MEDICAL EXECUTIVE COMMITTEE	12/06/2023
BOARD OF DIRECTORS APPROVAL	
	12/19/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
December 19, 2023 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

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SUBJECT: **340B DRUG PRICING PROGRAM COMPLIANCE**	SECTION: *Pharmacy* **Page 1 of 10**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the policy and outline the procedures to ensure compliance with all state and federal requirements related to Sierra View Medical Center's (SVMC) participation in the 340B Program, including but not limited to registration with the Health Resources and Administration's (HRSA) Office of Pharmacy Affairs ("OPA"), medication procurement, billing, inventory management, and prevention of diversion of 340B Drugs.

POLICY:

The Pharmacy Department shall purchase, manage the inventory, and dispense 340B drugs to eligible patients treated in eligible hospital areas (Covered Sites), in accordance with procedures described below.

The Manager of Pharmacy Services, in coordination with the Compliance Department, shall be responsible for overseeing compliance with this policy and ensuring that appropriate policies and procedures are in place to ensure such compliance. 340B Program compliance and oversight is the responsibility of SVMC Management, and the Manager of Pharmacy Services shall provide regular reports to the Compliance Committee.

DEFINITIONS:

- Authorized Official: The individual registered as the authorized official of SVMC on OPA's 340B Program database, and who is eligible to make changes to the database listing.
- 340B Drugs: Means prescription drugs purchased pursuant to the 340B Program for dispensing or administration to Eligible Patients in the outpatient care setting of a Covered Site.
- 340B Program: Means the 340B Program established by the Veterans Health Care Act of 1992, and is codified as Section 340B of the Public Health Service Act (42 U.S.C. 256b). The 340B Program limits the cost of covered outpatient drugs to certain federally recognized covered entities. The program enables these covered entities to stretch federal resources, reach more eligible patients and provide more comprehensive services.
- Contact Official: The individual registered on the OPA's 340B program database to receive and respond to communication from OPA on behalf of the entity. The contact official may make changes to the OPA database but these changes must be approved by the authorizing official.
- Covered Outpatient Drug: The category of drugs for which manufacturers must pay rebates to State Medicaid agencies under the Medicaid rebate program and give discounts to covered entities under the 340B Program. The 340B Program statute defines "covered outpatient drug" by referencing the definition found in Section 1927(k) (2) of the Social Security Act.+42++742
- Covered Site: Means those: (i) outpatient departments or mixed-use settings of SVMC located within the four walls of the hospital, and (ii) off-site locations of SVMC that appear as a reimbursable hospital-based facility on a filed SVMC Medicare cost report, and are registered with HRSA as part of the hospital.

- Eligible Patient: Means an individual who meets all of the following criteria and only during periods when such criteria are met:

  - A patient with whom a Covered Site has established a relationship such that SVMC maintains records of such patient's treatment and care; and; the patient receives health care services from an Eligible Provider.

  An individual will not be considered an Eligible Patient if the only care he or she receives from SVMC or a Covered Site is the dispensing of a drug or drugs for subsequent self-administration in the home setting.

- Eligible Provider: Means a health care professional who is either: (a) employed by Sierra View Medical Center, or (b) provides health care under a contract or other arrangement (e.g., referral for consultation) with SVMC such that responsibility for the care provided to individuals pursuant to such contract or arrangement remains with SVMC, but only with respect to those services.

- OPA: Means the Office of Pharmacy Affairs, which oversees the 340B Program, within the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

- Material Breach: Sierra View Medical Center defines a material breach of compliance as a violation(s) that exceeds 5% of total 340B purchases in a calendar year.

- Group Purchasing Organization (GPO): An organization that represents and organizes a group of hospitals to evaluate and select pharmaceutical products. Using the purchasing power of the entire group, the GPO negotiates contracts that are more favorable than a single organization.

PROCEDURES:

1. Program Eligibility

   Eligibility to participate in the 340B Program is based on meeting the following requirements, applicable to Disproportionate Share Hospitals (DSH):

   a. Meet one of the following: (1) be owned or operated by a unit of state or local government; (2) be a public or private non-profit corporation which has been formally granted governmental powers by a unit of state or local government, or (3) be a private non-profit hospital with a contract with a state or local government to provide health care services to low-income individuals who are not entitled to benefits under Medicare or Medicaid;

   b. Have a Medicare DSH percentage greater than 11.75 percent for the most recent cost reporting period; and

   c. The Authorizing Official shall complete written verification that outpatient drugs will not be obtained through a Group Purchasing Organization (GPO).

The Authorizing Official will notify OPA in the event of any change(s) in eligibility, location, operating status, and authorizing official/primary contact information.

2. **Service Site Eligibility**

a. SVMC recognizes that OPA relies on the most recently filed Medicare cost report to determine which facilities are an "integral part" of SVMC for purposes of the 340B Program. The Director of Pharmacy, with assistance from Finance, shall review and confirm that each Covered Site is listed as a reimbursable center on SVMC's most recently filed cost report.

b. The Authorizing Official will take all steps necessary to register Covered Sites that are not located within the four walls of the hospital in OPA's 340B Covered Entity Database as child sites of SVMC, or to de-register Covered Sites that are no longer operated by SVMC or no longer listed as a reimbursable centers on the most recently filed cost report. OPA does not currently require sites located within the four walls of the hospital to be separately registered as a Covered Site.

c. 340B Drugs will not be dispensed by or shipped to service sites that are not Covered Sites.

d. On no less than an annual basis, an independent auditor as well as the contact official and the authorizing official will review the Office of Pharmacy Affairs Information System (OPAIS) database to ensure that SVMC's parent and all child sites are registered and that the information is correct, accurate and complete including:

- Physical address of all registered locations
- NPI and Medicaid Billing numbers for all locations

If there are any changes in the parent or child site registration information then SVMC will update the OPAIS database in a reasonable and timely manner.

3. **Covered Outpatient Drugs**

A covered outpatient drug is defined in the Medicaid rebate statute and represents the category of drugs for which manufacturers must pay rebates to state Medicaid agencies under the Medicaid rebate program.

a. Exceptions to a listed covered outpatient drug (as defined in the Medicaid rebate statute) can be made if the drug is part of a bundled charge or incident to another service. Outpatient purchases may be made on a group purchasing organization (GPO) account for drugs that do not meet the definition of a covered outpatient drug.

b. A drug is not considered a covered outpatient drug if all of the following tests are met:

i. The drug is "part of" or "incident to" a service

ii. The drug is given in the same setting as the service
iii. The drug is paid as part of the service

c. Any drug that is given to or administered to an ambulatory patient that is billed separately with the intention of getting paid, shall be considered a covered outpatient drug.

d. Contrast Media, IV solutions, and anesthesia gases are considered "part of" or "incident to" a service and billed without the intention of getting paid above and beyond the service. These drugs and IV solutions shall be considered an exception, and not a covered outpatient drug.

e. These drugs shall be flagged in the accumulators for the mixed use hospital sites, allowing for ambulance and inpatient purchases to be made on the sites' GPO account.

4. **Recertification**

a. The Authorizing Official shall recertify/decertify the hospital's child sites on an annual basis.

b. The Authorizing Official, or the primary contact individual listed on the 340B Database, shall receive advance notification from HRSA/OPA prior to the start of the recertification period. Only the Authorizing Official will receive the username and password to complete the process.

c. Prior to submitting a recertification, the Authorizing Official shall consult with the Director of Pharmacy Services to review compliance with all 340B Program rules and requirements.

5. **Inventory Management**

- SVMC maintains both a virtual and physical inventory.

Virtual inventory accumulation process:

- All dispensations that occur within the hospital are accumulated via split billing software.
- An electronic data feed is transferred to the split billing software vendor on a daily basis.
- Order is developed through SVMC's wholesaler, originating in the WAC account.
- Order is then uploaded into split billing software where the system determines which account number each product needs to go to.

- Order is automatically (via EDI) transmitted back to wholesaler and order is sent to be filled.
- Invoices are processed daily in the split billing software.
- Temporary products are merged to CDMs accordingly.

Physical inventory accumulation process:

- A physical inventory is maintained for the outpatient departments of the Cancer Treatment Center (CTC), Ambulatory Surgery Center (ASD), Wound Healing, Urology Clinic, , Medical Office Building, and Women's Imaging.
- All patients of these departments are eligible outpatients; therefore all drugs are purchased off the 340B Program account.
- Separate purchase orders (POs) are placed off the hospital's 340B Program account with the PO including the name of the site for which the purchase was made.
- These orders shall be directly transferred to the respective departments or shall be stored in the designated areas(s) of the hospital inpatient pharmacy.

  Utilization of this stock is restricted to usage for the designated areas.

- Borrowing of the 340B Drugs in emergency situations
  - Notify the pharmacy buyer and pharmacy director.
  - Staff shall fill out "Borrowing/Replacing of 340B Drugs" form.
  - Pharmacy buyer shall replace the drug on the 340B Program account.
  - The "Borrowing/Replacing of 340B Drugs" form will be completed and a copy of the invoice will be attached.
  - Forms will be maintained in a binder in the pharmacy, per regulatory requirements.

6. GPO Prohibition Compliance

- As a DSH covered entity, SVMC shall not purchase covered outpatient drugs through a GPO or other group purchasing arrangement for any of its clinics or departments within the four walls of the hospital. SVMC shall only purchase outpatient drugs through a GPO or other group purchasing arrangement for outpatient facilities outside the four walls of the hospital if the facility meets all the following criteria:

- Is located at a different physical address from SVMC,
- Is not registered on the 340B Covered Entity Database as a child site of SVMC, the drugs are purchased through a separate pharmacy wholesaler account than used by SVMC DSH facility,
- SVMC maintains records demonstrating that any outpatient drugs purchased through the GPO at those sites are not utilized or otherwise transferred to SVMC or any of the hospital's registered child sites. SVMC shall purchase covered outpatient drugs for its clinics or departments within the four walls of the hospital using a non-GPO account and shall only replenish with 340B Drugs once 340B patient eligibility is confirmed and can be documented through auditable records.
- When using the split billing software, if the exceptional circumstance arises where an unmatched 11 digit NDC occurs, then the split billing software will default to a WAC (Non-GPO, Non-340B) purchase. To ensure compliance with the GPO prohibition in this circumstance invoices will be checked by the pharmacy buyer upon delivery of the drug to the pharmacy. In the event of a purchase not on a WAC account, the contact official will be immediately notified.

  In addition, weekly quality reports, (i.e., transaction reports) will be run that will identify crosswalk mismatches. These mismatches will then be validated for proper accumulation. Any discrepancies in any of these procedures will be immediately reported to the contact official.

6. **Anti-Diversion Program**

a. SVMC is committed to safeguarding against the diversion of 340B Drugs to: individuals who are not Eligible Patients, to entities other than a Covered Site or Contract Pharmacy, or to hospital inpatients; toward these ends, SVMC shall have in place the following components of an Anti-Diversion Program, and shall revise such components as necessary to reflect new or revised 340B Program guidance:

i. SVMC shall ensure that those sites that receive or dispense 340B Drugs are a Covered Site or, in-house pharmacy.

ii. SVMC shall ensure that where 340B Drugs are used in a mixed care setting (e.g., an emergency room or perioperative care settings), adequate procedures are in place to ensure that the 340B Drugs are administered only to those Eligible Patients who are receiving outpatient care in such a setting.

iii. SVMC shall permit and cooperate with HRSA and/or the manufacturer of 340B drugs (with respect to those drugs it manufactures) to audit the records that pertain to compliance with 340B Program requirements, provided that any such audit undertaken by a manufacturer is in accordance with those

procedures established by HRSA relating to the number, duration and scope of any such audits.

7. **Billing and Reimbursement**

a. SVMC is committed to ensuring that the Medi-Cal program (California's Medicaid program) does not claim rebates from manufacturers with respect to 340B Drugs purchased by SVMC.

b. For each Covered Site that will use 340B Drugs for Eligible Patients enrolled in the Medi-Cal Program, SVMC shall undertake the following:

- Follow the appropriate procedures for notifying the HRSA Office of Pharmacy Affairs that the site will use Program Drugs for Eligible Patients who have Medicaid coverage for outpatient drugs, including, but not limited to, reporting the Covered Site's Medi-Cal and/or NPI billing numbers to the HRSA Office of Pharmacy Affairs.

- Submit claims to the Medi-Cal program consistent with Medi-Cal's billing requirements for 340B Drugs: 340B actual acquisition cost plus single administration fee for professional services for injections if applicable and UD modifier.

- On a regular basis, not less than annually, confirm that the Medi–Cal and NPI billing numbers for each Covered Site location using 340B Drugs for Medicaid patients are listed in the Office of Pharmacy Affairs' Medicaid exclusion file and that such Program Drugs are being properly billed to the Medi-Cal program consistent with the Medi-Cal approved billing methodology for Program Drugs;

- On not less than an annual basis, audit the accuracy and effectiveness (see Program Compliance Monitoring and Auditing section) of the foregoing system and safeguards.

8. **Program Compliance Monitoring and Auditing**

SVMC has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B Program requirements.

a. On a monthly basis, SVMC shall select a sample of claims from the following areas:

- 15 hospital claims
- 5 Cancer Treatment Center claims
- 5 Ambulatory Surgery Center
- 5 Urology Clinic
- 5 Wound Healing
- 5 Women's Imaging
- As needed for Medical Office Building

SVMC shall review the hospital claims for the following criteria:

i. The patient was an outpatient at the time the drug was administered. Patient status, either inpatient or outpatient, will be determined by the patient's recorded disposition in the electronic medical record

ii. The drug accumulated on the correct account (i.e., 340B, GPO, WAC). Furthermore, accumulation will be checked on all sample claims in each of the areas monitored monthly. In addition, at least quarterly a split billing software report will be run to survey for accumulation inaccuracies. Any found discrepancy will be immediately reported to the contact official. Reconciliation will be made immediately in the software so that correct accumulations are maintained.

iii. The patient was an eligible patient, the medical records are owned and maintained by SVMC.

b. SVMC shall review the claims selected pursuant to subdivision (a) to confirm whether Medi-Cal or a Medi-Cal Managed Care Organization (MCO) was the payer. If none of the claims selected pursuant to subdivision (a) were submitted to Medi-Cal or a MCO, SVMC shall continue to select claims until 5 claims that were submitted to Medi-Cal and/ or a MCO have been selected.

- For each of these claims submitted to Medi-Cal or a MCO, SVMC shall review them to confirm the following criteria:

i. That it was billed at the 340B Program actual acquisition cost (AAC) and single administration fee for professional services for injections if applicable , and

ii. That the UD modifier was attached to the claim submitted to Medi-Cal

c. The audit activity, frequency, and method are designed to serve as a tool for the purpose of monitoring program activities and standard operating procedures for ongoing compliance. The auditing tool activities, frequency, and method may be adjusted accordingly by those parties responsible for SVMC's 340B Program oversight and integrity in order to validate that all systems are properly working.

d. Medi-Cal Managed Care claims will be billed according to California State Laws so that duplicate discounts will be prevented from occurring. On no less than an annual basis, the SVMC 340B committee will confirm compliance with California State billing requirements for MCOs.

e. SVMC shall retain auditable records related to 340B purchasing, dispensing, and screening in accordance with established hospital policies and procedures and for as long

as required by Federal and State laws. Auditable records shall include but may not be limited to: electronic health record from any system used at SVMC, drug purchasing and return records, automated dispensing cabinet records, or any other medium used to record patient information or drug disposition records.

f. Monitoring and auditing shall be completed in accordance with established hospital policies and procedures. Such audits may be performed by an independent third party.

g. The Director of Compliance shall work with the Manager of Pharmacy and other appropriate individuals to resolve material issues raised during audits or otherwise, to ensure ongoing compliance with all 340B Program rules. Such actions may include, without limitation, the education of staff, resolution or remedying of inappropriate billing or purchases, or de-registration of child sites, and recommendation of disciplinary actions against workforce members that have breached this policy.

h. Should the Manager of Pharmacy or any other SVMC employee reasonably suspect or determine that there has been a material breach of 340B Program requirements (e.g., diversion of 340B Drugs or a Medicaid duplicate discount); he or she shall report this suspicion or determination immediately to the Director of Compliance and CEO. Under the Director of Compliance and CEO's direction, SVMC shall take immediate action, including consultation with SVMC counsel, to investigate and remedy the specific occurrence or the factors that permitted the occurrence in order to ensure future compliance. As required by law or HRSA guidance, and as approved by the Director of Compliance and CEO, SVMC shall also notify the OPA regarding such material non-compliance and include in such notice the actions taken to remedy the non-compliance.

i. Sierra View Medical Center will utilize a three-year look-back period when investigating potential repayment obligations.

REFERENCES:

- Apexus Answers Prime Vendor. (n.d.). Retrieved October 12th, 2023, from https://www.340bpvp.com/about/apexus-answers/.
- 340B Health (n.d.). Retrieved October 12th, 2023, from https://www.340bhealth.org/.
- Health Resources and Services Administration. "Manufacturer Audit Guidelines and Dispute Resolution Process" Page 65407.

- **Attachment A**

340B Monitoring and Oversight Activity

		Area of Focus			
Activity	Frequency	**Program Eligibility**	**Diversion**	**Duplicate Discount**	**GPO Prohibition**
Review all OPA database information for SVMC, Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification	Annual	√			
Review 340B Self-Audit Reports (mixed-use, outpatient)	Monthly		√	√	√
3rd Party Vendor External Audit of Entity	Annual	√	√	√	√
Split-Billing software maintenance/auditing (CDM-NDC mapping, updates, etc.)	As required		√		√

SUBJECT: **ABBREVIATIONS IN THE MEDICAL RECORD**	SECTION: **Page 1 of 28**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the standardized abbreviations and symbols acceptable for use in the medical record at Sierra View Medical Center.

POLICY:

There shall be an approved abbreviation list available for use throughout the Hospital. Only abbreviations from this list shall be used in the medical record.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

1. The HIM Director, Vice President of Patient Care Services and the Vice President of Quality and Regulatory Affairs shall have the authority to add, delete, and otherwise update the abbreviation list as the needs of the hospital shall dictate.

2. The abbreviation list shall be submitted annually to the Medical Executive Committee and for review and approval.

3. The abbreviation list shall be an addendum to this policy and shall be available in all copies of the manual.

REFERENCE:

- The Joint Commission. (2023). Hospital accreditation standards. IM.02.02.01. Joint Commission Resources, Oakbrook Terrace, Illinois

SIERRA VIEW MEDICAL CENTER
APPROVED ABBREVIATION LIST
ATTACHMENT A

A

@	at
a	before
A1	aortic first sound
A2	aortic second sound
aa	of each
A	assistance
AAA	abdominal aortic aneurysm
AaDO2	alveolar-arterial oxygen difference
AAROM	active assisted range of motion
A&O	alert and oriented
A&P	auscultation and percussion
AB	abortion
ABD	abduction
abd	abdomen
abd pol	abductor pollicis
ABG	arterial blood gas
abn	abnormal
ABX	antibiotics
a.c.	before meals
AC	acromioclavicular
ACL	anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
ACT	activated clotting time
ACTH	adrenocorticotrophic (hormone)
ACVD	arteriosclerotic cardiovascular disease
A.D.	right ear (auris dextra)
ADA	American Diabetic Association
Adapt.	Adaptive
ADC	average daily census
ADD	attention deficit disorder
ADH	antidiuretic hormone
ADL	activities of daily living
ad lib	as desired
add pol	adductor pollicis
ADM	administrative
adm	admission
adq	abductor digiti quinti (muscle)
AE	above elbow
AFB	acid fast bacilli
A-fib	atrial fibrillation

ag	antigravity
AgNO3	silver nitrate
A/G Ratio	albumin-globulin
AGA	appropriate for gestational age
AGE	acute gastroenteritis
AHD	acute hemodialysis
AI	aortic insufficiency
AIDS	autoimmune deficiency syndrome
AIN	allergic interstitial nephritis
AK	above knee
AKA	above knee amputation
alb	albumin
alk.p'tase	alkaline phosphatase
alk.	alkaline
ALOC	altered level of consciousness
ALS	amyotrophic lateralizing sclerosis
a.m.	morning
AMA	Against Medical Advice
amb	ambulatory
AMI	acute myocardial infarction
amp	ampule
amt	amount
anes	anesthesia
angio	angiogram
ANS	autonomic nervous system
ant	anterior
A/O	alert and oriented
AOCD	Anemia of chronic dsease
AODM	adult onset diabetes mellitus
AP	anterior-posterior
APAP	acetaminophen (not abbrev. brand name)
APB	abductor pollicis brevis
APL	abductor pollicis longus
A/P	auscultation and percussion
ap	apical pulse
approx	approximately
appt	appointment
appy	appendectomy
APS	Adult Protective Services
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
AROM	artificial rupture of membranes
ART	Accredited Record Technician
art.	arterial
art.line	arterial line
artic	articulation

A.S.	left ear (auris sinistra)
AS	arteriosclerosis
ASA	acetylsalicylic acid (aspirin)
ASAP	as soon as possible
ASCVD	atherosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASIS	anterosuperior iliac spine
ASO	antistreptolysin titre O
Assoc.	association
asst	assistance
as tol	as tolerated
ASVD	arteriosclerotic vascular disease
asym	asymmetrical
A.T.C.	around the clock
A.U.	both ears
auth	authorize(d)
A-V	arteriovenous
AV	arterioventricular
AVB	atrioventricular block
AWMI	anterior wall myocardial infarction
ax	axilla

B

B+C	board and care
Bab.	Babinski
Bact	bacterium(a)
bal	balance
Baso	basophils
BBB	bundle branch block
BBS	bilateral breath sounds
BC	blood culture
BG	blood glucose
BIB	brought in by
b.i.d.	twice daily
bilat; bil	bilateral
BILI	bilirubin
bio	biological
BE	barium enema
BF	breast feeding
BK	below the knee
BKA	below knee amputation
bld	blood
BLE	bilateral lower extremities
BLS	basic life support

BM	bowel movement
BMEVT	bilateral middle ear ventilation tubes
BMR	basal metabolism rate
BMT	bilateral myringotomy/tube placement
BOA	born out of asepsis
BOM	bilateral otitis media
BOME	bilateral otitis media with effusion
BOOP	bilateral organizing obstructive pnemonia
BOW	bag of waters
BP	blood pressure
BPH	benign prostatic hypertrophy
BPPN	benign paroxysmal postural nystagmus
BPPV	benign paroxysmal positional vertigo
BR	bedrest
BRB	bright red blood
B.R.P.	bathroom privileges
Bs; B/S	blood sugar
bs	breath sounds
BS	bowel sounds
BSA	body surface area
BSC	bedside commode
BSGT	bedside glucose tolerance
BSO	bilateral salpingo-oohorectomy
BST	breast stimulation test
BSW	Bachelor of Social Work
BTL	bilateral tubal ligation
BUE	bilateral upper extremities
BUN	blood urea nitrogen
BUR	back up rate
BUS	Bartholin, urethral and Skenes glands
BTL	bilateral tubal ligation
btl.	bottle
bx	biopsy

C

C/O	complaints of
c	with
C	centigrade (celsius)
C&S	culture and sensitivity
Ca	cancer/carcinoma
Ca++	calcium
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calorie
Cap.	Capsule

CAPD	continuous ambulatory peritoneal dialysis
CAT	CAT Scan
Cat	cataract
cath	catheter/catheterization
Cauc	caucasian
CAVH	continuous arteriovenous hemoperfusion
CAVHD	continuous ateriovenous hemodialysis
CBC	complete blood count
CBOME	chronic bilateral otitis media with effusion
CBS	chronic brain syndrome
cc	cubic centimeter
CC	chief complaint
CCPD	Continuous Cycling Peritoneal Dialysis
CCS	California Children's Services
C.C.S.	Certified Coding Specialitst
CCU	coronary care unit
CDB	cough & deep breathe
CDC	Centers for Disease Control and prevention
CEA	carcinoembryonic antigen
CEO	Chief Exective Officer
ceph.floc.	cephalin flocculation test
cert.	Certification
cerv.	Cervical
CFO	Chief Financial Officer
CGA	Contact Guard Assist
CHAL	central hyperalimentation dialysis
CHD	coronary heart disease
CHF	congestive heart failure
chg	charge
CHO	carbohydrate
chol	cholesterol
Chole	cholecystectomy
CHT	Certified Hand Therapist
CI	cardiac index
CIE	counter immunoelectrophoresis
CIN	cervical intraepithelial neoplasia
circ	circumcision
CIS	carcinoma in situ
Cl	chloride
Cllig	clear liquid
cm	centimeter
CMCJ	carpometacarpal joint
CMV	cytomegalovirus
CNA	Certified Nurse Assistant
CNM	Certified Nurse Midwife
CNS	central nervous system

CO	cardiac output
c/o	complaint(s) of
CO2	carbon dioxide
Cocci	coccidioicomycosis
Cog	cognitive
COG	center of gravity
comp	compliance
conc.	Concentration
cong.	Congestion/congested
conj.	Conjunctiva(l)
cont.	continuous
contr.	Contractions
COO	Chief Operating Officer
COPD	chronic obstructive pulmonary disease
COS	Chief of Staff
COTA	Certified Occupational Therapy Assistant
C/P	cardiopulmonary
CP	cerebral palsy
cp	cold pack
CPAP	continuous positive airway pressure
CPD	cephalopelvic disproportion
CPK	creatinine phosphokinase
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CPS	Child Protective Services
C/R	cardiorespiratory
CRC	Cypress Rehabilitation Center
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
Cr nn 2-12	cranial nerves two through 12
CRS	community re-entry skills
CRT	Certified Radiology Technician
C/S	cesarean section
CSF	cerebrospinal fluid
CSM	circulation, sensation, motion
CSOM	chronic suppurative otitis media
C-spine	cervical spine
CST	Certified Scrub Technician
CT	computerized axial tomography
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
ctx	contraction
cu	cubic
cu.in.	cubic inch
C/V	cardiovascular
CVA	cerebrovascular accident

CVD	cardiovascular disease
CVP	central venous pressure
cx	cervix
CXR	chest x-ray

D

D&C	dilation and curettage
D&I	dry and intact
DAT	diet as tolerated
DB	diaphragmatic breathing
DBW	desired body weight
dc	discontinue
dep	dependent
DC	discontinue
dc'd	discontinued
D5W	IV Dextrose, 5% in water
DDS	Doctor of Dental Surgery
DDSc	Doctor of Dental Science
decub	decubitus
demo	demonstrate
Dept	department
diam	diameter
diff	differential
dig.	Digoxin,Lanoxin
dil	dilute(d)
DIPJ	distal interphalangeal joint
disch	discharge
dist	distilled
DJD	degenerative joint disease
DM	diabetes mellitus
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DPM	Doctor of Podiatric Medicine
DPT	diphtheria, pertussis, tetanus
Dr.	doctor
dr.	dram
drng	drainage
dsg	dressing
DT	diphtheria/tetanus
D.T.'s	delirium tremens
DTRs	deep tendon reflexes
dtr.	daughter

dur.	duration
DVT	deep vein thrombosis
Dx	diagnosis

E

E coli	escherichia coli
e.g.	for example
ea	each
EBL	estimated blood loss
EBV	Epstien-Barr virus
ECF	extended care facility
ECG;EKG	electrocardiogram
ECHO	echocardiogram
Ed	education
ED	emergency department
EDC	estimated date of confinement
EDD	estimated date of delivery
EDW	estimated dry weight
EEG	electroencephalogram
EENT	eye, ear, nose and throat
EFM	external fetal monitor
EGD	esophagogastroduodenostomy
EJ	external jugular
ELF	elective low forceps
elix	elixir
emerg	emergency
EMG	electromyo(myelo)gram
EMS	Electric muscle stimulation
EMT	Emergency Medical Technician
ENG	electroneptagmogram
ENT	ear, nose and throat
EOA	esophagogastric oral airway
EOB	edge of bed
EOM	extraocular movements
eos	eosinophils
EPB	extensor pollicis brevis
EPC	electronic pain control
Epi	epinephrine
epi	epidural
EPL	extensor pollicis longus
Equip	equipment
equiv	equivalent
er	external rotation
ERD	emergency room
ERCP	endoscopic retrograde cholangiopancreatography

ERS	extension rotation sidebend
ES	electrical stimulation
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
est	estimated
ESWL	extracorporeal shockwave lithotripsy
et	and
etal	and others
ET	endotracheal
ETA	estimated time of arrival
Etc.	et cetera (and so forth)
ETCO2	end tidal carbon dioxide
ETIOL	etiology
ETOH	ethyl alcohol
ev	eversion
eval	evaluate(ion)
ex	exercise
exam	examination
exp	expiratory
exs	exercises
ext	external
exte	extension
extr	extraction

F

F	fundus
F/B	followed up
FB	foreign body
FBS	fasting blood sugar
F.C.	FlexCare
FCE	functional capacity evaluation
FCH	Fresno Community Hospital
FCU	flexor carpi ulnaris
FDP	flexor digitorum profundus
FDS	flexor digitorum superficialis
fe	female
Fe	iron (ferrum)
FESS	functional endoscopic sinus surgery

Fetal positions and presentations:

LFA(RFA)	left frontoanterior (right)
FP(RFP)	left frontoposterior (right)
LFT(RFT)	left frontotransverse)right)
LMA(RMA)	left mentoanterior (right)

LMP(RMP)	left mentoposterior (right)
LMT(RMT)	left mentotransverse (right)
LOA	left occiput anterior
LOP	left occiput posterior
LOT	left occiput transverse
LSA(RSA)	left sacrum anterior (right)
LSP(RSP)	left sacrum posterior (right)
LST(RST)	left sacrum transverse
ROA	right occiput anterior
ROP	right occiput posterior
ROT	right occiput transverse
FEV	timed forced expiratory volume
FFC	fixed flexion contracture
FFP	fresh frozen plasma
FH	family history
FHM	fetal heart monitor
FHR	fetal heart rate
FHT	fetal heart tones
FI	fiscal intermediary
fib	fibrillation
FIL	fetal intolerance tolabor
Flliq	full liquid
FIM	Functional Independent Measure
Fi02	fraction of inspired oxygen
fl	fluid
fl oz	fluid ounces
flex	flexion
FLM	fetal lung maturity
FMS	fine motor skills
FNP	Family Nurse Practitioner
FOP	foot of bed
FPB	flexor pollicis brevis
FPL	flexor pollicis longus
FR	fluid restriction
Fr.	French
FRC	Functional Residual Capacity
freq	frequency
Fri	Friday
FROM	full range of motion
FRS	flexion rotation sidebend
FS	frozen section
FSH	follicle stimulating hormone
FT	fullterm
ft.	foot(feet)
FTA	fluorescent treponema antibody

F/U	followup
FUO	fever unknown origin
FVC	forced vital capacity
FVD	fluid volume deficit
FVE	fluid volume excess
FWB	full weight bearing
FWW	front wheeled walker
fx	fracture

G

G	gravid
GA	gestational age
GB	gallbladder
GBS	Guillian-Barre' Syndrome
GC	gonorrhea
GCS	Glasgow Coma Scale
gd	good
gen	general (appearance, anesthetic, etc)
GERD	gastroesophageal reflux disease
GH	glenohumeral
GI	gastrointestinal
gm	gram
GMC	gross motor control
gr	grain
GSW	gunshot wound
GT	gastrostomy tube
GTT	glucose tolerance test
gtt	drop
gtts	drops
GU	genitourinary
Gyn	gynecology(ist)

H

(H)	hypodermic into subcutaneous tissue
h	hour
H/H	hemoglobin/hematocrit
H&H	hemoglobin and hematocrit
HA	headache
hams	hamstrings
HB	heart block
HBP	high blood pressure
HCL	hydrochloric acid
HCO3	bicarbonate
Hct	hematocrit

HCVD	hypertensive cardiovascular disease
Hct	hematocrit
HD	hemodialysis
HEENT	head,eyes,ears,nose and throat
HEP	Home Exercise Program
Hep	hepatitis
Hg	mercury
Hgb	hemoglobin
hgm	hemogram
HHA	Home Health Agency
CHHA	Certified Home Health Aide
HHN	Hand Held Nebulizer
HHRN	Home Health Registered Nurse
HHVN	Home Health Vocational Nurse
hi cal	high caloric
hi chd	high carbohydrate
hi pro	high protein
hi vit	high vitamin
HIE	hypoxic encephalopathy
HIV	human immunosuppressive virus
HL	heparin lock
HLP	hyperlipoproteinemia
HM	Human milk
HNP	herniated nucleus pulposus
H/O	history of
HOB	head of bed
HOH	hard of hearing
HONK	Hyperosmolar nonketosis
hosp	hospital
H&P	history and physical examination
HP	hot packs
HPF	high power field (microscopic field)
HPI	history of present illness
HPPE	hyperpermeability pulmonary edema
HR	heartrate
hr	hour
h.s.	at bedtime
ht	height
HTL VIII	lab test for AIDS virus
HTN	hypertension
H2O	water
H2O2	hydrogen peroxide
HVD	hypertensive vascular disease
Hx	history
H20	water

I

I	independent
I131	radioactive iodine
IABP	intra-aortic balloon pump
IAC	ineffective airway clearance
IBCLC	International Board Certified Lactation Consultant
ibid	in the same place (ibidem)
IBW	ideal body weight
IC	iliac crest
ICN	Infection Control Nurse
ICP	intracranial pressure
ICS	intraclavicular space
ICT	intermittent cervical traction
ICU	Intensive Care Unit
ID	identification
I&D	incision and drainage
IDDM	insulin dependent diabetes mellitus
i.e.	that is (id est)
IGE	impaired gas exchange
IHSS	idiopathic hypertrophic subaortic stenosis
ILS	independent living skills
IM	intramuscular
IMI	brand name abbreviation for a radiant
Imp.	impression
IMV	intermittnet mandatory ventilation
in.	inch
inc.	increase
inf	inferior
inf mono	infectious mononucleosis
init	initial
inj	injection
insp	inspiration(ory)
int	internal
INTF	interferential
I&O	intake and output
IOL	intraocular lens
IPD	Intermittant Peritoneal Dialysis
IPJ	interphalangeal joint
IPPB	intermittent positive pressure breathing
I.Q.	intelligence quotient
IR	internal rotation
irrig	irrigate
I/S	incentive spirometry
ISE	internal scalp electrode

IUD	intrauterine contraceptive device
IUP	intra uterine pregnancy
IUPC	intrauterine pressure catheter
IV	intravenous
IVAB	intravenous antibiotics
IVC	inspiratory vital capacity
IVF	IV fluids
IVP	intravenous pyelogram(phy)
IV push	intravenous push
IVPB	intravenous piggyback
IVSS	intravenous soluset

J

J.P.	Jackson Pratt (hemovac/bulb)
JRA	juvenile rheumatoid arthritis
JV	jugular venous
JVD	jugular venous distention
JVP	jugular venous pressure or pulse
jt.	joint

K

K	potassium
KCI	potassium chloride
KDDH	Kaweah Delta District Hospital
kg	kilogram
K&K	Kline and Kohlmer (test for syphilis)
KUB	kidneys, ureters, bladder (x-ray)
KVO	keep vein open

L

L	liter
LAB	laboratory
LAD	lactic acid dehydrogenase
Lap	laporoatomy
LAO	left anterior oblique
LAQ	long arc quads
lat	lateral
LBBB	left bundle branch block
LBQC	large base quad cane
lb	pound
LC	Lactation consultant
LCL	lateral collateral ligament
LCSW	Licensed Clinical Social Worker

LD	left deltoid
LDH	Lindsay District Hospital
LE	lupus erythematosus
LF	left forearm
LFT	lower function test
Lg	large
LGA	large for gestational age
Litho	lithotripsy
LLE	left lower extremity
LLH	left lateral heelstick
LLL	left lower lobe
LLQ	left lower quadrant
LMH	left medial heelstick
LMP	last menstrual period
LOB	loss of balance
LOC	loss of consciousness
LOS	length of stay
LP	lumbar puncture
LR	lactated ringers
LS	lumbosacral
L-spine	lumbar spine
LSC	left subclavian
LSD	lysergic acid diethylamide
Lt	left
LTV	long term variability
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LVF	left ventricular failure
LVH	left ventricular hypertrophy
LVN	Licensed Vocational Nurse
L&W	living and well
LWBS	left without being seen
lymph	lymphocyte
lytes	electrolytes

M

M	male
m	minim
M1	mitral first sound
M2	mitral second sound
MA	milliamperes
MAC	monitored anesthesia care
macro	macrocytic(scopic)
MAE	moves all extremities

man.	manual(ly)
MAR	medication administration record
MAT	multifocal atrial tachycardia
max.	maximum
MAX A	maximum assistance
MCA	motorcycle accident
mcg	microgram
MCH	mean corpuscular hemoglobin
MCL	mid clavicular line
MCV	mean corpuscular volume
MD	Doctor of Medicine
mec	meconium
MED/SURG	medical/surgical unit
meds.	medications
MEF	maximal expiratory flow
mEq	milliequivalent
mg	milligram
Mg.	Magnesium
mgmt.	Management
mgr.	Manager
MI	myocardial infarction
micro	microscopic(cytic)
mid.	middle
MIN A	minimal assistance
min.	minute
ml	milliliter
Mlat	mediolateral
mm	millimeter
MMT	manual muscle test
mn	midnight
mo.	month
mob.	mobility
mod.	moderate(ly)
MOD A	moderate assistance
MOM	milk of magnesia
Mon.	Monday
monos	monocytes
MR	mitral regurgitation
MRI	Magnetic Resonance imaging
MRSA	methicillin resistant staphylococcus aureus
MS	morphine sulfate
M/S	multiple sclerosis
MSG	massage
MSS	medical social services
MSW	Medical Social Worker
MT	Medical Technologist

MTT	manual therapy
M+T	myringotomy and tubes
multip	multiparous
MVA	motor vehicle accident
MVP	mitral valve prolapse
MVV	maximum voluntary ventilation

N

N	nitrogen
N/A	not applicable
Na	sodium
N.A.	nursing assistant
NaCl	sodium chloride
NAD	no acute distress
NaHCO3	sodium bicarb
NB	newborn
NBN	newborn nursery
N/C	no charge
neg	negative
neuro	neurology(ist)(ical)
NG	nasogastric
NGT	nasogastric tube
NH3	ammonia
NICU	Neonatal Intensive Care Unit
NIDDM	noninsulin dependent diabetes
NKA	no known allergies
NKDA	no known drug allergies
NKDC	nonketotic diabetic coma
NKHHC	nonketotic hyperglycemic-hyperosmolar coma
nl	normal
NMES	Neuromuscular Electrical Stimulation
NN	nerves
No.	number
noc	at night (nocturia)
norm.	normal
NP	non-productive
NPO	nothing by mouth
NS	normal saline
N/S	no show
NSA	no significant abnormality
NSAID	nonsteroidal anti-inflammatory drugs
nsg.	nursing
NSR	normal sinus rhythm
NST	non-stress test
NSY	nursery

NT	non-tender
N/T	not tested
N&T	nose and throat
NTG	nitroglycerine
nullip	nulliparous
N&V	nausea and vomiting
NWB	nonweight bearing

O

O2	oxygen
OA	occiput anterior
OB	obstetrics
obl	oblique
OBS	organic brain syndrome
occ	occasional
OCG	oral cholecystogram
OCT	oxytocin challenge test
O.D.	right eye
od	overdose
OK	okay
OM	otitis media
OME	otitis media with effusion
OOB	out of bed
OPD	outpatient department
ophth	opthalmology
OPS	outpatient surgery
OR	operating room
ORIF	open reduction internal fixation
ortho	orthopedics
O.S.	left eye
os	mouth
O.T.	occupational therapy
O.U.	both eyes
oz	ounce

P

p	after
P	pulse
pa	pulmonary artery
PA	Physician Assistant
P&A	percussion and auscultation
PA-C	Physician Assistant-Certified
PAC	premature atrial contractions
PACO2	partial pressure carbon dioxide (arterial)

PACU	post anesthesia care unit
PAEDP	pulmonary artery end diastolic pressure
PAF	paroxysmal atrial fibrillation
PAFIB	paroxysmal atrial fibrillation
PA&L	poseterior, anterior and lateral chest x-ray
palp	palpate(ion)
PAP	Papanicolaou smear(test)
PAR	post anesthesia room
Para	parous(number of viable children)
PAT	paroxysmal atrial tachycardia
pap	papanicolaou, smear test
para	parity
path	pathology
PAWP	pulmonary artery wedge pressure
PBI	protein bound iodine
p.c.	after meals
PCA	patient controlled analgesia
PCE	physical capacity evaluation
PCL	posterior cruciate ligament
PCN	penicillin
pCO2	partial pressure CO2
PCV	packed cell volume
PCWP	pulmonary capillary wedge pressure
PDA	posterior descending artery
PDR	Physician's Desk Reference
PE	physical examination
PE tubes	pressure equalizaer tubes
ped.	pediatric
PEG	percutaneous endoscopic gastrostomy
PEEP	positive end expiratory pressure
per	by or through
peri	perineal
PERRLA	pupils equal, regular, react to light and accommodation
pf	plantar flexion
PF	peak flow
PFT	pulmonary function test
pg.	page
pH	hydrogen iron concentration
PH	past history
phal	phalanx
PI	present illness
PID	pelvic inflammatory disease
PIP	proximal interphalangeal joint
Pit	pitocin
PJC	premature junctional contractions
PKU	phenylketonuria

P.M.	afternoon
PMD	private medical doctor
PMH	past medical history
PMI	point of maximum impulse
PMR	polymyalgia rheumatura
PMS	premenstrual syndrome
PN	parenteral nutrition
PNC	premature nodal contraction
PND	paroxysmal nocturnal dyspnea
pneumo	pneumoencelphalogram
PNG	peripheral nerve glides
P.O.	phone order
p.o.	per mouth
pO2	partial pressure of oxygen
pO4	phosphate
POC	position of comfort
POD	postoperative day
Polys	polymorphonuclear leukocytes
POS	positive
post	posterior
postop	postoperative
POT	plan of treatment
POV	private vehicle
PP	postpartum
P&PD	percussion and postural drainage
PPD	purified protein derivative (tuberculin)
PRBC	packed red blood cells
PRBOW	prolonged ruptured bag of waters
pre	before
preg.	pregnancy
preop	preoperative
prep	preparation
prev.	previous
primip	primiparous (first birth)
prn	as necessary; when indicated
PROM	premature rupture of membranes
iPROM	prolonged ruptre of membranes
prog	progress
pro time	pro-thrombin time
prox.	Proximal
PSIS	posterior superior iliac spine
P.T.	physical therapy(ist)
PT/PTT	pro-thrombin/partial thromboplastin (time)
pt	patient
PTA	Physical Therapy Assistant
P.T.A.	prior to admission

PTC	prior to consult
PUD	peptic ulcer disease
PUW	pick-up walker
PVC	premature ventricular contractions
PWB	partial weight bearing
PXR	portable chest xray

Q

q	every
qam	every morning
qh	every hour
qhs	every bedtime
qid	four times a day
qns	quantity not sufficient
qs	to make sufficient quantity
qt	quart
QUAD	quadrant
quads	quadriceps

R

R	right
(R)	rectal thermometer
RA	rheumatoid arthritis
Rad	radiology
RB	read back
RBBB	right bundle branch block
RBC	red blood cell
RBOW	ruptured bag of water
RBS	random blood sugar
RCNA	restorative certified nursing assistant
R.D.	Registered Dietitian
RDS	respiratory distress syndrome
recert.	recertification
reg.	regular
rehab	rehabilitation
reps	repetitions
resp.	respiration(ory)
resist.	resistance
Rh	Rhesus factor
RHD	rheumatic heart disease
RHIT	Registered Health Information Technician
RL	ringers lactate
RLE	right lower extremity
RLH	right lateral heel

RLL	right lower lobe
RLQ	right lower quadrant
RMH	right medial heel
RML	right middle lobe
RN	Registered Nurse
RNA	ribonucleic acid
RNFA	Registered Nurse First Assistant
RNIP	Registered Nurse Interim Permittee
R/O	rule out
RO	routine orders
ROA	right occiput anterior
ROM	range of motion
ROP	right occiput posterior
ROS	review of systems
ROT	right occiput transverse
rot	rotation
RP	renal panel
RPR	rapid plasma regain test (for syphilis)
RR	respiratory rate
rrot	right rotator cuff
RSV	respiratory syncytial virus
R/T	released to
RTW	return to work
RTC	return to clinic
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription

S

s	without
SAB	spontaneous abortion
sang.	Sanguineous
SAQ	short arc quads
Sat	Saturday
sat	saturated
SBA	stand by assist
SBO	small bowel obstruction
SCH	supra condylar humerus
Schiz	shizophrenia
SCI	spinal cord injury
SCM	sternocleidomastoid (joint)
sec	second(s)(ary)
sed.rate	erythrocyte sedimentation rate (blood)

segs	segmented neutrophils
serol.	serology
serosang.	Serosanguineous
SF	side flexion
SFB	superficial femoral artery
S/G	Swan-Ganz
SGA	small for gestational age
SGOT	serum glutamic oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SH	social history
Shldr	Shoulder
SI	sacroiliac joint
SIADH	syndrome of inappropriate antidiuretic hormone secretion
SL	sublingual
SLE	systemic lupus erythematosus
SLR	straight leg raising
SNF	skilled nursing facility
SOAP	subjective/objective/assessment/plan
SOB	shortness of breath
sol	solution
SOM	serous otitis media
S/P	status post
spec	specimen
SPgr	specific gravity
SR	sinus rhythm
SROM	spontaneous rupture of membranes
ss	one half
SS	soapsuds
SSE	soapsuds enema
SS#	social security number
S/S	signs and symptoms
stab	band cell
staph	staphylococcus
stat	at once
strep	streptococcus
STSG	split thickness skin graft
STV	short term variability
St WP	sterile whirlpool
Sub-L	sublingual
Sub-Q	subcutaneous
Sun.	Sunday
sup	superior
surg	surg(ical)ery
SVD	spontaneous vaginal delivery
SVDH	Sierra View District Hospital
SVT	supraventricular tachycardia

Sx	symptom
sym	symmetrical

T

T	thermoscan (thermometer)
T&A	tonsillectomy and adenoidectomy
tab	tablet
TAB	therapeutic abortion
T&C	type and crossmatch
TAH	total abdominal hysterectomy
TAR	treatment authorization request (MediCal)
TAT	tetanus antitoxin
T.B.	tuberculosis
TBA	to be admitted
T.C.	traffic collision
Tbsp	tablespoon
TCDB	turn, cough, deep breathe
TCDHS	Tulare County Department of Health Services
TCU	Transitional Care Unit
TEA	thromboendarterectomy
tech	technician(ologist)
TED	antithromboembolic stockings
temp	temperature
TENS	transcutaneous electrical nerve stimulator
TFT	Thyroid Function Test
THEX	therapeutic exercise
THR	total hip replacement
thru	through
Thur.	Thursday
TIA	transient ischemic attack
TIC	transitional inpatient care
tid	three times a day
tinct	tincture
TJR	total joint replacement
TKO	to keep open
TKR	total knee replacement
TLC	triple lumen catheter
TM	tympanic membrane
TMJ	temporomandibular joint
TMJD	temporomandibular joint dysfunction
TMs	tympanic membranes
TNS	transcutaneous nerve stimulation
TO	telephone order
tol.	tolerate(d)
TOLAC	trial of labor after cesarean

tomo	tomogram
TORB	telephone order read back
TORCH	toxoplasmosis, syphilis, rubella, cytomegaloviras, herpes
TPA	tissue plasminogen activator
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	transfer
trach	tracheostomy
tsp	teaspoon
T-spine	thoracic spine
Tues.	Tuesday
T.U.R.	transurethral resection
TURBT	transurethral resection of bladder tumor
TURP	transurethral resection of prostate
TVH	total vaginal hysterectomy
TV	tidal volume
Tx	treatment

U

U	uranium
Ua	urinalysis
UAC	umbilical artery catheter
U/C, UC	uterine contraction
UBW	usual body weight
U.C.	unit clerk
UCG	urine chorionic gonadotropin
UGI	upper gastrointestinal
UE	upper extremity
UF	ultrafiltration
UKE	unknown etiology
UMC	University Medical Center
UO	undetermined origin
Upper GI	upper gastrointestinal
URI	upper respiratory infection
Uro	urology(ist)
U.S.	both eyes
US	ultrasound
USP	United States Pharmacopoeia
UTI	urinary tract infection
UV	ultraviolet

V

VA	visual acuity
Vag	vaginal

VBAC	vaginal birth after cesarean section
VC	vital capacity
VCH	Valley Children's Hospital
VD	venereal disease
VDRL	Venereal Disease Research Laboratory
VE	vaginal exam
Vent	mechanical ventilator
VFD	visual field deficit
V-fib	ventricular fibrillation
via	by way of
Vit	vitamin
VO	verbal order
vol	volume
VORB	verbal order read back
VPB	ventricular premature beat
Vre	Vancomycin Resistant Enterococci
VS	vital signs
v, vs	versus
VSD	ventriculoseptal defect

W

w/a	while awake
WB	weight bearing
WBAT	weight bearing is tolerated
WBC	white blood count(cells)
W/C	wheelchair
WDWN	well developed, well nourished
W &	white female
W %	white male
Wed.	Wednesday
WFL	within functional limits
WIC	Women, Infants & Children (assistance program)
wk	week
wlkr	walker
wnd	wound
WNL	within normal limits
w/o	without
WP	whirlpool
wt	weight

X

x	times
XRT	radiation therapy

Y

yd.	yard
yrs	years

SUBJECT:	SECTION:
ADMINISTRATION OF MEASLES, MUMPS, AND RUBELLA VACCINE	**Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY

PURPOSE: Establish a population of health care professionals (HCPs), who will minimize the spread of measles, mumps and rubella in the healthcare setting. This will be accomplished through the establishment of a standard procedure to identify adults, especially HCPs, who meet established criteria by the Centers for Disease Control and Prevention (CDC) for those who required vaccination against measles, mumps and rubella.

A. **BACKGROUND**: Measles, mumps and rubella are 3 highly contagious but preventable diseases that may result in severe complications including pneumonia, encephalitis, parotitis, lymphadenopathy, deafness and even death. Health care workers are about 18% more likely than the general public to become infected during their regular course of work. The asymptomatic rate for the 3 contagious diseases ranges from 20% to 50%, which means that an infected individual may not even know that they are contagious. In addition to a generalized rash, rubella may result in pregnancy complications up to and including miscarriage or stillbirth. These severe complications may be avoided simply through vaccination against measles, mumps and rubella.

B. **PREREQUISITES**: According to the Centers for Disease Control and Prevention (CDC), adults/HCP who meet the following criteria are eligible for eligible for MMR vaccination:

   a. Those with no history of acceptable evidence of immunity against measles, mumps or rubella including:

      i. Born after 1957
      ii. No written documentation of two doses of measles-containing vaccine administered after the first birthday
      iii. No laboratory evidence of immunity
      iv. No laboratory confirmation of disease

C. **PRECAUTIONS**: The following precautions should be considered prior to vaccination:

   a. Recent receipt (<11 months) of antibody containing blood product(s). The specific interval depends on the blood product received.
   b. A history of thrombocytopenia or thrombocytopenic purpura
   c. A recent moderate or severe acute illness with or without fever
   d. A clinical need for tuberculin skin testing or interferon gamma release assay (IGRA) testing. If active TB is suspected, MMR vaccination should be delayed
   e. A history (individual or family) of seizures

D. **PLAN**: Establish immunization against measles, mumps and rubella by vaccinating all adults, especially HCPs who are in need of vaccination and meet the criteria for vaccination

   a. Treatment:

i. Screen all adults for contraindications and precautions to measles, mumps and rubella vaccine
ii. Provide a copy of the most current Vaccine Information Statement (VIS) to the vaccine recipient. You must document in the medical record or office log the publication date of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language if available. These documents may be found at www.immunize.org/vis
iii. Administer the manufacturer's recommended dose of MMR vaccine, subcutaneous (SC), using a 23-25g, 5/8-3/4 inch needle in the posterolateral section of the upper arm.
iv. For adults in need of second doses of MMR, observe a minimum interval of 4 weeks between the first and second doses.

b. Documentation:

i. Medical chart – record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine.
1. **IMPORTANT** - If the vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal).

c. Pediatric Patients (under 18 years of age)

i. For all pediatric patients, educate patient/parent/care provider to follow up with primary care physician for vaccination.

E. PROFESSIONAL REQUIREMENTS FOR ADMINISTRATION:

a. Education: Licensed personnel (e.g. LVN, RN, MD)
b. Training: As required by initial and annual internal competencies
c. Experience: N/A
d. Initial Evaluation: Review of CDC immunization criteria, SBMC Standardized Procedures for immunization
e. Continuing Evaluation: Annually

REFERENCES:

Centers for Disease Control and Prevention. (2021, January 26). *Measles, mumps, and rubella (MMR) vaccination.* Centers for Disease Control and Prevention. Accessed 2023, October 27 at the website https://www.cdc.gov/vaccines/vpd/mmr/public/

Centers for Disease Control and Prevention. (2021b, January 26*). Routine MMR vaccination recommendations: For Providers.* Centers for Disease Control and Prevention. Accessed 2023, October 27 at https://www.cdc.gov/vaccines/vpd/mmr/hcp/recommendations.html#print

Centers for Disease Control and Prevention. *Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. MMWR 2011;60 (No. 7):[1 - 46]. Accessed 2023, October 27 https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

The Joint Commission (2023). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.01.05.01, EP1

SUBJECT: **BLOOD & BLOOD COMPONENTS, ADMINISTRATION OF**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 8**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- Provide guidelines for preparation, administration and monitoring of the patient receiving a blood transfusion.
- To ensure that the treating physician has obtained an informed consent from the patient.
- To provide the patient with the opportunity to exercise the right to give an informed consent or refusal for the transfusion recommended by the physician.
- To provide the patient with the opportunity to acknowledge that the physician adequately explained the benefits, risks, complications, alternatives to transfusion and discussed all information concerning the transfusion to the patient's satisfaction.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to verify, by means of the Blood & Blood Component Transfusion Record, that the patient's informed consent has been obtained by the treating/attending physician, before the patient receives a blood/blood component transfusion.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

EQUIPMENT:

1. IV pole and infusion pump
2. Solution of 0.9% Normal Saline IV bag
3. IV #18 or #20 gauge needle/catheter and accompanying equipment per IV Start Procedure
4. Blood administration set (Y-tubing with specific filter)
5. Prepared transfusion administration form / "pick-up slip"
6. Blood warmer (physician order is required for non-emergent use)
7. Pressure Infusion Cuff (physician order required)
8. Gloves

PROCEDURE:

PHYSICIAN RESPONSIBILITIES:

1. It is the exclusive duty and responsibility of the attending and/or treating physician to obtain informed consent.

2. It is the responsibility of the attending and/or treating physician to document in the medical record that a discussion was held with the patient, and that an informed consent was given. Any special circumstances should also be documented. The physician may also place into the record a copy of any written material he/she gave to the patient.

HOSPITAL PERSONNEL RESPONSIBLITIES:

1. If, at the time the Transfusion Consent Form is presented to the patient, the patient voluntarily indicates doubt or confusion about the blood/blood component transfusion and consequently there is a question raised as to whether or not informed consent has been obtained, the physician will be contacted immediately. Under no circumstances should the healthcare provider (e.g. Registered Nurse) attempt to obtain the patient's informed consent in such a situation.

2. Although the hospital personnel cannot and should not be responsible for securing the patient's informed consent and for giving the patient the information that is required in order to secure the patient's informed consent, it can be expected that patients will ask hospital staff who are performing a procedure pursuant to the physician's orders, questions about what they will be or are doing. Hospital personnel generally may answer such questions.

3. If it appears that the patient has significant questions about the nature of the procedure and its benefits or risks, which indicate that he/she may not have been given sufficient information about the transfusion or does not understand the information he/she was given, the hospital personnel should contact the patient's physician in order to allow him/her to answer the questions and thereby help to ensure that the patient has given an informed consent to the transfusion procedure.

COMPLETING THE HOSPITAL'S CONSENT FORM:

1. ***Time and Date of Signature***: The time and the date on the form should be the time and date the form is signed by the patient or the patient's legal representative, the date and time of the transfusion.

2. ***Witness***: One person should serve as a witness, then the patient or the patient's legal representative signs the form. The witness should be a responsible staff member of SVMC who, according to licensure or experience, understands the information provided.

PACKED RED BLOOD CELLS (PRBC) AND FRESH FROZEN PLASMA (FFP)

A. Ordering and Obtaining Blood Products

1. A physician order will include the component requested and number of units to be infused.

2. Explain the procedure to the patient and obtain written authorization.

3. The laboratory will draw a second sample of blood for T&C at a separate phlebotomy to reduce the risk of error in transfusion for non-emergent red cell transfusions, when patients have been ordered to receive packed cells and have no prior history of blood type. In the event of an emergent need for blood, the emergency release protocol will be followed (See Lab policy on comparison of past blood bank records).

B. Obtain blood product(s) from the lab.

1. Ascertain from the electronic record that the blood product is ready for use. Take the request for blood component slip, or "pick-up slip," to the lab. *This must be signed by the blood bank technologist and the clinical representative. This slip becomes part of the medical record.*

2. A clinical representative, defined as an employee in a clinical service and designated by the Charge Nurse, can pick up the blood and will double check the following with the blood bank technologist: If any of the information is missing or does not match, the blood cannot be released (Exception: type compatible but not type specific units).

   a. Patient's name

   b. Identification number

   c. Blood group, Rh type and antibody screen,

   d. Donor number

   e. Donor blood group and Rh type

   f. Expiration date and time

   g. Blood product ordered

3. Blood Bank Technologist, clinical representative, RN/LVN will sign the Blood Bank computer-generated Unit Issue Card, which becomes a part of the medical record. The record will be printed with all the pertinent patient blood bank information. There must be exact verification of all information before the unit leaves the blood bank.

NOTE: No more than 1 unit is to be removed from the Blood Bank at a time with the exception of a massive bleed, transfusion during dialysis or surgical patient with monitored refrigeration available for storage.

C. Preparing the patient

1. Provide transfusion reading material to the patient and/or family member(s) and allow for questions.

2. Obtain transfusion informed consent after the physician has spoken to the patient.

   a. Patient must agree and sign consent to the administration of blood/blood product(s) prior to the transfusion and prior to staff picking up the blood from the Blood Bank. If the patient refuses the transfusion, the refusal form must be completed.

3. Established IV access with #18 gauge catheter (preferred) prior to obtaining blood from Blood Bank. A #20 gauge catheter may be used in the event that a larger vein is not accessible. A #23 gauge catheter may be used for pediatric patients. ***(See pediatric policy: "Pediatric Blood Transfusion")***

4. Vital signs, including temperature, will be taken and recorded in the Transfusion Administration Record prior to start of transfusion.

D. At the bedside

1. The blood product will be verified by the transfusionist and scanned as the second verification. Scanning should include all indicators as listed below in order to qualify as the second verification. If unable to scan, the blood product can be verified with two (2) qualified licensed staff against the "Transfusion Administration Record" at the bedside. The one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient. At least two unique identifiers are used in the verification process and will be conducted after the blood or blood component matching the order has been issued or dispensed. The following information will be verified:

   a. Patient's name

   b. DOB

   c. Patient Account Number

   d. BBK#

e. Blood unit number

f. Donor blood group and Rh type

2. The patient's identification is verified by checking the name, date of birth and BBK.

3. The two (2) licensed staff sign in the space provided on the "Transfusion Record" if scanning is not used.

E. Preparation for Transfusion

1. Wash hands thoroughly. Put on gloves.

2. Run 0.9% Normal Saline solution through the "Y" tubing to remove air and clamp tubing. Make sure the fluid level in the drip chamber is above the entire filter.

3. Gently agitate the unit of blood to distribute all the cells.

4. Gently open either outlet of the plastic blood container.

5. Insert the "Y" tubing into the blood container.

F. Administration

1. Check the patient's vital signs and record on the Blood Administration Record.

2. Check to make sure that the IV site is patent. Apply arm board, if necessary, and then begin transfusion.

3. Check IV insertion site, rate of flow, and monitor for side effects. Vital signs are taken every 15 minutes times two, then PRN and at the completion of the transfusion.

4. Observe the patient closely for signs of reaction, e.g. fever (2 degrees F above the baseline), chills, rash, flank or back pain, hypotension (30mmHg below baseleine), dypnea, or uticaria (hives). ***Stop the transfusion if a reaction is suspected.*** Review "Blood & Blood Components, Transfusion Reaction" Policy.

   ***NOTE**: If a hemolytic reaction or anaphylactic reaction is going to occur, it usually will happen after a very small volume of blood enters the patient's circulation. A febrile reaction (2 degrees F above the baseline) may occur at any point during the transfusion or even after the transfusion.*

G. Completion of Transfusion

1. Clamp blood component bag.

2. If another unit of blood is to be transfused, obtain from the laboratory and repeat above steps. If transfusion is completed, flush the line with solution of 0.9% Normal Saline and resume parenteral infusion or maintain IV lock.
   NOTE: The filter within the "Y" tubing can be used for a maximum of four hours or two units of packed red blood cells. If maximum time or number of units has been reached, the tubing must be changed prior to the administration of additional units of blood.

3. Remove blood products and tubing
   a. Dispose of blood bag and tubing in appropriate biohazard container.
   b. Return blood bags to the lab only when a reaction is suspected.
   c. The Unit Issue Card is affixed to the patient's lab sheet in the medical record.

4. Document the patient's response to the transfusion.

PLATELETS

A. Platelets should be infused rapidly due to loss of viability (1.5 to 2 hours, but less than 4 hours).

B. Use the same procedure as when ordering and verifying PRBC's.

FRESH FROZEN PLASMA (FFP)

A. Use same procedure as when ordering and verifying PRBCs.

NOTE: Laboratory will need 30 minutes advance notification to thaw the unit.

B. Administration rate for adult infusion of FFP should be at 200ml/hr. Give slowly if circulatory overload is a potential problem.

SPECIAL CONSIDERATIONS

A. Blood components must be started within 30 minutes after being signed out from Blood Bank, and should be completely infused within 4 hours.

1. Unused blood should be returned immediately to the Blood Bank within 30 minutes of issue.

2. If the blood is returned after 30 minutes, it may not be re-issued and must be discarded by the Blood Bank.

3. Blood should not be laid in the sunlight, on top of microwave units, or near a heat source that could result in prolonged warming.

4. No drugs or fluids other than 0.9% NaCl should be given through the IV port where the blood is infusing.

B. Informed consent must be signed prior to administration of blood component(s).

C. Reading material must be provided to the patient and/or family. A "Patient's Guide to Blood Transfusions" by the California Department of Health Services will be provided in English. Pamphlets will also be available in Spanish.

D. The patient has the right to refuse the transfusion.

E. Type and screen is good for 72 hours but still requires a cross match before blood is made available.

F. Massive Bleed Protocol and initiation of process to obtain large amounts of blood rapidly:

1. In the event of a Massive Bleed (e.g. gun shot in the ED, DIC in the OR or OB), the provider will direct the RN to contact blood bank and state "Emergency release of uncross matched blood for a massive bleed in _____."

2. Blood bank will issue 2-4 units of PRBCs and 1 unit of FFP upon request, per specific situation and will work closely with nursing services to provide continued blood products as needed. Cross matched blood will be utilized upon availability.

3. Responsible physician will sign for release of uncross matched blood upon completion of the procedure.

DOCUMENTATION

A. Complete all information on the "Transfusion Administration Record"

REFERENCES:

- Kelly, William (2022). Health and Willness. Blood transfusion reactions: a comprehensive nursing guide. obtained from https://healthandwillness.org/blood-transfusion-reactions/

- Nettina, S. (2019). Manual of Nursing Practice, 11th edition. Ambler, PA. Lippincott Williams and Wilkins. pp 777-789.

- The Joint Commission (2023). Laboratory & Point-of-Care accreditation standards. QSA 05.18.01 EP1, EP 2, & EP3 Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCES:

- *Pediatric Blood Transfusion* – SVMC Policies and Procedures
- *Blood and Blood Components, Transfusion Reaction* – SVMC Policies and Procedures

SUBJECT:	SECTION:
CERTIFIED NURSING ASSISTANT CERTIFICATION VERIFICATION	**Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

It is the policy of this facility to hire only nursing assistants who are currently certified by the state in which they are employed.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANT (CNA), HUMAN RESOURCES*

PROCEDURE:

1. Human Resources will obtain a copy of the Nursing Assistant certification identification card.

2. Human Resources will verify Certified Nursing Assistant's current status by contacting the State Nurse Aid Registry prior to employment. This also includes a criminal background check. (See State Nurse Assistant Registry Reference Check.) Out-of-state registries will be contacted when there is evidence that the nurse assistant was employed out of state.

3. The Staff Developer verifies the Certified Nursing Assistant's certification during the employee's annual review process.

4. The Staff Developer will conduct the following competencies for all CNAs upon hire and annually thereafter:

    a. Communication personal skills

    b. Basic nursing and personal skills

    c. Mental health and social services needs

    d. Basic restorative services

    e. Resident's rights and responsibilities

5. Annual performance reviews will be completed by the Director and Staff Developer, which includes annual competencies identified in this policy and any special needs of residents identified by unit staff.

6. All Certified Nursing Assistants will be provided a minimum of 24 hours of in-service education per year.

REFERENCES: Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, HR. 01, 02, 05/EP-2, EP-3, EP-6, San Francisco, California,

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75 (e) United States of America, Med Pass Inc.

- California Department of Public Health (2020). Licensing and Certification. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LandCProgramHome.aspx.

SUBJECT: **CHANGE IN RESIDENT CONDITION**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To clearly define guidelines for timely notification of a change in resident condition.

POLICY:

It is the policy of this facility that all changes in resident condition will be communicated to the physician and family or legal representative.

AFFECTED PERSONNEL/AREAS: *NURSING STAFF (RN, LVN)*

PROCEDURE:

1. Acute Medical Change

   a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician using SBAR (Situation, Background, Assessment, Recommendation) report format with a request for prompt physician visit and/or acute care evaluation. The licensed nurse in charge will notify the physician AT ONCE.

   b. If unable to contact attending physician or alternate physician IN A TIMELY MANNER, NOTIFY MEDICAL DIRECTOR FOR FOLLOW–UP TO CHANGE IN RESIDENT CONDITION.

   c. The responsible party for making medical decisions regarding the resident will be notified that there has been a change in the resident's condition and what steps are being taken. (The resident may be the responsible party.)

   d. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met.

2. Routine Medical Changes/Need to Alter Treatment Significantly

   a. All symptoms and unusual signs will be communicated to the physician promptly. Routine changes are minor changes in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening, and weight loss or gain.

   b. The nurse in charge is responsible for notification of physician and family or legal representative prior to end of assigned shift when a change in a resident's condition is noted.

   c. If unable to reach physician, all calls to physicians or exchanges requesting callbacks will be documented on the Nursing Notes.

d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow-up.

e. If unable to contact attending physician or alternate IN A TIMELY MANNER, notify Medical Director and Nursing Director for response and follow-up to change in resident status.

f. Document resident change of condition and response in Nursing Notes, and update resident care plan as indicated.

g. All attempts to reach the physician and responsible party will be documented in the Nursing Notes. Documentation will include time and response.

3. Accident with Injury

a. Any injury that occurs as the result of an accident will be communicated to the physician and the family or legal representative promptly. A request for a prompt physician visit and/or acute care evaluation will be made by the licensed nurse in charge.

b. If unable to contact attending physician or alternate physician IN A TIMELY MANNER, NOTIFY MEDICAL DIRECTOR FOR FOLLOW–UP TO CHANGE IN RESIDENT CONDITION.

c. The responsible party for making medical decisions regarding the resident will be notified that there has been a change in the resident's condition and what steps are being taken. (The resident may be the responsible party.)

d. All nursing actions will be documented in the licensed progress notes as soon as possible after the resident needs have been met.

e. Notify State of California Health and Human Services Agency within 24 hours and fill out the SOC341 form (see Abuse Binder).

4. Decision to Discharge or Transfer

a. If a decision to transfer or discharge a resident is made, the charge nurse will notify the family or legal representative promptly.

b. All attempts to notify the family or legal representative will be documented in the Nursing Progress Notes. The documentation will include time and response.

5. Change in Room or Roommate

a. Refer to Social Service Policy Changes in Room/Roommate.

6. Change in Resident Rights

a. See Social Service Policy Notification and Excision of Rights and Responsibilities.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (3-E), San Francisco, California, Title 22.
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (lli) United States of America, Med Pass Inc.

SUBJECT: **CHANGE OF SHIFT REPORT**	SECTION:

PURPOSE:

To provide communication and continuity of resident care.

POLICY:

It is the policy of this facility that a resident status report will be given at each change of shift.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

PROCEDURE:

LICENSED

1. On-duty nurse prepares the nursing report which includes pertinent information:
    a. Change of condition
    b. Transfers, discharges
    c. Admissions
    d. Medications/treatment changes
    e. Any unusual occurrence or event
    f. Resident/family complaints
2. Report is given to the on-coming nurses for the next shift, during walking rounds.
3. This cycle is repeated every shift.

LICENSED TO NON-LICENSED (CNA)

1. Non-licensed staff will meet with the licensed staff at the designated time for report.
2. CNA staff going off duty will do walking rounds/ ADL Care with the oncoming CNA staff.
3. Licensed staff will give information pertaining to their specific assignments, which will include:
    a. Special needs
    b. Change of condition

4. This cycle is repeated every shift.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 2547, San Francisco, California, Title 22.

SUBJECT: **CHARTING**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to provide consistency in documentation of resident status and care given by Nurse Assistant staff.

POLICY:

It is the policy of this facility that the Certified Nurse Assistant (CNA) will document the care given to their assigned residents on a daily basis. He/she will complete the CNA Activities of Daily Living (ADL) Record in the electronic medical record (EMR), which indicates the resident's level of independence or dependence in functional activities of daily living, their behavior and general nursing care given. General observations of the resident's response to care may be documented on the designated area of the ADL Record. The Nurse Assistant will encourage each resident to participate in completion of ADL tasks to the greatest extent possible to foster resident independence in accordance with the resident's plan of care.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSE ASSISTANTS (CNAs)*

PROCEDURE:

1. Each Nurse Assistant will complete the CNA ADL Record for their shift on each resident assigned to their care.

2. Daily care will include, but is not limited to:

   a. Feeding – Percentage of each meal consumed, substitutes offered and amount eaten, the level of assistance required, where the resident takes their meals, and nourishments and fluids offered or if independent in taking fluids.

   b. Body Care – Personal hygiene care including bathing, oral care, hair and nail care, skin care, bed mobility and repositioning and pressure reducing devices used. Indicate level of independence and/or assistance required.

   c. Bowel and Bladder – Toileting methods used, level of contingency (includes presence of indwelling catheters), number of continent or incontinent voiding or eliminations, special care rendered peri care, catheter care, enema.

   d. Behavior – Resident behavior patterns.

   e. General Nursing Care – General nursing measures which are provided on a daily basis and may vary with resident. Indicate level of independence and/or assistance required.

3. Any new or significant change in the resident's condition will be reported to the licensed nurse immediately to enhance nursing intervention.

4. Bowel and bladder retraining will be documented on the appropriate form(s) according to policy and procedure.

5. Explanation for charting in the Electronic Medical Record:

6. Use care item choices as indicated for:

    a. DP/SNF VITAL SIGNS
    b. SHOWERED WITH ASSISTANCE
    c. INTAKE AND OUTPUT
    d. ORAL CARE
    e. AMBULATE WITH ASSISTANCE
    f. BED BATH PROVIDED
    g. DP/SNF NEUTRASHIELD
    h. NON-SKID FOOTWEAR
    i. CHANGE WATER PITCHER LINING
    j. TRANSFER WITH ASSIST
    k. TOILETING WITH ASSIST
    l. ELIMINATION RECORD
        i. GU SYMPTOMS
        ii. URINE CHARACTERISTICS
        iii. BOWEL PATTERN
        iv. STOOL
    m. FALL PADS
    n. WAFFLE CUSHION OR PRESSURE RELIEF DEVICE

REFERENCES:

- California Code of Regulations (2019). Title 22, Division 5, Chapter 3, Article 5, Section §72547. Retrieved from https://govt.westlaw.com/calregs/Document/I4E75E6D05F7B11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).

SUBJECT: **CIWA-Ar: ASSESSMENT AND TREATMENT OF ACUTE ALCOHOL WITHDRAWAL**	SECTION: **Page 1 of 14**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of this policy is to ensure a standard approach to the treatment of patients suffering from an acute alcohol withdrawal syndrome (AWS).

DEFINITIONS:

1. CIWA-Ar: Clinical Institute Withdrawal Assessment Revised
2. CPOE: Computerized Physician Order Entry
3. AWS: Alcohol Withdrawal Syndrome
4. RASS: Richmond Agitation Sedation Scale
5. Delirium Tremens (DTs): A rapid onset of confusion, auditory, and/or visual hallucinations usually caused by AWS. Occasionally, a very high body temperature or seizures may result in death.

POLICY:

A. It is the policy at Sierra View Medical Center (SVMC) to treat all patients suffering from AWS in a manner as to minimize withdrawal signs and symptoms without placing the patient in any danger of over sedation.

B. Any clinical history/assessment of alcohol abuse/withdrawal/dependence or anything else that elicits suspicion of potential AWS should initiate the CAGE questions (See CIWA-Ar ALCOHOL WITHDRAWAL SYNDROME (AWS) ORDER SET (see addendum 2 below)) and 2 positive responses to any of the four questions should be brought to the attention of the admitting physician.

C. Upon Physician's diagnosis of acute alcohol withdrawal syndrome, they are encouraged to place an order for the CIWA-Ar ALCOHOL WITHDRAWAL SYNDROME (AWS) ORDER SET (see Addendum 2 below). The RN is then to follow the procedural instructions as outlined in the aforementioned order set, which will be provided in the electronic medical record (EMR).

D. Registered Nurses will utilize the CIWA-Ar (CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED) ASSESSMENT QUESTIONAIRE (see addendum 1 below) to approximate the patient's current level of alcohol withdrawal. This assessment will be performed and calculated via Meditech (EMR). Depending on the outcome of the patient's score, they will be stratified into either Mild, Moderate or Severe as described below. Whether or not to transfer the patient should not be based solely on the outcome of the CIWA score. It should be based on the multidisciplinary clinical assessment of both the RN and Physician, with the final judgment belonging to the physician.

1. CIWA Score < 8 = **Mild** AWS = recommended department is minimally **Med-Surg.**
    a. Assess and document **q4hrs.**

2. CIWA Score ≥ 8 ≤ 15 = **Mild/Moderate** AWS = recommended department is minimally **Med-Surg**, but if deemed unmanageable by Med-Surg RN and Physician judgment, then transfer to **Telemetry.**

   a. Assess and document **q4hrs** on **Med-Surg.**
   b. Asses and document **q2hrs** on **Telemetry.**

3. CIWA Score ≥ 16 ≤ 25 = **Moderate/Severe** AWS = recommended department is minimally **Telemetry,** but if deemed unmanageable by Telemetry, RN and Physician judgment, then transfer to the **ICU.**

   a. Assess and document **q2hrs** on **Telemetry**
   b. Assess and document **q1hr in the ICU.**
   c. Whenever patient is transferred to ICU for AWS, RASS (see Addendum 3 below) will be used primarily to assess the patient's level of AWS and subsequent sedative requirements.

4. CIWA Score CIWA > 25, RASS 4-5= **Very Severe/Delirium Tremens** AWS = patient must be in **ICU with physician at bedside.**

   a. Assess and document **q15min.**

AFFECTED PERSONNEL/AREAS: *PHYSICIANS, REGISTERED NURSES AND PHARMACISTS IN THE ED, ICU, TELEMETRY, AND MED-SURG DEPARTMENTS.*

PROCEDURE:

A. PHYSICIAN

1. Upon initial patient assessment, or during stay if delayed onset, determine if patient is suffering from AWS. If signs/symptoms of alcohol withdrawal are present, then place order for CIWA-Ar ALCOHOL WITHDRAWAL SYNDROME (AWS) ORDER SET via CPOE.

   a. Consider contraindications to protocol (see bottom of AWS Order Set/Addendum 2 below.)

2. If patient isn't currently in the appropriate acuity level, then consider transferring to a more suitable department according to clinical judgment; use their CIWA score as a guide.

   a. Use CIWA-Ar FLOW SHEET (see addendum 4 below) for guidance.

3. Be available to respond to any nursing concerns bedside, especially if CIWA score is > 25 or if RASS is 4-5.

B. PHARMACIST

1. Verify that there are no contraindications to the CIWA-Ar AWS Order Set.

2. Ensure the appropriate medications, routes and dosing intervals are being prescribed and administered in the appropriate departments.

3. Upon escalation or de-escalation between order sets, discontinue previous order set's medication orders. Ensure there is no ambiguity surrounding the active CIWA orders.

4. Assist RNs with protocol decisions whenever consulted.

C. REGISTERED NURSE

1. Upon receiving orders for the initiation of the CIWA-Ar AWS Protocol, utilize the 10 question CIWA-Ar (CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED) ASSESSMENT QUESTIONAIRE (see addendum 1 below) via Meditech to calculate the patient's current CIWA Score.

2. Assess and document the patient's CIWA score and vital signs at the appropriate time intervals as instructed in the CIWA-Ar AWS Order Set (see addendum 2 below.)

3. Contact the attending physician if patient's protocol dose is still ineffective 30 minutes after administration.

REFERENCES:

- Hoffman, R.S. Management of moderate and severe alcohol withdrawal syndromes. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on August 24, 2023).
- Diazepam, Lexicomp. (Accessed on August 24, 2023).
- Propofol, Lexicomp. (Accessed on August 24, 2023).
- Lorazepam, Lexicomp (Accessed on August 24, 2023).
- Precedex, Lexicomp (Accessed on August 24, 2023).

Addendum 1:

Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?"

Observation:
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"

Observation:
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart.

Observation:
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Observation:
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS –

Observation:
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"

Observation:
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?"

Observation:
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

Observation:
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION –

Observation:
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"

Observation:
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days

3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

REFERENCES:

- Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M (1989). Assessment of alcohol withdrawal: The revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar).

- Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357.

Addendum 2:

Sierra View Medical Center
Alcohol Withdrawal Syndrome (AWS) Order Set

CIWA-Ar (Clinical Institute Withdrawal Assessment) Order Set

Mild AWS	CIWA-Ar <8	Med-Surg (q4hr)
Mild/Moderate AWS	CIWA-Ar 8 to 15	Med-Surg(q4hr)/Telemetry(q2hr)
Moderate/Severe AWS	CIWA-Ar 16 to 25	Telemetry(q2hr)/ICU(q1hr)
Very Severe/Delirium Tremens	CIWA-Ar >25, use RASS	ICU with Physician ordering sedatives at bedside (q15min)

I) Indications: The decision to implement AWS Management with the CIWA protocol should be considered based on the following:

a. Two positive responses to any of the four CAGE questions:
- Have you ever felt you needed to **C**ut the dose of (decrease the amount of) your drinking?
- Have people **A**nnoyed you by criticizing your drinking habits?
- Have you ever felt **G**uilty about drinking?
- 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?

II) The four CAGE questions should be prompted by either of the following:

a. Any clinical history/assessment of Alcohol/Abuse/Withdrawal/Dependence
or

b. An answer of "daily" alcohol use.

III) ALCOHOL WITHDRAWAL SYNDROME INTERVENTIONS (Check all that are appropriate) (MD to order, RN may place as Telephone Orders if necessary):

- Wernicke Encephalopathy Prophylaxis (if not already ordered)
  - Thiamine 100mg IM/IVPB x 1 STAT, then Thiamine 100mg PO BID x 5 days
  - Folic Acid 1 mg PO BID x 5 days (first dose now)
  - Adult Multivitamin 1 tablet PO daily x 5 days (first dose now)
- AM Labs: Phosphate level, Magnesium Level, Potassium Level GGT, Liver Panel (if not already done)
- Urine Screen for Drugs of Abuse (if not already done within last 72 hours)
- Serum Alcohol Level
- Routine Psychiatric/Addictions Consultation (Social Services Referral)
- Discharge Planning (Case Management Referral)
- Encourage oral fluids x 96 hours (if not NPO)
- Start 0.9% Sodium Chloride IV at _____mL/hr.
- Start D5NS IV at _____mL/hr. (only AFTER Thiamine administered)
- EKG (if electrolyte derangements)
- Restraints
- Continuous Observation (1:1 Sitter)

IV) CIWA MEDICATION DETOXIFCATION

a. General

- Utilize CIWA-Ar (Clinical Institute Withdrawal Assessment) Nursing Flowsheet for CIWA ≤25 (if score is >16 and patient is not manageable on Telemetry then consider transfer to ICU and utilization of RASS (Richmond Agitation Sedation Scale))

- Document

  a. CIWA Score *plus vital signs* (if **CIWA ≤25**)

     i. Every 4 hours on Med-Surg for **Mild (CIWA <8) or Moderate** AWS (**CIWA ≥ 8 ≤ 15**)

- Do not automatically transfer patient to Telemetry when CIWA score is between 8 and 15, first try to manage with **Mild order set** (PO Lorazepam q4hr) on Med-Surg. May use Lorazepam 1mg IV x1 PRN breakthrough agitation after consulting with physician.

  b. Every 2 hours on Telemetry for **Moderate** AWS (**CIWA ≥8 ≤15**) or **Severe AWS (CIWA ≥16 ≤ 25.**

- Do not automatically transfer patient to ICU when CIWA score is between 16 and 25, first try to manage with **Moderate order set** (IV Lorazepam q2hr) on Telemetry. May use Lorazepam 2mg IV x1 PRN breakthrough agitation after consulting with physician.

2. RASS *plus vital signs* (**if CIWA ≥16 and not manageable on Telemetry**)

   a. Every 1 hour in ICU for **Severe** AWS

   b. Every 15 minutes in ICU for Very Severe AWS/DTs

   - Provide patient/family with printed "Alcohol Withdrawal" Lexicomp education materials
   - Educate patient to signs/symptoms of withdrawal and importance of reporting to staff
   - **Discontinue CIWA Order Set after score <7 for 48 hours**

b. CIWA Medication Options for **Med-Surg.**

Administer meds q4hours PRN based on results of CIWA score as indicated below
ORAL (PO) LORAZEPAM (ATIVAN)

- If CIWA-Ar score 2 to 6, give Lorazepam 0.5mg PO q4hPRN
- If CIWA-Ar score 7 to 11, give Lorazepam 1mg PO q4hPRN

- If CIWA-Ar score 12 to 15, give Lorazepam 2mg PO q4hPRN
- If at least 2 hours after last dose patient is still agitated and it appears AWS is worsening, then consult MD about giving Lorazepam 1mg IV x1 PRN breakthrough agitation and/or Seroquel (quetiapine) 25mg PO BID PRN breakthrough agitation.
- Initiate discussion with physician regarding the potential need to transfer patient to Telemetry for closer monitoring and more frequent assessment and dosing.
- If CIWA score ≥16 at any time, or the patient becomes unmanageable on the Med-Surg unit, or 2mg PO Lorazepam dose ineffective after 2hrs, then contact the physician.
- If patient is combative or RN needs immediate assistance call RRT or Code Grey.
- Consider transfer to Telemetry if patient requires maximum dose (2mg PO) of Lorazepam every 4 hours for 12 consecutive hours without improvement.

c. CIWA Medication Options for Telemetry.
Administer meds q2hours PRN based on results of CIWA score as indicated below

- INTRAVENOUS (IV) LORAZEPAM (ATIVAN)
  - If CIWA-Ar score 8 to 13, give Lorazepam 0.5mg IV q2hPRN
  - If CIWA-Ar score 14 to 19, give Lorazepam 1mg IV q2hPRN
  - If CIWA-Ar score 20 to 25, give Lorazepam 2mg IV q2hPRN

    If at least 30 minutes after last dose patient is still agitated and it appears AWS is worsening, then consult MD about giving Lorazepam 2mg IV x1 PRN breakthrough agitation and/or Seroquel (quetiapine) 25mg PO BID PRN breakthrough agitation.

    Initiate discussion with physician regarding the potential need to transfer patient to ICU for closer monitoring and more frequent assessment and dosing.

    - If CIWA score >25 at any time on the Telemetry unit or 2mg IV Lorazepam dose ineffective after 30 minutes, then contact the physician.
    - If patient is combative or RN needs immediate assistance call RRT or Code Grey.
    - Consider transfer to ICU if patient requires maximum dose (2mg IV) of Lorazepam every 2 hours for 4 consecutive hours without improvement.
    - If CIWA <7 for 4 consecutive hours, and no other clinical indication for Telemetry, then call physician to discuss downgrade to Med-Surg.

d. CIWA Medication Options for ICU , **use RASS for assessment if CIWA > 25.**
Administer meds q1hr PRN CIWA Scores 16-25 based on results of RASS as indicated below

- INTRAVENOUS (IV) LORAZEPAM (ATIVAN)
- If CIWA-Ar score 16 to 19, give Lorazepam 1mg IV q1hPRN
- If CIWA-Ar score 20 to 25, give Lorazepam 2mg IV q1hPRN
- if CIWA score <16 for 2 consecutive scores (2 hrs.)discuss downgrade to Telemetry.
- IF CIWA >25, then use RASS for assessment
  - **Contact physician**
  - If RASS +1, give Lorazepam 1mg IV q15min PRN restlessness
  - If RASS ≥ +2, give Lorazepam 3 mg IV q15min PRN agitation
    - if CIWA score <16 for 2 consecutive scores (30 minutes) discuss downgrade to Telemetry.

e. **Very Severe** AWS/Delirium Tremens (CIWA > 25, RASS 4-5 despite medication administration and/or Delirium Tremens) PHYSICIAN DRIVEN
******Physician must be notified and present at the bedside to give orders******

- If physician not present, then notify physician immediately
- Physician to give orders at the bedside
- If not already in ICU, then call Rapid Response Team and obtain order to transfer to ICU ASAP
- Goal RASS 0 to -2.

f. Medication Options for **Very Severe** (CIWA >25, RASS 4-5)
Upon verbal order from physician give IV Diazepam Bolus Orders (10mg, 20mg, or 40mg) q10min PRN until RASS 0 to -2

If patient is given 120mg of Diazepam IV within 30 minutes and still not calming, then consider the following options:

1. Patient Not Intubated:

   a. Dexmedetomidine (Precedex) infusion with CIWA Severe AWS medication options (Lorazepam IV q15min PRN)

2. Patient Intubated:

   a. Fentanyl and Propofol infusions per analgesia/sedation protocols

IMMEDIATELY NOTIFY PHYSICIAN FOR ANY OF THE FOLLOWING:

To modify medications and/or consider transfer to ICU for any of the following:

1) Any single CIWA is score is > 16
2) CIWA score remains > 11 after 24 hours of medication detoxification
3) Patient receives max dosage in last 24 hours (Ativan = 12 mg; Valium = 40 mg)
4) Patient has Seizure Activity, Severe or Sudden Disorientation/Hallucinations

5) Patient has Respiration Rate < 10/min

If patient has or develops any of the following contraindications to CIWA:

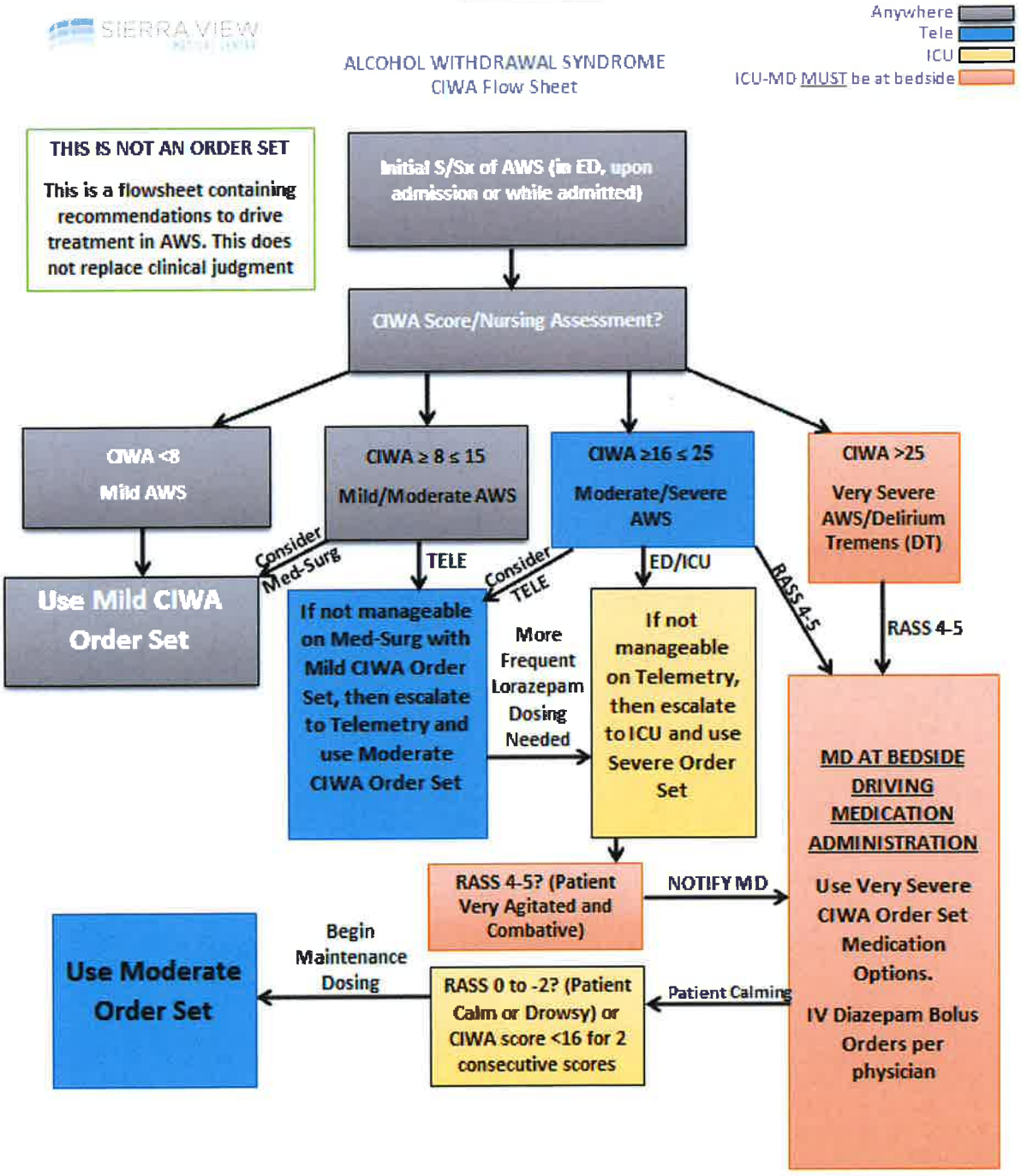
1) Paralysis
2) Pregnancy
3) Unable to take PO medications (if on mild/moderate AWS order set)
4) Severe or Poorly controlled Diabetes, Sepsis, or COPD
5) Requiring high dosages of Narcotic Pain Medications

Addendum 3

RASS score

Richmond Agitation & Sedation Scale		
Score	**Description**	
+4	Combative	Violent, immediate danger to staff
+3	Very agitated	Pulls at or removes tubes, aggressive
+2	Agitated	Frequent non-purposeful movements, fights ventilator
+1	Restless	Anxious, apprehensive but movements not aggressive or vigorous
0	Alert & calm	
-1	Drowsy	Not fully alert, sustained awakening to voice (eye opening & contact >10 secs)
-2	Light sedation	Briefly awakens to voice (eye opening & contact < 10 secs)
-3	Moderate sedation	Movement or eye-opening to voice (no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Un-rousable	No response to voice or physical stimulation

Addendum 4


SIERRA VIEW
ALCOHOL WITHDRAWAL SYNDROME
CIWA Flow Sheet
Anywhere
Tele
ICU
ICU-MD MUST be at bedside
THIS IS NOT AN ORDER SET
This is a flowsheet containing recommendations to drive treatment in AWS. This does not replace clinical judgment
Initial S/Sx of AWS (in ED, upon admission or while admitted)
CIWA Score/Nursing Assessment?
CIWA <8
Mild AWS
CIWA ≥ 8 ≤ 15
Mild/Moderate AWS
CIWA ≥16 ≤ 25
Moderate/Severe AWS
CIWA >25
Very Severe AWS/Delirium Tremens (DT)
Consider Med-Surg
TELE
Consider TELE
ED/ICU
RASS 4-5
RASS 4-5
Use Mild CIWA Order Set
If not manageable on Med-Surg with Mild CIWA Order Set, then escalate to Telemetry and use Moderate CIWA Order Set
More Frequent Lorazepam Dosing Needed
If not manageable on Telemetry, then escalate to ICU and use Severe Order Set
MD AT BEDSIDE DRIVING MEDICATION ADMINISTRATION
Use Very Severe CIWA Order Set Medication Options.
IV Diazepam Bolus Orders per physician
RASS 4-5? (Patient Very Agitated and Combative)
NOTIFY MD
Use Moderate Order Set
Begin Maintenance Dosing
RASS 0 to -2? (Patient Calm or Drowsy) or CIWA score <16 for 2 consecutive scores
Patient Calming

Addendum 5

If at any time Lorazepam becomes unavailable due to market shortages, recalls, etc. Sierra View Pharmacy will make an appropriate substitution in the protocol with therapeutically equivalent doses first moving to use Diazepam, then if also unavailable Midazolam. Doses in protocol may be rounded to nearest whole number to help prevent medication errors/discrepancies.

Approximate equipotent IV doses			
Potencies (IV):	Diazepam 10 mg	Midazolam 3 mg	Lorazepam 1.5 mg
Onset:	1 to 3 minutes	1 to 3 minutes	5 to 10 minutes
Peak:	1 to 3 minutes	5 minutes	30 minutes
The durations of effect for seizure control (the main consideration for severe alcohol withdrawal) for the listed medications are uncertain and vary depending on a range of factors (eg, severity of illness, nutritional status, liver function, age).			

SUBJECT: **CLINICAL DECISION UNIT ADMISSION CRITERIA**	SECTION: **PROVISION OF CARE, TREATMENTS & SERVICES**

PURPOSE:

To define the criteria for admission on the clinical decision unit.

POLICY:

Admissions will be processed efficiently and in an expedient manner. Every effort is made to facilitate the optimum care and placement of these patients.

AFFECTED PERSONNEL/AREAS: *CLINICAL STAFF*

PROCEDURE:

1. Clinical Decision Unit will be defined as Medical/Surgical beds 310-328

2. All members of the medical staff with admitting privileges may admit to the clinical decision unit.

3. Before admitting to the Clinical Decision Unit patient will be screened through Meghan's Law when mixing the pediatric population with the adult population. If patient appears in the Meghan's law search the patient will not be accepted to this area but place in the same level of care in a different area.

4. Patients may be admitted to Clinical Decision Unit in any of the following ways:

    a. **Direct Admissions** are admitted directly from their doctor's offices or their homes, with arrangements made by phone though the Utilization Review Department or the House Supervisor after hours. These patients may transport themselves to the hospital, and register at the Admitting Department after which they will be transported to the Unit. Orders should arrive with the patient. If no orders are received, the attending physician will be contacted to obtain orders.

    b. **Emergency Admissions** are admitted from the emergency room. Prior to transferring patients to the Clinical Decision Unit, emergency department personnel must confirm that transfer meets all criteria and orders for admission have been entered/written.

    c. **Transfer Patients** are admitted to Clinical Decision Unit from other units such as operating room (i.e. Surgical Day Care patients). Prior to transferring patients to the Clinical Decision Unit, the transferring department personnel must confirm that transfer meets all criteria and orders for admission have been entered/written.

CIRCUMSTANCES OF ADMISSION:

1. Patients admitted to the Clinical Decision Unit will have orders that specify:
   a. Admitting diagnosis and orders to admit as Surgical Day Care (SDC), Observation(OBS), or Inpatient status;
   b. Code status;
   c. Diet;
   d. Laboratory tests and procedures that need to be performed;
   e. Routine medications.
2. The RN assigned to the patient will notify the attending physician of the patient's arrival on the unit and of the patient's status.
3. Doctors will visit patients on the unit daily and provide appropriate medical documentation on their conditions.
4. The nursing staff will consider a patient's diagnosis, sex, age, and acuity level in placing him/her in a room.
5. Nursing responsibilities with regard to the newly admitted patient include:
   a. Compiling an admission database by the RN/LVN utilizing admission interventions and guidelines.
   b. The RN is responsible for completing and documenting the initial admission assessment and the general admission information.
   c. Developing a care plan initiated at the time of hospital admission.

INCLUSION CRITERIA:

- Hemodynamically stable
- Absences of ECG changes
- Initial cardiac biomarkers negative and continued serial monitoring
- Resolving pain
- Overflow

LIMITATIONS:

The unit is staffed and designed for patients who are hemodynamically stable. Patients who require remote telemetry monitoring must not have a new onset of cardiac problems or require acute intervention for cardiac arrhythmias. Patients who are NOT candidates for admission as Clinical Decision Unit include, but are not limited to:

- Pediatrics (those requiring remote telemetry monitoring will be transferred to a higher level facility)
- Registered Sex Offenders
- Patients with new onset of cardiac problems; requiring a cardiac drip (unless overflow from telemetry)
- Patients with elevated biomarkers and acute chest pain (unless overflow from telemetry)

NOTE: *Overflow in this area maybe from all other acute care areas including medical surgical, telemetry, and post-partum. Overflow patients will be assigned to a nurse competent in the level of care the patient is requiring*

REFERENCE:

- The Joint Commission (2021). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **COUNTS OF INSTRUMENTS, SPONGES AND SHARPS**	SECTION: **Page 1 of 7**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for performing sponge, sharp and instrument counts in the practice setting. Counts are performed to account for items and ensure that the patient is not injured or harmed as a result of a retained foreign body.

POLICY:

1. Sponge, sharps and instrument counts are to be performed by two persons; one of whom is the scrub person, and at least one of whom is a Registered Nurse (RN).

2. Sponges and instruments should be counted on all procedures in which the possibility exists that a sponge or instrument could be retained.

3. Sharps and other miscellaneous items should be counted on all procedures.

4. All sponges used during procedures are to be x-ray detectable.

5. Subsequent counts, if needed, are to be performed:

    a. Before closure of a cavity within a cavity

    b. Before wound closure begins

    c. At skin closure or end of procedure, and

    d. At the time of permanent relief of either the scrub person or circulating nurse (although direct visualization may not be possible).

6. When instrument counts are needed, the counts are to be done:

    a. Before each procedure to establish a baseline

    b. Before wound closure, and

    c. When feasible, at the time of permanent relief of the scrub person and/or circulating nurse

7. Ongoing inspection of instruments by surgical team and Central Processing Department (CPD) for signs of breakage – before and after use – to prevent the retention of device fragments.

8. A documented count is to be done on all items which could conceivably be lost in the patient during surgery.

a. Countable items include all sponges, towels used for packing, suture needles, hypodermic needles, blades, instruments, cautery tips, cautery cleaners, vessel loops, vascular slips, defogger bottles and caps, endo-stapler reload cartridges, laparotomy rings and others.

b. Sponges need not be counted or documented for cystoscopy (male cases only), endoscopy, ophthalmology, external otologic, and superficial plastics or skin graft cases, assuming there is no opportunity for a sponge to be retained.

c. Instruments need not be counted when a major body cavity has not been entered, or the depth or location of the wound is such that an instrument could not be left in the patient.

9. All laparoscopic cases have the potential to convert to an open case and an official preliminary count must be taken.

10. In cases of an unplanned opening of a scheduled closed procedure, a secondary "opening" count should be performed and documented to establish a baseline for the new procedure. All sponges, sharps and instruments counted on the initial procedure are to be accounted for in the final count.

11. In cases of an emergent unplanned opening during a scheduled procedure, an X-ray will be ordered and taken at the end of the procedure, read and cleared by the surgeon and/or a radiologist before the patient leaves the OR.

12. Only towels with radiopaque markers should be used within the wound. If used within the wound, towels should be included in the count as miscellaneous items and should be easily distinguishable from other items.

13. In the event of a broken needle, blade or instrument, at physician's discretion, an x-ray is to be ordered and taken at the end of the case to assure that no piece is retained.

AFFECTED AREAS/ PERSONNEL:

MAIN OPERATING ROOM (OR) AND OBSTETRICS (OB)-OR, AMBULATORY SURGERY DEPARTMENT, CARDIAC CATHETERIZATION LABORATORY (CCL), INTERVENTIONAL RADIOLOGY (IR); SURGICAL TEAM, MATERNAL CHILD HEALTH (MCH) & OR REGISTERED NURSES, CCL/IR REGISTERED NURSES, SURGICAL TECHNICIANS & CCL/IR TECHNICIANS

PROCEDURE:

A. **Counts:**

1. The Scrub and an RN count all items visually, verbally, and concurrently. The initial and closing count are the ultimate responsibility of the assigned Circulating Nurse. If the initial count is performed with the Scrub person by another RN, there must be a review of the count, using the white board and instrument count sheets (if applicable) before the procedure begins.

2. The Scrub separates all countable items to allow the RN to visualize each item during the count process. All sponges will be verified to have a radiopaque tape or string, and that there is not an extra sponge hidden between them.

3. All packaged items are grouped and counted in multiples corresponding to their original packaging, and each multiple is separated from other multiples during the count and recorded on the white board. (Example: Three packages of lap sponges are counted in three stacks of five, not in one stack of fifteen.)

4. When counting instruments, the contents of each tray is counted individually and verified against the number of items stated on the Instrument List from the Central Processing Department (CPD).

5. If original manufacturer packaging number of sponges is incorrect (i.e., 4 or 6 lap sponges in a package), the package is to be removed from the sterile field and isolated, but kept in the OR until the end of the procedure.

6. If an instrument tray or package from the CPD contains a count different from what is stated on the Instrument List, the actual count is to be verified by both the Scrub and the RN, and an annotation is to be made on the Instrument List and on the white board. The discrepancy is to be reported to relief personnel in both the Scrub and the RN roles, and communicated to CPD after the case.

7. The original count of all counted items (sponges, sharps, instruments and miscellaneous items) will be written on the board in the operating room, witnessed by both the scrub and circulator. Any additional items added to the sterile field throughout the procedure will also be recorded on the white board, witnessed by the scrub and circulator.

8. After the preliminary count, all subsequent counts of sponges and sharps are to be performed in the same sequence; i.e., the wound and sterile field, mayo tray, back table, sponge buckets and hanging sponge count bags. When counting sponges, the lap sponges are to be counted first, then raytex and smaller items.

9. All counted sponges, sharps and instruments are to remain within the OR during the procedure.

10. During procedures, the scrub tech is to open used sponges completely before discarding into designated sponge buckets.

11. Using proper handling technique to avoid blood exposure, the circulating nurse places the used sponges in clear hanging organizers, placing one sponge in each pocket, assuring that the sponges are separated in order to minimize errors. Each hanging bag has 10 pockets per bag, which can be converted to five pockets. When the sponge bags are full with either 5 or 10 sponges, a new bag will be hung on the same IV pole to collect future sponges. The bags are to be displayed so as to be easily visible to the anesthesia

provider for the purpose of estimating blood loss and to facilitate the counting of sponges.

12. Sponges are never to be cut. Altering a sponge increases the risk of a portion being contained within the wound as well as the lint from the cut areas of the sponge becoming a foreign body within the wound.

B. **Final Counts:**

1. For the closing counts, the Scrub and the Circulator count all items visually, verbally, and concurrently, starting at the wound and ending up with the hanging sponge count bags.

2. At the end of each closure, the surgeon is advised of the status of the count (correct or not, state what item(s) are missing.)

3. For the final count at the end of the procedure, all of the sponges (used and unused) are placed in the pockets of the sponge counting bags so that the bags are complete with totals of 5 or 10, depending on the number in the original package. The entire surgical team (surgeon, nurses and scrubs) verifies that the number of sponges documented on the white board agrees with the number of sponges in the sponge counting bags.

4. Non-radiopaque dressings are not opened onto the field until all of the counted sponges are removed from the operative field and placed into the appropriate hanging bags. (*Note:* If non-counted sponges are included in the custom packs, they must be separated and contained away from all other sponges in the sterile field; not to be brought forward until after the final count.)

5. Non-radiopaque gauzes or towels are to be used for skin clean-up instead of counted radiopaque sponges.

6. X-ray detectable sponges are never to be used as dressings.

C. **Incorrect Counts:**

1. If the count is not correct and there are empty pockets in the sponge counting bags, or the numbers do not match the white board or instrument sheets, perform the following:

   a. Advise the surgeon, who will check the wound.

   b. Inform the anesthesia provider so that he/she may maintain the patient at a safe level of anesthesia in the OR until the missing item is found or the X-ray is read as negative.

   c. The scrub person checks the sterile field and maintains the sterile field until the count is resolved in the event that the wound must be re-entered.

d. The circulator checks outside the sterile field, including trash and linen receptacles, and assures that there is only one sponge per pocket in the sponge count bags.

e. Anyone who has left the room will be contacted and the circulator will review any visitors in the room or opportunities for a sponge to have been inadvertently removed from the room; e.g., a pathology specimen, or with a newborn taken to the nursery.

f. If the missing item is found, or the initial count discrepancy is discovered, the count of all similar items (i.e., sponges, lap tapes, needles or specific instrument sets) is repeated from the very beginning to confirm correctness of the count.

g. If, after searching the room, the missing item is not found and the count remains incorrect:

- In the event the surgical count is "incorrect" (i.e.., discrepant), the entire surgical field is radiographed, and it should be interpreted by a physician at the completion of the operative procedure, prior to the patient's transfer from the OR. Direct communication between the surgical team and radiologist include the name of the missing item to aid in identification by the radiologist.
- The Circulator documents the results of the x-ray interpretation.
- The Circulator documents in the electronic incident reporting system any unresolved counts for retained objects.

D. **Emergency abdominal cases:**

Every attempt is made for an initial and closing count to be performed for every surgical case in which an object might be retained. In the event of an emergency where a count cannot be performed, it is documented in the patient record as an emergent case and that no count was performed. An x-ray is to be taken at the end of the case. Before the patient is awakened from anesthesia and transferred out of the operating room, the x-ray is to be read by the surgeon and/or a radiologist who determines if the wound is free of any retained foreign body. This is documented in the patient record.

E. **Patient leaving the OR with peritoneal packing:**

As these patients will return to surgery multiple times for packing changes and, finally, closure, the following is to be strictly followed:

1. Packing of the peritoneum is to be with x-ray detectable lap sponges only.

2. The Scrub and Circulator will verify with the entire surgical team the number of sponges left in the peritoneum.

3. An accurate tally of the retained sponges is to be documented on the nurses' intra-operative notes.

4. Count is documented as "Correct" when all sponges (packed and not packed) equal the original count.

5. A sign, "Notice of Retained Foreign Body" is to be placed on the front of the hard chart.

F. **Patient returning to the OR with peritoneal packing:**

1. The OR team is to determine the number of retained sponges by referring to documentation from the previous surgeries including: intra-operative nurse charting, MD notes, and "Notice of Retained Foreign body" on the front of the hard chart.

2. Scrub and Circulator are to count previously packed sponges as they are removed, verify the number against the number charted from the previous surgery, and bag and segregate the sponges from the rest of the count.

3. During the final visit to the OR, when the patient's peritoneum is closed, if there is any doubt that the count has not been scrupulously maintained, an x-ray is to be ordered, and cleared as per above.

G. **Counts for Vaginal Deliveries:**

1. Sutures and Raytec sponge counts are to be performed by two persons; one can be a scrub person, and at least one of whom is a Registered Nurse (RN).

2. Initial count will be done when the delivery table is set-up and be documented on the Delivery Record with initials of persons performing the count.

3. Additional sutures or raytec sponges will be counted and documented on the Delivery Record with initials of persons performing the count.

4. Final count will be performed after delivery is completed or after repair of episiotomy or perineal laceration. The final count will be documented in the Delivery Record with the initials of persons performing the count.

DOCUMENTATION:

A. Documentation of an official count on the permanent record is to include:

1. Items counted (e.g. sponges, sharps, instruments, other)

2. Number and types of counts performed
3. Names and titles of persons performing each count
4. Results of the final count
   a. Correct
   b. Not correct
   c. NA if a count is not required
5. Alert of the surgeon if the count is incorrect.
6. All actions taken if the count is incorrect.
7. A rationale, if counts are not performed or completed as indicated (Example: "First count omitted due to extreme trauma.")
8. The number of intentionally retained items leaving the OR with the patient.

REFERENCES:

- ~~Association of Perioperative Registered Nurses. (n.d.) Retrieved October 18, 2017 from http://www.aorn.org/.~~
- Association of Perioperative Registered Nurses. Retained Surgical Items. December 9, 2021. Retrieved from: https://aornguidelines.org/guidelines/content?sectionid=173723395&view=book#173723395

SUBJECT: **DP/SNF RESIDENT/FAMILY COUNCIL POLICY AND PROCEDURE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

For the residents living in the Sierra View Medical Center (SVMC) Distinct Part-Skilled Nursing Facility to have the right to form and run a self-governing council.

This council provides the residents with opportunities to participate in decision making through voicing their views and will help resolve issues and concerns.

POLICY:

The Resident Council is the voice of the individuals who reside in the facility. Many who cannot voice their opinions will rely on those who are capable and interested to speak for them.

PROCEDURE:

1. A president, vice president and secretary/treasurer should be elected from the residents willing to participate in the Council.

2. During a survey, the surveyors will ask to speak with the president and/or vice president, and also will lead a Resident Council meeting with only the residents involved to determine whether there are any issues the residents might want to confide in them without staff present.

3. The regular monthly meeting will consist of all interested residents, representative from the Ombudsman Program, any representatives of the residents choosing to speak for them and a staff member responsible for assisting the resident council.

4. The resident council members need to approve the staff member or visitors to the meetings. They can also request no staff members to attend if they want to meet to discuss issues confidentially.

5. The Resident Council is required to take place once a month. The chairperson keeps the minutes of these meetings and a list of attendees. The chairperson (activity coordinator) must document the facts and issues, be specific, and not include long narratives verbalized by the council members.

6. A copy of the minutes always goes to the administrator for review so they are always current on issues, concerns and resolutions.

7. The chairperson (activity coordinator) is responsible for scheduling the monthly meetings, announcing the meetings, creating an agenda, facilitating the meeting, recording the minutes and taking the issues and concerns to the responsible department head for review and resolution.

8. Agenda should consist of:

   a) Welcome
   b) Attendance
   c) Review of the last month's minutes

d) Review of past month's resolutions to issues
e) Review of specific departments involved
f) New business and issues
g) Request for visitors for the next month's meeting

9. All grievances and concerns need to be resolved by the identified departments. The department must write a plan of action, date it and sign it on the council's form, then return it to the chairperson.

10. All minutes must be filed and made available for surveyor review, administrative review and ombudsman review. They are a legal document.

11. Family Council:

- The day of Resident Council a list of family members, significant others, or resident representatives for the non- responsive residents (those who cannot speak for themselves) are called to discuss any concerns or issues they would like brought forward to the Interdisciplinary Team. The Chairperson will go over the resident's activity care plan, discuss what has been done for the resident for activities and to see if they have any new recommendations for the pertaining resident.

- The survey comment form is filled out with who was contacted and any concerns they may present. If unable to reach the resident representative on file, a message is left if able and documented as such.

- Documentation is made in the PCS Activity Participation Record, Resident Council section, the person who was contacted and if a Plan of Correction was filled out because an issue/ issues were brought forward by them.

AFFECTED PERSONNEL/AREAS: *DIRECTOR, MANAGER, ACTIVITY COORDINATOR, SOCIAL SERVICE DESIGNEE, LICENSED NURSES, CNA, DIETARY, RESPIRATORY, THERAPIES, MAINTENANCE*

REFERENCES:

- The National Long-Term Ombudsman Resource Center at the National Consumer Voice for Quality Long Term Care (2021). https://theconsumervoice.org/.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations. 483.15(c)(6), 483.15(c), United States of America, Med Pass Inc.

SUBJECT: **DISCHARGE MEDICAL SUMMARY**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure there is a written discharge summary completed by the physician for all residents at discharge.

POLICY:

Each physician will complete and sign a discharge summary within 7 days following the discharge of the resident. The Discharge Summary may be written or dictated per facility policy.

AFFECTED PERSONNEL/AREAS: *ATTENDING PHYSICIAN*

PROCEDURE:

1. The physician or his/her alternate will give discharge orders for the immediate care of the resident.

2. The physician will complete his/her part of the medical record, inscribe the final diagnosis and sign the records.

3. The discharge summary will be released to authorized persons/agencies with consent of the resident/legal representative in accordance with facility policy.

4. Key elements of the Discharge Medical summary include:

    a. Dates of admission and discharge

    b. Reason(s) for admission to DP/SNF Unit

    c. Course in medical and rehabilitation until recapitulation of residents stay and prior treatment.

    d. Admitting diagnosis

    e. Final diagnosis

    f. Discharge functions status/rehab potential, medical condition and prognosis at discharge

    g. Relevant laboratory/imaging results

    h. Discharge location – support – home, care, etc.

    i. Discharge medications

    j. Follow-up plans

    k. Next physician appointments

1. Visiting nurse/home/care/other support service

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1), 483.12 (a) (3). United States of America, Med Pass Inc.

SUBJECT: **DUTIES AND RESPONSIBILITIES OF CHAIR OF ANESTHESIOLOGY**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To outline qualifications and duties for the physician acting as the Chair of Anesthesiology.

POLICY:

1. The Chair of Anesthesiology will have the following qualifications:

   a. Member of the active medical staff;

   b. Licensed qualified physician who has successfully completed an anesthesiology program approved by the American Board of Anesthesiology and accepted by the state of licensure of the hospital.

   c. Elected by the Department of Anesthesia and approved by the Chief of Staff according to the medical staff bylaws of the hospital.

2. The duties of the Chair of Anesthesiology will include, but not be limited to, the following:

   a. Serve as chairperson of the Anesthesia Department.

   b. Shall be responsible to the Surgical Services Department and the Chief of Staff for the function of the department.

   c. Assures that anesthesia services are provided by qualified, licensed physicians and certified registered nurse anesthetists (CRNAs) who have been trained in anesthesia and are either board certified or board eligible in their specialty. Recommends privileges for all individuals who have responsibility for the administration of anesthesia. Clinical privileges are then processed through the appropriate medical staff committees.

   d. Periodically monitors the quality of anesthesia rendered by all anesthesia providers, and documents that information. Quarterly meetings will be held to review anesthesia care as necessary

   e. Reviews and evaluates at least quarterly, according to pre-established criteria, the quality and appropriateness of anesthesia care, both pre and postoperatively, as well as the safety regulations for the department and documents this information.

   f. Assures that all complications, both intraoperative and postoperative in all cases requiring anesthesia are reviewed as part of the quality improvement process.

   g. Periodically evaluates and recommends anesthesia equipment to provide a quality anesthetic environment. Assists with the updating of anesthesia equipment and

techniques in order to remain current with the standards of the medical community for anesthesia delivery.

h. Acts as a consultant in all measures concerning anesthesia services. Participates in continuing education programs for the medical staff, nursing staff, and other support staff as indicated by quality assurance monitoring.

3. Responsibilities:

a. The Chair of Anesthesiology will fulfill the duties and qualifications of the position and have 24-hour accountability for all anesthesia coverage provided either directly or by other members of the anesthesiology staff.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR)/MATERNAL CHILD HEALTH (MCH) OR/ANESTHESIA PROVIDERS*

SUBJECT: **EXAMINATION OF SURVEY RESULTS**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure the resident's right to examine the results of the most recent survey of the facility conducted by federal and state surveyors and any plan of correction in effect with respect to the facility. To ensure the resident's right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

POLICY:

The facility will make survey results available for examination in a place readily accessible to residents and visitors, and will post a notice of their availability. The facility will post information pertaining to how to contact state and local advocacy agencies.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, DP/SNF DIRECTOR*

PROCEDURE:

1. The Social Worker or Designee will inform the resident/responsible party of their rights to examine survey results during the admission process. The resident will also be informed of the right to contact and receive information from agencies acting as client advocates and provided a list of agency resources.

2. The DP/SNF Director will ensure that current results and plan of corrections from all federal and state surveys conducted in the facility are obtained from the Administrator and are placed in a conspicuous location.

3. The Social Worker or Designee will also monitor this process to ensure survey and advocacy information is maintained/updated on the consumer board and readily accessible for review.

The Social Worker or Designee will inform residents/responsible parties and staff of updates in survey and agency resource information and/or the location of postings.

REFERENCES:

- California Code of Regulations (2019). Title 22. §73723. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
EXPOSURE CONTROL SAFE ENGINEERED SHARPS	***Safety Management***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- The main purpose of engineered sharps safety is to reduce sharps injuries, which can transmit HIV, hepatitis B, hepatitis C and other blood borne pathogens. This is accomplished by stronger requirements for employers to use needles and other sharps which are engineered to reduce the chances of inadvertent needle sticks or other sharps injuries.

- Employers are required to keep a sharps injury log, which records the date and time of each sharps injury, as well as the type and brand of device involved in the exposure incident, the task being done when the injury occurred, and whether the injury occurred before, during or after the task was performed.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, STUDENTS, INSTRUCTORS

PROCEDURE:

DEFINITIONS

Sharp: Any object that can reasonably be anticipated to penetrate the skin or other parts of the body such as needle devices, scalpels, lancets, etc. Other items that are not sharp, but could be if broken, are included, such as glass objects and capillary tubes

Engineered Sharps Injury Protection: A physical attribute built into a device or into a non-needle sharp that effectively reduces the risk of an exposure incident

Sharps Injury: Any injury caused by a sharp, including but not limited to, needle sticks, cuts or abrasions

Medical Procedures Requiring Safety Devices:

- Accessing a vein or artery
- Withdrawal of body fluids
- Administration of medications or fluids
- Any procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available
- Non-needle sharps

Exceptions:

- Market availability
  - No safety device is available, e.g., lumbar puncture needle

- Patient safety
  - If device will jeopardize either the patient's safety or the success of the procedure
  - This must be *documented each time* it is used as a rationale.
- Safety performance
  - If employer can demonstrate through objective product evaluation criteria that the device *is not more effective* in preventing exposure incidents than an alternative, e.g., ABG syringes
  - The burden of evaluating devices and proving effectiveness is on the employer.

CRITERIA TO SELECT SAFETY DEVICES

The following criteria will be used in the selection of safety devices:

- The safety feature should provide a barrier between the hand and the needle after use.
- The safety feature should allow or require the worker's hands to remain behind the needle at all times.
- The safety feature should be an integral part of the device and not an accessory.
- Safety features should be in effect before disassembly and remain in effect after disposal, to protect workers who may subsequently handle the device.
- The device should be simple and easy to use, requiring little or no training.

In order to ensure effectiveness, education and evaluation of new safety devices (Annual Sharps Evaluation Plan) and engineering controls will be used in the an ongoing practice at this facility. Every effort will be made to provide and maintain a well-defined sharps injury protection program.

REFERENCES:

- Occupational and Safety Health Administration (OSHA). *Bloodborne Pathogens and Needlestick Prevention*. Accessed October 10, 2023. Available at: https://www.osha.gov/bloodborne-pathogens/evaluating-controlling-exposure
- Occupational and Safety Health Administration (OSHA). *Standards*. Accessed October 10, 2023. Available at: https://www.osha.gov/bloodborne-pathogens/standards
- DHHS Center for Devices and Radiological Health. August 9, 2005. *Guidance for Industry and FDA Staff, Medical Devices with Sharps Injury Prevention Features*. Accessed October 9, 2023 at:

https://www.fda.gov/regulatory-information/search-fda-guidance-documents/medical-devices-sharps-injury-prevention-features-guidance-industry-and-fda-staff

- Mary Temple Post, *Ambulatory Surgery Centers*. In: Boston, K.M., *et al.*, editors, APIC Text, 2014. Accessed October 09, 2023, Available at: https://text.apic.org/toc/infection-prevention-for-practice-settings-and-service-specific-patient-care-areas/ambulatory-surgery-centers

SUBJECT: **FALL PREVENTION (ADULT AND GERIATRIC)**	SECTION: **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To identify residents who may be at risk of falling and the implementation of interventions to ensure a safer and protective environment for all residents.

DEFINITIONS:

1. **Fall** - a sudden, uncontrolled, unintended, assisted or unassisted event resulting in a person coming to rest on the ground/floor

2. **Unwitnessed Fall** - a report of a person who has landed or been found on the floor that is unwitnessed

3. **Fall Risk Screening Tool** - a documentation tool used to determine the level of fall prevention interventions initiated that are specific to each resident based on risk

4. **Risk Stratification** – for the purposes of this procedure, assigning a level of risk for a fall, based on an assessment of fall risk factors

POLICY:

Residents who are assessed will be screened using the Fall Risk Screening Intervention in the Electronic Health Record to determine their risk of falling. This screening will be completed upon admission, once per shift, after any fall, post procedure as needed, upon transfer to another level of care, or more frequently based on nursing judgment. The Fall Risk Screening Tool is used to determine the level of fall prevention interventions to be used that are specific to each resident. When a resident is identified as "at risk", resident specific interventions will be implemented.

EXCEPTION: A resident designated as requiring intensive care services, until transferring to another level of care and reevaluated, are considered "at risk" for falls. All residents on the DP/SNF Unit who are total dependence or neurologically impaired are considered "at risk" for falls. All staff will be responsible for maintaining a safe environment and employing the full protection interventions as appropriate.

AFFECTED PERSONNEL/AREAS: *ALL DP/SNF STAFF*

PROCEDURE:

GENERAL PROCEDURES & DOCUMENTATION:

1. All residents are potentially at risk for falling during their hospital stay. A resident's fall risk factors are identified when the fall risk screening tool is completed.

2. Fall risk factors include:

   a. Age

b. Fall history

c. Mobility

d. Elimination

e. Mental status changes

f. Medications

g. Patient care equipment

3. Residents who score 11 or more points on the fall risk screening tool are considered to be a "Fall Risk". Critical thinking and nursing judgment continue to be an essential aspect of nursing care. Therefore, if a resident's fall risk score is less than 11 but nursing judgment indicates that a resident should receive more interventions, the nurse should initiate fall risk strategies in addition to other appropriate fall risk interventions based on the resident's needs.

INTERVENTIONS TO PREVENT PATIENT FALLS:

1. There are two levels of interventions:

a. **Fall Safety Protection** – to be initiated on admission *on all residents.* These interventions include:

- Call light within reach
- Orientation to environment
- Bed or chair in low position with brakes on
- Appropriate footwear
- Personal items within reach
- Bed rails up if indicated by the Bed Assessment for use of Side Rails
- Patient and/or family educated on fall protection
- Maintain clear pathways
- Appropriate lighting
- Assistive devices will be used as appropriate

b. **Fall Risk Interventions** – to be initiated on a resident who scores 11 or more points on the fall risk screening tool ("Fall Risk") or as nursing judgment deems necessary.

- Bed or chair alarm activated
  - When out of bed or chair, resident will be monitored at all times
  - When toileting, staff will remain within arm's reach
- Side rails up (with physician order and Consent) -- **or**
- Bed in lowest position. (Low beds used on residents in the DP/SNF Unit who are alert/ neurologically impaired and can move self out of bed.)
- Fall Mats at bedside if indicated
- Fall Risk indicator near door
- Toileting, offering food/drink, position change every two hours
- Ambulate with assist (if applicable)
- Fall Risk on Person Centered Care Plan

Additional interventions may be implemented as appropriate:

- Physical Therapy/ Occupational Therapy evaluation (requires physician order)
- Restraints (requires physician orders and Consent)
  NOTE: Avoid use of restraints if at all possible.

INTERVENTIONS FOR PATIENT WHO FALLS

1. Assess for injuries (i.e. abrasions, contusion, laceration, fracture, head injury) and provide appropriate aide.
2. Obtain and record vital signs/ neuro checks for 72 hours minimum.
3. Assess for change in range of motion and level of consciousness.
4. Notify physician/family/conservators.
5. Diagnostic tests per physician order.
6. Continue to monitor patient as condition warrants.
7. Document circumstances in medical record.

Complete electronic incident report.

8. Assess physiologic and environmental factors that contributed to the fall.

9. Designate patient as a fall risk for the duration of their stay and initiate Fall Risk Interventions as appropriate.

10. Charge Nurse will conduct a "HUDDLE" with all staff after a fall has occurred and interventions have been implemented and present occurrence at the huddles twice a shift for several days to ensure all staff is informed and aware.

11. Consider assistive devices to prevent repeat fall.

12. Notify California Department of Public Health (CDPH) if the fall resulted in any type of injury to the resident.

ASSISTED FALLS

1. Assess for injuries.
2. Notify physician, family, and conservator.
3. Resident Assessment for pain/discomfort will be reflected via the routine nursing assessment in the EMR.
4. Complete electronic incident report.

PRECAUTIONS, CONSIDERATONS AND OBSERVATIONS

1. One of the primary reasons for falling involves toileting issues. Elimination rounds for assistance with elimination needs are a basic and effective way of reducing the resident risk for falling.

2. Changes in mental status from an oriented baseline are significant contributing factors in resident falls and intervention is essential.

3. The majority of resident falls occur in the residents' rooms.

4. Poly pharmacy (four or more medications) increases the risk for patient falls; risk also increases with titration of medication.

5. Upper side rail use offers handholds/stabilizers for the patient to exit the bed (if indicated in the Bed Assessment for side rail use). A third lower rail can be used on the side where the patient tries to exit the bed without assistance and is a risk for falls. (This requires a physician's order and consent from family or conservator).

6. Preventing resident falls is challenging. Research of the effectiveness of a single intervention is limited. Interventions to reduce the risk of falling must be multifactorial, addressing residents' specific risk factors (i.e. altered elimination, altered mentation and altered mobility).

REFERENCES:

- Tool 3H: Fall Scale for Identifying Fall Risk Factors. Content reviewed 2018, February 20, Agency for Healthcare Research and Quality, Rockville, MD Retrieved from http:www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html.
- Centers for Disease Control and Prevention. STEADI, Older Adult Fall Prevention, July 26, 2021. Retrieved from: *cdc.gov/steadi*
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- American Nurse, 2020, *Preventing Falls In Long Term Care Facilities*, Sara Lewandowski DNP, MS, BA, BS, RN, CNE, HNB-BC., Retrieved from:https://www.myamericannurse.com

- Original Research Exploring Clinicians' Perceptions About Sustaining an Evidence –Based Fall Prevention Program, AJN, *American Journal of Nursing 2018; 118(5): 24-33.*

SUBJECT: **FALL PREVENTION (ADULT AND PEDIATRIC)**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 8**

PURPOSE:

To identify patients who may be at risk of falling and for the act of implementing the Fall Prevention Program to ensure a safer and protective environment for all patients.

DEFINITIONS:

1. **Fall** - a sudden, uncontrolled, unintended, assisted or unassisted event resulting in a person coming to rest on the ground/floor

2. **Unwitnessed Fall** - a report of a person who has landed or been found on the floor that is unwitnessed

3. **Fall Risk Screening Tool** - a documentation tool used to determine the level of fall prevention interventions initiated that are specific to each patient based on risk

4. **Risk Stratification** – for the purposes of this procedure, assigning a level of risk for a fall, based on an assessment of fall risk factors

POLICY:

The nurse will screen patients using the Fall Risk Screening Tool to determine patient risk and stratification for the risk of falling. This tool will be completed upon admission, and then once per shift. Additional considerations for assessing risks include but are not limited to, after any fall, post procedure as needed, upon transfer to another level of care as needed, or more frequently based on nursing judgment. When a patient is identified as "at risk", patient-specific interventions will be implemented based on risk stratification. Patients who are comatose or completely immobile do not require fall risk interventions.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

EQUIPMENT:

- Yellow arm bands
- Yellow socks
- Yellow gowns
- Bed alarms
- Chair alarm
- Toilet alarm

PROCEDURE:

A. Pediatric patients three (3) years of age and younger, those who are not at developmental milestones/stages appropriate for age, and those with chronic medical conditions are considered at "high risk" for falls. As such, the Fall Risk Screening Tool does not need to be completed each shift for these patients.

B. For inpatient areas the RN will initiate high fall risk interventions for pediatric patients three (3) years of age and younger, as appropriate. These include:

1. Orient patient and family to environment.

2. Beds in low position, brakes locked.

3. Children under the age of four (4) will be placed in cribs.

   a. High-sided or bubble-top cribs will be used when the patient/parents state or child demonstrates that he/she might climb out.

4. Consider use of nightlight on night shift.

5. Call light and personal items within reach, as developmentally appropriate.

6. Personal sensory aides and assistive devices accessible to the patient (i.e., eye glasses, hearing aids, safety straps, etc.).

7. Ambulating patients must wear non-skid socks.

8. Pediatric patients at risk for fall transported off the inpatient unit will be constantly supervised:

   a. Inpatients under the age of four (4) should be transported in a crib, bassinet, in a car seat or may be carried in parents' arms, but parent should be seated in a wheelchair.
   b. Children transported off the unit will be constantly supervised.

9. The RN will provide education on fall prevention interventions and purpose for the patient's family/care giver and reinforce this as needed.

C. In outpatient areas, the RN can consider using a crib, based on assessment of child and the family's wishes.
   1. Orient patient and family to environment.

2. Beds in low position, brakes locked.

3. Call light and personal items within reach, as developmentally appropriate.

4. Personal sensory aides and assistive devices accessible to the patient (i.e., eye glasses, hearing aids, safety straps, etc.).

5. Ambulating patients must wear non-skid socks.

6. Pediatric patients at risk for fall transported off the inpatient unit will be constantly supervised.

7. The RN will provide education on fall prevention interventions and purpose for the patient's family/care giver and reinforce this as needed.

D. The nurse completes the Fall Risk Screening Tool to determine the patient's fall risk factors. Fall risk factors for patients over the age of three (3) include:

1. Ambulatory aid such as cane, prosthetic, walker, etc. (assistive devices, holds on to furniture when ambulating).

2. History of a fall within the past 3 months.

3. Secondary diagnosis

4. Unsteady gait when transferring or ambulating

5. IV infusion

6. Cognition deficiencies (i.e., changes in mental status, unable to follow directions).

7. ***Nursing judgment***

E. Interventions to **Prevent Patient Falls** in Adult and Pediatric Patients

1. The Fall Prevention Program has three (3) levels of intervention.

2. **Level 1 interventions** are considered the Fall Prevention *Safety* portion of the program, and are initiated by the nursing team on admission for ALL inpatients and for outpatients, as appropriate. Level 1 interventions are:

a. Orient to Call light system

b. Call light within reach

c. Personal items and telephone within reach

d. Glasses and hearing aids on patient; ask family to bring from home

e. Patient and family education on Fall Prevention

f. Bed in lowest position with wheels locked

g. Reassess patient fall risk every shift and with status changes

h. Non-slip footwear when patient is out of bed

i. Instruct patient to call for assistance before getting out of bed or chair/toilet

j. Physically safe environment without spills, clutter, cords, or trip hazards. Consider use of nightlight on nightshift

k. Room and bathroom lighting operational

l. Bathroom call light cord within reach

m. Three (3) bed rails up; crib rails up in high position (peds)

3. **Level 2 interventions** are implemented for any patient whose fall risk screen results in identification of one (1) risk factor. Level 2 interventions include all level 1 interventions and:

a. Reinforce fall prevention safety measures with patient and family

b. Use bed and chair alarms

c. For admitted patients, implement Visual Cues from Fall Management Kit as follows:

i. Place yellow wrist band on patient

ii. Post the two (2) star Fall Risk sign outside of the patient's room

iii. Provide yellow socks

d. Implement Targeted Toileting Program as follows:

i. Before shift change

ii. Before sleep

iii. After meals

iv. As indicated

e. These next interventions in Level 2 are based on patient-specific risk factors:

i. Monitor gait and stability and use gait belt as needed

- Ensure that patient has their own assistive devices at the bedside. Check walkers and canes for non-skid covers.
- Obtain Physical Therapy initial evaluation with physician order if deemed appropriate.

ii. Monitor for mental status changes and reorient to person, place and time, and minimize distractions as indicated

iii. Provide interpreter or use interpreter phone as indicated to ensure that patient and family understand measures needed to prevent falls

f. **For Outpatients (ED, Perioperative), implement visual cues as follows:**

i. Place yellow wrist band on patient

ii. None skid socks

4. **Level 3 interventions** are implemented for any patient whose fall risk screen results in more than one risk factor. The Emergency Department and Post Anesthesia RNs will communicate Level 3 fall risk scores to accepting departments prior to transfer so appropriate room assignment can be made for the patient. Level 3 interventions include all level 1 and level 2 interventions and:

a. Arrange for a bed in one of the designated rooms nearest to the Nurses' Station when bed available

b. Reinforce fall prevention safety measures with patient and family

c. Use shower chair and stay within arm's length of the patient while in shower or during toileting

d. Remain within arm's length of the high-risk fall patient when they are out of bed and alarms are not in use. Consider use of gait belt when appropriate

e. Additional Visual Cues for inpatients

i. Post the *three (3) star* Fall Risk sign outside of the patient's room

ii. Provide yellow gown

F. Interventions for a **Patient Fall:**

1. Call for a Code STAR:

a. Dial 55 and ask Operator to announce a Code STAR overhead, giving your location (e.g., room number or unit/floor hallway)

b. Security staff will help maintain medical emergency vertical egress for responding staff.

c. The following staff report to the location of the Code STAR when available:

i. Nursing Supervisor or Unit Manager

ii. Charge Nurse

iii. Physical Therapist

iv. Chief Nursing Officer

v. Risk Management

2. Stay with the patient; do not attempt to mobilize the patient until help arrives.

3. If additional assistance is needed from Engineering staff, phone extension 55 and request Engineering help to your location.

4. Assess for injuries (i.e., abrasion, contusion, laceration, fracture - change in range of motion, head injury – change in level of consciousness) and provide appropriate first aide.

5. Obtain and record vital signs.

6. Notify physician, using SBAR (Situation-Background-Assessment-Recommendation) format.

7. Continue to monitor patient as condition warrants.

8. Document facts/circumstances in patient medical record.

9. Complete post fall intervention.

10. Assess physiologic and environmental factors that contributed to the fall.

11. Designate patient as a level 3 Fall Risk for the duration of their admission, initiate or escalate Fall Risk Interventions as appropriate, and modify the patient's plan of care based on risk factors leading to the fall.

12. Notify all team members of patient fall and interventions implemented.

13. Consider assistive devices to prevent repeat falls.

14. Avoid use of restraints if at all possible. Restraints require physician order. Follow the *Restraints Policy and Procedure* using alternatives first and documenting them, and then using the least restrictive restraints when necessary.

15. Notify the patient's next of kin of the fall and subsequent plan of care to prevent further falls.

G. Documentation of a revised Fall Risk Assessment, Fall/Safety Care Plan, and Post Fall Assessment.

1. The nurse enters the Fall Risk Assessment into the medical record each shift and with any status changes.

2. The Care Plan is updated daily and as needed based on patient status, including updates to the Fall/Safety Care Plan.

3. Fall Risk assessment and intervention is part of the individualized plan of care for each inpatient, and for outpatients as indicated.

REFERENCES:

- Tool 3H: Morse Fall Scale for Identifying Fall Risk Factors. (July 2023). Agency for Healthcare Research and Quality. Rockville, MD. Retrieved from https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/morse-fall-scale.html.
- The Joint Commission (2023). TJC Hospital Accreditation Standards. Joint Commission Resources. Oak Brook, IL. PC.01.02.08 EP 1-2

SUBJECT: **FEEDING, TRANSITIONAL-ENTERAL TO ORAL INTAKE**	SECTION:

PURPOSE:

To ensure that each resident is appropriately weaned from a tube feeding and is an appropriate candidate for oral intake only.

POLICY:

It is the policy of this facility to safely wean tube fed residents to oral intake under the direction of a physician with supervision provided by appropriate members of the interdisciplinary health team.

AFFECTED PERSONNEL/AREAS: *NURSING (RN, LVN), SPEECH THERAPY, DIETARY, NUTRITION SERVICES*

PROCEDURE:

1. An interest is expressed to discontinue a tube feeding, such as by resident request, physician order, and/or by recommendation of a speech therapist, nursing, or registered dietitian.

2. A physician order is obtained for a Speech Therapy evaluation to determine swallowing ability.

3. In order to stimulate the resident's appetite, it is recommended the transitional feeding formula be infused in the evening hours with the feeding ending no later than 6:00 a.m.

4. If the resident passes the swallow evaluation, then the resident will be offered foods and/or fluids as best tolerated. The therapist will actively work with the resident to promote safe oral intake. In order to promote continuity, the therapist will communicate with the restorative aide and/or nursing staff additional instructions for the feeding program.

    a. Accurate documentation of the percentage of oral (po) intake must be included on the "CNA Meal and Snack Intake" Section of the Electronic Health Record.

5. During this feeding program interval, a Dietitian will monitor po intake and calculate dietary adequacy.

    a. When the % amount indicates an accepted level of intake, orders will be obtained to discontinue the tube feeding. The resident will remain in the feeding program for continual close monitoring until released to staff by the Speech Therapist.

    b. If the calorie count indicates an acceptable level of intake cannot be achieved orally, a conference should be held by the physician and dietitian to determine the feasibility of additional therapy.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75(1) United States of America, Med Pass Inc.

- Charney, Pamela. (May 31, 2016). *Nutrition Assessment*. Momentum Press.

- **ASHA American Speech Language Association,1997-2022, *Alternative Nutrition and Hydration in Dysphasia Care,*** retrieved from: **https://www.asha.org**

- **Nutrition Care Systems, Staci Betticker, MS, RD, LDN, June 2022, Tube Feeding in a Long Term Care Facility. Retrieved from: https://www.nutritioncaresystems.com**

SUBJECT: **FINANCIAL COUNSELING IN DP/SNF**	SECTION: *Social Services* **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the Patient Accounting responsibility for assisting residents with income maintenance and benefits during their stay in the DP/SNF.

AFFECTED PERSONNEL/AREAS: *DP/SNF DIRECTOR, SOCIAL SERVICE DESIGNEE, PATIENT ACCOUNTING*

POLICY:

The Patient Accounting Designee is responsible to provide financial tracking for each resident to ensure income maintenance and a means of payment for care and services.

1. When a resident without income is admitted, the Patient Accounting Designee will research and advise the resident and/or responsible party of potential sources of income for the resident such as Supplemental Security Income, Social Security, VA (Veteran Affairs), benefits, or disability benefits. Upon request, or in the absence of a responsible party, the Patient Accounting Designee will assist with the research and application process to establish a source of income to meet resident's needs.

2. The Patient Accounting Designee will work with the resident/responsible party and benefit agencies to keep abreast of changes in resident's funding status, share of cost determinations, and all other such circumstances affecting resident's income or payment for care.

3. Each resident shall have a "Financial Face Sheet" maintained in the Social Service office, in the "Financial Tracking Log." These sheets shall be reviewed at least quarterly to make sure all information remains current and correct.

4. Patient Accounting will maintain an ongoing record of communication with all agencies involved in the resident's income or payer source. All pertinent phone calls and correspondence shall be maintained in the "Financial Tracking Log" in the Patient Accounting Office. Significant communication and changes should also be shared as needed with the Social Service Designee and Director of the DP/SNF and others who need to know. Pertinent communication with responsible party, family, etc., should be recorded in the Electronic Health Record (EHR).

5. No facility staff shall accept any type of payment, e.g. Medi-Cal Share of Cost, trust fund deposits, etc. from a resident or responsible party wishing to transact business at a time when the appropriate office is not available.

REFERENCES

- Thomson Reuters (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, #72453, 72529, San Francisco, California.

SUBJECT: **FREE CHOICE**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure the resident's right to free choice and self-determination in decision-making and care and treatment.

POLICY:

The resident will have the right to choose a personal attending physician. The resident will be fully informed in advance about care and treatment and any changes in that care or treatment that may affect his or her wellbeing. Unless adjudicated incompetent or otherwise found to be incapacitated under state law, the resident will participate in planning care and treatment or changes in care and treatment.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, PHYSICIAN, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. During the admission process, the Social Worker Designee will inform the resident of their right to choose an attending physician. This process will be implemented in accordance with the policy and procedure" Physician Services."

2. The Social Worker Designee will inform the resident or significant other of the interdisciplinary team processes and the right to attend the meetings with staff and physician to participate in his/her plan of care. The Social Worker Designee will ensure the resident and responsible party is invited to the meetings routinely and is represented, as needed, when unable to attend.

3. The physician will ensure the resident/responsible party receives information necessary about his/her medical status to make health care decisions, including options, alternatives, benefits and risks, as needed, to make informed consent prior to initiation (refer to procedures for "Informed Consent").

4. The Interdisciplinary Team will inform and consult with residents with impaired decision-making and those formally declared incompetent to the extent practicable about their personal preferences (i.e., schedules, activities, care planning).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, Resident's Rights, 42 CFR § 483.10, United States of America, Med Pass Inc.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: PHYSICIAN'S SERVICES

SUBJECT: **GUIDELINES FOR IMMUNOCOMPROMISED (NEUTROPENIC) PATIENTS**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY

INTRODUCTION:

SVMC will at the minimum utilize Standard Precautions and hand hygiene when caring for a patient who is known to be neutropenic or immunocompromised as these patients are at a greater risk for infectious diseases. The purpose of this policy then is to reduce the risk of the transmission of pathogens, especially within the immunocompromised patient population at SVMC.

PROCEDURE:

Patients who are immunocompromised are at greater risk for infection. This is because of the great reduction of circulating neutrophils (polymorphonuclear leukocytes) which are the first line of defense against invading microorganisms. When the absolute neutrophil count (ANC) is less than or equal to 1.0×10^3 cells/mm^3, the patient is at high risk for infection.

The information needed to calculate the ANC are the percent of segmented neutrophils (*segs*), the percent of neutrophil bands, and the total white blood cell (WBC) count. The formula is as follows:

$$ANC = [\% \text{ segs} + \% \text{ bands}] * [WBC]$$

NOTE: The segs and bands are in *percent*. To get a final value, the decimal point must be moved two places to the left to arrive at a useable number.

When the ANC is less than 1.0×10^3, the following guidelines may be helpful in reducing the risk of infection for the immunocompromised patient:

1. Apply Standard Precautions.
2. Pay rigorous attention to hand washing.
3. Patient education: teach the patient about his/her condition and the measures that they can use to prevent the acquisition of pathogens during periods of neutropenia:
    a. Maintain an optimal nutritional status.

b. Avoid cleaning of bird cages and cat litter boxes (home instruction).

c. Avoid areas containing dog feces because feces can contain a high level of fungus and bacteria (home instruction).

d. Maintain personal hygiene and cleanliness by showering/bathing daily.

e. Prevent injury to the rectal mucosa by avoiding rectal thermometers, rectal suppositories, enemas, and straining when having a bowel movement.

f. Assess for signs of infection frequently by taking the temperature daily at the same time of the day, reporting a temperature of > 100°F, and reporting any signs and symptoms of infection (e.g., cough with or without sputum, fever, burning on urination, urgency, frequency of urination, cloudy urine.)

g. Use a soft toothbrush to clean the mouth and teeth after every meal.

h. Avoid negative airflow rooms if at all possible.

i. Conserve energy and maintain adequate periods of sleep and rest.

j. Limit visitors, clearing visitors for communicable diseases.

k. Avoid crowded places.

l. Wash hands frequently using proper technique.

REFERENCES:

Centers for Disease Control and Prevention. (2023, May 15). Staying healthy during cancer treatment. Centers for Disease Control and Prevention. Retrieved October 10, 2023, from https://www.cdc.gov/cancer/survivors/patients/staying-healthy-during-cancer-treatment.htm .

- Delahanty K.M., Hinckley K.M., and Perego C., 2014. Infection Prevention in Oncology and Other Immunocompromised Patients. In Boston K.M., et al, eds. APIC Text, 2014. Accessed Oct. 30 2023. Available at https://text.apic.org/toc/infection-prevention-for-specialty-care-populations/infection-prevention-in-oncology-and-other-immunocompromised-patients .

- The Joint Commission (2023). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.01.03.01, EP1

- The Joint Commission (2023). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.02.03.01

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SUBJECT: **HAND CARE OF, CONTRACTURE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To maintain cleanliness, prevent injury or skin breakdown, and to prevent progression of the contracture.

POLICY:

It is the policy of this facility to provide for cleansing of the contracted hand on a daily and as needed basis, and to provide measures to prevent injury, skin breakdown or contracture progression on all shifts.

AFFECTED PERSONNEL/AREAS:

RNA, LICENSED NURSES

EQUIPMENT:

- Basin
- Soap
- Warm water or warm soapy water
- Washcloth
- Towel
- Hand roll
- Nail clippers
- Nail file

PROCEDURE:

1. Wash hands thoroughly and don gloves. Explain procedure to the resident. Provide privacy.
2. Fill basin with warm water not to exceed 105 degrees F.
3. Soak the affected hand for 5 minutes.
4. Wash hand with washcloth.
5. Gently lift fingers to wash underneath. Do not force fingers beyond range of easy mobility. This procedure can cause pain to the resident and forced movement could result in injury to the resident.

6. Spread the fingers to wash between each finger. Do not force fingers apart. Gentle movement and washing is essential to this procedure.

7. Rinse the hand well.

8. Dry the hand well with the towel. Gently dry beneath and between the fingers.

9. Clip nails to prevent injury to the hand.

10. Clean beneath the nails as necessary and file all rough areas of the nail.

11. Apply hand roll appropriately if used. Ensure that Velcro strap holding hand roll in place is not binding the skin or impairing skin or circulation if used. Ensure that the hand roll is properly placed for maximum efficiency.

12. Empty basin, wipe dry and store appropriately.

13. Place soiled linen in laundry hamper. Clean nail care items and return to appropriate storage area.

14. Ensure resident is comfortable.

15. Each shift will check all residents with contracted hands to ensure hand rolls are in place and are appropriately applied.

16. Report pertinent observations noted during cleansing procedure and check of hand rolls each shift.

DOCUMENTATION:

Report and/or document any unusual observations in the medical record.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (f), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
HEALTH CARE WORKER EXPOSURE TO MENINGOCOCCAL DISEASE	**Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To determine if healthcare workers had significant exposure to meningococcal disease and to provide guidelines for the management of healthcare workers who have been exposed.

POLICY:

Healthcare workers will receive prophylaxis for significant exposure to suspected/confirmed cases of meningococcal disease.

INTRODUCTION AND DEFINITIONS:

Meningococcal disease refers to any illness caused by bacteria *Neisseria meningitidis*. If meningococcal disease is suspected, samples of blood or cerebrospinal fluid (CSF) will be collected and sent for laboratory testing. The two most common types of meningococcal infections are meningococcal meningitis and Meningococcemia (meningococcal septicemia.) *Neisseria meningitidis* infection rarely results in Meningococcal pneumonia. If diagnosed with Meningococcal disease, antimicrobial treatment should start as soon as possible. If there is close unprotected contact with someone diagnosed with meningococcal disease then prophylactic treatment should be administered.

The risk of hospital-acquired meningococcal disease to health care workers is extremely remote under usual circumstances that includes the use of appropriate PPE, especially a surgical mask. Personnel having intimate exposure to oral secretions (i.e., unprotected mouth to mouth resuscitation, intubating without protection-mask) or exposure to microbiological specimens from a suspect case of meningococcal disease shall report to Employee Health Services (EHS) to determine if antimicrobial prophylaxis is appropriate.

PROCEDURE:

Healthcare Worker Exposure:

The Infection Prevention Department will notify all affected department managers or designated personnel of exposure incidents. Employee Health Services will assist with the notifications. After hours, the Nursing House Supervisor will notify the appropriate department managers/directors or designated personnel. Infection Prevention will also notify Employee Health Services.

- Once contacted, the manager/director or designated personnel will evaluate duration and closeness of contact and obtain a list of those employees who: (1) had close contact with oral secretions (i.e. mouth-to-mouth resuscitation, intubating without protection-mask) or mechanically manipulated microbiological specimens and (2) cared for patient with cough prior to the initiation of isolation while maintaining a distance of less than 3 feet.

- Healthcare workers meeting the above criteria should be counseled and offered prophylactic therapy and should be advised of the need for prophylaxis regardless of meningococcal vaccination status. If more than 48 hours have lapsed from the time of the employee's exposure, the employee should also

be instructed to report to EHS if onset of fever, or other signs/symptoms of illness arise. The employee should:

- Take temperature twice daily for one week
- Take note of the following symptoms such as altered mental status (confusion), headache, photophobia, chills, fatigue, malaise, nausea, vomiting, stiff neck, cold hands and feet, severe aches, rapid breathing, diarrhea, prostration or rash 1-10 days following exposure.

- Duration of exposure and closeness of contact will be evaluated by the Infection Prevention R.N.and Employee Health nurse if the manager/director or designated personnel is unsure of an employee's status.
- After a complete list of possible exposures has been compiled, the list should be submitted to EHS.
- Prophylactic therapy must be coordinated through EHS, Infection Prevention, and the Pharmacy.

GENERAL INFORMATION:

Treatment must be given within 24-48 hours, if recommended. If EHS is closed, see EHS the next clinic working day. If EHS is closed for more than 24 hours (weekends/holidays), please contact the House Supervisor or Administrator on Call (AOC). The House Supervisor or AOC will refer employee to the Emergency Department for initial evaluation and treatment. It is the employee's responsibility to contact EHS if further follow-up is needed.

REFERENCES:

- Centers for Disease Control and Prevention. (2022, February 7). *Meningococcal disease*. Centers for Disease Control and Prevention. Retrieved October 6, 2023, from https://www.cdc.gov/meningococcal/index.html .
- Ostrowsky, B., Central Nervous System Infections. In: Boston, K.M., et al., Editors, APIC Text. 2014. Accessed October 6, 2023. https://text.apic.org/toc/healthcare-associated-pathogens-and-diseases/central-nervous-system-infection
- Baracco, G., *Neisseria meningitidis*. In: Boston, K.M., et al., Editors, APIC Text. 2014. Accessed October 6, 2023. https://text.apic.org/toc/healthcare-associated-pathogens-and-diseases/neisseria-meningitidis
- Mayo Foundation for Medical Education and Research. (2023, October 4). *Meningitis*. Mayo Clinic. Retrieved October 6, 2023, from https://www.mayoclinic.org/diseases-conditions/meningitis/symptoms-causes/syc-20350508 .

- Nguyen, N., & Ashong, D. (2022, September 26). *Neisseria meningitidis*. StatPearls [Internet]. Retrieved October 6, 2023, from https://www.ncbi.nlm.nih.gov/books/NBK549849/ .