GUIDELINES

2.1 Triage care to medical clearance or admission

a. When triaging patients presenting with a chief complaint of assault, sexual assault, and/or neck/throat issues, the triage nurse will ask "Were you choked or strangled? Was anything placed on or around your neck, including hands?"

b. If the answer to the question above is (1) yes, (2) I can't remember, or (3) is in any way vague, refer to Management of Blunt Neck Trauma Due to Strangulation algorithm. (Attachment A).

c. Assess for the following: *Neurological signs and symptoms*, *petechial hemorrhage* to the conjunctiva, behind the ears, periorbital areas, *dysphagia*, *dysphonia*, *dyspnea*, and *subcutaneous emphysema*.

d. If any of the above are present, the patient should be medically cleared via the Blunt Neck Trauma Due to Strangulation Algorithm.

e. Contact law enforcement in the jurisdiction where the assault/ sexual assault occurred. (Refer to RUHS-MC Policy No. 626 Abuse, Neglect, and/or Domestic Violence Assessment and Reporting).

f. Once the patient is medically cleared, if a *Forensic Medical Examination* is requested by law enforcement, the patient will be transferred to the Sexual Assault Response Team for a *Forensic Medical Examination*.

2.2 Emergency Department Nursing Assessment

a. Perform a head-to-toe assessment, including detailed neck, face, eyes, eyelids, mouth, shoulders, chest, chin, behind the ears, and scalp inspection. Inspect hands and fingernails. Inspect for defensive or self-inflicted injuries.

b. Measure the circumference of the neck during initial assessment and every 12 hours while in Emergency Department.

c. If patient meets admission criteria, plan for 24 hour observation, to include neck measurements every 12 hours.

3. REFERENCES

3.1 Faugno, D., Trujillo, A., Bachmeier, B., Speck, P. *Manual Nonfatal Strangulation Assessment for Health Care Providers and First Responders*, 2017.

3.2 Training Institute on Strangulation Prevention. *Recommendations for the Medical/Radiographic Evalutation of Acute Adult, Non-Fatal Strangulation*, 2016.

3.3 *Stedman's Medical Dictionary, 28th Edition*, 2005.

3.4 California Emergency Management Agency, California Medical Protocol for the Examination of Sexual Assault and Child Abuse Victims, 2001.

4. ATTACHMENTS

A. Management of Blunt Neck Trauma Due To Strangulation Algorithm

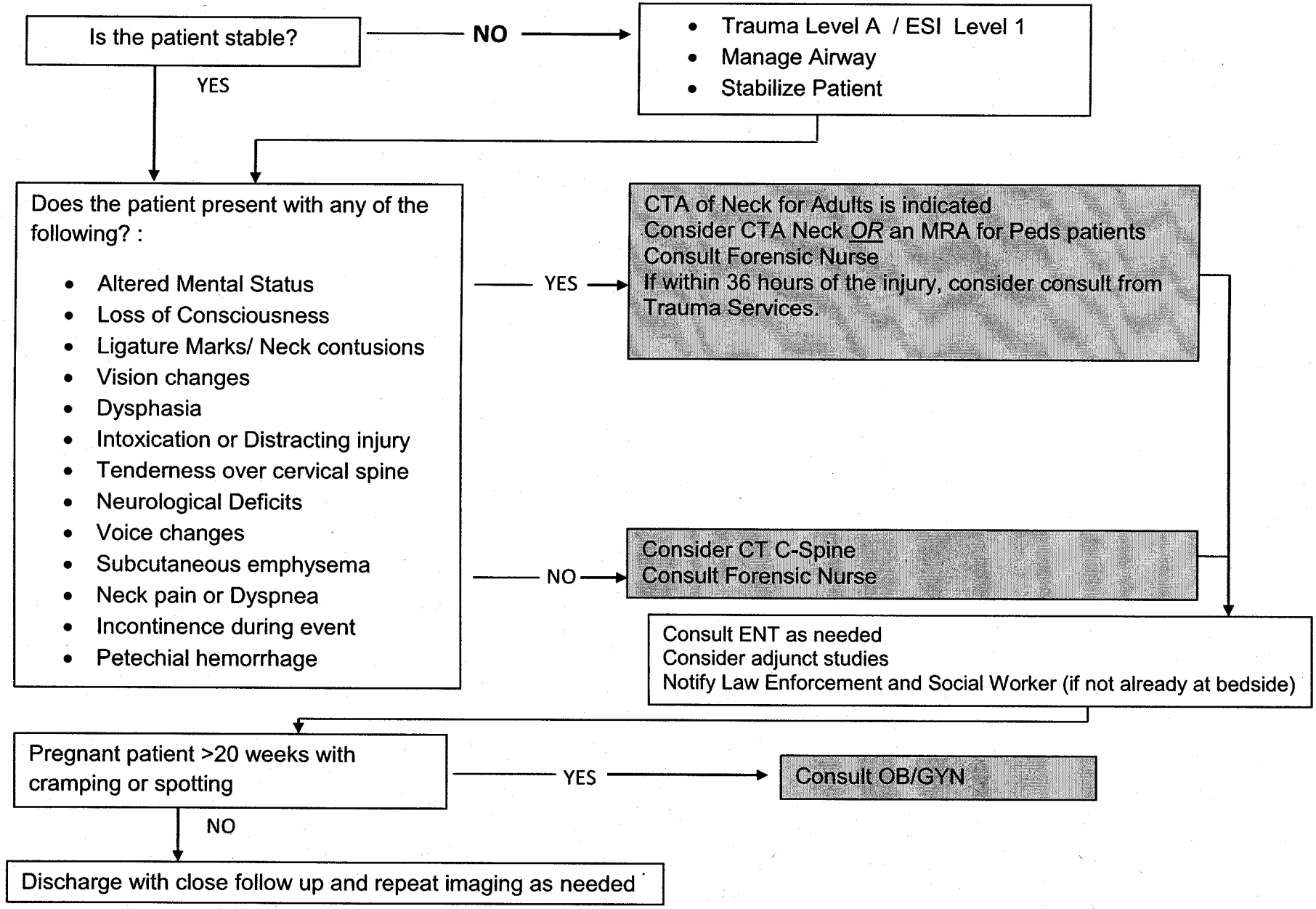
Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: Nursing Administration	**Replaces Policy:** N/A

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
6/5/2017	Sexual Assault Response Team	N	
8/16/2017	Nursing P&P		Some minor verbiage changes. Make sure to define all acronyms and use updated references. Algorithm should be clarified in regards to pregnant patients less than 20 weeks.
6/21/2018	Policy Approval Committee	Y	Minor wording
9/13/2018	Medical Executive Committee	N	

MANAGEMENT OF BLUNT NECK TRAUMA DUE TO STRANGULATION

(ATTACHMENT A)



RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 646	Page 1 of 2
Title: Processing 5150 and 5250 Involuntary Holds	**Effective Date:** 6/27/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jen Cruikshank, CEO/ Hospital Director		☐ Policy ☒ Procedure ☐ Guideline

1. DEFINITIONS

1.1 5150 (72 - hour involuntary hold): Trained personnel designated by the county may, upon probable cause indicating DTS/DTO or grave disability caused by a mental health condition, take or cause to be taken, a person into custody for a period of up to 72 hours involuntarily for assessment, evaluation, crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment. Trained personnel will be one of the following:

a. A peace officer.
b. A professional person in charge of a facility designated by the county for evaluation and treatment.
c. A member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment.
d. Designated members of a mobile crisis team.
e. A professional person designated by the county.

1.2 5250 (14 - day detention): An additional 14 days of involuntary treatment beyond the 72-hour hold placed when facility clinicians conclude that a person is in need of additional treatment and the person has first been offered voluntary treatment for a mental health disorder and has refused it.

1.3 Authorized Staff: A staff member with LPS training with a current certificate.

1.4 Danger To Others (DTO): Words or actions that indicate the person in question either intends to cause harm to a particular individual or intends to engage in dangerous acts with gross disregard for the safety of others.

1.5 Danger to Self (DTS): Words or actions that indicate the person in questions intends to deliberately harm him/herself (e.g. overdose) or who demonstrates a disregard for personal safety to the point where injury is imminent (e.g., wandering in heavy traffic). The danger must be present, immediate, substantial, physical and demonstrable.

1.6 Grave Disability: A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter. For persons under age 18, this is a person who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety and development, including food, clothing, shelter, even though provided to the minor by others.

1.7 Petition for Writ of Habeas Corpus: A legal request for release from a facility.

1.8 Probable Cause: The specific facts used to determine whether a person is DTO, DTS, or gravely disabled.

1.9 Lanterman-Petris-Short Act (LPS): The 1967 LPS Act (WIC§5000) concerns the involuntary civil commitment to a mental health institution in the State of California. The law requires that persons must be, as a result of mental disorder, a danger to

themselves, a danger to others, and/or gravely disabled before they can be detained against their will.

1.10 Voluntary Admission: A person willingly agrees to be treated in the hospital and may also ask to leave and be permitted to leave unless they are a danger to themselves, others, or gravely disabled (and the involuntary hold process is initiated).

1.11 PCLS: Psychiatric Consultation Liaison Team

2. REFERENCES

2.1 CA Welfare and Institutions Code. Division 5.Community Mental Health Services, Part 1. The Lanterman-Petris-Short Act. Chapter 2 Involuntary Treatment (5150-5349.5)

2.2 RUHS - Medical Center policy HIM 1003 Processing 5150 & 5250 Involuntary Holds – Legal Audit

2.3 RUHS – Medical Center NURS 258 Increased Observation of Patients

2.4 RUHS – Medical Center NURS 271 Suicide Prevention

Document History

Release Dates: 8/22/1999, 3/10/2000, 3/25/2003	**Retire Date:** N/A
Document Owner: Arlington Campus ACNO	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/23/2016	Arlington Campus ACNO	Y	Update terms and format
5/18/2017	CNO	Y	Amend references
6/16/2017	Chief of Psychiatry	Y	Minor deletions
12/19/17	Arlington Campus, PCLS, ED	Y	Update definitions, minor deletions, word rephrasing, document restructuring.
3/8/2018	PCLS	N	
5/10/2018	MEC	N	
6/21/2018	Policy Approval Committee	Y	Add reporting requirements for incarcerated patients
6/19/2018	RUHS Behavioral Health	Y	Added reporting requirements
6/19/2018	Riverside County Corrections	Y	Added reporting requirements to DCU Sergeant

Responsible Individual(s) – Main Campus	Process	Responsible Individual(s) – Arlington Campus
	5150 Hold, 72 hour involuntary hold for treatment (Time begins date and time legal hold is written and ends 72 Hours after date and time legal hold is written)	
Attending Provider	- If a patient arrives or is admitted on a legal hold, the attending provider places a Psychiatry Consult in the medical record.	**N/A**
Psychiatry Provider	-PCLS or Telepsychiatry evaluates patient and makes a decision regarding the legal hold. -Prior to or at the expiration of legal , PCLS re-evaluates patient and Releases patient; refers for further care and treatment on a voluntary basis, or Certifies patient for 14 days of intensive treatment (5250 Hold). -Documents the above in patient's medical records.	**Psychiatrist**
Nursing	- The primary nurse notifies PCLS team of patient admitted on a hold. - PCLS authorized staff provides patient with original Involuntary Patient Advisement (DCHS 1802) form, advising patient both verbally and in writing of the application of the 5150 hold. -Places a copy of the advisement in the patient's medical record. -PCLS Nurse tracks/ notifies PCLS provider to re-evaluate patient prior to the expiration of the hold. --Notifies the Charge nurse of each activity (All patients on a legal hold will be provided 1:1 sitter).	**The Primary Nurse is responsible. (1:1 sitter only if indicated per level of observation policy).**
	5250 Hold, 14 day intensive treatment	
Psychiatry Provider	PCLS Evaluates patient prior to the expiration of the 5150 Hold, and if indicated, places the patient on a 5250 hold -Evaluates, completes, and co-signs the Notice of Certification for Intensive Treatment (5250 form) with a licensed clinical staff (physician, psychologist, social worker, or registered nurse). -Prior to or at the expiration of the 5250 Hold, re-evaluates patient and a. Releases patient or b. Refers for further care and treatment on a voluntary basis, or c. If the patient meets criteria, places the patient on the next appropriate hold. d. Documents above in patient's medical records. -Amends the Original 5250 form if: a. the initial 5250 form is incomplete or the patient's behavior has changed, b. Completes a new 5250 to reflect the additional or new criteria and writes the word **"Amended"** at the top of the form. c. The effective date and time; and the expiration date and time will still be the same as on the original form. Time will NOT be added to the involuntary hold.	**Patient's attending psychiatrist is responsible** **In the absence of the attending psychiatrist, a covering psychiatrist provides these services.**

Responsible Individual(s) – Main Campus	Process	Responsible Individual(s) – Arlington Campus
	*** Any patient initially detained on an involuntary basis that subsequently becomes a voluntary patient, and then later requires involuntary detention within the same admission encounter may not have a total period of detention beyond 17 days (72 hour hold plus 14 days hold)******.	
Nursing	The PCLS Nurse ensures the completion of the following: -Initial 5250 Certification, -Calls Arlington Campus Legal Desk to obtain Certification review hearing schedule. - Provides the patient with a. "Patients' Rights Advocacy Program" Brochure, b. copy of the notice of certification c. An authorized Staff provides Advisement for admission on a legal hold or change in legal status utilizing the Involuntary Patient Advisement DHCS 1802 form, patient's rights to the Writ of Habeas Corpus, certification review hearing, assistance of a patients' rights advocate or attorney, the date and time of the hearing to determine whether or not probable cause exists to detain him/her. -Notifies the patient's designee regarding the legal hold and to attend the hearing. -Amended 5250 Certification, -An authorized staff provides the patient with the original of the amended 5250 form -Faxes a copy of all legal paperwork (completed forms of legal holds, advisements etc.) to the RUHS – MC Arlington Campus Legal Desk and file same in the patient's medical record. -At the conclusion of the hearing, an authorized staff advises the patient if the hold is -Upheld and patient's right to file for Writ of Habeas Corpus. -Released, and notify the designated psychiatric provider. -Files a copy of the hearing decision, and documents the above in the patient's medical record. -Updates the patient's legal status in the electronic health records as needed. -Notifies the Charge nurse of each activity (All patients on a legal hold will be provided 1:1 sitter). -Should the 5250 expire and patient needs the hold extended, psychiatry should be contacted for follow up as soon as possible	**The Primary Nurse is responsible. (1:1 sitter only if indicated per level of observation policy).**
Arlington Campus Legal Desk	-Schedules certification review hearing in RUHS – Medical Center within four (4) days from the date the 5250 certificate form (Notification of 14 Day Certificaiton) patient was certified. -Provides the patient's nurse with the hearing schedule and notifies the primary nurse of any changes thereof. -Provides copy of the legal paperwork to Patients' Rights Advocate	**Arlington Campus Legal Desk**

Responsible Individual(s) – Main Campus	Process	Responsible Individual(s) – Arlington Campus
	PC 4011.6 Incarcerated Patients	
PCLS Team	-If a prisoner has been detained for the purposes of 72-hour treatment and evaluation (5150 evaluation), RUHS Behavioral Health Specialist will transmit a confidential report to the Detention Care Unit (DCU) Sergeant , concerning the condition of the prisoner. A new report shall also be sent upon filing of temporary letters of conservatorship. - RUHS-Behavioral Health Specialist will transmit a new confidential report on the inmate's condition to the DCU Sergeant, counsel for the prisoner, and prosecuting attorney upon conversion to voluntary hold. - If a prisoner is due to be released from a 5150 or 5250 hold before the expiration date of their sentence, RUHS-Behavioral Health Specialist will notify counsel for the prisoner, the prosecuting attorney and the DCU Sergeant of the discharge who will make arrangements to transport and receive the prisoner back into jail or juvenile detention facility. - Documentation of any reports on an inmate's condition to the DCU Sergeant will be entered into the patient's electronic medical record by the RUHS Behavioral Health Specialist.	**Only applies to Moreno Valley Campus**

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 657	Page 1 of 2
Title: Peripherally Inserted Central Catheter (PICC) Guidelines in Non-Neonate	**Effective Date:** 10/1/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 PICC or Peripherally Inserted Central Catheters are single or multi-lumen venous access device, the tip of which resides centrally in either the superior vena cava or inferior vena cava depending on the point of insertion.

1.2 End-Stage Renal Disease (ESRD) is a medical diagnosis for patients receiving renal replacement therapy such as hemodialysis or peritoneal dialysis.

1.3 Vascular Access Services Registered Nurse (VAS RN) is a specially-trained registered nurse and have successfully completed the VAS competency.

1.4 Over-the-Wire catheter exchange is an aseptic procedure of replacing a mal-positioned or malfunctioning PICC line using an appropriate guide wire.

2. GUIDELINES

2.1 PICC line insertions require a physician or a Nurse Practitioner's written order in the patient's chart.

2.2 PICC line can only be inserted by the RUHS VAS RNs or RNs who have successfully completed training and demonstrated competency in PICC placement.

2.3 A signed informed consent is required prior to PICC line placement or Over-the-Wire exchange procedure, (see HW Policy 602: Patient Informed Consent)

2.4 ESRD patients require to have the nephrologist consulted prior to PICC line placement

2.5 Chest x-ray is required to verify the proper placement of all new PICC lines and PICC lines that were placed prior to hospital visit.

2.6 Physician order is required prior to using newly-placed PICC lines and for PICC lines that are already in place prior to patient's admission or hospital visit.

2.7 Only properly trained registered nurses, radiology technicians and physicians may access PICC lines for infusion or blood draws. Student nurses who need to access PICC lines will be directly supervised by their clinical instructor/s or a RN.

2.8 Verification of patency is required prior to every use of a PICC line as evidenced by blood return and being easily flushed.

2.9 PICC lines that present resistance to flushing and aspiration maybe partially or completely occluded. DO NOT flush against resistance. Follow de-clotting procedure per RUHS Medical Center protocol (refer to RUHS-Medical Center policy 264).

2.10 Written order is required for PICC line removal. The line can only be removed by VAS RNs or physicians.

3. REFERENCES

3.1 **Elsevier Performance Manager:** *Clinical Skills: Peripherally Inserted Central Catheter Insertion*

3.2 **Infusion Nurses Society Standards of Practice. (2016).** *Infusion therapy standards of practice. Volume 39 Number 1S.*

3.3 **National Kidney Foundation** *Clinical Practice Guidelines and Clinical Practice Recommendations, 2015*

3.4 **United States Centers for Disease Control and Prevention** *Guidelines for the Prevention of Intravascular Catheter-Related Infection, 2016*

3.5 **Journal of the Association for Vascular Access** *Positive Influence of a Dedicated Vascular Access Team In Acute Care Hospital, March 2017*

3.6 **Association for Vascular Access (AVA) and the American Society of Diagnostic and Interventional Nephrology (ASDIN) Position Statement:** *Preservation of Peripheral Veins in Patients with Chronic Kidney Disease, March 2011*

3.7 **California Board of Registered Nursing General Information**: *Nurse Practitioner Practice. Rev. 4/13/2011*

3.8 **American Society of Radiologic Technologists** *Administering Medication in Peripherally Inserted Central Catheter Lines or Ports with a Power Injector June 2017*

Document History:

Prior Release Dates: 10/2007	**Retire Date:** N/A
Document Owner: Vascular Access Services	**Replaces Policy:** NURS 262 PICC Use Non Neonate

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
2/07/2018	RUHS VAS team	Yes	Defocus from PICC insertion steps to use and maintenance by qualified staff
4/18/2018	Nursing P&P	Yes	Removed procedure which can be found in Elsevier.
7/19/2018	C. Wang, A. Madarang, M. Drayer	Yes	Removed more items duplicating Elsevier. Simplified and removed misleading verbiage.
8/7/2018	Policy Approval Committee	Yes	Approval with minor changes.
9/13/2018	Medical Executive Committee	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
HOUSEWIDE

	Document No: 677	Page 1 of 6
Title: Medication: Alteplase (Activase®) For Use in Acute Ischemic Stroke	**Effective Date:** 8/6/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ Policy ☐ Procedure ☒ Guideline

1. DEFINITIONS

1.1 National Institute of Health Stroke Scale (NIHSS): Defined as a standardized method used by healthcare professionals to measure the level of impairment caused by stroke.

2. COMPETENCY

2.1 Registered nurses must complete the online Alteplase Administration training module prior to administration of intravenous (IV) Alteplase (Activase®) for treatment of acute ischemic stroke.

2.2 The online Alteplase Administration training module is to be completed by registered nurses working in the critical care areas (Emergency Department, Adult Critical Care Unit & Progressive Care Unit) on an annual basis.

3. GUIDELINE

3.1 Alteplase (Activase®) will be given according to physician orders for patients experiencing acute ischemic stroke (AIS) by qualified staff, and in accordance with manufacturer's recommendations or best practice.

3.2 Alteplase (Activase®) shall be initiated within 4.5 hours of last known well time, and after computerized tomography (CT) scan to exclude intracranial hemorrhage.

3.3 Medication will be infused via a smart infusion pump utilizing the drug library. A second RN will perform an independent double check to confirm that: (1) the correct medication and dose have been prepared and (2) the infusion pump was programmed correctly.

3.4 Ensure the physician has reviewed with the patient and/or family the potential risks, consequences and benefits of Alteplase (Activase®) prior to administration as per the Informed Consent policy.

3.5 1:1 nursing ratio shall be implemented for the first 8 hours of the Alteplase (Activase®) infusion or longer based on therapeutic response and/or physician order.

4. PROCESS

4.1 Verify physician order.

4.2 Explain procedure to patient and/or family as appropriate.

4.3 Establish continuous cardiac and pulse oximetry monitoring.

4.4 Alteplase (Activase®) is to be reconstituted by pharmacy or RN deemed competent.

4.5 Obtain patient weight in kilograms.

a. Refer to Nursing Department policy, Clinical Practice Providing Care: Patient Weight Practice

4.6 Obtain baseline National Institute of Health Stroke Scale (NIHSS) .

4.7 Perform ordered invasive procedures prior to administration.

5. DOSAGE AND ADMINISTRATION

5.1 The recommended dose of Alteplase (Activase®) is 0.9 mg/kg.

5.2 The total dose for treatment of acute ischemic stroke shall not exceed 90 mg.

5.3 The discard quantity shall be removed prior to medication delivery and verified by a second RN unless reconstituted by pharmacy.

5.4 A dedicated IV line is required for the administration of IV Alteplase (Activase®).

5.5 The initial 10% bolus dose is to be delivered by the Registered Nurse via intravenous push (IVP) over one minute or via a smart infusion pump utilizing the Stroke Therapy options

a. Stroke Therapy options are based on a patient's weight.

i. Less than or equal to 100 kg – use for a patient who weighs less than or equal to 100 kg.

ii. Greater than 100 kg – Use for a patient who weighs greater than 100 kg.

5.6 The remaining 90% of the Alteplase (Activase®) infusion is to be infused over 60 minutes via a smart infusion pump, utilizing the built-in drug library.

5.7 Once the medication container is empty infuse 0.9% NS IV at the same rate via existing tubing to ensure the entire therapeutic dose is provided.

6. MONITORING

6.1 Monitor vital signs and neurological assessments:

a. Every 15 minutes x 2 hrs.

b. Proceed to every 30 minutes x 6 hrs.

c. Proceed to every 1 hour x 16 hours during and following Alteplase (Activase®) infusion.

6.2 NIHSS assessment:

a. Complete NIHSS ≤ 15 minutes from start of infusion.

b. Repeat again at 2 hours post infusion.

c. Repeat again at 8 hours post infusion.

6.3 Monitor blood pressure:

a. Blood pressure should be maintained systolic blood pressure (SBP) less than 180 mmHg or diastolic blood pressure (DBP) less than 105 mmHg during and post Alteplase (Activase®) administration.

b. Notify appropriate provider for SBP greater than 180 mmHg or DBP greater than 105 mmHg for intervention orders.

6.4 Continue to reassess and monitor the patient's neurological status. Report any changes immediately to the appropriate provider.

6.5 Alteplase (Activase®) side effects may include, but are not limited to:

a. Bleeding

b. Headache

c. Decreased level of consciousness (LOC)

d. Angioedema

6.6 Intracranial hemorrhage should be suspected secondary to Alteplase (Activase®) administration if the patient exhibits the following signs:

a. Onset of new headache.

b. Nausea and/or vomiting.

c. Change in level of consciousness.

d. Elevation of blood pressure.

e. Deterioration in motor examination.

6.7 If intracranial hemorrhage is suspected:

a. *Discontinue IV* Alteplase (Activase®) *immediately.*

b. Notify the treating physician *immediately.*

c. The physician is to consider the following:

i. STAT CT scan of head without contrast.

ii. Neurosurgery consult

iii. PTT/PT, INR, CBC with platelets, & fibrinogen level.

- 2 pooled units of cryoprecipitate containing factor VIII IV infusion.Infuse over 10-30 min (onset in 1 hour, peaks in 12 hours)

6.7.c.2 If cryoprecipitate if contraindicated, Transexamic acid 1000 mg IV

- Infuse over 10 minutes

6.8 Angioedema should be suspected secondary to Alteplase (Activase®) administration if the patient exhibits the following signs:

a. Acute swelling of the lips or tongue

b. Altered voice

c. Complaints of dysphagia

i. May be associated with patients that take angiotensin-converting enzyme inhibitors.

ii. Usually occurs near the end or shortly after the infusion has completed.

6.9 If angioedema is suspected:

a. Notify the treating physician immediately

b. The physician is to consider the following:

i. Maintain airway

- Endotracheal intubation may not be necessary if edema is limited to anterior tongue and lips.
- Edema involving the larynx, palate, floor of mouth, or oropharynx with rapid progression (within 30 minutes) poses higher risk of requiring intubation.
- Awake fiberoptic intubation is optimal. Nasal-traceal intrubation may be required but poses risk of epitaxis post IV Alteplase. Cricothyroidotomy is rarely needed and also problematic after IV Alteplase.

ii. Discontiune IV Alteplase and hold any angiotensin-converting enzyme inhibitor (ACEI)

iii. Administer IV methylprednisolone 125 mg.

iv. Administer IV diphenhydramine 50 mg.

v. Administer IV famotidine 20 mg.

vi. If further increase in angioedema, administer epinephrine (0.1%) 0.3 mL subcutaneously or by nebulizer 0.5 mL.

7. DOCUMENTATION

7.1 Document response to therapy and other interventions as appropriate.

7.2 Document on Medication Administration Record (MAR) per High Alert Medication Policy.

8. PRECAUTIONS

8.1 Standard Precautions

8.2 No anticoagulation or anti-platelet medication for 24 hours post IV Alteplase (Activase®) administration.

8.3 No intramuscular (IM) injections, naso-gastric (NG) tube placement, invasive procedures or invasive line placement for 24 hours post IV Alteplase (Activase®) administration.

8.4 Avoid indwelling urinary catheter placement during and 30 minutes post Alteplase (Activase®) infusion.

8.5 IV Alteplase (Activase®) is for intravenous administration only. Extravasations of Alteplase (Activase®) can cause ecchymosis and/or inflammation.

a. Extravasation management consists of terminating the infusion at the IV site and application of local therapy.

9. RELATED POLICIES

9.1 Nursing Department policy, 203.04 Clinical Practice Providing Care: Patient Weight Practice

9.2 Housewide policy, 852 Medication Administration

9.3 Housewide policy, 804 High Alert Medications

9.4 Housewide policy, 602 Informed Consent

10. ATTACHMENTS

10.1 Attachment 1- Guideline of Emergent Life-Threatening Reversal of Bleeds Induced by Alteplase (Activase®)

11. REFERENCES

11.1 Del Zoppo, G., Saver, J., Jauch, E., Adams, H. (2009). Expansion of the Time Window to Treatment of Acute Ischemic Stroke with Intravenous Tissue Plasminogen Activator. A Science Advisory from the American Heart Association/American Stroke Association (2009). *Stroke 2009; 40:2945-2948*

11.2 Demaerschalk, B., Kleindorfer, D., Adeoye, O., Demchuk, A., Fugate, J., Grotta, J., et al (2015). Scientific Rationale for the Inclusion and Exclusion Criterial for Intravenous Alteplase in Acute Ischemic Stroke: A Statement for Healthcare Professionals From the American Heart Association/American Stroke Association. *Stroke 2016; 47:581-641*

11.3 Hacke, Werner et al. Thrombolysis with Alteplase 3-4.5 Hours after Acute Ischemic Stroke. *N Engl J Med* 2008; 359;13:1317-1329.

11.4 Myslimi, F., Caparros, F., Dequatre-Ponchelle, N., Moulin, S., Gautier, S., Girardie, P., Cordonnier, C., Bordet, R., & Leys, D. (2016) Orolingual Angioedema During or After Thrombolysis for Cerebral Ischemia. *Stroke 2016; 47:00-00.*

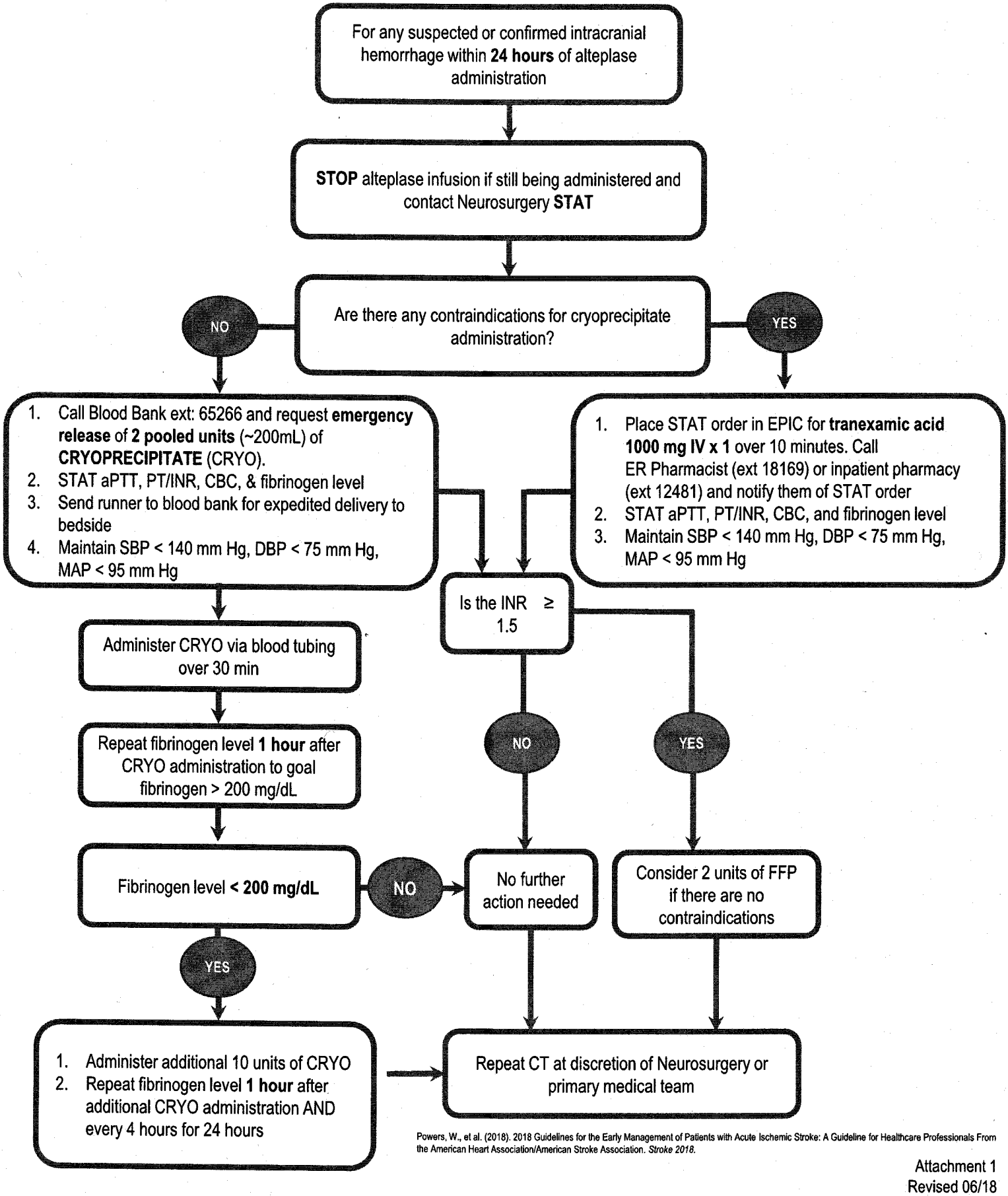
11.5 Powers, W., Rabinstein, A., Ackerson, T., Adeoye, O., Bambakidis, N., Becker, K., Biller, J., Brown, M., Damaerschalk, B., Hoh, B., Jauch, E., Kidwell, C., Leslie-Mazwi, T., Ovbiagele, B., Scott, P., Sheth, K., Southerland, A., Summers, D., and Tirschwell, D. (2018). 2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. *Stroke 2018.*

Document History:

Release Dates: 05/2012, 11/2012, 06/2013, 11/2013, 7/2016, 2/5/18	**Retire Date:**
Sponsored by: **Stroke Committee**	**Replaces Policy:** 270

Date Reviewed	Reviewed By:	Revisions Made?	Revision Description
2/2016	Stroke Committee	Yes	Minor formatting changes, removed location of medication administration and added competency requirements
3/2016	P&T Chair Dr. Chitsazan	No	Reviewed by Dr. Chitsazan on 3/29/2016. Informed policy did not need to go through P&T due to minor changed.
5/2016	Nursing P&P	Yes	Reviewed and submitted formatting changes to the sponsor including items that require clarification.
6/2016	P&T Committee	No	No changes requested
7/14/16	MEC	No	No changes requested
7/20/2017	Nursing P&P	Yes	Associcated policies noted as House-wide versus Nursing Department specific.
8/7/2017	P&T Committee	Yes	Add "greater than" language
10/18/2017	Stroke Committee	Yes	Removal of reguired written consent in 3-4.5 hour window to correlate with Code Stroke policy. Refer to HW Informed Consent policy
12/4/17	P&T Committee	No	
1/11/18	MEC	No	
2/5/2018	HEC	No	
4/18/18	Stroke Committee	Yes	Added reversal information r/t Alteplase associated ICH and angioedema. Reversal pathway to be added as an attachment
4/18/2018	Blood and Tissue Committee	Yes	Attachment to indicate 2 pooled units versus 10 units
5/16/2018	Nursing P & P	Yes	Additon of "***Physician*** to consider the following" for enhanced clarification
6/4/18	P&T Committee	Yes	Minor changes.
6/5/18	PAC	Yes	Minor changes.
6/14/18	MEC	No	
	CEO		

Physician Guideline of Emergent Life-Threatening Reversal of Bleeds Induced by Alteplase (Activase®)



Powers, W., et al. (2018). 2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. *Stroke 2018.*

Attachment 1
Revised 06/18

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 678	Page 1 of 7
Title: Blood Transfusion	**Effective Date:** 5/10/2018	☐ RUHS – Behavioral Health ☐ RUHS – Care Clinics ☒ RUHS – Medical Center ☐ RUHS – Public Health ☐ Departmental
Approved By: Jennifer Cruikshank Hospital Director/CEO		☐ Policy ☐ Procedure ☒ Guideline

1. POLICY

1.1 It is the policy of Riverside University Health System-Medical Center (RUHS-Medical Center) to outline the practice standards for processing and safe administration of blood transfusion in accordance to the current practice guidelines and procedure as follows.

2. GUIDELINES

2.1 Check physician order.

2.2 Obtain Specimen for Type and Cross or Type and Screen and place in a pink top tube.

a. Two licensed staff (two RNs, one RN and an LVN, or one RN and a physician) must check and verify the following together:

1) Medical Record to verify physician order (use down time form #630 when necessary).

2) Armband to assure correct identification of patient. Name, Date of Birth (DOB), and Medical Record # (MR#) are required to verify the correct patient.

3) Correct labeling of specimen with patient name, MR#, date and time of specimen collection and initials of person obtaining specimen and person verifying accuracy. In addition, crossmatch number matching armband will be placed on specimen tube: Every blood specimen is to be labeled at the bedside, in the presence of the patient from whom it has been collected.

4) Correct Blood armband with correct crossmatch numbers and date and time of draw is placed on patient.

5) Both should initial the label on the specimens. One of these **MUST** be an RN. Laboratory will not accept specimens that are not labeled properly.

6) NOTE: As per AABB Standards 5.14.5, a second Blood Bank specimen for ABORH RETYPE must be drawn at a different time and by two different nurses/physician if there is no previous ABORH history on file at RUHS Blood Bank. The Blood Bank will notify the Charge RN or the primary RN if a second draw is necessary. If a second set of staff are not available for the second blood draw, the RN shall notify the Lab and they will draw. The blood draw should occur within a short period of time from notification.

2.3 Patient Preparation:

a. Informed consent required on Form #163 entitled "Transfusion Information, Consent & Declination Form". Physician should document informed consent in medical record. The original consent will be placed into the patients chart.

b. Ask about previous transfusions and reactions Notify physician and Blood Bank if previous transfusions or reactions have occurred.

c. Take temperature, pulse, respirations and blood pressure and record within one hour prior to hanging blood.
   1) Notify physician if patient is febrile.

d. Start I.V. of 0.9% Sodium Chloride solution using blood tubing and appropriate technique.

e. Adjust to keep open rate of 10 ml per hour. Blood tubing may be piggybacked through an existing I.V. tubing only under the following circumstances.
   1) Main I.V. will be 0.9% Sodium Chloride.
   2) I.V. tubing should not have medication run through it.

3) If any solution or medication other than 0.9% sodium chloride is infused before component administration, the tubing should be flushed with 0.9% sodium chloride immediately before the blood infusion.

4) Piggy back at port closest to patient using luer connection extension tubing and clamp main line while blood is running.

2.4 Acquisition of Blood

a. The RN will release the blood orders when needed and fill out the crossmatch number on the printed sheet with the specific blood product. The crossmatch number is obtained from the patient's crossmatch armband.

b. The Nurse needs to physically check the Paul Gann Consent Form# 163 has been signed and is in the patient's chart.

c. Only 1 unit may be retrieved at a time (Exception: OR, ED, L&D, and ACCU) (Blood may also be issued in a cooler).

d. Anyone on the nursing staff or a volunteer may go to the laboratory for blood, but only one unit may be retrieved at a time (Exception: OR, ED, L&D, and ACCU).

e. Upon receiving the release, the laboratory technologist will dispense the correct unit of blood or component by verification of Transfusion record form #625 and Epic release form.

f. Consider activating Massive Transfusion Protocol No. 604.2, if patient meets criteria.

2.5 Patient-blood identification

a. **Two licensed staff (two RNs, one RN and an LVN, or one RN and a physician) must check and verify the following together <u>in the presence of the patient:</u>**

1) Physician order for transfusion

2) Patient's name, DOB and MR#

3) Blood unit donor number

4) Product type

5) Cross match armband number

6) Blood type and Rh factor of patient and donor

7) Donor Unit Expiration date

b. Both should sign on the appropriate space on the Transfusion Record Form #625.

2.6 Administration of Blood

a. Obtain baseline vitals. Notify Physician before obtaining unit of blood if patient is febrile.

b. Infusion of the blood must begin within thirty (30) minutes from the time it is released from the laboratory Pre-Transfusion Service and then must be completely transfused within four (4) hours.

c. If blood is NOT going to be used, it must be returned to the Laboratory Pre-Transfusion Service within the first thirty (30) minutes from the time that it was released from the Laboratory Pre-Transfusion Service in order to be re-issued.

d. Attach the blood bag to blood-tubing with a filter. Blood and components must be administered through an appropriate filter designed to retain blood clots and other debris. Assure filter is fully wetted with 0.9% sodium chloride solution.

e. Start blood infusion and administer slowly (set rate at 100 ml/hr to deliver 25 ml of blood in first fifteen (15) minutes after starting transfusion. If no problem is identified, adjust rate to finish unit in one and a half (1 ½) to two (2) hours (or less, if indicated).

f. To administer blood products via syringe (neonates, infants and small pediatric patients receiving less than a full unit),

1) Connect Y tubing to 60 mL syringe on "Y" and to extension tubing on bottom end.

2) Spike blood component; ensure extension tubing remains closed

3) Aspirate full volume of bag into syringe

4) Clamp tubing to bag and open clamp for extension tubing

5) Prime tubing with blood product

6) Turn off and disconnect IV fluids if infusing in IV line to be used for blood component administration.

7) Flush line with 0.9% sodium chloride solution

8) Connect syringe to IV pump designated for blood transfusion

9) Connect IV tubing to child's IV line

10) Open clamp to blood component

11) Start pump. Unless otherwise specifically indicated by the child's clinical condition, infusion should be run at 1 mL/kg/hr for the first 15 minutes (e.g., 1 mL/kg/hr) and then increased to the desired rate.

12) Observe patients closely for the first 15 minutes and take vital signs

13) After the first 15 minutes, if there are no problems, set pump rate on basis of prescribing practitioner's order: quantity of blood to be transfused divided by ordered length of time for transfusion. Set total volume to be transfused.

g. Document all required information on Form #625 Transfusion Record and in Electronic Health Record (EHR) under Blood Administration Flow Sheet.

1) Signatures of RN starting, verifying and stopping transfusion, date and time started and stopped, Vital signs (pre-transfusion, 15 min, post-transfusion within 1 hour, transfusion reaction (yes or no) and amount transfused.

h. Include donor number, site, prep used, gauge of needle and time.

i. Any transfusion reaction must be described in the progress notes.

j. **Exception: for patients in the OR department only:**

1) "See Anesthesia Records" is acceptable for the documentation of vital signs (pre-transfusion, 15 minutes and post within 1 hour) for patients in the OR department only. These can be found in the patients chart under anesthesia records. All signatures, date and time of start and stop, and transfusion reaction (yes or no) are still required.

k. Amount of blood transfused should also be noted on the In & Out section of the flow sheet.

l. All inpatients, Medical Observation patients, Outpatients and Clinic Patients who receive blood or blood products at RUHS-Medical Center must receive "Patient Instructions after Blood Transfusions" form #358.

2.7 Termination of Blood

a. Disconnect the blood bag from the blood-tubing and flush line with normal saline, discontinue the I.V. using appropriate technique if no more fluid is ordered.

b. Empty or used blood bags can be disposed of on the patient care unit in the Red Biohazard Containers UNLESS a suspected transfusion reaction occurs, then the blood bag must be returned to the Laboratory Pre-Transfusion Service.

c. Take vital signs and record on Form 625 Transfusion Record (must be done within one-hour following completion of blood)

d. Place chart copy of Transfusion Record Form 625 on Laboratory section of patients medical record

e. Send to Lab immediately the Blood Bank copy of the Transfusion Record form #625 in LAB OUTBOX in nurse's station.

2.8 Documentation of Transfusion must include:

a. Transfusion Record Form #625: Document the transfusionist's signature (start, verifier, stop), pre-transfusion vital signs (within one hour prior to transfusion, fifteen (15) minutes after beginning transfusion and within one hour after infusion is completed. After completion of the blood administration, include time completed, amount given, presence or absence of a suspected transfusion reaction and the signature of the nurses. Complete all required documentation in EHR.

2.9 In the event of a transfusion reaction, notify the patient's primary physician (or the on-call physician). Report symptoms and vital signs. The physician should evaluate the nature of the reaction if a hemolytic reaction is suggestive, the following must be done:

a. Notify Laboratory Pre-Transfusion Service regarding any suspected transfusion reaction and place order for transfusion reaction workup.

b. Return donor blood with tubing and lab copy of form #625 to the laboratory Pre-transfusion service. Re-examine label on the container and all records to assure that there has been no error in identifying the patient or the blood

c. Draw one large Pink top tube of blood. Label correctly. Identify specimens as "post-transfusion reaction" and send to the laboratory Pre-Transfusion Service and a physician order for a suspected Transfusion reaction.

d. Send a specimen of the first urine passed after the reaction to the Laboratory Pre-Transfusion service labeled "post-transfusion reaction".

2.10 Documentation of Suspected Transfusion Reaction

a. Symptoms of reaction, vital signs, and amount of blood infused.

b. Date and time blood transfusion was stopped.

c. Date, time and name of physician notified; time Pre-Transfusion Service was notified.

d. Date and time blood and urine specimens were collected and taken to lab, if applicable.

e. Date and time blood and tubing were returned to lab, if applicable.

f. Vital signs every thirty (30) minutes X 4—longer if patient's condition warrants.

g. Complete "Transfusion Reaction" section (yes or no) of Transfusion Record (Form #625).

NOTE: "Signs and symptoms suggestive of mild allergic reactions (e.g. urticaria) need NOT be reported to the Blood Bank or Transfusion service" (Section 7.4.1.2 25th ed. AABB Standards, 2008).

3. REFERENCES

3.1 Guidelines for perioperative practice Current Edition. AORN, Inc. Conner, R., & AORN.

3.2 Standards for Blood Banks and Transfusion Services AABB Technical Manual, Current Edition.

3.3 Clinical Nursing Skills—Basic to Advanced Skills, Current Edition. Prentice – Hall Inc.

3.4 AACN Procedure Manual for Pediatric Acute and Critical Care Current Edition, Saunders Elsevier, edited by Judy T Verger and Ruth M Lebet.

4. ATTACHMENTS

4.1 Cross match Administration Request Form 630

4.2 Transfusion Record Form 625

4.3 Transfusion Information (Paul Gann) and Consent Form 163

4.4 A patients Guide to Blood Transfusion

4.5 Patient Instructions After Blood Transfusions Form 358

4.6 Authorization to Release Blood Form 8

4.7 Suspected Transfusion Reaction Work-Up Form 675

Document History:

Prior Release Dates: 8/17/16	**Retire Date:** N/A
Document Owner: Operating Room	**Replaces Policy:** Nursing Policy 202.01 Blood Transfusion

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
7/03/2017	Marie L. West, Dee Mills, Oralia E-Lara, Cherrie Mayhall, Cedric Bol, William C. Hendra, Sunder Nambiar, Matthew De Fazio	Yes	Minimal policy changes and wording changes.
12/20/2017	Nursing P&P	Yes	Make housewide
3/6/2018	PAC	Yes	Minor wording
5/10/2018	MEC	Yes	Minor wording