Policy

Geisinger

Title: **Administration of Blood/Blood Products**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* September 01, 1999
This policy belongs to: Laboratory Medicine	
Committee/Council Approval(s): System Nursing Policy Council	*Date of COMMITTEE Approval(s):* September 19, 2024

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

This policy applies to the following Geisinger Entities:

CLINICAL ENTITIES *(includes Geisinger entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ **Community Medical Center (CMC or GCMC)**	☒ **Geisinger Lewistown Hospital (GLH)**
☐ Endoscopy Center of Geisinger Lewistown Hospital	☒ **Geisinger Medical Center (GMC)**
☒ **Geisinger Bloomsburg Hospital (GBH)**	☒ **Geisinger Medical Center Muncy (GMCM)**
☒ **Geisinger Clinic (GC)**	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☐ Geisinger Surgery Center - Highland Park
☐ Geisinger Encompass Health, LLC	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☒ **GMC Outpatient Surgery - Woodbine**
☐ Geisinger-HM Joint Venture (G-HM)	☐ GWV Outpatient Surgery - CenterPoint
☐ Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger-Lewistown Hospital	☐ Marworth
☒ **Geisinger Jersey Shore Hospital (GJSH)**	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

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☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

Blood Transfusion Procedure

Transfusion Reaction Process

PURPOSE

The purpose of the policy is to provide guidelines for the transfusion of blood/blood products or for when a patient experiences a blood transfusion reaction.

PERSONS AFFECTED

Blood and blood products shall be administered only by appropriately credentialed staff per the General Information Section, paragraph 4: Checking Blood.

These individuals shall have completed the GOALS course of study in orientation on the administration of blood and blood products prior to initiating therapy. A performance competency will be completed during clinical staff orientation and documentation of competency is maintained by unit leadership.

POLICY

It is policy to ensure safe and accurate administration of blood/ blood products and provide a consistent process for addressing a transfusion reaction.

DEFINITIONS

Independent Double Check - A procedure in which two authorized personnel independently and separately check each component of prescribing, dispensing, and verifying the blood/blood product before administering to the patient.

RESPONSIBILITIES

It is the responsibility of all personnel administering the blood or blood product to follow hospital policy for patient identification and transfusion administration.

EQUIPMENT/SUPPLIES

1. Unit of blood or blood product, as ordered
2. Administration set
3. Intravenous access
4. Gloves
5. Protective eyewear/glasses or goggles where aerosolization or splashing of blood or body fluids is likely to occur.
6. Gowns- should be worn during procedures that are likely to generate splashes or blood body fluids.

BLOOD TRANSFUSION PROCEDURE

PROCEDURE

General Information

1. Ordering human blood and blood components:
    a. EPIC – A provider will place the order using the Blood Transfusion order set.
        i. If components are required, the provider can choose the specific components and indicate:
            1. Special needs
            2. Indication for transfusion
    b. Paper/Downtime – The “Request for Laboratory Studies-Blood Bank” (Form # A-480-481-F) is filled out by the person transcribing the order.
2. Compatibility
    a. Blood bank testing for blood product transfusion

i. A validated electronic identification verification allows for Type and Screen and confirmatory ABORh to be performed on a single specimen.
ii. In the absence of such an electronic system, there must be a historical blood type on record in addition to a current Type and Screen, or else a second sample must be drawn by a different individual and/or at least 5 minutes after the first specimen.

b. Frozen plasma should be ABO compatible, except in an emergency release, when group A plasma is acceptable. As a cell free product, frozen plasma can be given without regard to Rh group. Compatibility testing is not necessary.
c. Rh compatibility
i. Blood bank will issue most appropriate products based on patient sex, age and product availability.
ii. i. In emergency transfusion situations, Rh compatibility is irrelevant, and the Blood Bank will issue the most appropriate available products for resuscitation.
iii. In routine transfusions, pRBC and Platelets should be Rh-compatible for Females under 50 years of age.
iv. ii. Rh-neg Females under 50 who receive only Rh+ platelets should be offered RhIg (e.g., RhoGam)

3. Only appropriately credentialed staff, per paragraph 4- Checking Blood, may hand the following blood components:
a. Whole Blood or red cells
b. Plasma
c. Platelets
d. Cryoprecipitate
e. Albumin
f. Granulocytes
4. Checking Blood
a. The following personnel are authorized to administer blood: RNs, Perfusionists, CRNAs, PA-C, Apheresis Techs, Critical Care Paramedics and Physicians.
b. The following personnel may be the independent double check and sign off in the electronic health record or on the product chart copy: RN's & LPN's, Perfusionists, Perfusion Assistants, Anesthesia Techs, CRNAs, PA-C, Apheresis Technologists, Rad techs, Critical Care Paramedics, Virtual ICU RN & Virtual Registered Nurses.
c. Personnel administering blood or performing the independent double check will complete an annual review of the Blood Administration Policy and GOALS course.
d. Apheresis plasma- Plasma used during Plasmapheresis Treatments (GMC and GWV only) will only require a single person sign-off by the Apheresis RN/Apheresis Technologist with the computer being the second check. This applies to plasma products ONLY. The Apheresis RN/Apheresis Technologist signing off on the Plasma must be the individual hanging the plasma product. All other blood/blood products will follow the dual person sign-off per this policy.
5. Normal saline should be ordered prior to, or, for alternate use with a blood transfusion (ADULTS ONLY). Only NSS can be mixed with blood to reduce viscosity. Other solutions intended for IV use may be used in an administration set or added to blood or components under either of the following conditions.

a. They have been approved for this use by the FDA.
b. There is documentation available to show that the addition to the component involved is safe and efficacious (Refer to Documentation).
c. A saline lock may also be used to infuse the blood/blood product. Choose appropriate size catheter to match patient size and prescribed therapy ensuring blood is transfused in the 4-hour time period.
    i. Use a large-gauge catheter when rapid transfusion is required (e.g., 18- to 20-gauge).
    ii. Transfuse red blood cells (RBCs) at a slower rate when using small-gauge catheters; the pressure with rapid transfusion via a small-gauge catheter may cause hemolysis.

6. **Nurses must never add medications to blood**. (The perfusionist may add heparin based on a provider order).
7. Blood administration sets
    a. Are good for a maximum of 2 units and a total of 4 consecutive hours unless otherwise specified by the tubing manufacturer.
    b. If blood administration tubing is infusing through a lower Y site on a primary IV tubing, the primary tubing must be changed within 4 hours of the start of the infusion.
    c. NICU- A platelet filter is used for all blood products. Albumin is drawn up with a filter needle. All products are given via syringe infusion pump.
8. Micro aggregate filters may be used with a provider's order.
9. RBC, plasma, platelets, and whole blood should be infused via infusion pump unless in emergency situation.
    a. Platelets need agitated every 15 minutes to maintain uniformity of the platelet infusion.
    b. A pump must be used if infusing through a PICC or central line.
    c. A PICC cannot be used in NICU for transfusions.
10. Warming blood
    a. Only use FDA approved blood warming coils or blood/fluid warmers.
        i. Do not warm blood on radiators, in microwave ovens or any other warming devices other than approved warming coils or blood fluid warmers.
    b. How to obtain blood warmers:
        i. GMC- request through EPIC Grand Central
        ii. GWV- dispensed through blood bank with product as needed
        iii. GBH- obtained from cabinets in PACU or from nursing supervisor after hours.
        iv. GCMC- warmers are available from the ICU or ED.
        v. GLH- obtained from the OR.
11. DO NOT transport patients with blood products actively transfusing unless clinically indicated, such as in an emergent situation.
    a. If patient must be transported, a full set of vital signs should be completed and documented and an RN must accompany them and sign over responsibility to an RN or MD, notifying the receiving RN or MD as to when the next set of vital signs is due.
    b. The receiving RN or Anesthesia will complete documentation of the transfusion.
12. **Blood tags must remain attached to the unit throughout the transfusion.**
    a. If a patient presents as a transfer/admission via air or ground with a blood product being transfused, the blood tag with that unit must go in the hospital chart. If the patient is transferred with a blood product that has NOT started transfusing, that unit must be sent to the blood bank.

Essential Steps in Procedure

1. Verify Transfusion order.
2. Verify provider and patient signature on either:
    a. Permission and Consent for Surgery or Procedures (#A-370-011-DMR).
    b. Blood Transfusion Consent / Refusal for non-emergent Transfusion (#A-370-082-FMR).
3. Verify blood is available in the blood bank.
    a. EPIC will be utilized to check for blood availability. In EPIC, a banner will appear across the patient screen stating the patient has blood products ready in the blood bank. Refer to the Blood Product Notification Policy in attachments.
4. Inform patient/family of need for transfusion. Verify that patient/family verbalized their understanding of the need for the transfusion.
5. Verify that IV access is present and patent without signs of phlebitis or infiltration.
    a. Transfusion should be given intravenously. Rare exceptions can be made for intra-arterial access in NICU patients.
    b. Transfusions may be given through an intraosseous line, peripheral IV sites, peripheral or central catheters, and implanted port devices. Refer to IV Therapy General Information 10.01.01 for more detail.
6. Obtain a full set of vital signs prior to obtaining blood (i.e. temperature, blood pressure, respiratory rate, pulse, pulse oximetry, if available).
7. ***Only after steps 1 -6 have been completed***, obtain blood from blood bank. Refer to the Blood Retrieval Policy in attachments.
    a. EPIC - Personnel are required to bring the EPIC 'Transfuse Order' to the Blood Bank.
    b. Paper/Down Time- Bring copy of 'Blood Bank - Product Request' (Form# A-480-119-F)
    c. Nursing will ensure appropriate staff retrieves the blood from the blood bank.
    d. BLOOD MUST NEVER BE PLACED IN NON-BLOOD BANK REFRIGERATORS.
    e. Transfusion of any blood product should start as soon as possible after obtaining it.
        i. If there is an unexpected delay, return product to Blood Bank immediately. PRBC must have a temperature between 1 - 10 degrees Celsius to be safe for reissue and 10 degrees Celsius can be exceeded in as little as 20 minutes.
    f. Emergency transfusions will be exempt from the 'Blood Bank - Product Request'
8. Once blood arrives to unit, identify patient using two unique identifiers.
9. Two credentialed staff members will complete independent double check separately at the patient's bedside.
    a. The following is checked:
        i. Patient's name and patient ID (medical record number) on the ID band against product chart copy.
        ii. Unit number on product chart copy with unit number on blood product label (Donor's number on product chart copy and bag).
        iii. Specific component on blood product label and on product chart copy form, e.g. packed red blood cells or platelets, in addition to any special needs (unit attributes) on the product chart copy and blood product label
        iv. Blood type of unit on blood product label and on product chart copy and blood type of patient on product chart copy.
        v. Blood product expiration date on product chart copy and on blood product label.

vi. All items "i" through "v" must match completely, with the exception that patient blood type does not always have to be identical to blood type of product. Otherwise, if there are any discrepancies, DO NOT HANG BLOOD and notify physician immediately. If physician does not arrive within 10 minutes, return blood to Blood Bank. All blood components not transfused must be returned to Blood Bank no matter how long the component has been out of Blood Bank.
    1. EXCEPTION: Blood in a cooler in the OR may travel with an unstable patient to the receiving floor (usually ICU). Be aware of the 12-hour limit on the coolers for later return to blood bank if unused.

vii. Also check the product chart copy for crossmatch compatibility. Per Blood Bank policy, a pathologist is notified by Blood Bank staff when crossmatch is incompatible. The pathologist is responsible for notifying the ordering provider of the risks and benefits of transfusing the incompatible unit(s).

b. Blood that is typed and crossmatched to the Emergency Department (ED) identifier (Trauma#/Alert number) must be checked with the recipient's ED identifier bracelet. This blood will be available for 72 hours after sample is collected. Refer to Patient Identification System Policy in attachments.
    i. The following must be checked:
        1. Patient's ED identifier and the ED identifier on the product chart copy.
        2. Follow steps 2-5 in the METHOD section above.
    ii. REMINDER:
        1. For the length of hospital stay, 2 ED/Trauma band identifier bracelets (one on wrist and one on ankle) must remain on the patient.
        2. The ED identifier (white band medical record number) can be used to request blood if blood is needed emergently.

c. EPIC documentation process
    i. The order on the Blood Administration flowsheet that you are documenting the transfusion against must have the same unit number as the unit you have in your hand.
    ii. The unit number is barcode scanned into the flowsheet when initiating verification checks and must match the unit number on the blood component you are transfusing without discrepancy.
        1. Select the Rate Row to open the product administration window.
        2. Scan the patient ID band, the Blood Product Unit Number and the Blood Product Unit Code
        3. Select the Product Name.
        4. Action defaults to new bag.
        5. Enter "Rate" and click "Accept" (initial rate 50-75ml/hr x 15 min.)
        6. if matching is complete, a green thumbs up sign displays to indicate the unit matches for this patient.

d. Downtime Documentation Process:
        1. Verify informed consent and initial.
        2. Signature and title (on hanging of blood products) by two qualified individuals
            a. In the absence of an electronic identification system such as during EPIC or barcode scanning downtime, or if the barcode on the blood product or patient's

name band will not scan, the two qualified individuals must be physically present at the patient's bedside. Virtual ICU Registered nurse and Virtual RNs may not perform the independent double check during and EPIC or barcode scanning downtime.

3. Time/date transfusion started and ended
4. Reaction (yes or no)
5. Amount transfused
6. Initials verifying 15-minute vital checks was completed.

ii. Administration documentation started on paper (OR, ED, LifeFlight), must be completed on paper.

1. The product chart copy is placed on the transfusion medicine product chart copy form in the patient chart.

e. EMERGENT TRANSFUSION

i. For transfusions requiring un-crossmatched blood, check emergent transfusion section of the blood tag. For un-crossmatched transfusions, this is the only information required.
ii. The individual transfusing the blood signs the emergent transfusion section on the blood tag. Refer to Emergent blood tag example in attachments.
iii. This is the minimal information required for un-crossmatched transfusions on the blood tag to be retained in patient's chart.

10. Prepare blood using appropriate PPE. Gloves must be worn while administering blood products.
    a. Prime blood administration set with Normal Saline using infusion pump before spiking blood bag. (Adults only)
    b. Ensure filter in administration set is completely covered to prevent air in tubing.
    c. Administer blood starting at 50-75mL/hr for the 1st 15 min (adults only), then adjust the rate to infuse over ordered time or within 4-hour window.
        i. If blood is not completed within the 4-hour window, stop transfusion, discard the bag with the remaining component and notify provider.
    d. Platelets should be given via an infusion pump unless in an emergent, life-threatening condition.
    e. General infusion rate guidelines:
        i. For stable, non-hemorrhaging patient infuse over 3-4 hours.
        ii. For acute patients, infuse over 1-2 hours.
        iii. Maximum allowable infusion rate for non-exsanguinating patients is 250mL/hr.
        iv. In cases of massive transfusion, blood may be administered as rapidly as clinically necessary and achievable.
11. **Staff are encouraged to stay with patient for first 15 minutes.**
12. Obtain full set of vital signs:
        i. 15 minutes after start of transfusion
        ii. Every hour of transfusion
        iii. At completion of transfusion
13. Observe for signs of transfusion reaction throughout transfusion. See chart below.
    a. If signs of reaction are present, follow process defined in Blood Transfusion Reaction section below.

b. If a reaction occurs, have ordering provider or floor team order Suspected Transfusion Reaction in Epic and return blood bag and administration set to the Blood Bank.
    i. ***If the provider refuses to order the transfusion reaction workup, and staff are concerned for a reaction, please contact the Pathologist on service for peer-to-peer follow-up.***

14. If transfusion in not infusing well, check for the following:
    a. Tourniquet in place
    b. Check IV site for complications, restart if necessary.
    c. Tubing kinked
    d. Clamp adjustment too tight. Open clamp and readjust.
    e. Blood bag height inadequate
    f. Size of IV device lumen, if inadequate gauge, restart
    g. Occlusion of cannula or needle against wall of vein, lift hub and stabilize with 2 x 2 gauze dressing.
    h. Unsatisfactory position of extremity
    i. Occlusion of filter, change filter and tubing
15. When prescribed amount has been infused:
    a. Document full set of vital signs
    b. Document STOP action and volume given in EPIC to complete the transaction.
        i. Downtime – Document end time on blood tag
    c. Remove blood tubing and flush saline lock with prescribed amount of NSS or reconnect ordered primary infusion.
    d. The blood bag is discarded on the patient unit in red isolation bags.
    e. Discontinue IV cannula if ordered.
    f. If PICC catheter was used for infusion, flush with prescribed amount of saline flush solution using (2) 10 ml syringes.
    g. If an implanted port is used to be de-accessed after the blood transfusion, first flush with prescribed amount of saline, then flush with heparin flush solution (100 units/ml) unless otherwise ordered by the provider.
16. Document
    a. If the patient is to be discharged post transfusion, vital signs (TPR and BP) must be completed within 15 minutes before discharge or 15 minutes after transfusion is completed and documented on appropriate nursing flow sheet. The patient must be stable and exhibit no signs and symptoms of a transfusion reaction.
    b. If patient receives a blood transfusion during this admission "Blood Component Transfusion Instruction" should be given to patient/family prior to or during discharge.

TRANSFUSION REACTION PROCESS

Transfusion of blood and components is ordinarily a safe and effective way of temporarily correcting hematologic deficits, but untoward results do occur. The time between suspicion of a transfusion reaction and investigation and initiation of appropriate therapy should be as short as possible. Responsibility for recognizing a reaction rests with the Transfusionist. The presenting events of fever (1^{o}C rise) and chills may be the same for life-threatening hemolytic reactions and less serious febrile or allergic reactions. Adverse symptoms or physical signs

occurring during transfusion of blood or its components should be considered a life-threatening reaction. With all possible transfusion reactions, the nurse must notify the blood blank even if the physician continues the transfusion. Febrile and allergic events may occur up to 4-hour post-transfusion for possible transfusion reaction. Dyspnea may occur up to 6 hours post-transfusion for possible TRALI or TACO. Related symptoms may occur up to 24 hours post transfusion for acute hemolytic transfusion reaction. Hypotensive transfusion reaction may occur up to 1-hour post-transfusion.

Transfusion reaction	Clinical presentation
Transfusion related Acute lung injury	**Within 2 to 6hrs of start of transfusion**
	Shortness of breath, work of breathing
	Coughing
	Tachypnea, hypoxemia
	Tachycardia
	Hypotension
	Fever
	Bilateral pulmonary infiltrates
Transfusion associated circulatory overload	**Within 6 hours of end of transfusion**
	Shortness of breath, chest tightness
	Cough
	Headache
	Tachypnea
	Tachycardia
	Hypotension
	Signs of volume overload: jugular venous distension, cardiac S3,
	Pulmonary edema
Acute hemolytic transfusion reaction	**Within 24 hrs. after transfusion**
	Fever
	Chills, rigors
	Apprehensiveness
	Pain in lower back, flanks, chest, along infusion vein
	Hypotension
	Bleeding
	Hemoglobinuria
	Renal failure
Sepsis	Fever, chills, sweats
	Warm or clammy skin
	Vomiting
	Rash
	Tachycardia, tachypnea
	Hypothermia
Delayed hemolytic transfusion reaction	Fever, chills
	Jaundice

	Malaise
	Back pain
	Unexpected anemia, **usually within first two weeks after transfusion (up to 4 weeks)**
Febrile non-hemolytic transfusion reaction	**Onset up to 4 hours after transfusion**
	Fever
	Chills, rigors, malaise
	Headache
	Nausea/ vomiting
	Increase in diastolic BP
Allergic transfusion reaction	**Within 4 hrs. after transfusion**
	Urticarial rash
	Pruritus
	Nausea, vomiting
	Diarrhea, abdominal cramps
	Anxiety
	Hypotension (less common)
	Dyspnea (less common)
Anaphylactic transfusion reaction	**Immediate respiratory distress (seconds to minutes)**
	Upper airway edema/obstruction
	Lower airway signs and symptoms (bronchospasm, wheezing, retractions, SOB)
	Loss of consciousness
	Vomiting
	Hypotension, weak pulses, with ultimately circulatory collapse

General Information

1. Document "stop transfusion" in Blood Administration flowsheet if suspected reaction occurs.
2. The provider may choose to continue the transfusion.
3. The Patient Blood Management Committee requests all possible transfusion reactions be reported and worked up by the Blood Bank.
4. If the patient develops urticaria and the physician decides to continue the transfusion, a transfusion reaction work up needs to be ordered.
    a. If the provider refuses to order the transfusion reaction workup, and staff are concerned for a reaction, please contact the Pathologist on service for peer-to-peer follow-up.
5. If blood is stopped due to a temperature elevation of 1°C/2°F or greater and there is a delay in contacting the provider of thirty minutes or longer, the blood, tubing, and saline should be returned to Blood Bank.
    a. If waiting longer than 10 minutes for provider orders notify blood bank and proceed with orders from the Blood Bank.
6. Whenever a transfusion reaction is called to the Blood Bank, the unit of blood/tubing and appropriate documentation must be returned to the Blood Bank along with a post transfusion blood sample.

Equipment/Supplies:

1. Blood Bag - Blood tubing

2. IV Solution
3. Blood Transfusion Reaction Form (Paper/Downtime) A-480-044 FMR
4. Blood Administration Record (Paper/Downtime)

Nursing Interventions

1. Stop the transfusion
2. Keep the vein open with KVO of NSS
    a. NICU - Cap and flush port
3. Recheck patient's identification with blood product. Bedside clerical checks of all forms, labels and patient identification are required to verify the correctness of the unit and the intended recipient.
4. Notify the physician immediately. Blood may or may not be discontinued.
5. Monitor vital signs every 15 minutes or more frequently if indicated based on presenting symptoms.
6. The nurse will initiate a transfusion reaction work up if signs and symptoms develop after the transfusion is started.
7. Place protocol orders for transfusion reaction.
    a. Click on "Order Sets"
    b. Search for order set and enter 4539.
    c. Collect blood specimen.
    d. Nursing/Lab/Medication orders are pre-selected by default.
    e. Sign order
    f. Select "Blood Reaction" from table of contents.
    g. Complete Blood Transfusion Reaction group.
    h. Print report by going to summary activity.

DOCUMENTATION

1. EPIC:
    a. Fill out the Blood Transfusion Reaction Flowsheet Group. Once this information is filled out, go to the Patient Summary Activity and select the Blood Reaction Report (INPATIENT ONLY).
    b. Print the report and send to the Blood Bank with remaining blood product and tubing. (To Print form: Patient Summary>Report>IP Blood Transfusion Reaction>Print)
2. Paper/Downtime:
    a. Immediately notify the Blood Bank and complete the Hospital Report of Transfusion Reaction form.
    b. The original must be submitted to the Blood bank if a transfusion reaction has occurred.
    c. Make a copy for the patient chart.
3. Complete MIDAS report.

ATTACHMENTS

Blood Product Notification Policy
Blood Retrieval Policy
Emergent Transfusion Tag Example
Hospital Report of Transfusion Reaction- Downtime Form

REFERENCES

Standards for Blood Banks and Transfusion Services. (34th ed). Bethesda MD: AABB: 2024

Cohn, C. S., Delaney, M., Johnson, S. T., Katz, L. M. Technical Manual (201st ed). Bethesda, MD: AABB; 2023

Circular of Information for the Use of Human Blood and Blood Components. AABB, ARC, ABC and ASBP. June 2024

Policy

Geisinger

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

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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

Geisinger

Title: **Adult Hypoglycemia Treatment Protocol**	
Joint Commission Chapter Section: 12.0 Nursing	*Date ORIGINAL policy was created:* 5-4-2023
This policy belongs to: Geisinger Healthplex Outpatient Surgery & Endoscopy Center a Department of Lewistown Hospital	
Committee/Council Approval(s): Operations Committe	*Date of COMMITTEE Approval(s):* 5-4-2023

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

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☐ Endoscopy Center of Geisinger Lewistown Hospital; an entity of GLH	☒ Geisinger Lewistown Hospital (GLH)
☐ Family Health Associates of GLH (FHA)	☒ Geisinger Medical Center (GMC)
☒ Geisinger Bloomsburg Hospital (GBH)	☒ Geisinger Medical Center Muncy (GMCM)
☐ Geisinger Clinic (GC)	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ Geisinger Wyoming Valley Medical Center (GWV)
☐ Geisinger Encompass Health, LLC	☐ GMC Outpatient Surgery - Woodbine; an entity of GMC
☐ Geisinger Endoscopy-Montoursville; an entity of G-HM	☐ GWV Outpatient Surgery – CenterPoint; an entity of Geisinger Wyoming Valley Medical Center
☐ Geisinger Gray's Woods Outpatient Surgery and Endoscopy Center; an entity of GC	☐ Lewistown Ambulatory Care Corporation (LACC)
☐ Geisinger-HM Joint Venture (G-HM)[1]	☐ Marworth
☒ Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger Lewistown Hospital	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

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☐ Geisinger Health Plan (GHP)	☐ ISS Solutions, Inc. (ISS)
☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

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] Geisinger-HM Joint Venture is an LLC representing a joint venture between Geisinger 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

Geisinger

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/dl **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

Geisinger

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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☐ Geisinger Clinic (GC)	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Encompass Health, LLC	☐ Geisinger Surgery Center – Highland Park (OSHP)
☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☐ GMC Outpatient Surgery - Woodbine
☐ Geisinger-HM Joint Venture (G-HM)	☐ GWV Outpatient Surgery - CenterPoint
☐ Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger-Lewistown Hospital	☐ Marworth
☒ **Geisinger Jersey Shore Hospital (GJSH)**	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

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☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

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

Geisinger

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: GNE Nursing Policy & Procedure	
Committee/Council Approval(s): GNE CNO, AVP Nursing Services	*Date of COMMITTEE Approval(s):* October 21, 2024

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

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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:

Geisinger 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

Geisinger Wyoming Valley Medical Center

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

Geisinger South Wilkes Barre

- MS3 South
- MS5 South
- MS6 South

POLICY

EXCEPTIONS: This policy does not apply to:

- At Geisinger Community Medical Center and Geisinger Wyoming Valley
  - Pediatric patients
  - Special Care Unit patients (GCMC PCU, GWV PCU, GCMC CSCU, GWV CSU, GWV EP, GWV Observation Unit, GWV ED, GWV Onc 5, GSWB ED)
  - 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 Geisinger 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. *GSWB - 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 (GCMC) 570-808-6500 (GWV) 570-808-8120 (GSWB) for Rapid Response Team if necessary.

2. That department staff member will check the patient; notify the patient's physician if present, Dial-55 (GCMC) 808-6500 (GWV) 570-808-8120 (GSWB) 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.
- GCMC 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.
- GWV/GSWB 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.
- GCMC- 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.

GWV/GSWB- 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:

- GCMC: CMR Tech will Discharge patient from Philips Monitoring system

- Clean Transmitters and lead wires with appropriate sanitizer
- Return transmitter to clean storage area

- GWV/GSWB: 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 (GCMC) or Nursing Unit personnel (GWV/GSWB) 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:

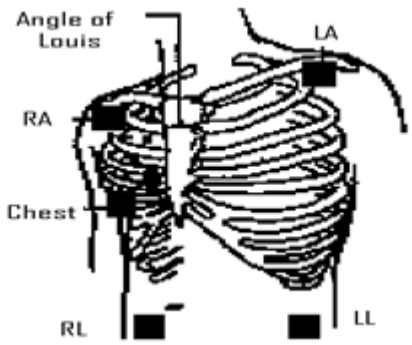
White electrode (-) Right shoulder below right second clavicle hollow

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

GCMC- 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. GWV/GSWB- 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.
- GCMC- The transmitter and supplies are obtained from the CMR by the respective unit's staff. GWV/GSWB- 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

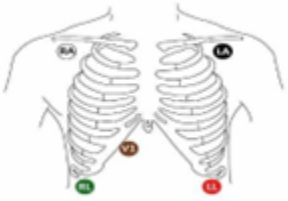
Red - Left Leg (LL) is placed below the rib cage on the left upper quadrant of the abdomen

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 GCMC and GWV 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 GCMC 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

Geisinger

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):* March 27, 2024, March 21,2024

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

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

CLINICAL ENTITIES *(includes Geisinger entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ **Community Medical Center (CMC or GCMC)**	☒ **Geisinger Jersey Shore Hospital (GJSH)**
☐ Endoscopy Center of Geisinger Lewistown Hospital; an entity of GLH	☒ **Geisinger Lewistown Hospital (GLH)**
☐ Family Health Associates of GLH (FHA)	☒ **Geisinger Medical Center (GMC)**
☒ **Geisinger Bloomsburg Hospital (GBH)**	☒ **Geisinger Medical Center Muncy (GMCM)**
☒ **Geisinger Clinic (GC)**	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Encompass Health, LLC	☐ GMC Outpatient Surgery - Woodbine; an entity of GMC
☐ Geisinger Endoscopy-Montoursville; an entity of G-HM	☐ Lewistown Ambulatory Care Corporation (LACC)
☐ Geisinger Gray's Woods Outpatient Surgery and Endoscopy Center; an entity of GC	☐ Marworth
☐ Geisinger-HM Joint Venture (G-HM)[1]	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

NON-CLINICAL ENTITIES *(includes Geisinger business/corporate entities not providing health care services)*	
☐ Geisinger Commonwealth School of Medicine (GCSOM)	☐ Geisinger System Services (GSS)
☐ Geisinger Health (GH or GHF)	☐ GNJ Physicians Group (GNJ)
☐ Geisinger Health Plan (GHP)	☐ ISS Solutions, Inc. (ISS)
☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

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 employees of Geisinger that access and care for CVADs.

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

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. A new pair of clean, non-sterile gloves are always worn when accessing central lines.

10. Use only sterile devices to access the needleless connector or hub of the catheter.

11. 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.

12. 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) If insertion site is visible, CVAD dressings will be changed every 7 days or sooner if the dressing becomes wet, soiled, or non-occlusive.
    I. Dressing changes will be done by a member of the Vascular Access Team or other practitioners trained in central line dressing changes.
    II. Loose or soiled dressing should be re-dressed without delay. Page Vascular Access Team or appropriate campus designees promptly to change dressing.
    III. If insertion site is not visible, dressings should be changed every two days (excluding in the presence of hemostatic agent per manufacturer instructions).
d) Any loose sutures will be secured with sterile steri-strips or securement device and the attending service notified.
e) 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.

13. 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.

14. 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

15. 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.

16. Push pause technique for flushing
    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.
    d. If a lumen is locked with a solution other than preservative free NSS, withdraw 3mLs and discard.

17. 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, or is not patent; notify the Vascular Access Team or specially trained nurse for trouble shooting /corrective actions.

18. 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.

19. 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 responsibly 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 patient and/or caregivers prior to 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

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 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 GHS, the VAMP tubing 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

Geisinger

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):* 4/25/24

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☐ Endoscopy Center of Geisinger Lewistown Hospital	☒ **Geisinger Medical Center (GMC)**
☒ **Geisinger Bloomsburg Hospital (GBH)**	☒ **Geisinger Medical Center Muncy (GMCM)**
☒ **Geisinger Clinic (GC)**	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Encompass Health, LLC	☐ Geisinger Surgery Center – Highland Park (OSHP)
☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☒ **GMC Outpatient Surgery - Woodbine**
☐ Geisinger-HM Joint Venture (G-HM)	☒ **GWV Outpatient Surgery - CenterPoint**
☒ **Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger-Lewistown Hospital**	☐ Marworth
☒ **Geisinger Jersey Shore Hospital (GJSH)**	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

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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 Geisinger 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 GWV's Emergency Department please see the following policy: Triage 10-17

*For Pediatric patients: Janet Weis Children's Hospital Pediatric Fall Prevention Policy

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 10.52

- 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.

Inpatient:

Additional Interventions:

- Safety Rounding – See Purposeful Hourly Rounding 10.08
- 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 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 Temporary Transvenous and Epicardial Pacing

- Ensure patient mobilization as appropriate. Refer to Mobility Screening and Nursing Mobility Progression Policy 10.71

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 Geisinger 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 Geisinger 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

- Purposeful Hourly Rounding
- Temporary Transvenous and Epicardial Pacing Policy
- Mobility Screening and Nursing Mobility Progression Policy
- Triage 10-17
- Janet Weis Children's Hospital Pediatric Fall Prevention Policy
- Continuous Video Monitoring Policy

REFERENCES

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Policy

Geisinger

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.**

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☐ Geisinger Clinic (GC)	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
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☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☒ GWV Outpatient Surgery - CenterPoint
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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.

<u>At Geisinger Lewistown Campus and Geisinger Bloomsburg Hospital</u>:

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. GBH Only

IR/PACU Process:

1. An electronic SBAR report will be given via each area specific note template in the EMR. GLH- 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 GLH 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 – **GLH 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. **GBH Only** – Report will be called to the receiving facility or agency and documented in progress note.

ATTACHMENTS

N/A

REFERENCES

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Policy

Geisinger

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.**

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☐ Geisinger Encompass Health, LLC	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
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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

GMC 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

Geisinger

Title: **Independent Double Check of High Alert Medications**	
Joint Commission Chapter Section: 11.0 Medication Management	*Date ORIGINAL policy was created:* October 09, 2007
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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☐ Geisinger Community Health Services (GCHS)	☐ Geisinger Surgery Center - Highland Park
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☐ Geisinger Health Plan (GHP)	☐ ISS Solutions, Inc. (ISS)
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PURPOSE

The purpose of the Independent Double Check of High Alert Medications is to establish guidelines for independent double-checking high alert medications.

PERSONS AFFECTED

All trained licensed personnel

POLICY

The policy of the Independent Double Check of High Alert Medications is to ensure safe administration of critical medications, verify the ancillary labels placed on the infusions bags, tubing and pump programming.

DEFINITIONS

High risk drugs are those drugs that require special handling due to a narrow therapeutic index, multiple drug/disease reactions, severe life-threatening side effect, or require special monitoring before, during or after the administration of the drug.
An Independent double-check of a high-alert medication is a procedure in which two licensed personnel, one of the independent double check personnel needs to be an RN, separately check (alone and apart from each other, then compare results) each component of prescribing, dispensing, and verifying the high-alert medication before administering it to the patient.

PROCEDURE

1. Two licensed persons (one an RN) will independently check the eMAR for the ordered medication.
    a. A graduate nurse (GN) with a temporary practice permit cannot perform the role of one of the licensed personnel completing the independent double check. Only licensed nurses who pass their state licensure exam can perform this function.
2. Use two unique identifiers to confirm the identity of the patient at the bedside.
3. Both licensed persons will verify that the medication is correct by comparing the medication label with the eMAR.
4. Validate ordered concentration, labels placed on infusion bags & tubings, and accurate pump setting.
    a. Verification of medication rate between eMAR and IV pump must occur.
5. This double check confirmation will occur at initiation of therapy, change of rate, change of concentration and at change of shift or change of nurse.
6. Documentation in eMAR both licensed personnel confirming the independent double check.
7. In areas where the VICU & Virtual Nurse Programs are available, the two licensed persons may be the bedside RN and the VICU/VRN.

REFERENCES

Institute for Safe Medication Practices. (2019). Independent Double Checks: Worth the Effort if Used Judiciously and Properly. Retrieved from https://www.ismp.org/resources/independent-double-checks-worth-effort-if-used-judiciously-and-properly

Koyama, A. K., Maddox, C. S., Li, L., Bucknall, T., & Westbrook, J. I. (2020). Effectiveness of double checking to reduce medication administration errors: a systematic review. *BMJ quality & safety*, *29*(7), 595–603. https://doi.org/10.1136/bmjqs-2019-009552

Policy

Geisinger

Title: **Indwelling Urinary Bladder Catheter (IUBC) Insertion, Maintenance, Irrigation and, Removal**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* 6/18/2015
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 Geisinger Entities:

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Key words: Foley, insertion, care, removal

PURPOSE

The purpose of the IUBC procedure establishes guidelines for insertion, care, maintenance and removal of urinary drainage devices.

PERSONS AFFECTED

All staff who place or provide care to patients with urethral catheters.

POLICY

1. **Situations where removal and replacement of an IUBC is indicated:**
    a. If a urinary infection is suspected, remove and/or replace the catheter and obtain urinalysis (UA) and obtain sterile culture and sensitivity (C&S) from the new system, as directed by the provider order.
    b. If at any time the catheter is not functioning properly or has been grossly contaminated, an order to remove and/or replace the catheter should be obtained.
    c. If the closed system must be broken for the changing or addition of a collection bag/urometer, the IUBC system should be removed and replaced.
    d. If a urine culture is ordered an the IUBC has been in place for greater than 48 hours, remove and/or replace the catheter and obtain a sterile C&S from a new system. Obtain a new IUBC order.

2. If a difficult insertion is anticipated, the nurse should consider taking an extra catheter and extra sterile gloves into the room and, if necessary, contacting urology.
    a. GMC Only – Contact the Difficult urinary catheter (DUC) insertion team for difficult IUBC insertions.

3. If the patient has a known latex allergy, a latex safe catheter should be used.

4. If a male patient has a history of an enlarged prostate or is over the age of 50, use a Coudé catheter

5. **Urinary Catheter Care Bundle:**

    i. Always maintain catheter drainage bag below the level of the patient's bladder, document every shift.

    ii. Maintain tension reducing device at all times, document every shift.

    iii. Review need for drainage device every shift.

    iv. Cleanse perineal area and or urinary meatus during routine patient care or as needed. Remove any visible debris from the catheter during cleaning.

        1. Male patient: Cleanse peri-urethral area. Draw back foreskin in uncircumcised patients to cleanse, dry area and roll foreskin back in place.

        2. Female patient: Cleanser periurethral area moving from front to back.

        3. Refer to Bathing of the Hospitalized Patient policy .

    v. Document care in EHR.

6. **IUBCs are not to be irrigated without a provider order.**
    a. Continuous irrigation rates should aim for light pink to clear drainage:
        i. Moderate bloody – 120 drops/minute
        ii. Very bloody – 180 drops/minute
        iii. Flushing – wide open/full flow

7. The manufacturer of the indwelling catheter kit does not recommend test-inflating the balloon prior to insertion.

8. Refer to the Nursing Driven Protocol for the Timely Removal of Indwelling Urinary Bladder Catheters (IUBC).

RESPONSIBILITIES

It is the responsibility of the nurse to confirm the order for insertion is present along with the appropriate indication for placement prior to insertion or exchange of a urinary catheter.

It is the responsibility of the individual inserting the catheter to ensure the appropriate steps have been followed when placing, caring for or removing a urinary catheter.

If catheter was placed in OR, verify an order to maintain IUBC.

EQUIPMENT/SUPPLIES- N/A

PROCEDURE

Female insertion

Peds Female Insertion

Male insertion

Peds Male Insertion

IUBC Care and Maintenance

Suprapubic catheter care

Indwelling urinary catheter (Foley) irrigation

Continuous bladder irrigation

IUBC Removal

Urine Specimen Collection from an IUBC Procedure

ATTACHMENTS

Nurse Driven Protocol for the Timely Removal of Foley Catheters

REFERENCES

Lippincott Procedures

DEFINITIONS – N/A, EQUIPMENT/SUPPLIES- N/A

Policy

Geisinger

Title: **Insulin Continuous Infusion for Adult Non-intensive Care Areas**	
Joint Commission Chapter Section:(REQUIRED) 11.0 Medication Management	*Date ORIGINAL policy was created:* October 1, 2016
This policy belongs to: System Nursing Professional Practice Council	
Committee/Council Approval(s): System Nursing Professional Practice Council, System Diabetes Committee	*Date of COMMITTEE Approval(s):* December 21, 2023

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

This policy applies to the following Geisinger Entities:

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PURPOSE

To establish guidelines for the use of Continuous Insulin Infusion in non-intensive care areas to assist patients to maintain target glucose levels.

PERSONS AFFECTED

Providers, Licensed Independent Practitioners, Registered Nurse, Licensed Practical Nurses

POLICY

1. This policy is to ensure that patients' blood glucose levels are maintained within set parameters as outlined in the procedure below.
2. Dual sign-off protocol applies to all continuous insulin infusions using independent double-check verification process for this high-risk/high alert medication.
3. The Registered Nurse is primarily responsible for the continuous insulin infusion and may seek dual sign-off from a second RN or LPN. The LPN may be the secondary sign off.
4. NOTE: This policy is NOT intended to guide the initial treatment for patients admitted with Diabetic Ketoacidosis (DKA) or Hyperosmolar Hyperglycemic Nonketotic Syndrome (HHNS). Focus is on hyperglycemic and patient with diabetes.

DEFINITIONS

Hypoglycemia – a condition where the patient experiences low blood glucose levels, usually below 70mg/dl

Hyperglycemia – a condition where the patient experiences high blood glucose levels

DKA – (diabetic Ketoacidosis) a condition where cells receive insufficient glucose for energy and the body begins to burn fat for energy which produces ketones. The ketones build up in the blood creating an acidotic state that can lead to coma or even death.

HHNS – (Hyperosmolar Hyperglycemia Nonketotic Syndrome) a condition that can occur in poorly uncontrolled Type 1 or 2 diabetic patients. As blood glucose levels rise the body tried to eliminate the excess though urination, eventually urinary frequency slows and the urine becomes dark. Excessive thirst may be experienced by some patients, other may have no desire to drink leading to dehydration. The dehydrated state can leader to seizures, coma and eventually death.

RESPONSIBILITIES

The Provider is responsible for initiating the Continuous Insulin Infusion using order set #4769.

The Registered Nurse is responsible for adjusting the insulin infusion according to the orders. The RN, LPN, trained nursing assistants or tech's can obtain the finger stick blood glucose levels.

EQUIPMENT/SUPPLIES

Infusion pump, tubing and medication infusion.

PROCEDURE

General Information:
In order to start an insulin infusion or accept an admission or transfer with a continuous insulin infusion to a non-intensive care area the following criteria must be met.

1. Those patients with a diagnosis of DKA must be on the Maintenance Phase or Management of Transition Phase. Patients may be on the medical-surgical units only if the non-intensive care insulin drip is ordered. Those in this

phase will have **"DKA Maintenance Phase"** added to the First line of the Administration instructions for the Insulin Infusion in the Maintenance phase of the DKA protocol.

a. **GUIDELINE** for patients to be in this phase of the DKA protocol:
    i. Blood glucose ≤ 250mg/dL and Anion gap is normalizing

2. A dextrose source must be ordered and may include:
    a. PO diet order, tube feedings, TPN, PPN, D5W or D5W 1/2NSS.
    b. Populations that may not require a dextrose source include: post-op bariatric surgery patients or others at the discretion of the provider.

Ordering Information:

1. The ordering clinician will determine the starting Insulin Infusion Rate Level base on immediately obtained blood glucose. The glucose can be obtained via venous, arterial or finger stick. The guidelines for each level are on order set #4769
2. If the patient will be off of the unit longer than 2 hours, it is recommended to contact the provider for insulin infusion management orders if not already established in the provider orders.

Administration Information:

1. The initiation and maintenance of the insulin infusion will be done by the RN via infusion pump.

2. All consecutive dose titrations must be completed by the RN.

3. Insulin will require an additional 20mL prime of solution to be wasted after the initial prime to minimize the effect of insulin adsorption to the tubing.

4. A blood glucose will be completed immediately before starting the infusion and every 2 hours for the duration.

Exception:

If the patient glucose level is within the target range of 80-150mg/dl at the 2000 glucose check, glucose checks may be completed every 4 hours until 0600. At 0600, a glucose level should be obtained, and the patient should resume with every 2-hour testing.

1. The insulin infusion rates will be adjusted every 2 hours within the level as ordered by the provider. If the patient's blood glucose is not within the 80-150 mg/dl range within 4 hours after the infusion initiation the nurse will:
    a. Advance to the next highest level and notify the provider (GWV, GCMC, GLH, GBH)
    b. Notify the provider of the blood glucose measurements and obtain an order to advance to the next highest level at the provider's discretion (GMC only).
2. Monitoring and interventions for hypoglycemia:
    a. If a patient verbalizes or exhibits signs/symptoms of hypoglycemia, immediately obtain and glucose level.

i. Insulin should be stopped based on the levels outline in the Insulin Infusion order set. Treatment as per Adult Hypoglycemia Protocol.
    1. Do not restart the insulin infusion without a provider order.

Special Considerations

1. When transitioning to subcutaneous basal infusion it is recommended that you discontinue the insulin infusion as follows (NOTE: Discontinuation times may vary among providers)
    a. Lantus/Levemir – 2 hours after the initiation
    b. NPH - 1 hour after the initiation
2. If transitioning to a Continuous subcutaneous insulin infusion (Home insulin pump), nurse should follow procedure outlined in the Continuous Subcutaneous Insulin Infusion policy.
3. If a patient is receiving an oral diet, prandial carbohydrate coverage should be ordered.

Documentation.

1. Standard Documentation requirements to complete the following rows:
    a. Glucose Level
    b. Insulin Dose (units/hr)
2. Additional rows of diabetes group may be completed per campus routine.
    a. GMC Campus – Insulin level used, carbs consumed in grams, Hypoglycemia Treatment
    b. GWV, GCMC, GLH – All rows in diabetes group as appropriate

ATTACHMENTS

Non-Intensive Care IV Insulin Infusion Protocol
Adult Hypoglycemia Treatment Protocol
Care of Continuous Subcutaneous Insulin Infusion (Home Insulin Pump)

REFERENCES

1. ADA. (2022). Common Terms. Retrieved from American Diabetes Association: http://www.diabetes.org/diabetes-basics/common-terms/
2. Breeding, A., Seeber-Combs, C. & Hanson, D. (2023). Administering an IV Insulin Infusion. CINAHL Nursing Guide, EBSCO publishing.

Know the Codes

- **Code Orange –** Lockdown/suspicious incident that may threaten patients, staff or visitors.
- **Code Gray –** assistance in securing an out of control or disruptive patient or visitor that presents an immediate danger to self, others, or that exhibits patient behaviors such as verbal outbursts indicating harm to themselves or others.
- **Code Amber–** indicates that a child or infant is missing/abducted.

- **Code Black –** mass casualty.
- **Code Yellow** – Hospital Incident Command Activation
- **Code Green –** Evacuate area

- **Code Blue / Pediatric Code Blue** – indicates an adult/pediatric cardiac arrest.
- **Code Lavender-** indicates an obstetric or postpartum event that is related to pregnancy or postpartum period.
- **Code Red –** indicates that a fire or suspected fire has been detected.
- **Code Silver** – this code is activated when there is a person or persons on the premises that has used or continues to use a gun against person(s) on the Geisinger property.

Policy

Geisinger

Title: **Mobility Screening and Nursing Mobility Progression**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date original policy was created:* December 22, 2011
This policy belongs to: System Nursing Policy Council	
Committee/Council Approval(s): N/A	*Date of Approval(s):* N/A

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

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☐ Family Health Associates of GLH (FHA)	☒ **Geisinger Medical Center (GMC)**
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☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

PURPOSE

Adult mobility progression is a multidisciplinary process that allows the nurse to determine the appropriate level of activity for their patients using evidence-based tools. This process will be applied to all patients as applicable.

PERSONS AFFECTED

All members of the healthcare system.

DEFINITIONS

AM-PAC – Activity Measure for Post-Acute Care is screening tool used to determine the patient's ability to complete physical tasks that reflect their functional mobility. The AM-PAC screening tool will auto-generate an AM-PAC Mobility score to correlate with the JH-HLM.

JH-HLM – The Johns Hopkins Highest level of Mobility Scale is a tool used to initially set the patient's mobility goal and then to measure their actual performance related to mobility.

JH HLM Goal – Set daily based on the patient's AM PAC score. Reflects the patient's capacity and activity goal for the day.

JH HLM Achieved- documented with every episode of mobility to show progress or regression throughout the day related to the patient's performance with mobility related activities.

POLICY

All patients will be evaluated to ensure safe participation in mobility related activities upon admission, daily, and with any change in condition through the utilization of the Activity Measure for Post-Acute Care (AM-PAC) assessment tool.

The score will generate an appropriate Daily Mobility Goal utilizing the Johns Hopkins Highest level of Mobility Scale (JH-HLM).

Evaluation of the patient's performance by the care team will aide in determining the need for physical and or Occupational therapy services.

RESPONSIBILITIES

It is the responsibility of the Registered Nurse (RN) or Licensed Practical Nurse (LPN) to complete and document the patient's level of mobility utilizing the AM-PAC tool. This will then determine the highest level of mobility goal via the JH-HLM.

1. AM-PAC: On admission the nurse will, through observation, document the patient's current level of mobility. Based on the AM-PAC score, the JH-HLM goal will automatically determine the expected highest level of mobility. The nurse will also provide and document education for the patient, family and caregivers regarding mobility. The AM-PAC tool is to be completed on admission and daily thereafter.
2. JH-HLM: The mobilization goal for the patient will be automatically determined. Documentation of each episode of mobility is to occur every time activities regarding mobilization are conducted. It is the responsibility of the care team member conducting the episode of mobility (RN, LPN, NA, provider, etc.)

It is the responsibility of all Licensed inpatient Nursing Staff to complete a review of Progressive Mobility in GOALs and upon hire and annually thereafter.

It is the responsibility of the care team to discuss and ensure an order for therapy services has been placed when appropriate. This decision should be based on the patient's current performance and mobility goals.

EQUIPMENT / SUPPLIES

Will be determined by the patient's condition and abilities. Assistive devices may include a walker, cane, crutches, lift devices, etc.

PROCEDURE

A. Safety Screen – A safety screen must be competed on all patients prior to any activity. If the patient is determined to be stable, the nurse may proceed with mobility related activity. If the patient is determined to be unstable related to hemodynamics, Neurologic issues, respiratory issues, or physician order; nursing will not proceed and will continue to re-evaluate patient until they are appropriate to participate in progressive mobility. The inability to participate in activities related to mobility must be documented in the EHR with each episode.
B. The AM-PAC tool will be completed following normal daily activity. The tool consists of the following questions:
    a. How much assistance does the patient currently require from another person to complete the following:
        i. Turning from your back to your side while in a flat bed without using side rails?
        ii. Moving from lying on your back to sitting on the side of a flat bed without using side rails?
        iii. Moving to and from a bed to chair (including wheelchair)?
        iv. Standing up from a chair using your arms (e.g., wheelchair or bedside chair)?
        v. To walk in hospital room?
        vi. Climbing 3-5 steps with a railing?
    b. Scoring:
        i. 1 = Total- Patient requires total assistance
        ii. 2 = A lot – Patient requires maximum to moderate assistance
        iii. 3 = A little – Patient requires minimal assistance, contact guard or supervision
        iv. 4 = None – Patient is independent
C. Based upon the score above (upon admission) and the patient's actual performance (daily) the mobility goal will be generated utilizing the JH-HLM (see tool attached). During the patient's stay, the score should be utilized to set the goal for the current day. This level of activity should be completed and documented each time the patient is moved. If the patient is unable to meet their mobility goals, an appropriate reason must be documented for each episode.

ATTACHMENTS

JH-HLM

Range of Motion

REFERENCES

- Hoyer, E. H. (2018). Toward a Common Language for Measuring Patient Mobility in the Hospital: Reliability and Construct Validity of Interprofessional Mobility Measures. Physical Therapy.

Policy

Geisinger

Title: **Restraint/Seclusion**	
Joint Commission Chapter Section:(REQUIRED) 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* March 01, 1995
This policy belongs to: System Nursing Policy Council	
Committee/Council Approval(s): Clinical Leadership Council	*Date of COMMITTEE Approval(s):* August 17,2023

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

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

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PURPOSE

The purpose of the Restraint/Seclusion policy is to reduce the frequency of restraint use, striving to eliminate the use of restraints. Limiting restraint use by defining the terms restraint, seclusion, and pharmacologic restraint. Using these protective measures in accordance with regulatory standards.

PERSONS AFFECTED

All skill levels of care providers.

POLICY

It is the policy of Geisinger Health System to:

1. Limit the use of restraints/seclusion to protect the immediate physical safety of the patient, staff, or others.
2. Preserve the rights, safety, wellbeing, and dignity of the patient when restraints are used.
3. Use restraint/seclusion only to improve the patient's wellbeing and when other less restrictive interventions have been determined to be ineffective.
4. Provide the Patient's Rights & Responsibilities pamphlet to patient/family upon admission. This pamphlet describes the right to be free from restraint or seclusion, or any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

EXCEPTIONS TO RESTRAINT USAGE: CMS 482.13 Exceptions

Standard practice that includes limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, Electroconvulsive Therapy, conscious sedation, and the related post-procedure care process. These mechanisms can include, but are not limited to:

1. IV arm boards not secured to the bed or protection of a treatment site.
2. Surgical dressings or bandages.
3. Helmets
4. Therapeutic holding or comforting
5. Devices that can easily be removed by the patient. For example, when a patient requests a limb immobilizer during a hemodialysis treatment, a limb holder will be loosely applied below the patient's fistula to prevent infiltration on the condition that patient is able to demonstrate the ability to remove the holder.
6. Forensic restrictions used for security purposes (i.e. handcuffs or other restrictive devices applied by law enforcement officials).
7. Voluntary adaptive support in response to physical needs of the patient (i.e. postural support, orthopedic appliances).
8. Medications used as part of the treatment plan and not for the purpose of pharmacologic restraint. Medications are <u>not</u> restraints if they allow the patient to move effectively or appropriately function in the world around them.
9. Recovery from anesthesia that occurs when a patient is in a critical care or post-anesthesia care unit is considered part of the surgical procedure. However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary.
10. A cool down period in which the patient consents to being alone in a designated area for an agreed upon time frame during which the patient is not physically prevented from leaving the room. This may be used to provide the patient an opportunity to regain self-control.
11. Bed rails:
    a. If patients have the ability to get out of bed, they have the right to get out of bed. If the patient has

no ability to move at will four bed rails may be used as a safety intervention and are not considered a restraint

b. If four bed rails are used to prevent the patient from willfully exiting the bed, then the four bed rails are considered a restraint. Even if patient or family member requests the use of four bed rails, it is considered a restraint unless the patient can demonstrate the ability to lower the bed rails.

12. Other exceptions include:
    a. Pediatrics - Age or developmentally appropriate protective safety interventions such as raised crib and/or bed rails. Posey beds are not a restraint.
    b. Side rails used on a stretcher
    c. Law enforcement, prison personnel
    d. Seizure precautions- raised bed rails to protect a patient experiencing involuntary movements
    e. Specialty bed per manufacturer's recommendations or when the bed will not function without the use of the four bed rails

RESTRAINT TYPES:

System approved devices to be used according to manufacturer's instructions.

1. Soft wrist/ankle
2. Lap belt restraint (NOT available at GWV, GCMC, GLH)
3. Four bed rails (when the ability to get out of bed is restricted for behavioral reasons)
4. Red/Blue Velcro restraints
5. Mitts
6. Posey Beds (Adults)

GCMC, GWV Facility Specific Restrictions

1. Do not sure soft restraints in a 4-point application with non-violent orders.
2. For use of 4-point violent restraint, a code grey must be called and Security must respond.
3. Do not use double restraints (i.e., a mitt and a soft wrist restraint on the same extremity).

DEFINITIONS

1. Physical restraint is defined as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
2. Seclusion is defined as the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.
3. Pharmacological restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. (If the overall effect of a drug or medication, or combination of drugs or medications, is to reduce the patient's ability to interact with the world effectively or appropriately around the patient, then the drug or medication is not being used as a standard of treatment or dosage for the patient's condition.)
4. Manual Hold is defined as holding a patient in a manner that restricts the patient's movement against the patient's will.
5. Episode of restraints is an uninterrupted period of time that a patient is restrained.

6. A violent or self-destructive patient is defined as a patient who attempts to harm themselves, others, or the environment.
7. A non-violent or non-self-destructive patient is one who tries to remove lines, drains, tubes, or an airway and compromises their own safety. Types of situations that may cause cognitive changes can include post-operative confusion, adverse reactions to medication, or other medical conditions.
8. Licensed Practitioners (LP) who can order restraint/seclusion are defined as MD/DO/Physician Assistant (PA-C)/Resident and Certified Registered Nurse Practitioner (CRNP).
9. Licensed Nursing Staff include Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).
10. Nursing Staff include licensed nursing staff and unlicensed assistive personnel who participate in patient care, such as nursing assistants, techs, Mental Health Workers, etc.
11. Non-nursing staff include trained security personnel
12. Trained RN -Registered nurse that has completed an additional competency for face to face evaluation.

RESPONSIBILITIES

Licensed Practitioners are responsible for:

- Assessing and documenting the need for restraint usage by identifying the clinical justifications and associated risk factors on the Restraint/Seclusion Order Set
- Promptly ordering the least restrictive type of restraint required by the patient as soon as patient safety is ensured
- Adhering to time-limited parameters
- Adhering to in-person evaluations as required per regulation

Licensed Nursing Staff are responsible for:

- Employing less restrictive alternatives to restraint use until deemed unsafe for patient and or staff
- Obtaining order for restraint (RN only)
- Matching order to restraint on patient
- Adhering to time-limited parameters
- Informing patient/family of discontinuation criteria (tell the patient/family what the patient has to do to have the restraints removed, i.e., stop pulling out the IV)
- Monitoring and evaluating patient's need for restraint
- Modifying individualized plan of care/treatment plan (RN only), except for in Emergency Department
- Discontinuing restraints as soon as the behavior requiring the restraint is resolved or controlled using an alternative to restraint. Staff must document on the Restraint flow sheet under Physical Restraint Type/select "Discontinued."

EQUIPMENT/SUPPLIES

N/A

PROCEDURE

General Restraint Guidelines:

1. In an emergency application situation, the RN may initiate the restraint prior to obtaining an order. In these situations, the order must be obtained promptly.
2. If the initiation of restraint is based on a significant change in the patient's condition or the restraint is new for the patient (i.e., not a renewal of an existing restraint order), the attending physician or service will be notified promptly/immediately when patient is placed in restraints.
3. P.R.N. orders for restraints are not permissible.
   Exception: A single order is permitted that determines the type of restraint to be used based on the location of the patient (i.e., an order for four bed rails while in bed, lap belt while in chair).
4. A temporary, directly-supervised release of restraints that occurs for the purpose of caring for the patient's needs (i.e., toileting, feeding, repositioning, moving from bed to chair, range of motion exercises, etc.) is not considered a discontinuation of the restraint or seclusion intervention. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint or seclusion.
5. If the restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating the use of the restraint or seclusion

Pharmacological Restraints:

1. Pharmacological restraints must be ordered on the Restraints and Seclusions Order Set and include pharmacologic agent, dose, and route. These are one-time orders. See definition Pharmacological Restraint.
2. After administration of a Pharmacological restraint, the monitoring of the patient will be as follows:
   a. Vitals signs and intake/output as ordered by the provider.
   b. Staff will monitor the awake patient every 15 minutes or at a frequency determined by the provider for 1 hour for, respiratory effort, emotional/behavioral status, and level of consciousness. Staff will also assess the need for and/or provide food/fluids, toileting, hygiene, and range of motion at least once during this time and as appropriate for the patient.
   c. Staff will monitor the sleeping patient at minimum every 15 minutes for 1 hour for respiratory rate, respiratory effort, and skin color.

Non-Violent Patient/Non-Self-Destructive Patient:

1. Restraint orders are time-limited – for the Non-Violent or Non-Self-Destructive Patient order once each calendar day.
2. The original restraint order may only be renewed within the required time limits for up to 24 hours. After the original order expires, a physician or other LP must see and assess the patient before issuing a new order.
3. Monitoring:
   a. Staff will monitor the awake patient at minimum every 2 hours for signs of injury/circulation issues from physical restraint use, respiratory rate, emotional/behavioral status, level of consciousness, the need for and/or provide food/fluids, toileting, hygiene, and range of motion.

b. Staff will monitor the sleeping patient at minimum every 2 hours for, signs of injury/circulation issues from physical restraint use, respiratory rate, respiratory effort, and skin color.

Violent or Self-Destructive Patient:

1. Restraint/Seclusion orders for the violent patient are time-limited based on age:
   a. Ages 18 and older: 4 hours
   b. Ages 9-17: 2 hours
   c. Ages 8 or under: 1 hour

   Note: Orders for restraint/seclusion purposes are valid until either the time limit of the order expires, or the restraints are discontinued because the patient no longer demonstrates the behavior that required the restraint/seclusion. A new order must be obtained if the patient again requires the use of restraints/seclusion or if the limb(s) restrained change.
2. Every 24 hours, a LP primarily responsible for the patient's on-going care will see and evaluate the patient.
3. **One Hour Face-to-Face**: An in-person evaluation within 1 hour after initiation of manual hold for forced medication, restraint, or seclusion must be completed by a physician, Resident, PA-C, CRNP or a trained RN. The patient evaluation must include:
   a. Immediate situation
   b. Reaction to the intervention
   c. Medical and behavioral condition
   d. Need to continue or terminate the restraint or seclusion

   Note: If a trained RN conducts the face-to-face evaluation, they must consult the attending physician or other LP who is responsible for the patient's care as soon as possible after completing the 1-hour evaluation. Another face-to-face evaluation is not required when the original order is renewed. The original restraint or seclusion order may only be renewed within the required time limits for up to a total of 24 hours (i.e. 5 consecutive renewals for an adult). After the original order expires, an LP must see and assess the patient before issuing a new order.
4. Monitoring:
   a. Staff will monitor the awake patient every 15 minutes or at a frequency determined by the provider for, signs of injury/circulation issues from physical restraint use, respiratory rate, emotional/behavioral status, and level of consciousness. Staff will also monitor the need for and/or provide food/fluids, toileting, hygiene, and range of motion every 2 hours.
   b. Staff will monitor the sleeping patient at minimum every 15 minutes or at a frequency determined by the provider for, signs of injury/circulation issues from physical restraint use, respiratory rate, respiratory effort, and skin color.
5. Seclusion is only permitted if the patient is continuously (ongoing without interruption) monitored by either of the following:
   a. Face-to-face by an assigned, trained staff member; or
   b. By trained staff using both video and audio equipment. This monitoring must be in close proximity.

ADMINISTRATIVE:

Leadership
- The role of leadership is to create an environment that minimizes the circumstances that may give rise to restraint/seclusion usage and maximizes safety.

Performance Improvement/Risk Management
- Performance Improvement tools will be utilized to collect and evaluate data. Information obtained from the data will be used to determine what measures are effective in reducing restraint use.
    - Each death that occurs while a patient is in restraint or seclusion.
    - Each death that occurs within 24 hours after the patient has been removed from restraint and seclusion.
    - Each death known to the hospital that occurs within one week after restraint or seclusion, where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to the patient's death.
    - Each death reference above must be reported to DOH via PA-PSRS by completing electronic form CMS 10455.

Infection Control
- Single patient use restraints are discarded when soiled or discontinued.
- If a reusable restraint is used, the restraint is cleaned per Infection Control Guidelines. See Infection Control Standards of Practice Policy 5.04.

STAFF EDUCATION:
Staff members who are involved in the application of restraints, implementation of seclusion, providing care for a patient in restraints or seclusion, or with assessing and monitoring the condition of a patient in restraint or seclusion will have education and training during orientation and annually as part of competency evaluation.

Education for Licensed Practitioners includes:
- Restraint/Seclusion Policy Review
- Annual completion of online restraint program
- One-hour face-to-face evaluation training (Selected RNs as per CMS 482.13 (f)(1), (2)(vi)

Education for Staff/Agency Personnel includes:
- Restraint/Seclusion Policy Review
- Annual completion of online restraint program
- Safe and proper application/release of restraints used in hospital
- Behavioral Health/Emergency Department (ED) – Implementation of Seclusion
- Monitoring, assessment, and providing care for a patient in restraints
- Use of documentation tools as appropriate to role.

Online Restraint Program Includes:
1. Underlying cause of threatening behaviors
2. Preventative strategies
3. Restraint alternatives
4. Aggressive behavior related to medical conditions
5. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
6. Use of non-physical intervention skills.
7. Choosing the least restrictive intervention bases on an individual assessment of the patient's medical or behavioral status or condition.

8. Recognizing signs of physical and psychological distress.
9. Potential bed rail entrapment.
10. Clinical identification of specific behavioral changes that indicate restraint or seclusion is no longer necessary.

ATTACHMENTS

N/A

REFERENCES

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Geisinger

Title: **Suicide/Self-harm Precautions - Nursing**	
Joint Commission Chapter Section: 10.0 Provisions of Care, Treat/Service	*Date ORIGINAL policy was created:* December 1, 1980
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 Geisinger Entities:

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☒ **Community Medical Center (CMC or GCMC)**	☒ **Geisinger Lewistown Hospital (GLH)**
☐ Endoscopy Center of Geisinger Lewistown Hospital	☒ **Geisinger Medical Center (GMC)**
☒ **Geisinger Bloomsburg Hospital (GBH)**	☒ **Geisinger Medical Center Muncy (GMCM)**
☐ Geisinger Clinic (GC)	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☐ Geisinger Surgery Center - Highland Park
☐ Geisinger Encompass Health, LLC	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☐ GMC Outpatient Surgery - Woodbine
☐ Geisinger-HM Joint Venture (G-HM)	☐ GWV Outpatient Surgery - CenterPoint
☐ Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger-Lewistown Hospital	☐ Marworth
☒ **Geisinger Jersey Shore Hospital (GJSH)**	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

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☐ Geisinger Health Plan (GHP)	☐ ISS Solutions, Inc. (ISS)
☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

PURPOSE

The purpose of this policy is to ensure an effective method for suicidal assessment, monitoring, and treatment of patients at risk for suicide/self-harm or who may endanger others. Patients presenting with acute medical care needs may also be assessed for exhibiting acute psychiatric conditions, chronic mental disturbances, substance abuse and be at risk of self-harm.

PERSONS AFFECTED

All clinical Staff

POLICY

1. Patients ages 11 and older presenting to the Emergency Department, outpatient areas, and direct admissions are screened for suicide ideation using appropriate evidenced based tool.

2. Detection and handling of suicidal intention in patients remains the responsibility of the provider.

3. Annual education for all affected staff is completed via an online education system.

DEFINITIONS

Columbia Suicide Severity Rating Scale (C-SSRS) – Evidence based suicide risk assessment tool to assess suicidal ideation.

Continuous observation – continuous in person 1:1 observation monitoring **for high risk patients**

Direct Visual Observation – constant observation in person or by video **for moderate risk patients**. Observation of multiple patients (no more than 2:1 in person) or can utilize in person and video monitoring for patients simultaneously per nursing/provider judgement.

Suicide Ideation – specific behaviors/thoughts/ verbal cues which may be indicative of an individual's intent to kill oneself.

Suicide -- Death caused by self-directed injurious behavior with an intent to die as a result of the behavior

Suicide Attempt -- A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury

RESPONSIBILITIES

All Geisinger staff are responsible to ensure a safe environment for patients with suicidal ideation

EQUIPMENT/SUPPLIES

NA

PROCEDURE

The suicide evaluation will consist of 4 areas of screening. Patients who screen positive for suicide ideation (suicidal thoughts) without intent, the Provider gets a 'Best Practice Alert (BPA)'. It is the provider's responsibility to acknowledge the BPA and complete a patient evaluation. See attached EPIC screen shots.
Any patient that arrives to Emergency department with active suicide attempt is automatically placed on high risk 1:1 observation.

EMERGENCY DEPARTMENT PROCEDURE

Complete the Columbia Suicide Severity Rating Scale (C-SSRS) on every patient . The patient will be re-assessed with any change in patient behavioral condition to determine if a change in risk level and/or intervention is needed.

Assessment Interventions (Refer to attachments)

- Interventions initiated based on level of risk assigned per C-SSRS outlined in the Geisinger Health Suicide Risk Assessment Interventions.
    - For patients with a Glasgow Coma Scale (GCS) of less than 7, a 1:1 is not needed. Once the GCS reaches 7 or greater, a 1:1 will be required.
    - Emergency Department EmPATH space/area (GMC only)
        - Refer to ED EmPATH interventions attachment

Nurse	Provider
a. Completes assessment and initiates appropriate interventions. b. Notifies provider	a. Assess patient b. Modify interventions based on risk assessment, may consider a psychiatric consultation.

GWV- Psychological evaluation(consultation) by the Crisis Service will be requested as soon as the patient is medically stable. Psychiatric commitment procedures are the responsibilities of the Crisis Service. They are responsible for coordinating admissions, legal compliance with the Mental Health Procedure Act and precertification with the patient's insurance carrier. The Emergency Department physician may be involved as a petitioner in the commitment process.

1:1 observation may be discontinued after assessment and upon order of the provider/consulting behavioral health practitioner.
GWV – 1:1 cannot be discontinued without psychiatric evaluation

Discharge/Transfer from ED

1. ED provider/psychiatric consultant who identifies that a patient has access to means of contemplating suicide must make responsible family member aware prior to release of patient to home. Once assessed, an appropriate plan/disposition must be made.

a. Patients released from the ED will receive discharge instructions as appropriate for the patient including crisis intervention phone numbers/ community resources

b. Crisis Safety Plan – Emergency Department completed as appropriate. Copy retained for EHR and copy given to patient. Refer to attachments.

c. Patients medical cleared from ED in need of additional inpatient psychiatric inpatient care will have their transfer coordinated by appropriate staff or community resources

Nurse	Provider
a. Review discharge instructions with patient b. Coordinate with appropriate staff and	a. Make responsible family member aware of suicidality prior to release to home

community resources for patient release	

2. Patients transferred from ED to Inpatient areas of hospital will be accompanied by 1:1 direct visual observation
   - Security may be contacted to assist with the escort, If needed.

Inpatient Medical Units

1. The nurse will screen the patient for suicide and implement appropriate interventions. Refer to attachments for screening tool.

   - Interventions initiated based on level of risk assigned per C-SSRS outlined in the Geisinger Health Suicide Risk Assessment Intervention.
     - For patients with a Glasgow Coma Scale (GCS) of less than 7, a 1:1 is not needed. Once the GCS reaches 7 or greater, a 1:1 will be required.

2. Patients who screen positive for suicide ideation (suicidal thoughts) without intent, the Provider gets a 'Best Practice Alert (BPA)'. It is the provider's responsibility to acknowledge the BPA and complete a patient evaluation.

3. 1:1 Observation may be discontinued after assessment and upon order of the provider/consulting behavioral health practitioner.
   GWV – 1:1 cannot be discontinued without psychiatric evaluation

Nurse	Provider
a. Screen the patient with the age appropriate screening tool. b. Initiate/continue appropriate interventions c. Notify provider, if not previously done.	a. Acknowledge BPA b. Complete patient evaluation

OUTPATIENT PSYCHIATRIC CLINIC PROCEDURE

Essential Steps to be taken when the patient has a primary emotional or behavioral disorder and point of entry into the system is the Outpatient Psychiatric Clinic.

Emergency outpatient contacts in the Division of Psychiatry will be screened for suicidal ideation at the time of the initial telephone contact by the triage personnel. At the point of referral, which is typically by telephone, information will be obtained in regard to presenting problems and current symptoms. If risk for suicide is evident, the patient will be assessed by a member of the psychiatric staff. If deemed to be at imminent risk, the psychiatric staff will arrange for a face-to-face evaluation. This can be done in the outpatient clinic, the ED or via the County Crisis Unit.

Outpatients being seen in the Division of Psychiatry will be evaluated at admission and throughout the course of outpatient treatment. If suicidal risk is imminent, the primary clinician will involve the psychiatric staff to facilitate the admission process and arrange inpatient hospitalization. If admission is not warranted, the patient will be directed to the most appropriate level of care.

OUTPATIENT CLINIC PROCEDURE

Essential Steps to be taken when a patient is seen in an Outpatient Location.

If a patient reports statements of suicide intent, voices a desire to die, or has made a suicide attempt:

1. Take immediate steps to ensure safety by:
    a. Initiating 1:1 direct visual observation
2. It may not be feasible to make a patient observation room entirely hazard free. Therefore, the staff will determine what will be removed from the room. Objects to be considered are the telephone, cords, glass, belts, plastic bags, home medications, and sharp objects.
3. Inform the attending provider of the potential risk.
4. Provider assesses suicide risk. The suicide evaluation will consist of 4 areas of screening: suicidal ideation, suicidal intent, suicidal intent with a plan, and actual suicide attempt.
5. In the event the provider is not available to assess the suicide risk of the patient:
    a. On site outpatient clinics should notify the ED and transfer the patient to the ED for evaluation.
    b. Off campus clinics should call 911 to transfer the patient to the nearest ED for evaluation.
6. For off campus clinics, once the provider assesses the patient to be suicidal, call 911 for transport to the nearest ED.
7. Provide 1:1 direct visual observation until the patient is transferred to the ED or the patient is no longer deemed suicidal.
    a. 1:1 direct visual observation will be provided by the outpatient personnel. The level of outpatient personnel will be determined based on the assessment of the patient.
    b. Outpatient personnel will provide continuous visual observation even if patient's family members are present until the precautions are discontinued by the provider.
    c. For privacy of the patient during toileting, outpatient personnel providing 1:1 direct visual observation may remain outside the bathroom door leaving the door slightly ajar, but outpatient personnel must always keep visual contact of patient.
    d. When patients are outside of the room, they should be accompanied by a minimum of 1 staff member. they should not be allowed away from the clinic unless no longer deemed suicidal or for further treatment.
8. Needle/sharps box in locked bracket may remain in the patient room.
   in the event the patient attempts to leave:
    a. On site outpatient clinics should notify security.
    b. Off campus clinics should call 911 to report incident to obtain assistance.
9. Complete MIDAS report
10. Document in the patient chart what the patient states, what is done, and that the physician is made aware

ATTACHMENTS

Epic Screenshots

Geisinger Health Suicide Risk Assessment Interventions

Geisinger Direct Visual Room Check

REFERENCES

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Policy

Geisinger

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

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PURPOSE

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

PERSONS AFFECTED

All Geisinger 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. Geisinger may also utilize an independent vendor for these services if needed.
g. Since many commonly used HD agents are thought to volatilize, Geisinger Pharmacy will work with other organizational departments to form an HD Spill Response Team (SRT). It is not feasible to teach all staff and patients potentially exposed to spills to differentiate between HDs that volatilize and those that do not. Therefore,

general staff will be instructed on simpler actions to take and HD SRT staff will perform Spill Management which is detailed in Section 4 of this SOP.

h. 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

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

Geisinger

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 Geisinger Entities:

CLINICAL ENTITIES *(includes Geisinger entities providing health care services, i.e., hospitals, group practices, clinics)*	
☒ **Community Medical Center (CMC or GCMC)**	☒ **Geisinger Lewistown Hospital (GLH)**
☐ Endoscopy Center of Geisinger Lewistown Hospital	☒ **Geisinger Medical Center (GMC)**
☒ **Geisinger Bloomsburg Hospital (GBH)**	☒ **Geisinger Medical Center Muncy (GMCM)**
☐ Geisinger Clinic (GC)	☐ Geisinger Pharmacy, LLC
☐ Geisinger Community Health Services (GCHS)	☒ **Geisinger Wyoming Valley Medical Center (GWV)**
☐ Geisinger Encompass Health, LLC	☐ Geisinger Surgery Center – Highland Park (OSHP)
☐ Geisinger Endoscopy-Montoursville (a facility of G-HM)	☐ GMC Outpatient Surgery - Woodbine
☐ Geisinger-HM Joint Venture (G-HM)	☐ GWV Outpatient Surgery - CenterPoint
☐ Geisinger Healthplex State College Outpatient Surgery and Endoscopy Center, a department of Geisinger-Lewistown Hospital	☐ Marworth
☒ **Geisinger Jersey Shore Hospital (GJSH)**	☐ West Shore Advanced Life Support Services, Inc. (WSALS or Geisinger EMS)

NON-CLINICAL ENTITIES *(includes Geisinger business/corporate entities not providing health care services)*	
☐ Geisinger Commonwealth School of Medicine (GCSOM)	☐ Geisinger System Services (GSS)
☐ Geisinger Health (GH or GHF)	☐ GNJ Physicians Group (GNJ)
☐ Geisinger Health Plan (GHP)	☐ ISS Solutions, Inc. (ISS)
☐ Geisinger Quality Options, Inc. (GQO)	☐ Keystone Health Information Exchange, Inc. (KeyHIE)

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)