Policy

Title: **Adult Critical Care - MINDS Tool**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* April 05, 2021
This policy belongs to: System Wide Critical Care Nursing Council	
Committee/Council Approval(s): N/A	*Date of COMMITTEE Approval(s):* N/A

☐ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
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PURPOSE

The purpose of the MINDS tool is for the management of alcohol withdrawal symptoms in critical care patients. Patients experiencing withdrawal seizures on current admission may require modification of the treatment component at the provider's discretion.

PERSONS AFFECTED

Registered Nurses

POLICY

The purpose of the MINDS tool is to assess patients who are critically ill, intubated, or unable to answer questions and at risk for alcohol withdrawal in the critical care areas.

DEFINITIONS

MINDS – Minnesota Detoxification Scale

CAGE - screening questionnaire to id potential problems with alcohol.

CIWA – Clinical Institute Withdrawal Assessment for Alcohol.

RESPONSIBILITIES

On Admission:

1. Perform a MINDS assessment after obtaining a CAGE score of 2 or more.
2. Document and notify provider with initial MINDS score.

Routine Assessment:

1. Complete a MINDS Tool Assessment as ordered.
2. Notify the provider of Assessment results as ordered.

Transfer Assessment:

1. Prior to transferring a patient to a lower level of care a CIWA-AR Assessment should be performed to establish a baseline score prior to leaving critical care area.

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

1. Nursing will screen patient on admission to assess for risk of alcohol withdrawal using the CAGE Questionnaire:
    a. *Have you ever felt you needed to **C**ut down on your drinking?*
    b. *Have people **A**nnoyed you by criticizing your drinking*
    c. *Have you ever felt **G**uilty about drinking?*
    d. *Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?*

    A score of two or more is used as the criteria for the identification of patients who have a potential for alcohol withdrawal.

2. Perform the MINDS Assessment Tool.

PARAMETER (Patient receives score based on real-time assessment)	**SCORE**
Pulse (beats per minute)	
<90	0
90-110	1
>110	2
DIASTOLIC blood pressure (mmHg)	
<90	0
90-110	1
>110	2
***Tremor** – Assess with patient's arms extended and fingers spread.	
Absent	0
Slightly visible or can be felt fingertip to fingertip	2
Moderate – Noticeably visible with arms extended	4
Severe – Noticeable even with arms not extended	6
Sweat	
Absent	0
Barely; Moist palms	2
Beads visible	4
Drenching	6
***Hallucinations** – Feeling crawling sensations over skin (tactile), hearing voices when no one has spoken (auditory), or seeing patterns, lights, beings, or objects that are not there (visual).	
Absent	0
Mild – Mostly lucid, sporadic/rare hallucinations	1
Moderate/Intermittent – Hallucinating at times (when first waking up or in between conversations/patient care) with moments of lucidity but able to be reoriented	2
Severe, continuous while awake	3
***Agitation** – Assess using the Richmond Agitation-Sedation Scale (RASS)	
Normal activity or sedated (RASS of 0 or less)	0
Somewhat > normal (RASS of +1)	3
Moderately fidgety, restless (RASS of +2)	6
Pacing, thrashing (RASS of ≥+3)	9
***Orientation**	
Oriented x3 (person/place/time OR at patient's baseline OR too sedated to assess orientation)	0
Oriented x2	2
Oriented x1	4
Disoriented	6
***Delusions** – Unfounded ideas that can be related to suspicions or paranoid thoughts, i.e., patients believe their things have been stolen or they are being persecuted unjustly	
Absent or unable to assess	0
Present	6
Seizures	
Not actively seizing	0
Actively seizing	6
TOTAL	
***If unable to assess a parameter secondary to over sedation or mechanical ventilation, score = 0**	

Heavner J et al. Implementation of an ICU-specific alcohol withdrawal syndrome management protocol reduces the need for mechanical ventilation. Pharmacotherapy 2018;38(7)

3. Page provider with results or treat as per Provider orders.

4. Frequency of assessment is based on the severity of MINDS score and treatment chosen. Orders will be placed

in the patient's chart by the Provider for MINDS Assessment Frequency. (these orders may include)

MINDS score – Assessment Frequency

MINDS SCORE	Phenobarb + Benzodiazepine	Phenobarb + Phenobarb
Greater than 19	15 minutes*	60 minutes*
15-19	30 minutes	60 minutes
5-14	60 minutes	60 minutes
Less than 5	2 hours**	2 hours**

*if score is greater than 19 for 3 consecutive assessments despite rescue therapy, NOTIFY PROVIDER
**if score is less than 5 on 3 consecutive assessments can repeat assessments every 4 hours

ATTACHMENTS

N/A

REFERENCES

Heavner, J., Akgun, K., Heavner, M., Eng, C., Drew, M., Jackson, P., and Honiden, S. (2019). Implementation of an ICU-Specific Alcohol Withdrawal Syndrome Management Protocol Reduces the Need for Mechanical Ventilation. Pharmacotherapy. doi:10.1002/phar.2127)

Policy

Title: **Adult Hypoglycemia Treatment Protocol**	
Joint Commission Chapter Section: 12.0 Nursing	*Date ORIGINAL policy was created:* 5-4-2023
This policy belongs to: [redacted]	
Committee/Council Approval(s): Operations Committe	*Date of COMMITTEE Approval(s):* 5-4-2023

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PURPOSE

The purpose of this Adult Hypoglycemia Treatment policy is to provide a hypoglycemia treatment protocol for patients in an acute care setting when there are no pre-existing orders documented. This also enables the nurse to recognize signs, symptoms, and common causes of hypoglycemia, and to provide treatment based upon signs, symptoms and/or glucose levels. This protocol empowers the nurse to care for his/her patient and start treatment for hypoglycemia to support patient safety.

[1] [redacted]-HM Joint Venture is an LLC representing a joint venture between [redacted] Medical Center and Highmark Health.

PERSONS AFFECTED

Registered Nurse (RN), Licensed Practical Nurse (LPN), Graduate Nurse (GN), Providers, other members of the healthcare team in direct contact with patients.

POLICY

- The nurse may treat the patient with symptoms or signs of hypoglycemia.
- The nurse will be prepared to administer medications as detailed in this protocol based upon the treatment levels.
- The nurse will notify the provider promptly of all hypoglycemia events, interventions, treatment outcomes, and inform provider of protocol as indicated.
- The nurse will enter the hypoglycemia order set per protocol, for subsequent co-signature by the attending physician

DEFINITIONS

Adult: Patient age 16 and over
ADA: American Diabetes Association
NPO: Nothing by mouth/orally
Hypoglycemia: Low blood glucose or low blood sugar. Occurs when a patient's blood glucose level drops below normal levels, defined as a blood glucose less than 70 mg/dl and/or symptoms of hypoglycemia. ADA defines clinically significant hypoglycemia as blood glucose less than 54 mg/dL.
Hypoglycemia Unawareness: Patients with longstanding Type 1 and Type 2 diabetes may have a syndrome known as hypoglycemia unawareness. Patients may experience repeated episodes of hypoglycemia without visible signs and symptoms. Patients need to be evaluated and treated immediately. Nurses should have a high level of suspicion for hypoglycemia in such patients and perform point of care testing when in doubt.

Signs and Symptoms: Hypoglycemia may include one or more of the following and vary from patient to patient:		
Shakiness	Lightheadedness	Weakness or fatigue
Nervousness or Anxiety	Hunger and Nausea	Anger, Stubbornness, or sadness
Sweating, chills, & Clamminess	Sleepiness	Lack of coordination
Irritability or impatience	Blurred/Impaired Vision	Nightmare or crying out during sleep
Confusion, including delirium	Tingling or numbness in lips or tongue	Seizures
Rapid/Fast heartbeat	Headaches	Unconsciousness

High Risk Patients:

- Patients with diabetes on multiple doses of insulin or insulin secretagogues (glyburide, glimepiride, glipizide, glinides)
- Patients with renal, liver, or pancreatic disease
- Patients of advanced age
- Patients who have recently started on incretin mimetics

Common Risks for Hypoglycemia:		
NPO/refusing meals/meals delayed for testing/change in nutritional status	Multiple daily injections/different insulin	Mismatch in timing, amount, or type or insulin and carbohydrates intake
Dose or time errors with oral hypoglycemia agent	Delayed gastric emptying (gastroparesis)	Near normal glycosylated Hemoglobin levels or history of frequent hypoglycemic events
Adjustment of steroid dosing	Different disease states including renal failure and liver disease	Hypoglycemia unawareness
Vigorous exercise	Alcohol use/abuse	Malnutrition

Carbohydrates:

One of the three nutrients in food that provides calories. It is the main nutrient that affects blood glucose levels. Carbohydrates are broken down into blood sugar within 1.5 - 2 hours after consumption. Simple sugars are used in the treatment of hypoglycemia.

Examples of carbohydrates that contain 15 grams:

- 1 tube of glucose gel (preferred)
- 4 glucose tablets
- 4 oz. apple juice
- 3 graham cracker squares

Examples of carbohydrates that contain 30 grams:

- 2 tubes of glucose gel (preferred)
- 8 oz. apple juice
- 4 oz. apple juice and 3 graham cracker squares
- 8 oz. skim milk and 3 graham cracker squares

Glucose Gel: If treating with glucose gel, insert entire tube of gel into patient's mouth aiming for the buccal cavity between

RESPONSIBILITIES

SPECIAL CONSIDERATIONS:

Fluid Restrictions: recommend glucose gel or glucose tablets for treatment
Renal Restrictions: recommend glucose gel or glucose tablets for treatment: Avoid orange juice, colas, and milk
Swallowing Precautions where patient needs thickened liquids: if treating with juice or milk, recommend thickener Appropriate for liquid viscosity indicated.

Enteral Nutrition (PEG tube or functioning nasogastric tube): preferred treatment is apple juice.
J tube: preferred treatment is IV dextrose per protocol.
Patient on acarbose (Precose): only use glucose gel to treat hypoglycemia. Treatment with sucrose (juice, jelly, soda, sugar) is ineffective

TREATMENT APPROACH:

- **Oral Access** – Patients that are cooperative, conscious, and able to eat and swallow safely. This does not apply to the NPO patient (refer to IV ACCESS or NO IV ACCESS treatment approaches).
- **IV Access** – Patients who are unable to eat or swallow safely, are NPO, are uncooperative, or are unconscious but have a viable and functional IV access.
- **NO IV Access** – Patients who are unable to eat or swallow safely, are NPO, are uncooperative, or are unconscious, but have no IV access.

EQUIPMENT/SUPPLIES

- Portable blood glucose meter and testing supplies
- Simple carbohydrates (see list)
- Dextrose or Glucagon kit
- Watch or clock

PROCEDURE

Use of this protocol is intended for patients that do not have orders in place for emergency hypoglycemic treatment.

A. Treatment

In the event the patient develops symptoms of hypoglycemia or becomes hypoglycemic, the protocol will be initiated by the nurse for treatment. If no physician order for treatment is present, the nurse will place the hypoglycemia protocol order set (Hypoglycemia Management Adult Order Set 12684) in the electronic health record and notify the covering provider.

a. Important – Following these treatment guidelines will assist in preventing overtreatment of the patient during a hypoglycemic event
b. Should a patient exhibit symptoms suggestive of hypoglycemia, the nurses will perform a STAT blood glucose using the hospital glucose meter.
c. Initiate appropriate treatment level based on blood glucose result.
d. Notify provider of all hypoglycemia events, interventions, and treatment outcomes.
e. Document into the EHR treatment provided and patient outcomes in the Diabetes/Insulin Management Flowsheet, Bedside Glucose Flowsheet, or Nursing Note

B. Treatment Levels

		Treatment Level 1	Treatment Level 2
		Glucose 54-69 mg/DL, or glucose 70-100 with symptoms. If glucose above 100 mg/di with symptoms, no treatment but recheck blood glucose in 15 minutes & reassess the patient for symptoms.	Glucose less than 54mg/dL
ABLE TO SWALLOW	**ALERT** patient	**1**.Give 15 grams of simple carbohydrate (1 tube of glucose gel(preferred); 4 glucose tablets; 4 oz apple juice; or 3 graham cracker squares) **2**. Recheck blood glucose in 15 minutes **3**.If Hypoglycemia or symptoms continue, repeat steps 1 & 2 until glucose above 70 mg/di **4**. Notify provider, discuss any therapy adjustments, and document all hypoglycemia events, interventions and treat outcomes.	**1**.Give 30 grams of simple carbohydrate (2 tubes of glucose gel; 8oz apple juice; 4oz apple juice & 3 graham cracker squares: of 8 oz skim milk & 3 graham cracker squares) **2**. Recheck blood glucose in 15 minutes **3**. IF hypoglycemia or symptoms continue, repeat steps 1 & 2 until glucose is above 70 mg/dI **4**. Notify provider, discuss any therapy adjustments, and document all hypoglycemia events, interventions and trat outcomes.
DECREASED LEVEL OF CONSIOUSNESS, NPO, OR UNABLE TO SWALLOW	**IV access**	**1.** Administer ½ ampule Dextrose 50% prefill syringe (25mL) IV push. **2.** Recheck Blood glucose in 15 minutes and reassess the patient for symptoms **3.**If hypoglycemia or symptoms continue, administer a second dose. **4**. Recheck blood glucose in minutes. Talk to provider before administering a third dose. **5**. Notify provider, discuss any therapy adjustments, and document all hypoglycemia events, interventions, and treatment outcomes.	**1**.Administer 1 ampule Dextrose 50% pre-filled syringe (50 mL) IV push. **2**. Recheck blood glucose in 15 minutes and reassess the patient for symptoms. **3.** If hypoglycemia or symptoms continue administer a second dose. **4**. Recheck blood glucose in 15 minutes. Talk to provider before administering a third dose. **5.** Notify provider, discuss any therapy adjustments, and document all hypoglycemia events, interventions, and treatment outcomes.
DECREASED LEVEL OF CONSIOUSNESS, NPO, OR UNABLE TO SWALLOW	**NO IV ACCESS**	**1**. Give glucagon 1 mg subcutaneously. **2**.Recheck blood glucose in 15 minutes and reassess the patient for symptoms **3**. Notify provider, discuss any therapy adjustments, and document all hypoglycemia events, interventions, and treatment out comes	

SPEICAL SITUATIONS	
Insulin Pump	1.Follow hypoglycemia protocol 2.Suspend the insulin pump until blood glucose is above 60mg/dl 3. If patient has a change of level of consciousness (ranging from confusion to coma), remove insulin pump/ 4. Notify physician for subsequent treatment orders and reassessment of patients' ability to safely, self-manage insulin pump.
Enteral Nutrition	Patients receiving tube feeds and insulin are placed at a high risk for developing hypoglycemia if the feeds are stopped or held abruptly. If the feed is stopped/held abruptly, notify the provider, and discuss therapy adjustments (possible need for dextrose containing fluids). Document the event, intervention, and treatment outcome.

POST TREATMENT INTERVENTIONS

1. Notify provider of all hypoglycemia events, interventions, treatment outcomes, and educate on protocol as indicated. The nurse will enter into the electronic health record (EHR) the hypoglycemia order set per protocol (Hypoglycemia Management Adult Order Set 12684) for subsequent co-signature by the attending physician.
2. Advance or revert treatment levels as needed based on repeat blood glucose results.
3. Consider initiating the Rapid Response Team (RRT) if the patient condition warrants (i.e., altered mentation).
4. Check blood glucose in one hour after patient is asymptomatic and blood glucose is stabilized, i.e. above

DOCUMENTATION

Key areas of documentation include:

A. All nursing assessments and treatment
   a. Blood glucose levels upon initiation and after treatment
   b. Signs and symptoms observed and/or reported by patient
   c. Patient's response to treatment
B. Provider notification
C. Education provided to patient and family
D. Can be completed via Diabetes/Insulin Management Flowsheet, Bedside Glucose Flowsheet (both found under vitals flowsheet section in EPIC) or Nursing Note

ATTACHMENTS

- NOVA Glucose Meter Procedure
- Care of Continuous Subcutaneous Insulin Infusion (Home Insulin Pump) Policy
- Rapid Response Team Policy

REFERENCES

American Diabetes Association Professional Practice Committee, American Diabetes Association Professional Practice Committee: 16. diabetes care in the hospital: Standards of medical care in Diabetes—2022. Diabetes Care. 2022;45(Supplement_1):S244-S253.

Tracy. F., Manchester. C., Mathiason. M., Wood. J., & Moore, A. (2021). Adherence to a Hypoglycemia Protocol in Hospitalized Patients: A Retrospective Analysis. Nursing Research. 70(1). pgs. 15-23. doi:10.1097/NNR.000000000000478

Policy

Title: **Bathing of a Hospitalized Patient**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* November 19, 2019
This policy belongs to: System Nursing Policy Council	
Committee/Council Approval(s): N/A	*Date of COMMITTEE Approval(s):* N/A

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

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PURPOSE

To provide general skin cleansing, decrease surface bacteria for all hospitalized patients.

PERSONS AFFECTED

All nursing staff caring for hospitalized patients.

POLICY

1. Depending on age, mental status, mobility, level of cooperation, and physical health, patients should be offered or provided appropriate bathing assistance and perineal care at least daily.

2. During bathing, the clinician checks the skin for moisture level, turgor, color, temperature, any new or worsening irritation or breakdown.

3. Document procedure, skin inspection findings or patient refusal of bath in electronic health record.

Application of CHG with patients who have central lines/tubes/drains or patients in Critical Care:

1. Visible debris should be removed prior to use of CHG wipes.
2. Patients outside of critical care or progressive care areas, greater than 2 months of age, with central venous access and/or invasive devices that enter sterile areas will be treatment with 2% CHG wipes daily. Examples include but are not limited to: Nephrostomy tubes, chest tubes, etc.
3. ALL patients in the critical care areas will be treated with CHG daily.
4. 2% CHG wipes will be used from the neck down and are not to be used on the face/head.
    a. CHG should not contact eyes, ears, or mouth
    b. CHG wipes should not come in direct contact with open wounds.
5. Beginning at insertion site, wipe 6 inches on to lines, drains, tubes with CHG wipe.
6. Any concerns for adverse reaction to CHG wipes are to be communicated to provider (i.e. Rash, skin hypersensitivity)
7. For patients who are refusing to complete the full body process, despite adequate counseling and provider escalation, the CHG wipes should be utilized in the surrounding vicinity of the line, drain or tube.
    a. For example, if the patient as a left arm PICC, CHG wipes would be used on the entire left arm, left axillary area, and left side of torso.
8. Discontinue use of CHG if irritation, sensitization, or generalized rash develops.

Patients who are greater than 2 months of age with central lines, invasive devices (Refer to the Pediatric Bathing/CHG Treatment policy):

1. Any patients greater than 2 months of age, with central venous access and/or invasive devices that enter sterile areas (examples include but are not limited to: nephrostomy tubes, chest tubes) will be treated with 2% CHG wipes daily.
    a. All visible dirt should be removed with bath/shower prior to use of CHG wipes
    b. 2% CHG wipes will be used from the neck down and will not be used on the face/head
        i. CHG should not come in contact with eyes, ears, or mouth
        ii. CHG wipes should not come in direct contact with dressings, invasive devices, or open wounds
        iii. Beginning at insertion site, wipe 6 inches on to lines, drains, tubes with CHG wipe.

2. Any concerns of adverse reaction to CHG wipes are to be communicated to provider (i.e., Rash, skin hypersensitivity)

Bathing/surgical clipping in preparation for surgery

1. Patients scheduled for surgery will be bathed the night before and morning of surgery, unless ordered otherwise or contraindicated.
    a. 2 % CHG wipes will be utilized for routine bathing on unit prior to surgery case.
2. All surgical preps will be completed in the Perioperative Area or Same Day Surgery except:
    a. First case open heart preps which will be completed on the nursing unit the morning of surgery.
    b. Pediatric surgical preps.
    c. Patients transferred from the nursing unit directly to the Operating Room, bypassing the holding area.
3. Any skin abrasion will be documented in EPIC.
4. Only prep definite surgical areas (not possible areas).
5. Orthopedic splints, braces, or traction are not removed, and therefore no prep done, unless specifically ordered by the physician.

DEFINITIONS – N/A

RESPONSIBILITIES

It is the responsibility of the primary nurse to perform or delegate the appropriate bathing method.

EQUIPMENT/SUPPLIES

1. Hospital provided CHG compatible cleanser or bathing wipes
2. CHG compatible lotion
3. CHG impregnated wipes if patient has a central line/tubes/drains
4. Surgical clipper if preparing patient for surgery is required.

PROCEDURES

Bed bath

Preoperative skin preparation

ATTACHMENTS

CHG Bathing Diagram

Pediatric Bathing/CHG Treatment policy

REFERENCES

Lippincott Procedures

Policy

Title: **Cardiac Telemetry Monitoring Adult Medical/Surgical Patient**	
Joint Commission Chapter Section: 12.0 Nursing	*Date ORIGINAL policy was created:* June 09, 2020
This policy belongs to: [redacted]	
Committee/Council Approval(s): [redacted]	*Date of COMMITTEE Approval(s):* October 21, 2024

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PURPOSE

1. To provide guidelines for the admission/transfer/discharge of patients requiring telemetry monitoring based on diagnosis.
2. To provide a continuous centralized monitoring area where telemetry technicians would monitor all patients and be the primary alarm notification system to the responsible registered nurse.

PERSONS AFFECTED

This policy applies to:

[redacted] Community Medical Center

- B3 Women's & Children's (Adult Patients Only)
- Cardiac Telemetry (D8A)
- D7 EMU
- D6 A & B
- D5 Orthopedics
- D4 A & B
- D3 Admissions
- ED Holds

[redacted] Wyoming Valley Medical Center

- MS5E (Trauma 5)
- MS6 East
- MS6 West
- MS3 West
- MS4 West
- Obstetrics

[redacted] South Wilkes Barre

- MS3 South
- MS5 South
- MS6 South

POLICY

EXCEPTIONS: This policy does not apply to:

- At [redacted] Community Medical Center and [redacted] Wyoming Valley
  - Pediatric patients
  - Special Care Unit patients ([redacted])
  - Intensive Care Unit Patients
  - Surgical Services

DEFINITIONS

The transmitter is a defibrillation protected device which is carried by the patient in a pocket or pouch that amplifies EKG signal and sends it by intranet connection to the Central Monitor Room on [redacted] Community Medical Center D8 Cardiac Telemetry. Inpatient system alert will be through the use of designated monitor phone on each unit. The I-phones will be identified by a "red" Telephone Case

RESPONSIBILITIES

1. Remote Telemetry Staff Role/Responsibilities:

Telemetry Tech role and responsibilities:

- Under the direction of the D8 Cardiac Telemetry Nurse Manager and/or Clinical Leader and telemetry nurse, the telemetry technician supports patient care by continuous cardiac rhythm monitoring, maintaining proper functioning of monitoring equipment, maintaining appropriate communication with nursing staff of involved departments concerning life threatening dysrhythmias and changes in patient's cardiac rhythm.
- Reports to: Nurse Manager Cardiac Telemetry and Clinical Leaders

Daily Responsibilities of Remote Telemetry Control Room Staff:

- Rhythm strip is obtained on admission to cardiac telemetry, every four hours and if changes occur. Documented on the strip is the patient's name, room number, bed assignment, and rhythm strip analysis.
- Lead II and MCL 1 leads are to be utilized.
- Rhythm strips are filed in the patients' Epic Medical Record.
- A Telemetry Log will be maintained for each patient with the rhythm documented at least every four hours.

2**. Role of The Remote Telemetry Staff**

- During the monitoring period, the patient's nurse or designee notifies the CMR if there is a change in the patient's medical condition or medications which may affect hemo-dynamic status, as well as symptoms the patient may report, such as angina, palpitations, dizziness, etc.

- During routine patient assessments, the nurse checks the telemetry monitoring equipment for correct connection and placement of lead wires and electrodes and verifies a rate and rhythm on the telemetry transmitter.

Communications:

- The CMR Tech notifies nursing unit of rhythm changes
- Patient unit notifies Central Monitor Room:
    1. When there are change of cardiac medications
    2. When a patient is off the unit and their location
    3. When telemetry monitoring is discontinued
    4. When a patient is transferred to another unit
    5. With change in patient's clinical status

Cell Phone Communication System:

- A designated nurse on each unit will carry a red cell phone and will respond to calls for that department, ensuring that all follow up is completed. This red cell phone will be passed on to the on-coming designated nurse at the change of shift and changed over to the day phone at 7:30a and the night phone at 7:30p.
- CMR tech will ensure connection with the nursing units at change of shift, 7:30a, 3:30p, 7:30p, 11:30p every day.
    1. CMR tech will Tiger Text the Tele Nurse role for each unit and get a response.
    2. If no response, then a call to the appropriate shifts red phone will be made. If unable to connect with the shifts red phone at change of shift, then the CMR tech will call the next shifts phone.
    3. If still unable to connect call the appropriate nursing supervisor and begin step 1 process.

3. Alarm/Alerting/Notification:

Appropriate Response to Telemetry Alarms /

Nursing:

- Alarm configurations in the CMR are maintained as determined by default settings and modified according to specific patient's rhythm history. *(Alarm lights: High-150 Low-50)*
- Alarms are turned on at admission of the patient and remain on for the duration of monitoring.
- The CMR Technician notifies nursing staff immediately when a patient has a significant event. These checks are categorized according to Priority.

    Red Alarm

    Yellow Alarm

Blue Notification

Red Alarm: Life-threatening. The Telemetry Technician will immediately notify the unit of a life-threatening arrhythmia via the red/designated phone and will call an RRT to the appropriate patient room. (NOTE: this policy does not change any of the operational aspects of the Code Blue policy.) An arrhythmia read-out will be noted on the monitor screen. *[redacted] - The Telemetry Technician will announce the RRT overhead and repeat the message 3 times. The nursing unit is responsible to notify security and the operator. A monitor strip will run automatically and will be analyzed and sent to the Epic Medical Record.

Priority I arrhythmias include the following:

- Asystole
- Ventricular Tachycardia
- Ventricular Fibrillation
- Extreme Bradycardia <40
    a. Red alarms cannot be turned off.
    b. Nursing staff will immediately go to the bedside to assess patient condition.
    c. Nursing staff will notify the CMR Technician of patient outcome.

Yellow Alarm: The Telemetry Technician will notify the appropriate unit immediately of any unusual arrhythmia or changes by sending a tiger connect message to the Tele CMR role on the red/designated telephone. A monitor strip can be run and analyzed and sent to the Epic Medical Record. An arrhythmia read-out will be noted on the monitor screen in Yellow.

Priority II arrhythmias include the following:

- New Onset A-fib
- Non-sustained V-Tach
- Extreme Tachycardia
- Pause
- SVT/MAT
    a. Nursing staff will assess patient condition.
    b. Nursing staff will notify the CMR Technician of patient condition via the red telephone to clarify the situation.
    c. Determine cause of alarm.
    d. The Nursing Staff will assess the patient and situation and call the physician for further orders.
    e. The CMR Technician will use appropriate cell phone for the patient's unit.
    f. In the event of system failure of cell phone communication, the Telemetry Technician will follow the emergency communication policy.

Blue Alarm: These alarms consist of events that interfere with the transmission of the telemetry signal, such as low battery, leads off, improper lead placement, etc.

a. Unit staff are notified by tiger connect message to the Tele CMR role of these conditions and will troubleshoot the signal transmission problem immediately after notification by the CMR Technician of the interruption in signal.

b. CMR Tech will use escalation algorithm (attached to policy) if issue is not addressed by Nursing staff.

c. Nursing contacts the CMR Technician to verify that adequate signal transmission has been re-established.

In troubleshooting the "Blue" Alarms, the Nurse or trained NA will:

1. Verify the patients name, room number/bed assignment
2. Assess the patient
3. Check lead wire connections
4. Check electrode placement for secure adhesion
5. Check battery status
6. Call the CMR Technician to be sure the problem was corrected

The Unit Nurse will notify CMR tech by Tiger Connect message to the GCMC CMR Tech role when:

1. Telemetry is discontinued
2. The patient leaves/returns to the unit
3. The telemetry unit is taken off for any reason and when it is replaced
4. Medications or treatments may affect the patient's EKG rhythm.
5. The patient has an internal device such as: AICD or Pacemaker
6. **The Nurse will notify physician with:**

   a. Changes in rate and rhythm and /or change in assessment of patients' condition

   b. Occurrence of life-threatening dysrhythmias

   c. Requests for orders to discontinue Telemetry monitoring

When the patient is off a designated department and a change occurs requiring notification:

1. The CMR technician will notify the department where the patient is located at the time (e.g. CT Scan). The CMR tech will convey to that department that the patient is in serious condition and Dial-55 ([redacted]) 570-808-6500 ([redacted]) 570-808-8120 ([redacted]) for Rapid Response Team if necessary.
2. That department staff member will check the patient; notify the patient's physician if present, Dial-55 ([redacted]) 808-6500 ([redacted]) 570-808-8120 ([redacted]) for Rapid Response Team if necessary, for Rapid Response Team if necessary.

3. Lethal dysrhythmias: The CMR technician will notify the designated nurse on the patient's assigned department regarding the arrhythmia
    a. The nurse will proceed to the patient's bedside:
        1. Assess the patient
        2. Confer with the department physician as necessary
        3. Notify the physician
        4. Perform appropriate intervention
        5. Document all findings/ actions in the Epic Medical Record

When either the CMR or the unit are impacted and unable to visualize the waveforms:

1. **If the CMR is unable to visualize waveforms, the telemetry technician will call the nursing unit via tele nurse red phone.**
2. **If the nursing unit is unable to visualize waveforms, a call will be made to the CMR.**
3. **The respective staff member will also notify for all IT GNE locations. The call will be dispatched based on where the call is coming from to get ISS 24/7.**
4. **The respective staff member will notify the nursing supervisor by calling ISS / on-call person at 570-808-7737 the supervisor cell phone.**

4. Documentation

- The initial assessment and all reassessments will be in the patients' Epic Medical record by assigned nurses.
- At the time of admission, the beginning of each shift, every four (4) hours, and as necessary related to any changes in rhythm, the CMR Technician will analyze and document telemetry monitoring strips and send the strips to the patients' Epic Medical Record.
- Documentation will include the patient's name, room number, bed assignment, date, time, rate, PR interval, QRS interval, QT interval interpretation and a full signature.
- A telemetry log record will be utilized to enter information on all Telemetry patients. This record will be updated each shift by the CMR technician on duty.

5.Transport

- The provider must decide if the patient is able to travel for testing without cardiac monitoring and if so, place an order for same.
- Transporter must obtain chart of patient being transported, as necessary.
- Transporter requests "Passport" from responsible RN. "Hand Off" communication from RN to Transporter occurs at this time.

- Before patient is transported off the unit, the transporter/unit staff notifies the CMR that the patient is leaving the unit and their destination.
- At that time, the CMR Technician places a sticker on the monitor as to the patient's location.
- When the patient is transported, the telemetry pack and wires travel with the patient at all times, except for MRI/MRA where the monitor will be taken off prior to entering the room.
- When patients are transported off the unit to an area where remote telemetry is not possible or available (i.e. signals cannot be received due to infrastructure availability), cardiac monitoring cannot be done by the CMR until the patient returns to an area that permits signal transmission. Procedural personnel will provide cardiac monitoring according to standards of practice while patients are in those areas.
- [redacted] Patients who are going to the Operating Room or GI Lab should be accompanied by Nursing personnel who can retrieve the Telemetry transmitter and lead wires and bring them back to the unit for the patient on return.
- [redacted]/[redacted] patient who are going to a higher level of care, should be accompanied by Nursing personnel to destination unit if there is no order stating patient can travel without tele monitoring.
- Upon returning to the department, the transporter/unit designee will notify the CMR of the patient's return.
- Whenever the patient is received by a nursing unit, test area or other department, the nurse staff of the receiving area notifies the CMR of the patient's new location so that they may quickly contact the area if there is an issue with the patient's rhythm.

6. Discharge

- Each Telemetry order is accompanied by a 48-hour expiring time.
- Upon order of discharge from telemetry or the hospital, the nurse or designee notifies the CMR Technician of discontinuation order.
- [redacted]- Qualified nursing personnel will remove the lead wires and transmitter from the patient and discard the electrodes, battery, and pouch, as well as return the telemetry equipment to the Central Monitoring Room on Telemetry.

[redacted]/[redacted]- Qualified nursing personnel will remove the lead wires and transmitter from the patient and discard the electrodes, battery, and pouch, as well as return the telemetry equipment to the designated location on the unit.

Discontinuation of Telemetry:

- [redacted]: CMR Tech will Discharge patient from Philips Monitoring system
  - Clean Transmitters and lead wires with appropriate sanitizer
  - Return transmitter to clean storage area
- [redacted]/[redacted]: Identified staff on each unit will clean transmitters and return transmitter to the designated location on the unit.

- CMR Tech will complete log on all patients

DISCONTINUATION CRITERIA:

During IDT meetings, the Nurse Manager/Clinical Leader or Charge Nurse, in collaboration with the Unit Hospitalist for that day, will review the patients requiring telemetry monitoring. Guidelines to be utilized in the decision to discontinue telemetry include:

- Reversal/control of the cardiac condition that prompted the initiation of remote telemetry
- Cardiac etiology of chest pain ruled out
- Angina controlled
- Blood pressure controlled
- Respiratory status improving
- Mental status stable
- No unstable arrhythmia last 24 hours
- No ischemic ECG changes last 24 hours
- Hematology values stable last 24 hours and bleeding controlled
- Absence of excessive drug levels
- No life-threatening laboratory values (i.e. hypokalemia)
- Patient or family request no resuscitation (full DNR/DNI)

EQUIPMENT/SUPPLIES

Transmitter

I-phone

PROCEDURE

1. **Physician Ordering**

- The order to place a patient on telemetry monitoring may be given by any physician on staff who is responsible for the care of the individual patient.
- The physician's order for admission will delineate that the patient be admitted to "Med-Surg".
- A separate "Telemetry Monitoring" Order must be placed as well as the Indication for Telemetry Monitoring – which includes unstable coronary syndrome, arrhythmia, heart block 2nd or 3rd degree, heart failure, post cardiac procedure, stroke/tis/syncope, proarrhythmic drugs/toxins, or "other" which requires a specific comment with the indication for Telemetry Monitoring.

- The telemetry Monitoring order is active for 48 hours, then the provider will receive an alert in Epic to renew the Telemetry Monitoring Order as well as the indication. The alert will fire every 24 hours as long as the patient has an active Telemetry Monitoring order.
- Telemetry may be ordered for patients requiring monitoring who are not classified as critical. The physician must decide if the patient is able to travel for testing without cardiac monitoring and if so, place an order for same. These patients will be admitted to an aforementioned department.

Note-Continuous Cardiac monitoring order is not a telemetry order and is only used in the Emergency Department and MSICU.

ADMISSION / INITIATION CRITERIA:

A. **Patient Population Defined:** Please see attached table

NURSING ALERT: If a patient is required to leave the nursing unit, for an invasive procedure or when on an IV antiarrhythmic or vasoactive drug, cardiac monitoring will be continued.

1. **Bed Request**
   - Patients are admitted to respective units based on their diagnosis and patient needs through Patient Placement, Bed Coordinators or at times through the Nursing Supervisor.
2. **Obtain/Maintain Equipment**

   Equipment and supplies needed:
   - Philips MX40 Telemetry transmitter or Philips TRX tele transmitter
   - Two AA Battery
   - Lead Wire Set
   - Electrodes

- Returned equipment will be cleaned by the CMR Tech ([redacted]) or Nursing Unit personnel ([redacted]/[redacted]) between patient use.
- Damaged or defective equipment, once identified, will be tagged and sent to Clinical Engineering for repair.
- To assure uninterrupted monitoring, **batteries in the telemetry packs of monitored patients must be changed every evening/night during 2300 Vital Signs.**
- Telemetry electrodes should be changed at least every 72 hours or sooner if needed to preserve skin integrity.

Lead Placement:

- **Angle of Louis Placement (Standard Placement)**

*Five-Lead Monitor:

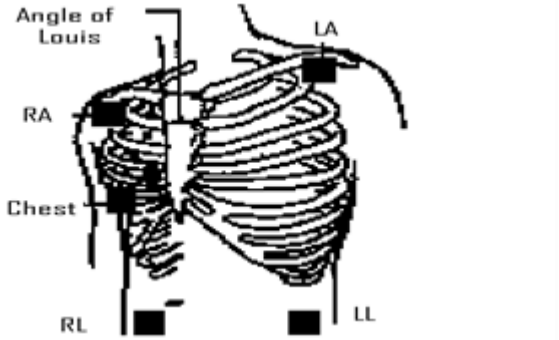
White electrode (-) Right shoulder below right second clavicle hollow

Black Electrode (-) Left shoulder below left second clavicular hollow

Brown electrode (+) Right sternal border fourth intercostal space

Green electrode (REF) Right anterior line below the rib cage

Red electrode Left anterior axillary line below the rib cage



3. Initiate Telemetry

- The nurse or unit secretary on the patient's unit is to notify the Cardiac Monitoring Room staff with the patient's name, medical record number, room number, and diagnosis.
- Information needs to be provided to the CMR Tech in order to admit patients to system and logbook:
- Patient Name
- Patient's Room Number and Bed location
- Implanted or Temporary Device, such as pacemaker or AICD
- Any doctor "call orders" for arrhythmia or rate
- Patient's Code Status
- Patient's Cardiac History
- Arrhythmia Medication

CMR Tech will verbally confirm to Nurse:

- Patient identification (name/room number/bed assignment)

- Hook up/connection
- Interpretation of baseline rhythm
- Nurse will repeat back and verify patient identifiers and baseline rhythm to CMR Tech

[redacted]- The CMR Tech will admit the patient into the Philips Monitoring System – assigning them into a sector. The CMR Tech will then assign a transmitter to that sector on the Monitor. [redacted]/[redacted]- Once the patient arrives to the floor, the Registered Nurse/Licensed Practical Nurse will admit the patient into the Philips

- Monitoring System – assigning them into a sector. The Registered Nurse/Licensed Practical Nurse will then assign a transmitter to that sector on the Monitor.
- [redacted]- The transmitter and supplies are obtained from the CMR by the respective unit's staff. [redacted]/[redacted]- The transmitter and supplies are obtained on the nursing unit
- Once the patient is placed in the bed, the need for cardiac monitoring and the application process is explained to the patient.
- If cardiac monitoring is already in process, new lead positioning and confirmation of signal via the transmitter – checking that the rhythm is clear and that the correct patient's name is listed on the transmitter must occur before portable monitoring discontinued.
- Recommended skin preparation
    - Wash skin with soap and water
    - Rinse well to remove all of the soap residue
    - Wipe skin with alcohol swab if skin is oily, exposed to diaphoresis, (if skin integrity is compromised do not use alcohol)
    - Rub skin with gauze to increase capillary blood flow and remove skin cells and oil

Telemetry functions with 5 leads:

White - Right arm (RA) is placed in the infraclavicular fossa close to the right shoulder

Black - Left arm (LA) is placed in the infraclavicular fossa close to the left shoulder

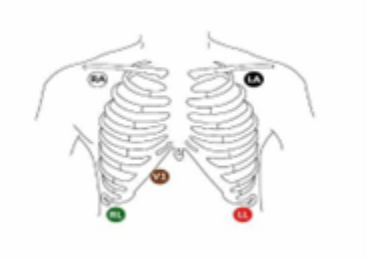
Red - Left Leg (LL) is placed below the rib cage on the left upper quadrant of the abdomen

Green – Right Leg (RL) is placed below the rib cage on the right upper quadrant of the abdomen

Brown- (V1) is placed below the rib cage in between (RL) and the xiphoid process

If the patient has a permanent pacemaker:

Check that the monitor settings are set to 'paced', if it is not picking up the pacing spikes then move the RA electrode down to the 5th intercostal space and the LL electrode is moved up to the 5th intercostal space



Lead placement should follow the manufacturer's diagram on the transmitter face.

- Two AA batteries are inserted in the telemetry monitor which can be placed in a disposable pouch which is worn outside the patients' gown or in the middle pocket of the patient's gown.
- Once the pack is placed, the nurse must assure the patient's cardiac rate and rhythm are clear on the transmitter screen – again ensuring that the correct patient's name is on the transmitter.
- Patients are to be instructed **not** to take a shower with their telemetry unit on.

5. Assessment:

At the beginning of each shift and as needed, the Registered Nurse/LPN assesses the following:

- Correct Lead Placement
- Vital signs, including an apical heartbeat
- Monitor on and functioning (alarms on and audible)
- Verification of rhythm with CMR Technician or Provider

6. Staffing:

- CMR Technicians will be assigned to watch the monitors 24/7
- If a CMR Technician is not scheduled, any qualified person who has successfully passed a basic electrocardiogram (ECG) test may be assigned to monitor the Cardiac Telemetry patients.
- A Registered Nurse on shift may rotate to this position.
- The CMR Tech or Nurse assigned to monitor cardiac telemetry patients may not leave the monitors unattended at any time. Coverage will be provided for breaks and lunch.

Telemetry Issue Communication and Escalation Process:

1. *If an issue with the telemetry equipment is identified by any clinical staff, clinical staff will call ISS (using the normal urgent request dispatch process at 866-755-7814) and notify the nursing supervisor for the specific campus. ISS will notify the CMR to determine CMR involvement. If the CMR is impacted, the CMR will notify both* [redacted] *and* [redacted] *nursing supervisors via Tiger Connect of the CMR impact if any. Then ISS will communicate back to IT, the CMR, and others in ISS with any updates and resolution.*

2. *If an issue with the telemetry equipment is identified by the CMR, CMR staff will call ISS (using the normal urgent request dispatch process at 866-755-7814) and specify which location is impacted so the dispatcher will include the correct ISS personnel, then the CMR should make a call to the GCMC nursing supervisor to provide any additional details. ISS will then communicate back to IT with updates and resolution, the CMR with any additional details and others in ISS when appropriate.*
3. *If an issue with the telemetry equipment is identified by ISS, ISS will notify both IT, the CMR of the problem and when appropriate notify others in ISS. Then ISS will communicate back with updates and resolution to IT and the CMR with any additional details.*
4. *If an issue with the telemetry equipment is identified by IT, IT will notify ISS (using the normal urgent request dispatch process at 866-755-7814), ISS will then notify the CMR and when appropriate notify others in ISS. Then ISS will communicate back to IT with updates and resolution and the CMR with any additional details.*
5. *Communication can be completed via Tiger Connect if Tiger Connect is not impacted. The [redacted] CMR Tech 1, 2, 3 or 4 roles can be used for communication with the CMR.*
6. *Identify a clinical, biomed and IT point person to ensure all areas are informed.*
7. *The GNE Cardiac Monitor Broadcast List should be used for mass communication, message initiated by ISS.*
    - *Example of information to include:*
        - *That we're down and what is down.*
        - *Who is involved?*
        - *IT or ISS working on the issue.*
        - *Then follow up as things start to come up.*
        - *Complete resolution of issue.*
8. *A MIDAS must be submitted by the CMR.*
9. *Downtimes greater than 4 hours must be reported to the state.*

ATTACHMENTS

See attached tables.

REFERENCES

AHA (2017). Practice Standards for Electrocardiographic Monitoring in Hospital Settings. Circulation III: 2721-2745.

Policy

Title: **Central Venous Access Device (CVAD) Care/Maintenance**	
Joint Commission Chapter Section:(REQUIRED) 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* 01/01/1981
This policy belongs to: Vascular Access/Infusion Therapy Subcommittee	
Committee/Council Approval(s): Vascular Access/Infusion Therapy Subcommittee, System Nursing Policy Council	*Date of COMMITTEE Approval(s):* 12/18/24, 12/19/24

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities: (REQUIRED) *Please select the box before the entities that apply*.

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ [redacted]	[redacted]
☐ [redacted]	[redacted]
☒ [redacted]	[redacted]
☒ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☒ [redacted]	[redacted]

NON-CLINICAL ENTITIES *(includes [redacted] business/corporate entities not providing health care services)*	
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]
☐ [redacted]	[redacted]

PURPOSE

To provide evidence-based policy and procedures to reduce the incidence of Central Line-Associated Bloodstream Infections (CLABSI) and other complications related to vascular access devices.

PERSONS AFFECTED

All [redacted] employees who access and care for CVADs (including implanted venous access devices (IVAD), i.e., Mediport).

POLICY

1. Neonatal Intensive Care Units are excluded from this policy. Refer to NICU-specific policies.

2. Hemodialysis catheter – May be used in emergent situations only with provider approval, preferably nephrologist.
    a. If capped with Heparin or citrate, withdraw 5mL to remove heparin or citrate before use.
    b. Lock with appropriate lock solution after use.

3. Apheresis- May use for infusions as needed. Refer to the Central and Peripheral Access Guidelines.

4. Lines used for ECMO are excluded from the scope of this policy.

5. An order must be placed that the line is okay for use.

6. Femoral lines or temporary non-tunneled CVAD lines where the central line bundle elements were not met SHOULD BE replaced within 24-48 hours of insertion unless clinically contraindicated. This would include lines from other facilities where the insertion date and process are unknown.

7. Central lines, excluding tunneled catheters, may be removed by trained RNs and Vascular Access RNs with a provider's order after completing competency instruction.

8. Use an IV pump for all infusions.

9. New clean, non-sterile gloves are always worn when accessing central lines.

10. Only sterile devices are used to access the needleless connector or hub of the catheter.

11. IVAD specific interventions:

    a. When a trained inserter is available, it is preferred to access an implanted vascular access device (IVAD) instead of placing a new peripheral IV, midline, PICC, or CVC.

        a. If only one point of access is required and a PIV was placed when no trained inserter was available, removing the PIV and accessing the IVAD as soon as a trained inserter is available is most appropriate.

        b. If a patient's IV therapy needs to decrease from two points of access to only requiring one point of access, then remove any PIVs in place and maintain access to the IVAD.

    b. Before accessing an IVAD, identify if the patient has a standard (non-power) device or a power injectable IVAD.
        i. Acceptable identification methods include:
            1. Review of the patient's EMR for product information and/ or procedure documentation

2. X-ray

ii. Note- palpation alone is not an acceptable identification method.

c. If the patient has a power injectable IVAD, this may be used in CT scan for power injection. This IVAD must be accessed with a power injectable needle prior to CT power injection.

d. IVAD systems are MRI-compatible.

12. Daily assessment of CVAD site for continued need of CVAD.
    a. Line necessity is assessed daily.
    b. All CVADs shall be assessed daily for complications, including erythema or drainage. Additionally, to ensure that the securement device, including sutures, are intact and the dressing is clean, dry, and occlusive on all sides.
    c. Notify the provider if any complications are noted at the insertion site.

13. Appropriate dressing is clean, dry, and intact and changed with appropriate frequency
    a) All CVADs will have a Chlorhexidine (CHG) dressing over the site.
        I. Only accepted contraindications to CHG dressing include:
            - Pediatric patient under 2 months of age
            - Documented allergy to Chlorhexidine
            - Broken or open skin
        II. If the patient has an allergy to the transparent dressing with border, an approved alternative dressing may be used
        III. Use of an approved alternative dressing may be used if patient is allergic to CHG.
    b) After initial line placement, if bleeding is present or expected, a hemostatic agent should be used per manufacturer instructions.
    c) <u>If insertion site is visible, CVAD dressings will be changed every 7 days or sooner if the dressing becomes wet, soiled, or non-occlusive.</u>
        I. Change the non-coring access needle and needless connector of IVADs every 7 days.
        II. Dressing and needle changes will be done by a member of the Vascular Access Team or other practitioners trained in central line dressing changes.
        III. Loose or soiled dressing should be re-dressed without delay. Page Vascular Access Team or appropriate campus designees promptly to change dressing.
        IV. If insertion site is not visible, dressings should be changed every two days (excluding in the presence of hemostatic agent per manufacturer instructions).
    d) It is recommended to use adhesive removal solution wipes (supplied in kit) to loosen the dressing and decrease the incidence of medical adhesive-related skin injury (MARSI).
    e) Any loose sutures will be secured with sterile steri-strips or securement device and the attending service notified.
    f) Skin tissue adhesive or hemostatic agent should be used with central line insertions and dressing changes. Do not use both together, apply per manufacturer instructions.

14. Maintain alcohol disinfectant caps on unused needleless connectors and IV tubings.

a. Keep a needless connector on each port of the catheter, even for continuous infusions (excluding closed system blood collection devices).
b. Keep an alcohol disinfectant cap on any unused access point.
c. A new needleless connector is applied:
    i. Whenever the needleless connector is removed from the port.
    ii. Weekly when the dressing is changed.
    iii. Daily with parenteral nutrition bag change.
    iv. If there is bloody residue in the neutral displacement end cap after flushing with the appropriate amount of normal saline.

15. Tubing changes at appropriate intervals and labeling
    a. All continuous IV tubing (i.e., a primary IV that is continuously infusing at an ordered rate) is changed every 7 days, unless noted below, by the nurse responsible for the patient.
        i. The appropriate colored day of the week label is applied to the IV tubing when it is hung.
    b. Intermittent tubing (i.e., an IV infusion that is attached intermittently to a saline lock (peripheral or central) at scheduled intervals) will be changed every 24 hours.
    c. In addition to routine changes, change the administration set with any change of the vascular access device or a new insertion of a vascular access device. (Exception: if care of patient would be compromised).
    d. The tubing for lines to administer lipid based infusions must be changed when the vial is changed or at least every 12 hours.
        i. If a lipid based infusion has been transferred to a syringe or another container, the tubing must be changed every 6 hours.
    e. Blood tubing is changed every 4 hours. If the blood tubing is Y-sited into primary tubing, the primary tubing must be changed every 24 hours. Refer to Administration of Blood/Blood Products policy.
    f. TPN/PPN tubing is change every 24 hours including a needleless connector change. Refer to the Adult Parenteral Nutrition policy.
    g. Label lumen of the line that is locked with an Antimicrobial or Anticoagulant with appropriate labels

16. Scrub the hub for a minimum of 15 seconds using a twisting motion with friction followed by 5 second dry time with new alcohol swab.
    a. Disinfectant caps are not to be reused after removal from needless connector. A new one is applied.

17. Flushing of CVAD
    a. CVADs are flushed using a push pause method before and after each medication delivery or as ordered.
        i. If there is not a flush order, notify the provider for an order.
    b. Flush with a minimum of twice the internal catheter volume when blood has been present in the line.
        i. Adults: 10 mLs
        ii. Pediatrics: 3-5 mLs
    c. If an antimicrobial or ethanol lock solution is used, please refer to Appendix 6 of Antimicrobial Stewardship Program policy.

18. Assess for patency with each access
    a. CVADs are checked for patency (3mLs of blood per 3 seconds) with each access or as ordered.
    b. Use a 10mL syringe to check the patency of the line.
        i. After confirmation of patency by detecting no resistance and the presence of blood return, use syringes appropriately sized for the medication being injected.
    c. If CVAD is occluded, malfunctions, does not have blood return, or is not patent, notify the Vascular Access Team or specially trained nurse for troubleshooting/corrective actions.

19. Daily skin antisepsis
    a. Daily bathing will be done per the Bathing of a Hospitalized Patient or Pediatric Bathing/CHG Treatment policy.
    b. Bed linens are changed daily per Linen policy.

20. Minimize blood draws through the CVAD
    a. Blood should not be obtained routinely through a CVAD, but rather through peripheral venipuncture.
    b. There are certain situations (lack of peripheral sites) and patient populations (oncology and pediatric patients) in which the use of the line for routine blood sampling may be appropriate.
        i. In these cases, the following is required:
            i. Attending Physician documentation in EPIC note as to the nature of the need.
            ii. Attending Physician documentation in EPIC orders allowing the CVAD to be used for routine blood draws (order can be entered by resident with notation of which attending provider approved the use of the line for blood draws).
            iii. Limit routine blood draws to twice daily by batching lab requests.
    d. When obtaining specimens from indwelling lines that may contain heparin, the line should be flushed with 5 mL of saline, and the first 5 mL of blood or 6-times the line volume (be drawn off and not used for coagulation testing.

RESPONSIBILITIES

It is the responsibility of all staff caring for CVADs to provide care outlined in this policy.

EQUIPMENT/SUPPLIES

Varies- see individual procedures

EDUCATION:

1. Provide appropriate education to the patient and/or caregivers before discharge.

PROCEDURES

CVAD flushing and locking

Central venous access device dressing change

PICC dressing change

CVAD needleless connector change

CVAD blood sampling

CVAD Declotting

Central venous access catheter removal

Implanted port accessing (includes troubleshooting information)

Implanted port flushing and locking

Implanted port dressing change

Implanted port blood sampling

VAMP METHOD

The Venous-Arterial Blood Management Protection (VAMP) system should only be used where staff have been appropriately trained.

VAMP is set up with NSS and a pressure bag. Tubing is primed and directly connected (no needleless connector) to the distal end of the CVAD or the red lumen of a PICC after cleansing the port with an alcohol swab using a twisting motion for 15 seconds followed by a 5-second dry time. The VAMP tubing is changed every Tuesday and Friday, except at [redacted], where it is changed every 96 hours.

Procedure:

1. Gather supplies needed for procedure:
    a. Alcohol pad(s)
    b. Vacutainer needleless adapter
    c. Appropriate tubes for laboratory testing
2. Perform proper hand hygiene
3. Identify yourself
4. Identify patient using two patient identifiers
5. Explain the procedure to the patient in a developmentally appropriate manner
6. Perform proper hand hygiene
7. Have visitors exit area of procedure until complete
8. Don clean, non-sterile gloves
9. Blood is pulled back into the VAMP for discard and the in-line stopcock is turned off to the VAMP.
10. In-line rubber cap is scrubbed for 15 seconds with alcohol and allow to dry for 5 seconds.
11. Clear adapter is connected to vacutainer and inserted into rubber port.
12. Maintaining the correct order of draw all laboratory tubes needed are obtained via vacutainer.
13. Adapter and vacutainer are removed and discarded.
14. Stopcock is turned open to VAMP.
15. Blood for discard is re-infused into patient along with NSS flush via pressure bag.
16. Tubes are labeled per policy and sent to the laboratory.
17. Discard supplies in appropriate receptacle.

18. Hand hygiene is performed.
19. Document procedure in patient EMR.

If fluids were infusing:

- Scrub the end cap with an alcohol pad by twisting the pad around the end cap for a minimum of 5 seconds and allow to dry for 5 seconds.
- Remove the sterile cover from the end of the infusion tubing.
- Connect the tubing to the needless connector and restart infusion.

If line is locked:

- Scrub the needless connector with an alcohol pad by twisting the pad around the end cap for a minimum of 5 seconds and allow to dry for 5 seconds.
- Attach new alcohol disinfectant cap to the needless connector.
- Ensure the catheter is clamped if clamp is present.

ATTACHMENTS- N/A

REFERENCES

College of American Pathologists Hematology and Coagulation Checklist: CAP accreditation program https://documents-cloud.cap.org/appsuite/learning/LAP/TLTM/resources/checklists/2020/cl-hem.pdf

Lippincott Procedures

Venous-Arterial Blood Management Protection (VAMP) system IFU

Policy

Title: **Fall Prevention – Inpatient & Outpatient Clinics**	
Joint Commission Chapter Section:(REQUIRED) 2.0 Risk Management / Patient Safety	*Date ORIGINAL policy was created:* October 01, 2003
This policy belongs to: System Inpatient/Outpatient Fall Prevention Council	
Committee/Council Approval(s): System Nursing Policy Council	*Date of COMMITTEE Approval(s):* 11/21/2024

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
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NON-CLINICAL ENTITIES *(includes [redacted] business/corporate entities not providing health care services)*	
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PURPOSE

The purpose of the inpatient and outpatient clinic fall prevention program is to establish guidelines for the recognition of those patients at risk of a fall through the use of the appropriate screening tool. The policy also establishes interventions for those at risk as well as a procedure for monitoring those that have fallen during their hospital stay.

PERSONS AFFECTED

All members of the healthcare team involved with direct patient care in the [redacted] Health System. This would include, but is not limited to nursing, physicians, therapists, transport personnel, hospital-based clinic staff and any other staff that may be involved in the direct care of a patient.

POLICY

It is the policy of the Inpatient and Outpatient Clinic Fall Prevention Program to ensure that patients admitted to the hospital and those in a procedural area or clinic setting for a provider visit are screened and evaluated for fall risk. Those found to be at risk will be properly identified and steps will be taken to minimize or eliminate the risk of a fall.

Included Populations: Hospital based and designated Outpatient clinics, Procedural area patients, Inpatients that are admitted or categorized as observation or SORU and all patients in the Emergency Department* as well as overnight admitted patients held in PACU.

Excluded Populations*: Visitors, students, and staff members.

*For patients triaged and held in the waiting area at [redacted] Emergency Department please see the following policy: Triage

*For Pediatric patients: Pediatric Fall Prevention

DEFINITIONS

A patient fall is defined as a sudden, unintentional descent, with or without injury to the patient that results in the patient coming to rest on the floor, on or against another surface, on another person, or an object.

- Baby Drop: A fall in which a newborn, infant, or child being held or carried by a healthcare professional, patient, family member, or visitor falls or slips from that person's hands, arms, lap, etc. , and can occur when a being transferred from one person to another.
- Developmental Fall: A fall in which an infant toddler or preschooler who is learning to stand, walk, pivot, or run falls as a part of acquiring those skills.
- Suspected Intentional Fall: A fall event that occurs when a patient age 5 or older falls on purpose or falsely claims to have fallen.
- Assisted Fall: A fall in which any staff member was with the patient and attempted to minimize the impact of a fall by slowing the patient's descent.
- Falls During Play: A fall that occurs in a pediatric or psychiatric gym or designated play area for patients during normal play activities.
- Physiologic Fall: A fall attributable to one or more intrinsic physiology factors, i.e. delirium, intoxication, dementia, gate instability, or visual impairment

CVM – Continuous Video Monitoring

RESPONSIBILITIES

Inpatient: Licensed nursing staff is responsible for evaluation/documentation of patient's fall risk upon admission and change of shift (a minimum of once in a twelve-hour period) or, with any change in condition that may increase a patient's risk of falling. Licensed staff is also responsible for ensuring required interventions are in place as appropriate.

- Nursing staff must complete a Fall Prevention Program review in GOALS upon hire and annually thereafter.

Outpatient: Designated staff will be responsible for completing and documenting the Rooming Tool. Staff is also responsible for ensuring required interventions are in place as appropriate

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

A. Inpatient: The appropriate screening tool will be completed upon admission, change of shift (a minimum of once in a twelve-hour shift) and when there are clinical or cognitive changes that may indicate an increased risk of falling.

In the emergency department, patients will be scored during the initial assessment and when there are clinical or cognitive changes. For patients admitted and held in the ED the tool will also be completed at change of shift (a minimum of once in a twelve-hour shift).

MORSE FALL SCALE			
History of Falling – Physiologic Fall in Last Six Months	No= 0	Yes = 25	
Secondary Diagnosis*	No = 0	Yes = 15	
Ambulatory Aide	None, Wheelchair, Bedrest, Nurse = 0	Crutches, Cane, Walker = 15	Furniture = 30
IV/Saline Lock	No = 0	Yes = 20	
Gait/Transfer	Normal, Immobile, Bedrest = 0	Weak = 10	Impaired = 20
Mental Status	Oriented to Own Ability = 0	Forgets Limitations = 15	

*Consider Medications that may put your patient at increased risk of falling, including but not limited to: Medications causing sedation, confusion, impaired balance, orthostatic blood pressure changes. Consider Medication Consult to Pharmacy as appropriate.

*Consider Diagnoses that may put your patient at risk including but not limited to: Greater than two medical diagnoses in chart, Incontinence, Seizures, Vision problems, Multiple medications, Orthostatic Hypotension

1. The patient's Morse Fall Score will determine the intervention to be implemented.

2. Those patients in critical care or emergent care settings, with a Glasgow Coma Score of 7 or less, will be exempt from the fall risk interventional process listed below.

B. Outpatient:

Outpatient clinic/procedural area patients will be evaluated during completion of the initial intake documentation

Fall Rooming Tool Questions:

1. Repeat history of falls within the last six months? Yes/No. If yes, what caused the fall?
2. Will any of the medications or procedures this patient may encounter during their visit put them at an increased risk of a fall? Yes/No
3. Does this patient demonstrate any physical impairment or altered mental status that places them at an increased risk for falls? Yes/No
4. Does this patient have poor footwear? Yes/No
5. Does the patient utilize an assistive device, such as a cane, walker, crutches, wheelchair, or scooter? Yes/No
6. Was the patient or family given the "Preventing Falls" brochure? Yes/No
7. Does the patient warrant fall precautions? Yes/No

NOTE: Any "Yes" answer to questions 1 through 5 will result in the patient being considered at increased risk of a fall. Fall precautions should be documented and the appropriate interventions put in place.

	Interventions/Precautions **INPATIENT**	**Low Risk** **(Score 0-24)**	**Moderate Risk** **(Score 25-45)**	**High Risk** **(Score >45)**
1	Educate patient and family: - Fall Risk - Purposeful Hourly Rounding - White Boards	**X**	**X**	**X**
2	Keep Frequently used items in reach	**X**	**X**	**X**
3	Maintain adequate lighting	**X**	**X**	**X**
4	Maintain are free of clutter	**X**	**X**	**X**
5	Use non-skid footwear	**X**	**X**	**X**
6	Maintain bed in lowest position with wheels locked	**X**	**X**	**X**
7	Utilize personal (pad or tab)/bed alarms* - Moderate risk when appropriate - **ALL high-risk patients (including cognitive impairment)**		**X**	**X**
8	Assist with needs to/from bathroom/bedside commode		**X**	**X**
9	**Maintain Arm's Length****			**X**
10	Apply Fall Risk Band		**X**	**X**
11	Accompany patient during ambulation		**X**	**X**

12	Consider Physical Therapy Evaluation		**X**	**X**
13	Educate Patient to rise slowly to avoid dizziness	**X**	**X**	**X**
14	**Forgets Limitations*** **	**X**	**X**	**X**
15	Post appropriate signage		**X**	**X**
16	Consider CVM***	**X**	**X**	**X**

- Universal Precautions – Applies to all patients and includes Environmental safety, items within reach, Nonskid footwear, Access to call bell, Purposeful hourly rounding, fall risk assessment, adequate hygiene, care planning as appropriate, patient and family education and adequate lighting.

- Application of Bed Alarms – It is recommended for nursing staff to utilize the middle level of alarm. The exit alarm should only be used for physical independent patients who need their activity monitored.

- *Bed Alarms/Personal Alarms – Document patient refusal. (Inpatient only) -- Documentation regarding refusal should be completed at least once a shift or with a change of nurse.

- Apply non-slip material under and above chair alarm pad

- **Arm's Length – Nursing staff must stay at least at arm's length when assisting a high-risk fall patient to/in/from the bathroom. Nursing will stay at least at this distance while in the bathroom, on the bedside commode, in the shower and during the return to either the chair or bed.

- ***Any patient with documented "Forgets Limitations" in their Morse Fall Score regardless of the total Morse Fall Score will have bed and chair alarms activated and be considered at high risk of a fall. See Personal Alarm policy .

- Mental status changes such as delirium, dementia, or psychosis may cause patients to be more agitated and confused, putting them at risk for falls. Consider CVM for this population. Refer to the Continuous Video Monitoring policy.

Inpatient:

Additional Interventions:

- Safety Rounding – See Purposeful Hourly Rounding policy.
- Any post-procedure/post-operative patient must have bed alarms in place for 24 hours or until fully recovered from sedation/anesthesia as determined by the nurse. *Anyone unable to communicate or demonstrate understanding of nursing expectations (use of call bell, need for assistance, limitation of abilities) should have bed alarms continued for the remainder of hospital stay.
- Excludes Inpatient Psychiatry. Patients on this unit will be monitored by nursing staff and re-evaluated for fall risk following procedures.

- For patients requiring Temporary Transvenous and Epicardial Pacing please refer to the Temporary Transvenous and Epicardial Pacing policy.
- Ensure patient mobilization as appropriate. Refer to the Mobility Screening and Nursing Mobility Progression policy.

Post Fall Management:

- Post fall, the patient will be evaluated immediately following the event, and again each shift thereafter for 24 hours, or more frequently if ordered by provider. The evaluation may include but is not limited to vital signs, pain, neurological assessments, and a focused evaluation on any area of concern
- The nurse will document the event in electronic record by opening the "POST FALL GROUP" into the vital signs flow sheet. Any areas not addressed in this format should be addressed through a narrative note in the Nursing Progress Notes.
- Re-evaluation of the patient's Fall Risk score should also be completed when appropriate and documented.
- Incorporate or re-evaluate the Plan of Care related to Fall Prevention as necessary.
- Place appropriate signage outside patient's room and/or above patient's bed.
- Notify unit management team immediately during normal business hours of any fall. Notify nursing supervisors immediately outside of normal business hours of any fall. Management or Nursing Supervisors will complete Post Fall Huddle.

Outpatient:

*All patients in the Hematology Oncology clinic are considered at high risk of a fall and will not have a fall risk band applied. Any unaccompanied patient will be assisted when ambulating in the clinic, to the bathroom, to the nourishment area etc. Patients will also be assisted from the waiting room and escorted to their appointments in the clinic. This will be done in addition to all other listed interventions to maintain safety.

Procedural Area Intervention Bundle:

- All patients found to be at risk of a fall shall be banded with yellow fall prevention arm band. Band is to remain in place until departure from [redacted] property.
- Keeping pt. on lowest surface possible
- Side rails up (Side rails are okay with Joint Commission since in procedural areas)
- Lock wheels on stretcher and chairs
- Patient will have access to a staff member at all times, unless using a call bell
- Education pamphlet available
- Utilize the StaySeated or PedsStaySeated Smartphrase as needed to document patient education.
- Those who had a completed procedure will be instructed to call for assistance when going to the restroom.

Clinic Area Intervention Bundle:

- All patients found to be at risk of a fall shall be banded with yellow fall prevention arm band. Band is to remain in place until departure from [redacted] property.
- Keeping patient on lowest surface possible
- Lock wheels on stretcher and chairs
- Signage for areas with fall risk preventions as appropriate.

- Floor free of clutter
- Assistance on/off exam table
- Assist patients in/out of exam rooms
- Offer educational brochure
- Utilize the StaySeated or PedsStaySeated Smartphrase as needed to document patient education.

Post Fall Management:

- Post fall the patient will be evaluated immediately following the event by the provider.
- The nurse will complete appropriate documentation in the Electronic Health Record.
- Complete an Incident Report
- Notify management team and complete the online Outpatient Fall Huddle Form (see links).

ATTACHMENTS – N/A

REFERENCES

- 2023 American Geriatrics Society Beers Criteria® Update Expert Panel. (2023). American Geriatrics Society 2023 updated Beers criteria® for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society, 71*(7), 2052–2081.

- Preventing Falls in Hospitals. Content last reviewed February 2024. Agency for Healthcare Research and Quality, Rockville, MD https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

- Macieira, T., G., Yao, Y., Smith, M. B., Bian, J., Wilkie, D., & Keenan G. M. (March/April 2020). Nursing care for hospitalized older adults with and without cognitive impairment. Journal of Nursing Research, 69(2), 116-126.

- The Joint Commission. (September 28, 2015). Sentinel Event Alert: Preventing falls and fall-related injuries in health care facilities, Issue 55, 1-5. Retrieved from A Complimentary Publication of The Joint Commission Issue 55, September 28, 2015

Policy

Title: **Hand Off Communication**	
Joint Commission Chapter Section: 2.0 Risk Management / Patient Safety	*Date ORIGINAL policy was created:* August 01, 2006
This policy belongs to: System Nursing Policy Council	
Committee/Council Approval(s): N/A	*Date of COMMITTEE Approval(s):* N/A

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
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Key words: Patient Passport

PURPOSE

Implement a standardized approach to "Hand Off" communications, including an opportunity to ask and respond to questions as part of Joint Commission National Patient Safety Goal to improve effectiveness of communication among caregivers.

PERSONS AFFECTED

Hospital Personnel assuming permanent or temporary responsibility for a patient.

POLICY

The policy of Hand Off Communication to ensure a standardized approach to "hand off" communication when permanent or temporary responsibility is assumed for the patient.

DEFINITIONS

Hand off Communication – refers to a contemporaneous process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care. The information is usually about, but not limited to, the patient's current condition, ongoing treatment, recent changes in condition and possible changes or complications.

RESPONSIBILITIES

It is the responsibility to follow the hand off process as outlined in this policy.

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

Hand off Communication Process:

1. Hand offs should:
    - Be verbal or face to face whenever possible.
    - Occur in a setting that minimizes interruptions and maintains patient confidentiality.
    - Include the opportunity to ask questions.
    - Follow an approved, standardized approach.
    - Occur minimally at the following times:
        i. Change of shift or responsibility
        ii. Change of care of the hospital, including when patients are sent for procedures or treatments
2. Consider using the Geisinger "Handoff Communication Reference" tool (paper), or electronic SBAR under "Notes-Communication" in EPIC.
3. The "Patient Passport" is to be used whenever a patient is transported for a procedure or treatment. This printed tool is not a part of the medical record.
    - Hand off signatures will be obtained:

        i. Transport arrives at the unit and obtains the patient's passport. UDC or designee makes connection with assigned or designated nurse to alert transport is on unit.
        ii. Transport will wait outside the room until the assigned or designated nurse arrives. Transport should not enter a patient room without the nurse.
        iii. If 5 minutes pass without response, transport will report back to the nurse's station to notify nursing staff/UDC that no one has come to the patient room for handoff.
        iv. Transport returns to outside patient room to wait for assistance from the nurse. If no one comes after an additional 5 minutes we are to return to the desk to inform them that we are postponing the job. Place job in postpone and move on to the next task.

v. On arrival to the unit, transporter will sign paper passport along with nurse prior to transferring patient off the unit
vi. On arrival of patient to designated location; handoff, transfer, and signature of paper passport will occur between transporter and ancillary staff.
vii. Upon completion of the test/procedure/study; handoff, transfer, and signature of paper passport will then occur between ancillary staff and transporter.
viii. On arrival back to the unit, handoff, transfer, and signature of the patient paper passport will occur with transporter and the nurse

4. Electronic SBAR report from the ED is found in EMR under "Notes-Communication"

Hand Off Communication Process from the ED to an Inpatient Unit:

1. When the assigned bed is in progress, the ED nurse assigned to the patient will call/text the assigned floor and ask for the name of the nurse receiving the patient. The ED nurse will enter the receiving nurse's full name on the electronic SBAR. The ED nurse will enter the ED extension number on the electronic SBAR form, so the floor nurse knows who to contact. The nurses name will be automatically entered on the form. If the receiving unit is unable to provide the nurse's name, the SBAR report to be addressed to the charge nurse (by name).
2. The electronic SBAR is placed in the chart during the first call.
3. The receiving nurse will have until the bed becomes CLEAN on the bed board to review the electronic SBAR.
4. The receiving nurse will review the electronic SBAR and contact the ED nurse if there are any questions.
5. Verbal reports will be given on trauma alert patients that have had their documentation on the trauma alert sheet.

At [redacted] Lewistown Campus and [redacted] Bloomsburg Hospital:

1. The ED patient will be assigned a clean bed.
2. A verbal or telephone report will be given prior to patient transfer.
3. All patients who received treatment with IV thrombolytics (e.g. Alteplase, Tenecteplase) will have an RN to RN bedside hand off to include the NIHSS.
4. ED nurse will document receiving nurses' name in progress note. [redacted] Only

IR/PACU Process:

1. An electronic SBAR report will be given via each area specific note template in the EMR. [redacted]- verbal is also completed at bedside.

Transfers:

2. Transferring patients to nursing homes, rehab facilities or when a home health agency is involved with post discharge care, nursing will send copies of the appropriate forms to the facility:
    a. The Transfer Form
        i. **At** [redacted] **only**, completed for transfers to other acute care facilities.
    b. The After Visit Summary (AVS).
    c. MAR for the last 24 hours

   d. Medical Necessity – [redacted] **only**. For any company transport (i.e. ambulances, cars, etc)
3. In addition, a report will be called to the receiving facility or agency.
   a. [redacted] **Only** – Report will be called to the receiving facility or agency and documented in progress note.

ATTACHMENTS

N/A

REFERENCES

Bergman, L., & Chaboyer, W. (2019). *Adverse event during intrahospital transport.* Patient Safety Network. Agency for Healthcare Research and Quality.

Desmedt M, Ulenaers D, Grosemans J, Hellings J, Bergs J.(2021) Clinical handover and handoff in healthcare: a systematic review of systematic reviews. *Int J Qual Health Care.;33* (1):mzaa170. doi: 10.1093/intqhc/mzaa170. PMID: 33325520

Joint Commission (2017). Sentinel Event Alert 58: Inadequate hand-off communication

Policy

Title: **Heparin Nomogram**	
Joint Commission Chapter Section:(REQUIRED) 11.0 Medication Management	*Date ORIGINAL policy was created:* August 01, 1999
This policy belongs to: System Nursing Policy Committee	
Committee/Council Approval(s): Pharmacy & Therapeutics Committee	*Date of COMMITTEE Approval(s):* Oct 27, 2023

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

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PURPOSE

To ensure the safest most efficient administration and monitoring of therapeutic unfractionated heparin to all patients admitted to the Geisinger Health System

PERSONS AFFECTED

All health care providers that order, monitor, dispense, and administer unfractionated heparin continuous infusions to patients admitted to the Geisinger.

POLICY

VTE – All patients admitted to Geisinger in which a heparin drip is intended for therapeutic anticoagulation related to VTE should utilize EPIC order set Anticoagulation Nomogram Orders with DVT/PE Heparin Nomogram chosen.

Cardiac – All patients admitted to the Geisinger Health System in which a heparin drip is indicated for a cardiac indication should utilized EPIC order set Anticoagulation Nomogram Orders with Cardiology/ACS/AF Heparin Nomogram chosen.

Neurology/Stroke - All patients admitted to the Geisinger Health System in which a heparin drip is indicated for a neurologic indication should utilized EPIC order set Anticoagulation Nomogram Orders with Neurology/Stroke Heparin Nomogram chosen.

Subtherapeutic – To be used post-procedure where evidence of the benefit of subtherapeutic heparin has been demonstrated. Subtherapeutic heparin nomogram should be chosen from EPIC order set Anticoagulation Nomogram Orders.

APTT – To be used for patients who were receiving a Xa inhibitor (rivaroxaban, apixaban, edoxaban) prior to admission/prior to initiation of heparin infusion due to interference of the Xa inhibitor on the anti-Xa (Unfractionated Heparin) level. Heparin nomograms with aPTT monitoring should be ordered based on the appropriate indication from Anticoagulation Nomogram Orders order set in EPIC.

Impella – For patients who have been ordered heparin during the use of an Impella device order set Anticoagulation Nomogram Orders will be utilized with the appropriate nomogram chosen by the provider.

Respiratory ECMO – For patients who have been ordered heparin infusion during VV ECMO using order set.

The text, dosing, goals, and content of the order set will not be altered in anyway. Doing so will place a patient at risk for errors.

Actual body weight will be used for calculating all heparin doses and adjustments except for obese patients as defined by >20% above ideal body weight. Obese patients will be dosed based on an adjusted body weight using the formula:

Adjusted wt (kg)=IBW(kg) + 0.4 (Actual weight kg – ideal weight kg)

Pharmacists are responsible for the accuracy of all calculations in the nomogram. All errors will be automatically corrected by the pharmacist PRIOR to verification. Pharmacists will document all corrections made via an I-vent under ‘dose adjustment’ PRIOR to verification.

Pharmacists are responsible to ensure that all contraindicated medications are discontinued. Absolutely contraindicated medications that will be automatically discontinued by pharmacy will be all prior heparin orders including LMWH, fondaparinux, argatroban, etc.

Only pharmacists shall use and access appropriate EPIC order set for the purposes of making corrections and/or completing all calculations.

DEFINITIONS

Heparin drip-unfractionated heparin administered to a patient via continuous infusion whereas the primary goals is not intended for prophylaxis of DVT or PE

RESPONSIBILITIES

Nursing is responsible for:

- Ensuring all labs are collected when indicated.
- Adjusting the heparin drip per the ordered nomogram.
- When changing rates, holding infusion, or administering boluses the nurse will document each change on the MAR including the date, time, and rate. The signatures of two trained licensed personnel, one of whom is an RN, are required as stated in Policy 11.02.05 Medication Management: Independent Double Check Policy of High Alert Medications.
- Administer bolus doses for all subtherapeutic levels per the ordered nomogram.
- Ensuring the following documentation on the heparin flowsheet:
    - Current heparin rate in units/kg/hr
    - Heparin Level result (automatic from lab)
    - Heparin change required for levels not at goal or "NO CHANGE required" for levels that are at goal.
    - Bolus Given (when applicable per nomogram)
    - Updated heparin rate in Units/kg/hr
    - When the next heparin level is due. In 6 hours OR in the following AM if 2 consecutive levels are in therapeutic range (or when applicable per specific nomogram orders).

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

[redacted] ONLY:

- To expediate the laboratory process for patients on a Heparin Infusion, RNs will place Heparin Infusion Lab orders using the protocols.
- The following protocols can be used for patients based off of the ordered Heparin Infusion:
    - Unfractionated, Heparin Level in 6 hours
    - Unfractionated, Heparin Level – Daily
    - aPTT in 6 hours
    - aPTT – Daily
- Labs will be ordered utilizing the current attending as the ordering physician.
- It will be the responsibility of the staff physician assigned to the patient to sign the electronic chart order placed using the appropriate protocol.

Key Points

- While the provider has the option to omit the initial bolus of heparin, doing so will result in delays to therapeutic anticoagulation.

- The initial bolus is recommended for most patients who require therapeutic anticoagulation EXCEPT those using heparin for a neurological indication after ECMO cannulation, and/or where the risk of severe hemorrhage outweighs the benefit of reaching therapeutic goals faster.
- The therapeutic level of heparin will be determined by the unfractionated, heparin level only (except aPTT nomogram).
- At one-time baseline aPTT will be obtained for purpose of detecting a baseline coagulopathy.
- aPTT will not be used for the purpose of monitoring heparin and will not be ordered for the purpose of monitoring heparin (unless the aPTT nomogram is ordered for patients who had been taking oral Xa inhibitors prior to admission).
- aPTT should be ordered prior to invasive procedures at the discretion of the provider to determine if it is safe to perform the procedure.
- An undetectable or subtherapeutic heparin, unfractionated level will not detect patient-specific coagulopathies and should not be ordered or interpreted for any purpose other than monitoring heparin.
- All doses will be in units/kg/hr
- Patient's weight will be placed in the pump requiring dual sign off.
- All adjustments will be made in units/kg/hr

ATTACHMENTS

Independent Double Check Policy of High Alert Medications

REFERENCES

N/A

Policy

Title: [redacted] **Interpreter Policy for Deaf/Hard of Hearing and Non-English-Speaking Patients**	
Joint Commission Chapter Section: 9.0 Ethics, Rights, Responsibilities	*Date ORIGINAL policy was created:* 03/01/2008
This policy belongs to: Quality, Safety and Patient Experience	
Committee/Council Approval(s): Clinical Leadership Council	*Date of COMMITTEE Approval(s):* 5/16/2023

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] **Entities:**

CLINICAL ENTITIES *(includes* [redacted] *entities providing health care services, i.e., hospitals, group practices, clinics)*	
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NON-CLINICAL ENTITIES *(includes* [redacted] *business/corporate entities not providing health care services)*	
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PURPOSE

Good medical care depends upon effective communication between employees, patients, family members, care givers, and providers. This policy and process outlined below are to facilitate effective communication between Deaf/Hard of Hearing and non-English speaking patients, family members, care givers, and the staff responsible for the patient's care in compliance with [redacted] Patient Rights and Responsibilities, the Americans with Disabilities Act (ADA), Joint Commission standards, and the Affordable Care Act (ACA) Section 1557.

[1] [redacted]-HM Joint Venture is an LLC representing a joint venture between [redacted] Medical Center and Highmark Health.

PERSONS AFFECTED

All patients, family members, caregivers, and staff.

POLICY

This policy is to ensure equal communication access for all Limited English Proficient (LEP) and Deaf/Hard of Hearing patients throughout the [redacted] system. Inadequate or poor communication in a healthcare setting can contribute to adverse events that may compromise the quality of care, treatment, and safety of our patients.

- Staff will facilitate effective communication between patients, family members, care givers, and the staff responsible for the patient's care in compliance with [redacted] Rights and Responsibilities, the Americans with Disabilities Act (ADA), Joint Commission, and the ACA Section 1557.

- An on-site qualified medical interpreter or Language Line interpreter must be used for all exchange of medical information including intake, inpatient, Emergency Department, office visit, financial assistance, testing, doctor rounds, social workers, addition, discharge, and all other programs offered by [redacted].

- Any person not trained to be a qualified medical interpreter cannot interpret for the patient. This includes friends, family members, children, ad hoc or other untrained individuals, and staff members who have not been tested and trained to be qualified medial interpreters

- **GOOGLE TRANSLATE is not an approved source for interpretation or translation services.**

- Bilingual clinicians and non-clinical staff (including but not limited to MDs, DOs, NPs, PAs, nurses, technologists, therapists, medical assistants) who wish to share medical information directly with patients in a language other than English must be assessed, formally tested, and receive a passing grade for fluency in the targeted language. This assessment does not qualify the individual to serve as an interpreter. Even if the employee or contractor is a heritage speaker of the foreign language, they are still required to pass the bilingual fluency assessment.

- If a patient insists that a family member or friend act as an ad hoc interpreter, during an in person visit, the family member/friend can do so. However, [redacted] has the right and obligation to ensure effective communication. [redacted] staff must use a qualified interpreter when communicating with individuals who are LEP or deaf/hard of hearing. Staff must complete documentation, including the Refusal/Waiver of Interpreter Service form (A-663-006 FRM), which is available in English (for Deaf/Hard of Hearing patients), Russian, Spanish, Arabic, Nepali, Chinese and Vietnamese. This form must be completed each time a different interpreter is named by the patient (see Procedure for Refusal/Waiver of Interpreter Services process). For non-in person visits, please use the Smartphrase **.interpreterverbalwaiver** wherever staff would document in the medical record.

DEFINITIONS

Americans with Disabilities Act (ADA) – A federal law requiring public entities to provide accessibility to individuals with disabilities.

Affordable Care Act (ACA) – Requires the use of a qualified interpreter for all medical interpretation in the language preferred by the patient or family.

Ad hoc interpreter – An untrained person, such as an adult family member, bilingual hospital staff, or a friend who is not a qualified interpreter. They are not permitted to provide interpretation to patients in the medical setting. If the patient insists, a waiver must be signed with the understanding that [redacted] may use a qualified interpreter.

Interpreter –A person who renders a spoken message or signed message from one language to another.

Qualified Interpreter (spoken language) – An individual who, via a remote interpreting device or on-site appearance, adheres to generally accepted interpreter ethics, including client confidentiality; has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly using any necessary specialized vocabulary, terminology, and phraseology. They must have received a certificate of qualifications from a vetted organization. Staff will be identified on their badge as being an interpreter in specified language.

Qualified Interpreter (sign language) – A sign language interpreter who holds a valid certification from the Registry of Interpreters for the Deaf (RID) or the National Association of the Deaf (NAD) and is state-registered with the Pennsylvania Office for the Deaf and Hard of Hearing (ODHH) to provide interpreting services in Pennsylvania.

In-person interpreter – A qualified interpreter who is either employed by or contracted with [redacted] and whose services are requested at a specific site to interpret for a limited English-speaking or Deaf patient/family members.

Qualified Translator –

1. A translator converts written text from one language to another.
2. Has demonstrated proficiency in speaking and understanding both English and at least one other spoken language.
3. Adheres to accepted translator ethics and principles, including client confidentiality.
4. Translates effectively, accurately and impartially to and from the target language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.
5. Meets the requirement of being a qualified medical interpreter and has been assessed for translation skills.

Language Line – The remote video and phone interpretation system, testing and training of qualified interpreters, fluency assessment, and translation company contracting with [redacted].

Interpreter Service Refusal/Waiver – A refusal/waiver is obtained verbally from the patient through a hospital-provided interpreter resource (in-person, by phone, or via a video remote interpreter) when the patient refuses the hospital-provided interpreter resource and chooses to use another individual (over the age of 18) to interpret on their behalf. The verbal refusal of a hospital interpreter must be documented in the patient's medical record, along with the full name and relationship of the person chosen by the patient to provide the interpretation. To assure accurate information is being provided to the patient via the family/friend, [redacted] has the right to have a qualified interpreter present. The vendor can be contacted and informed that they are to listen to the conversation and only interject for clarification.

Interpreter Encounter Documentation - All interpreter-facilitated interactions between providers and patients who are LEP and/or Deaf will be documented into the patient's medical record by hospital staff. Hospital staff are obligated to record the name/ID number of the in-person, telephone, or video remote interpreter resource utilized by staff to facilitate patient communication. If a family member or friend is used, document their name and relationship in the note. The waiver should also include the name.

Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and who have limited

ability to read, write, speak, or understand English.

Qualified Bilingual Staff – A member of the workforce designated by [redacted] to communicate directly with patients in a language other than English as part of their current job responsibilities. They must demonstrate that they:

1. Are proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology.
2. Can effectively, accurately, and impartially communicate directly with individuals in their preferred language and **WILL NOT SERVE** as an interpreter.
3. Have completed and passed the fluency assessment arranged through interpreting services. The type of test will be determined based on their role.
4. Are identified on their badge as being fluent in the specified language.

Heritage Speaker – A member of the staff who has learned a language from their family. These individuals must be tested for medical fluency before discussing medical issues with patients or family members.

Fluency Assessment – An evaluation of the staff's ability to converse in a medical setting in both English and another language.

RESPONSIBILITIES

Staff will be responsible for following the steps listed in the procedure to contact an interpreter if the chart documents any of the following:

1. The patient has a preferred language other than English.
2. The patient, family member, or care giver requests an interpreter.
3. The staff requests an interpreter.

Staff will be responsible for knowing how to:

- Contact an interpreter to come on-site for in-person interpretation.
- Use Language Line video remote devices.
- Use Language Line over the phone.

Staff will also be responsible for documenting the use of a qualified interpreter in the medical record. The note must reflect the name and ID number of the interpreter.

EQUIPMENT/SUPPLIES

Language Line remote device – iPad (video and audio) and phone

Paper/pen for writing notes

Computer for typing notes

PROCEDURE

For Deaf Patients:

At the start of any encounter with a patient/family member, immediately call 570-214-9115 to request a Sign Language Interpreter. For emergent needs after normal business hours, message the TigerConnect role, "Coordinator Sign Language Interpreting Services," or call 570-764-3145. While waiting for a sign language interpreter to arrive, use a Language Line video interpreter. This procedure applies to all [redacted] locations including but not limited to the following:

Emergency Department
In-patient unit
Walk-in Clinics
Urgent Care Centers
Upon scheduling, canceling, or re-scheduling an appointment/procedure at any location

For Limited English Proficiency patients (LEP)

Upon arrival at the Emergency Department, Inpatient unit, or clinic site all patients who have a preferred language other than English must be provided with language interpretation. The patient's preferred language is indicated in the EPIC medical record. All employees are responsible to provide appropriate language interpretation. The patient's communication needs will be identified by a beige wrist band. Examples of communication barriers are blind, deaf, aphasic, speaks another language other than English

Language Line video remote devices are available throughout the system. Follow guidelines that are attached. Language line provides audio for over 200 languages and video for over 41 languages, including ASL. Language line also provides audio service (excluding ASL) that can be utilized from any telephone. Staff will need to provide specific details to the interpreter, i.e., Patient's MR#, location, etc.

Refusal/Waiver of interpreter services process

1. The process for a patient to request an unqualified ad hoc interpreter must be communicated to the patient by the clinical staff through a qualified interpreter (in person, by phone, or via video) and must include staff disclosure to the patient that the hospital's interpreters are provided free of charge.
2. The discussion should be in private, following HIPAA guidelines, to ensure patients are refusing hospital interpreter services of their own accord and not because of pressure from family members or others to do so. The ad hoc interpreter must be over the age of 18, must also consent to be their interpreter
3. The refusal of hospital provided interpreters will be documented by hospital staff in the patient's medical record by using the refusal/waiver form and will include the qualified interpreter's name/ID number utilized to interpret the form, as well as the full name and relationship of the person appointed by the patient who agrees to interpret. The form should be reviewed at each inpatient or outpatient encounter.
4. If a patient who is LEP, Deaf, or Hard of Hearing elects to use any other consenting adult other than a hospital provided qualified interpreter, the clinical staff must still use a qualified interpreter provided by the hospital to ensure full and accurate interpretation takes place.
5. When the patient refuses to use a qualified interpreter during a **non-in person** visit, document in the medical record by using the Smartphrase **.verbalwaiver**

Informed consent

1. The responsibility for informed consent shall reside with the provider
2. A qualified, approved medical interpreter **must** be used when obtaining informed consent from a patient who is Deaf/Hard of Hearing and/or Limited English Proficient
3. When a bilingual physician or other clinician has been qualified as having fluency in the patient's preferred language, they may obtain direct consent without the assistance of an interpreter as they are simply providing their scope of practice in a different language.

Limitations

1. This policy outlines the parameters of interpreting services. It is not [redacted] intent or policy to have interpreters available to perform any duties OTHER than the provision of medical interpreter services.
2. Medical interpreters (in person, video, or telephone) may not be asked or are required to interpret for legal representatives (including, but not limited to, police, private lawyers, insurance agents, legal interviews concerning child abuse, domestic violence, elder abuse, or sexual assault). If interpretation is needed, then the outside agency must arrange for their own interpreter.

Procedure for Language Line video:

1. Staff will obtain a language line iPad remote video device for use during the appointment/encounter.
2. Double-click on the round home button on the Language Line iPad device.
3. Tap on the video or audio option for the desired language. If video, the interpreter will appear on the screen. If audio, you will hear the voice of the interpreter.
4. Provide the information requested by the interpreter.
5. For the deaf patient, focus the camera on the patient's head and torso. For other language focus the camera on patient and person speaking with the patient.
6. Speak directly to the patient using first-person language.
7. Record the interpreter's name and ID number in the medical record.
8. If appropriate, ask the interpreter to use the digital white board on the screen to verify medications, instructions, etc.
9. The unit should be cleaned as per policy in between each patient use.

Procedure for Language Line audio:

To be utilized when video is unavailable, to make a conference call when family is not present, or to call a patient/family member at home.

1. Dial Language line from any [redacted] phone - #4LANG - #45264
2. Option 2 – 1-833-942-2204
3. Provide the language needed.
4. Identify yourself.
5. Provide the MR# of the patient.

ATTACHMENTS –

1. Patient identification (inpatient and outpatient) policy
2. Language Line instructional video
3. English Waiver of Interpreter services
4. Arabic Waiver of Interpreter services
5. Chinese Waiver of Interpreter services

6. Nepali Waiver of Interpreter services
7. Spanish Waiver of Interpreter Services
8. Vietnamese Waiver of Interpreter Services
9. Russian Waiver of Interpreter Services

REFERENCES - N/A

Policy

Title: USP 800 Policy	
Joint Commission Chapter Section: 8.0 Environment of Care	*Date ORIGINAL policy was created:* 09/25/2019
This policy belongs to: Enterprise Pharmacy	
Committee/Council Approval(s): N/A	*Date of COMMITTEE Approval(s):* Month DD, YYYY

☐ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ [redacted]	☒ [redacted]
☒ [redacted]	☒ [redacted]
☒ [redacted]	☒ [redacted]
☒ [redacted]	☒ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☒ [redacted]
☐ [redacted]	☒ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☒ [redacted]	☐ [redacted]

NON-CLINICAL ENTITIES *(includes [redacted] business/corporate entities not providing health care services)*	
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]

PURPOSE

The purpose of this policy is to outline how hazardous drugs (HD) should be handled

PERSONS AFFECTED

All [redacted] staff who receive, prepare, administer, and discard HD.

POLICY

This policy reflects the requirements for the management of HD.

DEFINITIONS

N/A

RESPONSIBILITIES

N/A

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

Section 1: HD Employee Training and Safety Program - See USP 800 Policy Exhibit A for additional detail

I. Purpose

a. This scope of this SOP is limited to pharmacy training and a compounding pharmacy safety program associated with the drugs defined as hazardous by The National Institute for Occupational Safety and Health (NIOSH). NIOSH uses 6 criteria to define hazardous drugs: carcinogenicity; teratogenicity (or other development toxicity); reproductive toxicity; genotoxicity; and structure and toxicity profiles of new drugs that mimic existing drugs already determined to be hazardous by one of the five criteria previously listed.

b. The list also breaks HDs into the following categories: antineoplastics, non-antineoplastics and reproductive risk only. Entities may choose to exempt some dosage forms of HDs (as long as they are not Active Pharmaceutical Ingredients (API) or antineoplastic drugs that require further manipulation beyond counting or repackaging the final dosage form) from specific containment strategies and/or work practices if an Assessment of Risk is performed, documented, and reviewed at least annually.

c. This SOP refers to all HD API, any antineoplastic HD, and other non-antineoplastic HD dosage forms that are not exempted by Geisinger Pharmacy. Though other chemicals (such as common cleaning chemicals) can present hazards to employees, requirements regarding those chemicals and substances are defined elsewhere in organizational policy and procedure.

d. It governs worker and environmental safeguards/surveillance as well as required employee training and competency evaluation required relative to all aspects NIOSH designated hazardous drug handling which includes receiving, storage, compounding, packaging, labeling, transport, administration, and disposal.

II. Policy Statements

a. Hazardous drugs (HDs) are received into inventory, stored, prepared, labeled, packaged, transported, administered, and disposed of only under conditions that protect healthcare workers.

b. An HD safety program that incorporates administrative, engineering and work practice controls is developed and maintained to provide maximum protections to healthcare workers.

c. Any personnel who may encounter HDs during the normal course of their job duties receive training on HD handling that is specific to their job duties.

d. Personnel who may not be involved in compounding but may be expected to participate in other HD handling duties such as inventory receiving, stocking, labeling, packaging, transport, administration, or

cleaning of areas associated with HD preparation or storage also receive training prior to performing those activities.

e. Compounding personnel complete all required training associated with non-hazardous drug compounding as well as complete non-hazardous compounding written tests and competencies prior to completing training and competency requirements associated with hazardous drug compounding.

f. Training and competency verification occur before performing any HD related activities.

g. Training is documented according to OSHA standard and any other applicable federal state and local regulations.

Section 2: HD Handling: Receiving, Storage, Labeling, Packaging and Transport - See USP 800 Policy Exhibit B for additional detail

I. Purpose

a. This SOP governs the general aspects of hazardous drug (HD) handling. Specific aspects of handling include receiving, storage, labeling, packaging, and transport activities that are not directly associated with compounding activities. For the purposes of this SOP, HDs are those substances which appear in **the NIOSH List of Antineoplastic and Other Hazardous drugs in Healthcare Settings, 2016:** **https://www.cdc.gov/niosh/topics/antineoplastic/pdf/hazardous-drugs-list_2016-161.pdf** **(See content linkage)** as well as any subsequent updates to the NIOSH HD list as they become official. Entities may choose to exempt some dosage forms of HDs (as long as they are not Active Pharmaceutical Ingredients (API) or antineoplastic drugs) from specific containment strategies and/or work practices if an Assessment of Risk is performed, documented, and reviewed at least annually. This SOP refers to all HD API, any antineoplastic HD, and other non-antineoplastic HD dosage forms that are not exempted by Geisinger Pharmacy

II. Policy Statements

a. Hazardous drugs will be received, stored, labeled, packaged, and transported using methods that protect employees, the surrounding environment and others who may encounter them in the healthcare environment.

b. Hazardous class 1A drugs will be stored separately from other non-hazardous drug inventory.

c. Hazardous drug (HD1A drugs that will be manipulated/compounded) storage will occur in a room (with fixed walls) that is negative pressure to the surrounding areas since some hazardous drugs may be volatile at room temperature and the hazardous drug storage area is externally ventilated and has at least 12 air changes per hour (ACPH).

d. Any employee who may during their normal pharmacy job duties, be expected to come in proximity (during inventory receiving, distribution, stocking, inventory control, order picking, compounding, packaging for distribution or disposal) to hazardous drugs will wear appropriate personal protective equipment (PPE) as defined in this SOP.

Section 3. Hazardous Drug Garbing and Compounding Techniques - See USP 800 Policy Exhibit C for additional detail

I. Purpose

a. This SOP communicates information and establishes work practice requirements that specifically apply to activities associated with garbing and compounding hazardous drugs (HDs). It builds upon SOPs already established related to work practices, use of primary engineering controls and aseptic compounding techniques

II. Policy Statements

a. Containment Primary Engineering Controls (C-PECs) and Containment Secondary Engineering Controls (C-SECs) including Containment Segregated Compounding Areas (C-SCAs) alone are not sufficient to protect and safeguard either the sterility of CSPs or the safety of workers handling HDs.

b. Specifically designed Personal Protective Equipment (PPE) must be used during the handling of HDs.
c. Different compounding techniques are used when compounding HDs to minimize the risk of contamination of the compounding area and CSP final packaging with HDs.
d. Unless otherwise noted, all policies and procedures will be followed.
e. Non-compounding person such as those performing cleaning from an outsource vendor or internal Environmental services must receive training in hand hygiene and garbing (including competency verification) in the same manner as those who perform compounding. The only exception is that cleaning personnel do not have to pass gloved fingertip testing since these persons do not perform any activities inside the C-PECs. Only trained, authorized compounding personnel may perform decontamination, cleaning and disinfection of the inside surfaces of C-PECs.
f. Care in properly doffing HD PPE is critical to preventing HD contamination from migrating beyond the C-SEC and so Geisinger Pharmacy will create a doffing area immediately inside the C-SEC and doff contaminated items according to this policy to reduce the risk of migration of HD contamination.

Section 4. HD Decontamination, Spill and Waste Management See USP 800 Policy Exhibit D for additional detail: Link to Industrial Hygiene for Spill clean-up specifics

I. Purpose

a. The purpose of this SOP is to define the activities necessary to properly decontaminate areas used for hazardous drug (HD) compounding as well as provide instructions on proper spill management and disposal of HDs

II. Policy Statements

a. Since safe levels of exposure to HDs have not yet been determined, it is imperative that the work practice controls to minimize exposure of employees and environment be established and strictly adhered to by all staff
b. HD residues are decontaminated prior to cleaning and disinfection on a regular basis as described in this document. Rather than separate “deactivation” and “decontamination,” for the purposes of this SOP, decontamination means the transfer of chemically active or inactive hazardous drug residues from the target surface to a wipe which is subsequently disposed in the appropriate HD waste container for disposal.
c. This SOP is strictly limited to the waste management provisions of those drugs designated as hazardous by the NIOSH. Though these substances will, at times described in this document, be handled, and managed as RCRA (RCRA means the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended, 42 U.S.C. section 6901) waste, there are other substances that require special handling and disposal that are not the subject of this SOP (such as SOP-listed substances or narcotics).
d. Local, state, and federal guidelines have been established relative to the management of HDs; employee safety and the right to know; regulated waste management and transport and related topics and pharmacies must establish policies per individual local and state requirements. Written SOPs must be established related to all Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA) and Department of Transportation (DOT) requirements.
e. The pharmacy maintains an SDS for all chemicals in the pharmacy (e.g., such as cleaning chemicals) however these chemicals are outside of the scope of this SOP.
f. Personnel who open BSCs and CACIs for decontamination, cleaning and disinfection or open them during the required access below the deck to perform decontamination and cleaning; as well as those responsible for spill cleanup will be fit-tested and properly instructed in the use of either full-face, dualchamber respirators or half-face, dual-chamber respirator with goggles that have been fitted with combination (particulate and vapor) filter cartridges. [redacted] may also utilize an independent vendor for these services if needed. detailed in Section 4 of this SOP.
g. Persons who handle HDs must be knowledgeable of the spill management procedures and have access to the

required supplies and equipment to carry out these actions. Spill management is part of an institution-wide safety program and is developed in conjunction with other departments and disciplines.

1.1.1.1 Call EVS for chemo spills.

1.1.1.2 Call Security and Call Eldredge, Inc at 610-436-4749 for spills >250mL.

ATTACHMENTS

I. HD Employee Training and Safety Program
II. Receiving, Storage, Labeling, Packaging and Transport
III. Hazardous Drug Garbing and Compounding Techniques IV. HD Decontamination, Spill and Waste Management
IV. HD Handling Consensus statement 2017

REFERENCES

N/A

Policy

Title: **Withdrawal Assessment Screening - Nursing**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* January 31, 2017
This policy belongs to: System Nursing Policy Council	
Committee/Council Approval(s): N/A	*Date of COMMITTEE Approval(s):* N/A

☒ **This Policy contains one or more PROCEDURES outlining the methods and applicability of this Policy.**

This policy applies to the following [redacted] Entities:

CLINICAL ENTITIES *(includes [redacted] entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ [redacted]	☒ [redacted]
☐ [redacted]	☒ [redacted]
☒ [redacted]	☒ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☒ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☒ [redacted]	☐ [redacted]

NON-CLINICAL ENTITIES *(includes [redacted] business/corporate entities not providing health care services)*	
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]
☐ [redacted]	☐ [redacted]

Key Words: COWS, CIWA, CAGE

PURPOSE

The purpose of this policy to identify patients at risk for opioid or alcohol withdrawal using validated screening tools in inpatient areas and the emergency departments.

PERSONS AFFECTED

RNs & LPNs

POLICY

1. Appropriate validated screening tools will be used to identify patients at risk for drug or alcohol withdrawal.
2. The CAGE questionnaire will be used to screen for alcoholism.
    a. If the patient identified as having a potential for alcohol abuse, the Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA- AR) will be completed to assess for withdrawal.
3. An Opioid Risk Assessment will be initiated on all patients 18 years and older.
    a. The Clinical Opiate Withdrawal Scale will be used if the first question is answered "Yes"

DEFINITIONS

N/A

RESPONSIBILITIES

Nursing is responsible to conduct appropriate assessments and contact provider with results of withdrawal assessment.

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

CAGE Questionnaire

1. Nursing will screen the patient on admission to assess for risk of alcohol withdrawal using the CAGE Questionnaire:
    a. Have you ever felt you needed to Cut down on your drinking?
    b. Have people Annoyed you by criticizing your drinking?
    c. Have you ever felt Guilty about drinking?
    d. Have you ever felt you needed a drink first thing in the morning (Eye- opener) to steady your nerves or to get rid of a hangover?
2. A score of > 2 is used as the criteria for the identification of patients who have a potential for alcohol withdrawal.
    a. The continued monitoring of CIWA-Ar will require the nurse to assess and document on the CIWA-Ar flowsheet
3. If the CAGE score is <2 but there is a clinical concern for alcohol withdrawal, nursing should complete CIWA-Ar as above.
    a. This includes, but is not limited to, any patient with a history of alcohol withdrawal requiring treatment, a history of delirium tremens, or recent heavy alcohol use.

CIWA-AR

1. Initiate CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol Revised)
    a. Assessment for the following:
        i. CAGE score 2 or more
        ii. Clinical concern for the risk of developing withdrawal or exhibiting symptoms of alcohol withdrawal.
        iii. A patient with a history of alcohol withdrawal requiring treatment, a history of delirium tremens or recent heavy alcohol use, is at greater risk of alcohol withdrawal

2. Document and notify provider
    a. If CAGE greater than or equal to 2, notify provider with initial CIWA.
    b. Refusal or inability to obtain CAGE answers and/or CIWA-Ar Score.

COWS

1. Nursing will screen patients 18 years and older on admission to assess for risk of opioid withdrawal using the Opioid Risk Assessment.
    a. Have you ever taken prescription medication that was not prescribed to your or illegal drugs?
        i. If "Yes", the questions below will cascade open in EPIC.
            1. Have you taken prescription pain medication that was not prescribed to you within the last 2 weeks?
            2. Have you used fentanyl or heroin within the last two weeks?
            3. Nursing entry: Is the patient here for an overdose?
    b. If the first question is answer Yes, complete COWS, notify provider and await order set, if indicated.

ATTACHMENTS

REFERENCES

Ewing JA. Detecting Alcoholism: The CAGE Questionnaire. *JAMA.* 1984;252(14):1905–1907. doi:10.1001/jama.1984.03350140051025

Clinical Opiate Withdrawl Scale (nih.gov)

Alcohol Withdrawal Syndrome - StatPearls - NCBI Bookshelf (nih.gov)