

**PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE
MEDICAL EXECUTIVE COMMITTEE**

February 6, 2024

Agenda Attachment

Policies & Procedures

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POM: Decorations, Receptacles and Heating

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Oxygen Handling

Response to Surge Inpatient Volume

Policy and Procedure Management

Safety Management Plan

Current Status: Pending

PolicyStat ID: 14999272



Providence
Little Company of Mary
Medical Center
Torrance

Origination: 11/2020
Effective: Upon Approval
Last Approved: N/A
Last Revised: 01/2024
Next Review: 3 years after approval
Owner: Debra Buffham: Executive
Director Nursing
Policy Area: Patient Care Services
References:
Applicability: CA - Providence LCM MC
Torrance

[Regional] Constant Observer (CO) Assessment, Implementation and Discontinuation

In keeping with the mission and values of Providence Saint Joseph Health, Providence Little Company of Mary Medical Center Torrance adopts the ~~“Constant Observer (CO) Assessment, Implementation and Discontinuation~~ Constant Observer (CO) Assessment, Implementation and Discontinuation” regional clinical policy for use in the following*:

Providence Little Company of Mary Medical Center Torrance:	
X	Acute Care
X	Transitional Care Center
	Providence Little Company of Mary Home Health

*An "x" identifies inclusion and the absence of an "x" indicates exclusion or exception.

Attachments

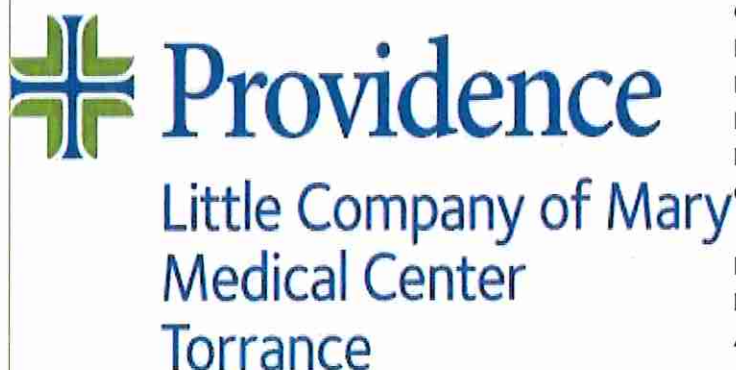
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Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024

Applicability

CA - Providence LCM MC Torrance



Origination: 02/2021
Effective: Upon Approval
Last Approved: N/A
Last Revised: 12/2023
Next Review: 3 years after approval
Owner: Maria Aoki: Director
Rehabilitation Services
Policy Area: Therapy Services
References:
Applicability: CA - PH&S Little Company of Mary Service Area

Therapy Services: Lymphedema and Related Disorders Program

POLICY:

In keeping with the mission and values of Providence Health & Services, it is the policy of the Rehabilitation Services Department at Providence Little Company of Mary Medical Center (PLCMMC) to deliver the most effective and efficient care to patients with lymphedema and other oncology diagnoses. The purpose of this policy is to provide instruction and training to facilitate functional independence for patients who have lymphedema as primary lymphedema or secondary lymphedema as a result of cancer surgery, lymphatic insufficiency, chronic venous insufficiency, general surgery, radiation, trauma to lymph nodes, or need general oncology rehabilitation.

PROCEDURE/GENERAL INSTRUCTIONS:

1. Target population

- A. Post-operative mastectomy, lumpectomy, or other cancer/general surgeries where lymph nodes have been ~~reseted~~ resected or obstructed, and the lymph transport system compromised.
- B. Lymphedema due to trauma, insufficiency of the lymphatic system and/or scarring from radiation treatment, or chronic venous insufficiency.
- C. Patients requiring increased flexibility and strength in affected limb(s) following surgeries or post radiation tissue changes where scar adhesions limit movement or function.
- D. Primary lymphedema (e.g. Milroy's Disease)
- E. Chronic venous insufficiency
- F. Patients requiring cancer rehabilitation

2. Indications

- A. The patient is evaluated by an Occupational or Physical Therapist certified in lymphedema management, and meets the following criteria:
 - 1. Sufficient cognition to follow instructions and motivated to incorporate techniques into their lifestyle

2. Medically stable - No active involved limb infections (~~has completed course of~~ no acute infection/cellulitis or 48-72 hours on antibiotics in addition to showing signs of resolution of symptoms), no active venous thromboembolism (VTE) or active congestive heart failure (CHF)

~~3. Body weight (<500 pounds and physical ability to participate in an ongoing home program~~

~~4. No acute infections/cellulitis or 48-72 hours on antibiotics~~

~~5.~~3. Able to actively participate or bring in a consistent caregiver who is physically able to participate in any ongoing home program

3. Program goals

- A. The patients attain maximum potential with all activities of daily living (ADL).
- B. Decrease edema and susceptibility to infection and facilitate development of permanent collateral drainage
- C. Decrease fibrosis and operative adhesions due to scarring and chronic disease process.
- D. Maximum range of motion (ROM), strength, and dexterity is achieved to facilitate functional independence.
- E. Pain reduction to within functional limits.
- F. Improve body image and quality of life
- G. The patient is proficient in methods of the following, where indicated/appropriate:
 - 1. Self manual lymph drainage (MLD)
 - 2. Positioning/Postural consideration
 - 3. ROM and strengthening exercises
 - 4. Vasopneumatic pump, if indicated
 - 5. Scar remodeling techniques
 - 6. Bandaging, and/or bandaging alternative systems, or compressive garment application, if indicated
- H. The patient is proficient in their home exercise program.
- I. The patient is instructed in skin care, lymphedema precautions, energy conservation techniques, and infection prevention

4. Procedure

- A. Initial visit
 - 1. Evaluation includes but is not limited to the following items when indicated:
 - a. Medical history
 - b. Allergies, medications, precautions
 - c. Cognition assessment
 - d. Wound assessment
 - e. Pain assessment

- f. ROM, Strength, coordination, and sensation assessment
 - g. Circumferential measurements
 - h. Skin inspection and assessment of lymphedema
 - i. Work history and ADL assessment
 - j. Social situation/adjustment
 - k. Functional assessment survey
 - l. Postural assessment
 - m. Gait assessment (Physical Therapy)
 - n. Compression garment education
2. Home exercise program of flexibility, postural correction, and lymphatic decongestion exercises and limb positioning is initiated.
3. Patient/family education is initiated with basic lymphedema precautions. Printed handouts are issued
- B. Subsequent visits
1. Each visit includes the following as indicated based on each individual patient care plan:
- a. ROM, strengthening, lymphatic decongestive exercises and scar remodeling
 - b. Manual lymph drainage
 - c. Intermittent sequential ~~vaspneumatic~~vasopneumatic pump
 - d. Patient education
 - e. Bandaging or bandage alternative system ~~lifting~~/modification
 - f. Dressing changes
 - g. Kinesiotaping
 - h. Joint and soft tissue mobilization
 - i. Splinting with secondary nerve complications
 - j. Low level laser
 - k. Instrument assisted soft tissue mobilization
 - ~~i. Lymphotouch~~
 - i. Lymphatouch or Phsio
2. During the course of therapy the following are addressed as indicated:
- a. Precautions, energy conservation and work simplification instruction
 - b. ADL training
 - c. Postural re-education
 - d. Training in use of ~~assistive~~assissitive devices

- e. Work simulation
- f. Upgrading of exercise programs
- g. Patient and family training in scar remodeling
- h. weekly summary reassessment with update of home exercise program treatment
- i. Patient/family training in self bandaging or application of bandage alternative systems

C. Final visits include the following as indicated:

1. Review and update of home exercise program
2. Patient and family training in manual lymphedema drainage, compression garment/bandaging
3. Facilitate issuance of compression garment with community vendors
4. Facilitate set up of home pump unit
5. Recommendation of ~~assistive~~ assistive devices
6. Referral to community program

D. Patient and family education includes the following as indicated:

1. Verbal and written instruction on lymphedema with detailed precautions and contraindications, skin conditioning, infection prevention, disease process
2. Written home exercise program/ADL handouts
3. Instruction in compensatory techniques
4. Instruction in use of compression garments and/or bandages, self massage and vasopneumatic pump
5. Handouts in appropriate body mechanics and energy conservation techniques/position, exercises and proper posture

REFERENCE(S)/RELATED POLICIES:

- American College of Surgeons - 2020 Standards - Optimal Resources for Cancer Care - Rehabilitation Care Services.
- Goldi, Michael, Prof. h.c. Dr. Med; Foldi, Ethel, Prof h.c. Dr. med. (2003). Textbook of Lymphology for Physicians and Lymphedema Therapists. Urban and Fischer.
- International Society of Lymphology. (2016 revision). Consensus document of the International Society of Lymphology. The diagnosis and treatment of peripheral lymphedema. *Lymphology*, 49 (2016) 170-184
- Lawenda, Brian, MD; Tammy DPT; Johnstone, Peter MD. (2009). Lymphedema: A Primer on the Identification and Management of Chronic Condition in Oncologic Treatment. *CA Cancer J Clin* 9, vol 59, number 1
- Petrek MD, J & Pressman MD, J. (2014). Lymphedema: Current issues in research and management. *Lymphatic Research CA: A Cancer Journal for Clinicians*
- Carati, C PhD; Anderson, S B.Sc.; Gannon, B PhD, Pillier; N PhD. (2003). Treatment of post-mastectomy Lymphedema with Low Level Laser Therapy - a double blind,, placebo-controlled trial. *Department of Anatomy, School of Medicine, Flinders University, Adelaide, South Australia, Australia.*
- Lasinski, B. MA, PT; Thrift, S. (2012, August). A systemic review of the evidence for complete decongestive therapy in the treatment of lymphedema from 2004 to 2011. *Physical Medicine and*

Rehabilitation, Elsevier, vol 4, issues 8 580-601.

- Moffatt, C. & International Lymphoedema Framework. (2006). *International consensus best practice for the management of lymphedema*. Medical Education Partnership (MEP) Ltd. Retrieved June 18, 2020.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
Policy Committee	Maria Aoki: Director Rehabilitation Services	12/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	12/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



Origination: 07/2009
Effective: Upon Approval
Last Approved: N/A
Last Revised: 02/2021
Next Review: 3 years after approval
Owner: Candice Washilewski: Executive Director Nursing
Policy Area: Patient Care Services
References:
Applicability: CA - Providence LCM MC Torrance

Gait Training and Progressive Ambulation

PURPOSE:

The purpose of this policy is to provide rehab guidelines for proper gait training and nursing staff guidelines for ambulation techniques for patients while promoting progressive healing and safety.

DEFINITION:

Gait training involves retraining or improving a patient's gait that has become impaired by disease and/or injury. These patients may require various types of assistive devices such as canes, crutches, walkers, and varying degrees of assistance, and they may also require therapeutic exercises to further improve their gait and balance. After the patient has been gait trained by physical therapy, they may require assistance for ambulation when skilled therapy is no longer necessary.

POLICY:

All patients will be assessed by an RN on admission. The functional screen and fall risk assessments will be completed at this time. Fall risk assessments will be done by the RN at time of admission and every shift thereafter. If the patient has a decline in their function or are high risk for falling, indicating a positive functional screen, a referral for physical therapy will be obtained from the Attending Physician. PT will then collaborate with the nursing team while addressing needs for gait training and ambulation. Therapy personnel are responsible for documentation of education that is being performed for patients, family and nursing staff that will care for the patient when PT is no longer necessary. The therapist must report to the patient's RN that therapy is no longer needed and document in the daily notes or the therapy discharge assessment.

RESPONSIBILITY:

Physical Therapist

PROCEDURE:

A. Preparation

1. Obtain relevant information from patient chart and/or by interviewing patient/family to identify ambulation risks:
 - a. Diagnosis

- b. Weight-bearing status, FWB (*full weight-bearing*), PWB (*partial weight-bearing*), NWB (*non-weight bearing*), etc.
 - c. Type of assistive equipment used
 - d. Distance patient is safe to ambulate
 - e. Special instructions/limitations, i.e., hip precautions, etc.
2. Preparing Patient for Ambulation
- a. Explain ambulation procedure.
 - b. Non-skid foot ware should be worn when ambulating
 - c. Place gait belt around patient's waist. Gait belts can be placed around the chest area if needed due to incisions. **ALL Patients who are high risk for falls MUST have a gait belt on for ambulation and should have two (2) staff for ambulation.**
 - d. Have assistive equipment (*walker or cane*) ready.

B. Technique:

Ambulating Patient

1. Position assistive device properly for patient and ensure it is at the proper height.
2. Provide necessary amount of assistance for patient to obtain an upright posture.
3. Give patient verbal and/or physical cues for appropriate use of assistive device as needed.
 - a. With walker, assistance is given standing on one side or behind as needed.
 - b. Cane (*type to be specified by P.T.*) carried in upper extremity opposite weakest lower extremity with assistance to be given standing on the patient's weak side.
 - c. Crutches: Assistance is given standing behind or to one (1) side.
4. Walk behind or to the involved side and slightly behind patient holding on to gait belt.
 - a. Make sure patient is bearing proper amount of weight.
 - b. Watch patient at all times.
5. Watch for signs of fatigue, DO NOT push patient beyond his/her capabilities.

Completing Ambulation Activity

1. When patient has finished ambulating, have the patient back in toward chair, wheelchair, or bed until he feels chair or bed at the back of his legs.
2. Have patient place one (1) hand at a time on the arms of the chair or on the bed and slowly lower onto the surface.
3. Remove gait belt from patient when seated.
4. Position patient comfortably in chair or bed as the situation indicates.

C. Documentation:

1. Distance completed with assistive device need
2. Duration of treatment.

3. Ability of the patient to tolerate the activity, fatigue, endurance, pain, etc.

4. Patient/family or staff education provided.

- D. Nursing Ambulation Responsibilities: All patients that have been cleared by the Physical Therapist for "Ambulation with Staff" will be assisted daily to ambulate by the nursing team in collaboration with therapy team's recommendations. Follow the same procedures outlined above. Therapy and nursing must document care to be provided in the interdisciplinary care plan.

Indication for ambulation with nursing staff: Patients who are able to weight bear on at least one lower extremity and use upper extremities with assistive devices or use both lower extremities and are at less than an independent level for ambulation.

Contraindication for ambulation with nursing staff: Patients who are on non-weight bearing status of both lower extremities, or one (1) lower extremity who cannot safely maintain this due to cognitive problems.

REFERENCE(S) / RELATED POLICES:

- Palmer, L. (1992). Manual for Functional Training, Ambulation and Gait Training, 137-139
- Community Medical Centers. (2003). Patient Care Policy Manual: Fall Precautions – Inpatient (Brochure).
- DeLisa, J. (2005). Physical Medicine and Rehabilitation, Lippincott Williams & Wilkins.
- Department of Veterans Affairs. (n.d.). VA National Center for Patient Safety Fall Prevention and Management. Retrieved April 12, 2004, from VA National Center for Patient Safety Web Site: <http://www.patientsafety.gov/FallPrev>
- Evans, D., Hodgkinson, B., Lambert, L., & Wood, J. (2001). Falls Risk Factors In The Hospital Setting: A Systematic Review. International Journal of Nursing Practice, 7, 38-45.
- GnataVICIUS, D. (2000). Do You Help Staff Rise To The Fall-Prevention Challenge? Nursing Management, 31(1), 27-30.
- The Joint Commission National Patient Safety Goal
- Ledford, L., & Titler, M. G. (Eds.). (1997). Research-Based Protocol: (Vol.). Iowa City: The University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core.
- Document Central policy number: LCT-PC-352

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
CPC	Cindy Wishon: Nurse Educator [PH]	12/2023
Policy Committee	Scott Ciesielski: Chief Nursing Officer	11/2023

Step Description	Approver	Date
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023
Applicability CA - Providence LCM MC Torrance		



Provident

Little Company of Mary Medical Center Torrance

Origination: N/A
Effective: Upon Approval
Last Approved: N/A
Last Revised: N/A
Next Review: 2 years after approval
Owner: Maria Virata: Point of Care Coordinator
Policy Area: Lab - Point of Care Testing
References:
Applicability: CA - Providence LCM MC Torrance

Abbott I-STAT System

	Laboratory Department Policies and Procedures		
Provident-Little	Subject:	Abbott i-Stat System	Initial and date
Company-of	Section:	Point of Care Testing	POCT Coordinator:
Mary Medical	Author:	Connie B. Ramirez	Laboratory Director:
Center-Torrance	Adopted: 09/19 Revised:		Medical Director:

ABBOTT i-STAT SYSTEM

1. PRINCIPLE

1. PRINCIPLE

1. The i-Stat System performs point of care blood analysis using a single disposable cartridge which contains micro-fabricated sensors, a calibrant solution, fluidics system, and a waste chamber.
2. The measurements of the different assays are electrochemical, using the micro-fabricated sensors housed in each cartridge to measure analyte concentrations directly in a single whole blood sample.
3. The analyzer used is the handheld i-Stat Portable Clinical Analyzer.
4. When a cartridge is filled with blood and inserted into the i-Stat Analyzer for analysis, it automatically controls all functions of the testing cycle including fluid movement within the cartridge, calibration, and continuous quality monitoring.
5. An Infrared Interface Link (IR Links) for handheld analyzers allows for transmission of patient records from several analyzers to the DE software and in to the QML program.
6. Data can then be stored, organized, edited, and is transferred to Providence little company of Mary's LIS system.

1. OPERATORS

2. OPERATORS

1. Only qualified, trained personnel shall operate the Abbot I-Stat® instrument.

2. Personnel may include Clinical Laboratory Scientists and Registered Nurses.
3. Competency testing is done 6 months after initial training and annually thereafter.

~~2.2. Personnel may include Clinical Laboratory Scientists and Registered Nurses.~~

~~2.3 Competency testing is done 6 months after initial training and annually thereafter.~~

~~1. SPECIMENS COLLECTION AND PREPARATION~~

3. SPECIMENS COLLECTION AND PREPARATION

1. Follow all safety policies and use universal precautions when collecting and handling blood specimens.
 - 3.1.1 You must clean the I-stat analyzer between patient use when I-stats are used in direct patient care and when analyzer is visibly soiled. Wipe the I-stat analyzer with Sani-cloth wipe, or a 10% bleach solution.
 - 3.1.2 Do not allow any cleaning product to enter the I-stat cartridge port.
 - 3.1.3 The i-STAT System tests can be performed using venous or arterial samples. (Venipunctures and Arterial Punctures.)
2. **Specimen for Troponin, Chem8+ and B-HCG:**
 - 3.2.1 Fresh whole blood collected in a Lithium Heparin (Green Top) Vacutainer tube. Fill collection tube to capacity. Test within 30 minutes.
3. **Indwelling line.**
 1. Fluid drip through the line must be discontinued.
 2. If blood must be drawn from an indwelling line, possible heparin contamination and specimen dilution should be considered, the line should be flushed with 5mL. Of saline and the first 5 mL. of blood or six dead space volumes. Withdraw the sample for testing into appropriate vacutainer.
4. **Extracorporeal line.**
 1. Flush the extracorporeal blood access line by withdrawing 5 mL. of blood into a syringe and discard the syringe.
 2. Withdraw the sample for testing into appropriate vacutainer.

~~1. Specimen Labeling:~~

4. Specimen Labeling :

1. The specimen container must be labeled with the following information:
 - a. Patient first and last name
 - b. Patient Medical Record Number (MR#)
 - c. Time and date of collection
 - d. Collector ID.

~~1. Criteria for Specimen Rejection:~~

~~1. Evidence of clotting:~~

~~2. Specimens collected in vacuum tubes with anticoagulant like lithium or sodium heparin~~

2 Criteria for Specimen Rejection:

- a. Evidence of clotting.
- b. Specimens collected in vacuum tubes with anticoagulant like lithium or sodium heparin

5. Precautions: Avoid the following circumstances

1. Drawing a specimen from an arm with an I.V.
2. Stasis (tourniquet left on longer than one minute before venipuncture)
3. Extra muscle activity (fist pumping)
4. Hemolysis (alcohol left over puncture site, or a traumatic draw)

5. EQUIPMENT/MATERIALS and STORAGE REQUIREMENTS:

6. ~~Precautions: avoid the following circumstances~~

- ~~1. Drawing a specimen from an arm with an I.V.~~
- ~~2. Stasis (tourniquet left on longer than one minute before venipuncture)~~
- ~~3. Extra muscle activity (fist pumping)~~
- ~~4. Hemolysis (alcohol left over puncture site, or a traumatic draw)~~

5. ~~EQUIPMENT/MATERIALS and STORAGE REQUIREMENTS:~~

6. ~~Cartridges:~~

- ~~1. Cartridges are sealed in individual pouches or portion packs.~~
- ~~2. Store the main supply of cartridges at a temperature between 2 to 8°C (35 to 46°F).~~
- ~~3. Do not allow cartridges to freeze.~~
- ~~4. Cartridges may be stored at room temperature (18 to 30°C or 64 to 86°F) for the time frame indicated on the cartridge box.~~
- ~~5. Cartridges should not be returned to the refrigerator once they have been at room temperature and should not be exposed to temperatures above 30°C (86°F).~~
- ~~6. If the pouch has been punctured, the cartridge should not be used.~~
- ~~7. Write the date on the cartridge box or individual cartridge pouches to indicate the room temperature expiration date.~~
- ~~8. Cartridges should remain in pouches until time of use.~~
- ~~9. Do not use after the labeled expiration date.~~

Cartridges	Room Temp Storage
Troponin, Chem8+ and B-HCG	14 Days

7. ~~Controls:~~

Analyte	Chem8+	Troponin	B-HCG
Form	Ready to Use Liquid Controls	Frozen Liquid Controls	Ready to Use Liquid Controls

Stability unopened	Refrigerated 2-8°C. until printed expiration	Frozen @ ≤ -18 until expiration date	Refrigerated 2-8°C. until printed expiration
Stability once opened	At room temperature (18 to 30 °C, for five days.	4 hours when stored at 2-8°C	30 days at 2-8°C
Number of Levels	Three Levels	Three Levels	Three Levels

8. Electronic Simulator:

1. The external electronic simulator is a quality control device for the analyzer's cartridge signal-reading function. It simulates two levels of electrical signals that stress the analyzer's cartridge signal detection function both below and above measurement ranges.
2. Store at room temperature and protect contact pads from contamination by replacing the plastic cap and placing the Electronic Simulator in its protective case after use.

9. Blood Collection Equipment:

1. Skin puncture: not recommended. Except for PT/INR testing.
2. Venipuncture and arterial puncture should be collected in a lithium Heparin Vacutainer (Green top tube)

Cartridges:

- a. Cartridges are sealed in individual pouches or portion packs.
- b. Store the main supply of cartridges at a temperature between 2 to 8°C (35 to 46°F).
- c. **Do not allow cartridges to freeze.**
- d. Cartridges may be stored at room temperature (18 to 30°C or 64 to 86°F) for the time frame indicated on the cartridge box.
- e. **Cartridges should not be returned to the refrigerator once they have been at room temperature and should not be exposed to temperatures above 30°C (86°F).**
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<u>Cartridges</u>	<u>Room Temp Storage</u>
Troponin , Chem8+ and B-HCG	14 Days

7. Controls:

<u>Analyte</u>	<u>Chem8+</u>	<u>Troponin</u>	<u>B-HCG</u>
<u>Form</u>	Ready to Use Liquid Controls	Frozen Liquid Controls	Ready to Use Liquid Controls
<u>Stability unopened</u>	Refrigerated 2-8°C. until printed expiration	Frozen @ ≤ -18 until expiration date	Refrigerated 2-8°C. until printed expiration

<u>Stability once opened</u>	<u>At room temperature (18 to 30 °C, for five days.</u>	<u>4 hours when stored at 2-8°C</u>	<u>30 days at 2-8 °C</u>
<u>Number of Levels</u>	<u>Three Levels</u>	<u>Three Levels</u>	<u>Three Levels</u>

8. **Electronic Simulator:**

- a. The external electronic simulator is a quality control device for the analyzer's cartridge signal-reading function. It simulates two levels of electrical signals that stress the analyzer's cartridge signal detection function both below and above measurement ranges.
- b. Store at room temperature and protect contact pads from contamination by replacing the plastic cap and placing the Electronic Simulator in its protective case after use.

9. **Blood Collection Equipment:**

- a. Skin puncture: not recommended. Except for PT/INR testing.
- b. Venipuncture and arterial puncture should be collected in a lithium Heparin Vacutainer (Green top tube)

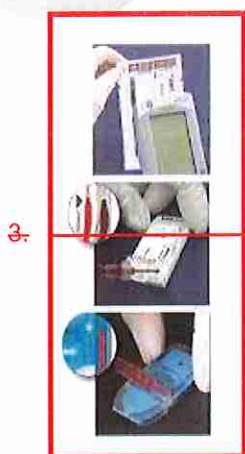
10. **PROCEDURE FOR ANALYSIS**

1. **Preparation for Use**

1. ~~An individual cartridge may be used after standing 5 minutes, in its pouch, at room temperature. An entire box should stand at room temperature for one hour before cartridges are used.~~

2. **Procedure for Cartridge Testing**



1. ~~DO NOT insert cartridge to start test.~~
2. ~~DO NOT open cartridge pouch before scanning the barcode.~~





3.

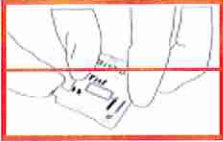
~~If Quality Check Code 60 or 140 appears, see Analyzer Coded~~


Messages Technical Bulletin for Troubleshooting Information.

1.	Press		to turn on handheld.
2.	Press		for i-STAT.
3.	Follow the handheld prompts.		
4.	Scan the lot number on the cartridge pouch.		

	<ul style="list-style-type: none"> Position barcode 3-9 inches from scanner window on handheld.
<ul style="list-style-type: none"> Press and hold  to activate the scanner. 	
<ul style="list-style-type: none"> Align the red laser light so it covers the entire barcode. 	
<ul style="list-style-type: none"> The handheld will beep when it reads the barcode successfully. 	
<p>Note: If cartridge pouch does not have a barcode, enter the lot number manually using the numbered keys or press  to bypass the prompt. You may ignore any letters in the lot number.</p>	

2. Applying the sample

- 

Handle the cartridge from its edges and avoid touching the contact pads or exerting pressure over the center of the cartridge.
- Following thorough mixing of the sample, discard 1 drop from the delivery device to clear unseen bubbles.
- Touch the next drop to the well allowing cartridge to draw sample in. DO NOT use a needle. Fill only to the "RED FILL LINE" diagram.
- 

Close the cartridge by using the thumb and index finger of one hand to grasp the cartridge from its side edges away from the sample inlet. Use the thumb of the other hand to slide the plastic closure clip to the right until it locks into place over the sample well.
- NOTE: When sliding the closure clip, do not place fingers near the sample well.
- Push the sealed cartridge into the handheld port until it clicks into place. Wait for the test to complete.
- NOTE: Do not remove the cartridge while 'Cartridge Locked' message is displayed on the screen.
- Note: For ACT, Hct, and immuneassay testing, the handheld must remain on a level surface with the display facing up during testing. A level surface includes running the handheld in the downloader/recharger.
- Review results.

a. Preparation for Use

- An individual cartridge may be used after standing 5 minutes, in its pouch, at room temperature. An entire box should stand at room temperature for one hour before cartridges are used.





2. Procedure for Cartridge Testing

1. DO NOT insert cartridge to start test.
2. DO NOT open cartridge pouch before scanning the barcode.

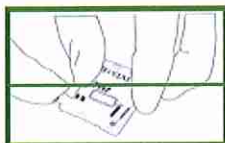


3. If Quality Check Code 69 or 140 appears, see Analyzer Coded

Messages Technical Bulletin for Troubleshooting Information.

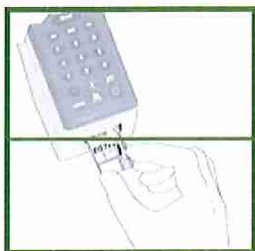
1.	<u>Press</u>		<u>to turn on handheld.</u>
2.	<u>Press</u>		<u>for i-STAT.</u>
3.	<u>Follow the handheld prompts.</u>		
4.	<u>Scan the lot number on the cartridge pouch.</u>		
	▪ <u>Position barcode 3-9 inches from scanner window on handheld.</u>		
	▪ <u>Press and hold</u>		<u>to activate the scanner.</u>
	▪ <u>Align the red laser light so it covers the entire barcode.</u>		
	▪ <u>The handheld will beep when it reads the barcode successfully.</u>		
<u>Note: If cartridge pouch does not have a barcode, enter the lot number manually using the numbered keys or press  to bypass the prompt. You may ignore any letters in the lot number.</u>			

b. Applying the sample



1. Handle the cartridge from its edges and avoid touching the contact pads or exerting pressure over the center of the cartridge.
2. Following thorough mixing of the sample, discard 1 drop from the delivery device to clear unseen bubbles.
3. Touch the next drop to the well allowing cartridge to draw sample in. DO NOT use a needle. Fill only to the "RED FILL LINE" diagram.

4.



Close the cartridge by using the thumb and index finger of one hand

to grasp the cartridge from its side edges away from the sample inlet. Use the thumb of the other hand to slide the plastic closure clip to the right until it locks into place over the sample well.

5. NOTE: When sliding the closure clip, do not place fingers near the sample well.

6. Push the sealed cartridge into the handheld port until it clicks into place. Wait for the test to complete.

7. NOTE: Do not remove the cartridge while 'Cartridge Locked' message is displayed on the screen.

8. Note: For ACT, Hct, and immunoassay testing, the handheld must remain on a level surface with the display facing up during testing. A level surface includes running the handheld in the downloader/recharger.

9. Review results.

11. RESULTS:

1. ~~Calculations~~

~~1. The i-STAT handheld contains a microprocessor that performs all calculations required for reporting results.~~

2. ~~Displayed Results~~

~~1. Results are displayed numerically with their units. Electrolyte, chemistry, and hematocrit results are also depicted as bar graphs with reference ranges marked under the graphs.~~

3. ~~Critical Results~~

~~1. Critical Results will be flagged on the meter and will require a critical result comment code.~~

~~1. Action:~~

~~2. Enter 1 to acknowledge the critical result and signify that test will be repeated. Enter a critical value comment code of 9 to indicate a nurse or doctor are notified or 10 to indicate that a stat specimen is being sent to the lab.~~

4. ~~Suppressed Results~~

~~There are three conditions under which the i-STAT System will not display results:~~

~~1. Results outside the System's reportable ranges are flagged with a < or >, indicating that the result is below the lower limit or above the upper limit of the reportable range respectively. (See the table of Reportable Ranges.) The < > flag indicates that the results for this test were dependent on the result of a test flagged as either > or <.~~

~~1. Action:~~

~~1. Enter a critical value comment code of 9 to indicate a nurse or doctor are notified or 10 to indicate that a stat specimen is being sent to the lab. Order and send a sample to~~

~~the clinical lab.~~

- ~~2. Cartridge results which are not reportable based on internal QC rejection criteria are flagged with ***.~~

~~1. Action:~~

- ~~1. Analyze the specimen again using a fresh sample and another cartridge. If the result is suppressed again, send specimen(s) to the laboratory for analysis.~~

- ~~3. A Quality Check message will be reported instead of results if the handheld detects a problem with the sample, calibrant solution, sensors, or mechanical or electrical functions of the handheld during the test cycle.~~

~~1. Action:~~

- ~~1. Take the action displayed with the message that identifies the problem. Refer to i-STAT 1 System Manual's troubleshooting section or the "Analyzer Coded Messages" Technical Bulletin if necessary. Contact the POCT Coordinator or i-STAT technical support at 1-800-366-8020 if you have repeated quality code errors, use another analyzer if available. A backup i-STAT Analyzer is available in the clinical lab if necessary. Include documentation of problems with the analyzer when bringing your i-STAT to the lab for replacement.~~

5. Printing and Transmitting Results

Note: Printouts are not suitable as a permanent chartable record.

1. Without Downloader or Downloader/Recharger:

1. Turn printer on if green power light is not on.
2. Align IR windows of handheld and printer.
3. Display results.
4. Press the Print key.
5. Do not move handheld or printer until printing is complete.
6. If printer is not powered from a wall outlet, turn printer off.

2. With Downloader or Downloader/Recharger

1. Place handheld in Downloader or Downloader/Recharger that is wired to the printer.
2. Display results.
3. Press the Print key.
4. Do not move handheld or printer until printing is complete.

3. Printing more than one result

1. Turn the handheld on.
2. Press the Menu key.
3. Press 2 for Data Review.
4. Press 7 for List.

5. Scroll through the test records using the arrow keys.
6. Press the numbered key for the test record(s). (Press the numbered key again to deselect a record.)
7. Align handheld and printer IR window or place in Downloader or Downloader/Recharger attached to printer. Press the Print key.
8. Do not move handheld or printer until printing is complete.
9. If printer is not powered from a wall unit using the AC adapter, turn printer off.
4. **Transmitting Results from the i-STAT 1 Analyzer to the Data Manager**
 1. Place handheld in a Downloader or Downloader/Recharger.
 2. Do not move handheld while the message "Communication in Progress" is displayed. If this message does not appear within 10 seconds, remove i-STAT from downloader.
 3. Disconnect power to downloader and reconnect. Check Ethernet cable also. Contact Point of Care coordinator at 35211 if problems persist.

a. Calculations

1. The i-STAT handheld contains a microprocessor that performs all calculations required for reporting results.

b. Displayed Results

1. Results are displayed numerically with their units. Electrolyte, chemistry, and hematocrit results are also depicted as bar graphs with reference ranges marked under the graphs.

c. Critical Results

1. Critical Results will be flagged on the meter and will require a critical result comment code.
 1. **Action:**
 2. Enter 1 to acknowledge the critical result and signify that test will be repeated. Enter a critical value comment code of 9 to indicate a nurse or doctor are notified or 10 to indicate that a stat specimen is being sent to the lab.

d. Suppressed Results

There are three conditions under which the i-STAT System will not display results:

1. Results outside the System's reportable ranges are flagged with a < or >, indicating that the result is below the lower limit or above the upper limit of the reportable range respectively. (See the table of Reportable Ranges.) The < > flag indicates that the results for this test were dependent on the result of a test flagged as either > or <.
 1. **Action:**
 1. Enter a critical value comment code of 9 to indicate a nurse or doctor are notified or 10 to indicate that a stat specimen is being sent to the lab. Order and send a sample to the clinical lab.
2. Cartridge results which are not reportable based on internal QC rejection criteria are flagged with ***.
 1. **Action:**

1. Analyze the specimen again using a fresh sample and another cartridge. . If the result is suppressed again, send specimen(s) to the laboratory for analysis.

3. A Quality Check message will be reported instead of results if the handheld detects a problem with the sample, calibrant solution, sensors, or mechanical or electrical functions of the handheld during the test cycle.

1. **Action:**

1. Take the action displayed with the message that identifies the problem. Refer to i-STAT 1 System Manual's troubleshooting section or the "Analyzer Coded Messages" Technical Bulletin if necessary. Contact the POCT Coordinator or i-STAT technical support at 1-800-366-8020 if you have repeated quality code errors, use another analyzer if available. A backup i-STAT Analyzer is available in the clinical lab if necessary. Include documentation of problems with the analyzer when bringing your i-STAT to the lab for replacement.

e. Printing and Transmitting Results

Note: Printouts are not suitable as a permanent chartable record.

1. **Without Downloader or Downloader/Recharger:**

1. Turn printer on if green power light is not on.
2. Align IR windows of handheld and printer.
3. Display results.
4. Press the Print key.
5. Do not move handheld or printer until printing is complete.
6. If printer is not powered from a wall outlet, turn printer off.

2. **With Downloader or Downloader/Recharger**

1. Place handheld in Downloader or Downloader/Recharger that is wired to the printer.
2. Display results.
3. Press the Print key.
4. Do not move handheld or printer until printing is complete.

3. **Printing more than one result**

1. Turn the handheld on.
2. Press the Menu key.
3. Press 2 for Data Review.
4. Press 7 for List.
5. Scroll through the test records using the arrow keys.
6. Press the numbered key for the test record(s). (Press the numbered key again to deselect a record.)
7. Align handheld and printer IR window or place in Downloader or Downloader/Recharger attached to printer. Press the Print key.

8. Do not move handheld or printer until printing is complete.
9. If printer is not powered from a wall unit using the AC adapter, turn printer off.

4. Transmitting Results from the i-STAT 1 Analyzer to the Data Manager

1. Place handheld in a Downloader or Downloader/Recharger.
2. Do not move handheld while the message "Communication in Progress" is displayed. If this message does not appear within 10 seconds, remove iSTAT from downloader.
3. Disconnect power to downloader and reconnect. Check Ethernet cable also. Contact Point of Care coordinator at 35211 if problems persist.

12. **QUALITY CONTROL**

4. **DAILY PROCEDURES:**

1. **Electronic Quality Control:**

Electronic Simulators:

~~The Electronic Simulator (both external and internal) is a quality control device for the analyzer. It simulates two levels of electrical signals that stress the analyzer's signal detection function both below and above measurement ranges. It provides an independent check on the ability of the analyzer to take accurate and sensitive measurements- of voltage, current and resistance from the cartridge. An analyzer will pass or fail this test depending on whether or not it measures these signals within specified limits. The Electronic Simulator will fail if high relative humidity interferes with the measurements, making separate recording of humidity unnecessary.~~

1. **Internal Electronic Simulator:**

- ~~1. The Internal Electronic Simulator runs every 8 hours for blood gases and for all the analytes every 24 hours.~~
- ~~2. Inserting a cartridge triggers the internal simulator. When 8 hours has elapsed since the last Electronic Simulator test (internal or external), it will automatically perform the internal test before the sample is tested, adding about 15-20 seconds to the testing cycle.~~

2. **External Electronic Simulator:**

- ~~1. The External Electronic Simulator is a stable electronic device, which is inserted into the cartridge port of the analyzer as described above. It should be run when:~~

a. **DAILY PROCEDURES:**

1. **Electronic Quality Control:**

Electronic Simulators:

The Electronic Simulator (both external and internal) is a quality control device for the analyzer. It simulates two levels of electrical signals that stress the analyzer's signal detection function both below and above measurement ranges. It provides an independent check on the ability of the analyzer to take accurate and sensitive measurements- of voltage, current and resistance from the cartridge. An analyzer will pass or fail this test depending on whether or not it measures these signals within specified limits. The Electronic Simulator will fail if high relative humidity interferes with the measurements, making separate recording of humidity unnecessary.

1. **Internal Electronic Simulator:**

1. The Internal Electronic Simulator runs every 8 hours for blood gases and for all the

analytes every 24 hours.

2. Inserting a cartridge triggers the internal simulator. When 8 hours has elapsed since the last Electronic Simulator test (internal or external), it will automatically perform the internal test before the sample is tested, adding about 15-20 seconds to the testing cycle.

2. External Electronic Simulator:

1. The External Electronic Simulator is a stable electronic device, which is inserted into the cartridge port of the analyzer as described above. It should be run when:

- ~~a. The analyzer has been dropped.~~
- ~~b. Every six months~~
- ~~c. After major malfunction~~
- ~~d. Replacement analyzer received from i-STAT.~~
1. Verify the performance of each handheld in the i-STAT System using the internal or external Electronic Simulator every 24 hours of use, or as needed for regulatory compliance.
2. In the USA, verification is required every 8 hours.
3. The internal electronic simulation is automatically programmed to run every 8 hours of use.
4. The i-STAT is automatically programmed to lock out being used if the internal or external simulator does not pass the quality control.
- a. The analyzer has been dropped.
- b. Every six months
- c. After major malfunction
- d. Replacement analyzer received from i-STAT.
- e. Verify the performance of each handheld in the i-STAT System using the internal or external Electronic Simulator every 24 hours of use, or as needed for regulatory compliance.
- f. In the USA, verification is required every 8 hours.
- g. The internal electronic simulation is automatically programmed to run every 8 hours of use.
- h. The i-STAT is automatically programmed to lock out being used if the internal or external simulator does not pass the quality control.

To run external Simulator:

- a. Press the Menu key to access the Administration menu.
- b. Press the #3 for Quality test.
- c. Press the #4 for Simulator
- d. Insert the simulator into the analyzer with the "I" facing up. (Do not touch the contact pads).

Cartridge Locked is displayed indicating that the simulator should not be removed. DO NOT ATTEMPT TO REMOVE THE SIMULATOR WHILE THE Cartridge Locked MESSAGE IS DISPLAYED. AN ATTEMPT TO REMOVE FORCIBLY THE SIMULATOR DURING THIS CYCLE MAY DAMAGE THE ANALYZER.

1. Electronic Simulator Results and Action:

1. If **PASS** is displayed on the handheld screen (after using the external Electronic Simulator)

1. Remove the external Electronic Simulator after the LCK or Simulator Locked message disappears from the display screen.
2. Transmit the result to the Central Data Station.
3. Use the handheld as required.

Note: If the internal Electronic Simulator is used, the "PASS" message will not be displayed on the handheld screen. The "PASS" record will appear in the handheld's stored results for transmission to the Central Data Station.

2. If **FAIL** is displayed on the analyzer screen:

1. Repeat the procedure with the same external Electronic Simulator or rerun the cartridge if the internal Electronic Simulator is being used. If PASS is displayed use the handheld as required.
2. If FAIL is displayed repeat the procedure with a different external Electronic Simulator.
3. If PASS is displayed with the second external Electronic Simulator:
4. Use the handheld as required.
5. Deliver the questionable external Electronic Simulator to the i-STAT System Coordinator.
6. If Fail is displayed with the second external Electronic Simulator:
7. DO NOT analyze patient samples with the handheld.
8. Transmit the results to the Central Data Station. Contact the POCT Coordinator at ext. 35211.
9. Deliver the faulty handheld to the i-STAT System Coordinator or Clinical Lab for a backup meter.
10. Record the failure in the i-STAT QC Log along with the action taken.

The IStat will lock out users from performing patient testing until the simulator displays PASS and electronic control is successful.

2. Verification of Cartridge Storage Condition

1. Refrigerated Cartridges

1. Verify that the cartridges stored in the refrigerator are all within the expiration date printed on the boxes, deliver any expired cartridges to the i-STAT System Coordinator.
2. Verify that the refrigerator did not exceed the limits of 2 to 8 °C (35 to 46°F).
3. Document in the i-STAT QC Log.

Action:

If the temperature of the cartridge storage refrigerator is within the range of 2 to 8°C (35 to 46°F) use cartridges as required. **The clinical lab stores I- Stat cartridges in a 24 hour a day monitored refrigerator.**

If the temperature of the cartridge storage refrigerator is outside the range of 2 to 8°C (35 to 46°F), quarantine the cartridges into the storage refrigerator. Notify the i-STAT System Coordinator immediately. DO NOT USE the cartridges from this refrigerator. Record the QC failure in the i-STAT QC Log along with the action taken.

2. Room Temperature Cartridges

1. Verify that all boxes of cartridges at room temperature have been out of the refrigerator less than the time frame indicated on the cartridge box.
2. Deliver any expired cartridges to the i-STAT System Coordinator. Verify that room temperature has not exceeded 30°C (86°F).
3. Document in the i-STAT QC Log.

Action:

If the measured temperature of the room has been continuously below 30°C (86°F) use cartridges as required.

If the measured temperature of the room has been continuously above 30°C (86°F) for any period of time:

Quarantine the cartridges. Notify the i-STAT System Coordinator immediately.

DO NOT USE the cartridges. Record the out-of-control event in the i-STAT QC Log and the action taken.

1. MONTHLY PROCEDURES

1. Print Electronic Simulator Results

1. Print a copy of the Electronic Simulator results from the Central Data Station.
2. Include the report in the i-STAT QC Log.
3. CDS version 5 and above: Click on the Simulator Viewer.

2. Print Control Fluid Analysis Results

1. Print results for any control fluids analyzed from the Central Data Station.
2. Include the report in the i-STAT QC Log.
3. CDS version 5 and above: Click on the Simulator Viewer.

3. Periodic Control Fluid Analysis Results

1. For acceptance of newly received cartridge lots, check the Temperature Monitor and perform integrity testing.
2. Note: This is not a manufacturer's system instruction.
3. It is a suggestion to comply with regulatory requirements that may pertain to your laboratory.

4. Check Temperature Monitor

1. i-STAT cartridges are shipped refrigerated with a four-window indicator to monitor temperature during transit.
2. Note: All control and calibration verification materials, except for those shipped on dry ice, will also include a four-window indicator to monitor temperature during transit.

Action:

3. Fill out the record of receipt and forward materials to refrigerator.
4. If all windows are white or if only the A or B windows are blue or the 1 or 2 Windows are red, then transit temperatures were satisfactory and the cartridges can be used.
5. If the C or D windows are blue, or the 3 or 4 windows are red:
 - a. Quarantine the suspect cartons.
 - b. Notify the i-STAT System Coordinator immediately.

- c. DO NOT USE cartridges from the suspect cartons.
- d. Record the out-of-control event in the i-STAT QC Log.

1. Integrity Testing* (Liquid Quality Control):

- 1. Verify the integrity of cartridges included in every shipment, upon receipt, by analyzing the appropriate levels of controls for each test you are performing.
- 2. **Note:** the information in the above paragraph is not a manufacturer's system instruction, it is a suggestion to comply with regulatory requirements that may pertain to your laboratory.

3. Liquid Quality Control must be performed:

- a. On every analyzer prior to initial placement for patient testing
- b. On every new lot number and every new shipment of cartridges
- c. When there's a suspected cartridge or storage problem
- d. On any back up analyzer placed in use before patient testing
- e. On all cartridge/reagent types as well as all analytes. If the same analyte occurs on multiple
- f. Cartridge/reagent types, it must be tested on every cartridge/reagent type.
- g. Monthly to check storage conditions of cartridges.

4. Control Testing Procedure:

4. Procedure for testing cartridges with i-STAT TriControls Level 1, 2 and 3 Controls for Chem8+ and B-HCG:

- 1. Prior to testing cartridges, ampules may be used once the fluid has reached room temperature, approximately 30 minutes for individual ampules. For best results, ampules, cartridges and analyzers should be at the same temperature.
- a. Press ON to turn on handheld.
- b. Press MENU to change screen to Administration Menu.
- c. Press #3 for the Quality Tests menu.
- d. Press #1 for Control.
- 1. Immediately before use, shake the ampule vigorously for 5-10 seconds to equilibrate the liquid and gas phases. To shake, hold the ampule at the top and bottom with forefinger and thumb to minimize increasing the temperature of the solution. If necessary, tap the tip of the ampule to send solution back into the bottom section of the ampule. Protect fingers with gauze, tissue, or glove, or use an ampullate breaker to snap off the tip of the ampule at the neck.
- 2. Immediately transfer the solution from the ampule into a syringe.
- 3. When using a syringe (1 cc or 3 cc syringes with 16 to 20 gauge needles are recommended), slowly draw approximately 1 mL of solution from the bottom of the ampule. If air is trapped between the leading edge of the solution and the plunger, do not invert the syringe to expel it; this will not affect solution near the tip of the syringe. If air bubbles are continually drawn into the syringe, or if a bubble is trapped near the tip of the syringe, discard the ampule and syringe, and use a fresh ampule or syringe. Expel one or two drops from the syringe before filling the cartridge.
- 4. Do not use solution left in the syringe, ampule, or capillary tube for additional testing of the cartridges that

contain sensors for ionized calcium, pH, pCO₂ or pO₂. However, cartridges without these sensors may be tested with remaining fluids if within 10 minutes of opening the ampule.

5. Fill the cartridge with the control fluid. Fold the closure over the sample well until it snaps into place.
6. Push cartridge into the handheld port until it clicks into place, and do not remove until the "DO NOT REMOVE CARTRIDGE — CARTRIDGE LOCKED" message is gone.
7. Review Results
8. Compare results on handheld to the Value Assignment Sheet.
If any result is out of range, repeat the control testing with a fresh ampule and syringe.
11.1.10 If any result is still out of range, do not use the cartridge lot, and call POCT coordinator.

1. **Special Procedure for testing cartridges with i-STAT TriControls Level 1, 2 and 3 Controls for Troponin. — Control Testing Procedure:**

The Procedure of Testing is similar to the Chem8+ controls but the Control materials are different.

Do not use if the controls arrive thawed or uncapped.

Remove vial from freezer and thaw at room temperature (18-30°C) for 15 minutes.

Gently invert the vial 10 times, then swirl the vial 10 times. Inspect the sides of the vial to ensure that no particulate matter is clinging to the sides of the vial. If solids are observed in the control fluid or on the vial wall, repeat the mixing procedure. If further mixing does not homogenize the sample, discard the vial and thaw a fresh vial.

Open the vial and transfer a drop of solution directly from the vial into the Troponin cartridge and seal the cartridge. If short term storage (<4 hrs) is desired, tightly recap the bottle immediately after all sampling is complete, and store at 2-8°C.

Follow the same steps as in Chem8+ procedure.

NOTE: Do not remove the cartridge while 'Cartridge Locked' message is displayed on the screen.

The results will then be displayed on the screen. Compare results to the value assignment sheet ranges. If results are within the expected ranges, use the cartridges as needed. Record your results.

Remove the cartridge after the 'Cartridge Locked' message disappears. The analyzer is ready for the next test immediately.

1. **Procedure for testing cartridges with i-STAT TriControls Level 1, 2 and 3 Controls for Chem8+ and B-HCG:**

1. Prior to testing cartridges, ampules may be used once the fluid has reached room temperature, approximately 30 minutes for individual ampules. For best results, ampules, cartridges and analyzers should be at the same temperature.
 - i. Press ON to turn on handheld.
 - ii. Press MENU to change screen to Administration Menu.
 - iii. Press #3 for the Quality Tests menu.
 - iv. Press #1 for Control.
2. Immediately before use, shake the ampule vigorously for 5-10 seconds to equilibrate the liquid and gas phases. To shake, hold the ampule at the top and bottom with forefinger and thumb to minimize increasing the temperature of the solution. If necessary, tap the tip of the ampule to send solution

back into the bottom section of the ampule. Protect fingers with gauze, tissue, or glove, or use an ampullate breaker to snap off the tip of the ampule at the neck.

3. Immediately transfer the solution from the ampule into a syringe.
4. When using a syringe (1 cc or 3 cc syringes with 16-to-20-gauge needles are recommended), slowly draw approximately 1 mL of solution from the bottom of the ampule. If air is trapped between the leading edge of the solution and the plunger, do not invert the syringe to expel it; this will not affect solution near the tip of the syringe. If air bubbles are continually drawn into the syringe, or if a bubble is trapped near the tip of the syringe, discard the ampule and syringe, and use a fresh ampule or syringe. Expel one or two drops from the syringe before filling the cartridge.
5. Do not use solution left in the syringe, ampule, or capillary tube for additional testing of the cartridges that contain sensors for ionized calcium, pH, pCO₂ or pO₂. However, cartridges without these sensors may be tested with remaining fluids if within 10 minutes of opening the ampule.
6. Fill the cartridge with the control fluid. Fold the closure over the sample well until it snaps into place.
7. Push cartridge into the handheld port until it clicks into place, and do not remove until the "DO NOT REMOVE CARTRIDGE – CARTRIDGE LOCKED" message is gone.
8. Review Results
9. Compare results on handheld to the Value Assignment Sheet.
If any result is out of range, repeat the control testing with a fresh ampule and syringe.
11.1.10 If any result is still out of range, do not use the cartridge lot, and call POCT coordinator.
10. **Special Procedure for testing cartridges with i-STAT TriControls Level 1, 2 and 3 Controls for Troponin.:**
 1. The Procedure of Testing is similar to the Chem8+ controls but the Control materials are different.
 2. **Do not use if the controls arrive thawed or uncapped.**
 3. Remove vial from freezer and thaw at room temperature (18-30°C) for 15 minutes.
 4. Gently invert the vial 10 times, then swirl the vial 10 times. Inspect the sides of the vial to ensure that no particulate matter is clinging to the sides of the vial. If solids are observed in the control fluid or on the vial wall, repeat the mixing procedure. If further mixing does not homogenize the sample, discard the vial and thaw a fresh vial.
 5. Open the vial and transfer a drop of solution directly from the vial into the Troponin cartridge and seal the cartridge. If short-term storage (<4 hrs) is desired, tightly recap the bottle immediately after all sampling is complete, and store at 2-8°C.
 6. Follow the same steps as in Chem8+ procedure.
NOTE: Do not remove the cartridge while 'Cartridge Locked' message is displayed on the screen.
 7. The results will then be displayed on the screen. Compare results to the value assignment sheet ranges. If results are within the expected ranges, use the cartridges as needed. Record your results.
 8. Remove the cartridge after the 'Cartridge Locked' message disappears. The analyzer is ready for the next test immediately.

1. Calibration and Calibration verification:

1. Calibration:

1. Calibration is automatically performed as part of the test cycle on each cartridge. Cartridges are self-calibrating. Operator intervention is not necessary.
2. Every cartridge includes a sealed foil pack, which contains a calibrant solution with a known concentration of each analyte.
 - 12.1.2.1 During the first part of the testing cycle, the calibrant solution is automatically forced out of the foil pack and over the sensors.
 - 12.1.2.2 The signals produced by the sensors in response to the calibrant solution are stored.
 - 12.1.2.3 Once this sequence is completed, the analyzer automatically moves the sample over the sensors.
 - 12.1.2.4 By comparing the sensors' response to the sample with that of the calibrant, the concentration of each analyte in the sample is calculated.
 - 12.1.2.5 A message and quality check code will be displayed if calibration fails. 12.1.2.6 If a failure occurs, take a new cartridge, and try to perform testing again. If the failure reoccurs, refer to the i-Stat System Manual for troubleshooting purposes.

2. Calibration Verification (Linearity Check):

Every 6 months, linearity checks are performed using the calibration verification set.

1. Calibration Verification is a procedure intended to verify the accuracy of results over the entire measurement range of a test.
2. The performance of this procedure at defined intervals may be required by regulatory or accreditation bodies.
3. While the Calibration Verification Set contains five levels, verification of the measurement range could be accomplished using the lowest, highest, and mid-levels.

3. i-STAT CHEM8+ CALIBRATION VERIFICATION SET and Procedure:

1. A five-level Calibration Verification Set is available to verify the calibration of i-STAT CHEM8+ cartridges throughout the reportable ranges.
 2. Refrigerated storage at 2 to 8 °C (35 to 46°F) should be maintained until the printed expiration date on the box and ampule labels.
 - 12.3.2.1 i-STAT CHEM8+ Calibration Verification fluids may also be stored at room temperature for up to 5 days (18 to 30 °C or 64 to 86°F).
 - 12.3.2.2 Prolonged storage at temperatures greater than 30 °C (86°F) may cause changes in the values of some analytes. Do not use beyond the expiration date on the box and ampule labels.
 3. Prior to testing cartridges, ampules may be used once the fluid has reached room temperature, approximately 30 minutes for individual ampules.
 4. For best results, ampules, cartridges and analyzers should be at the same temperature.
2. Press ON to turn on handheld.
 3. Press MENU to change screen to Administration Menu.
 4. Press #3 for the Quality Tests menu.
 5. Press #3 for Calibration verification.
 6. Follow the steps for running QC.

7. **i-STAT Troponin and BNP CALIBRATION VERIFICATION SET and Procedure:**

1. A three level Calibration Verification Set is available to verify the calibration of Troponin and BNP cartridges throughout the reportable ranges.
2. Store at $\leq -18^{\circ}\text{C}$ (-1°F) in a non-defrosting freezer. After thaw, the opened or unopened vial is stable for 4 hours when capped and stored at $2-8^{\circ}\text{C}$ ($35-46^{\circ}\text{F}$).
Do not re-freeze. Do not use if arrive thawed or uncapped
3. Procedure Steps are similar to running QC please follow the QC Steps.

~~12.3.3.1 For best results, ampules, cartridges and analyzers should be at the same temperature.~~

- ~~a. Press ON to turn on handheld.~~
- ~~b. Press MENU to change screen to Administration Menu.~~
- ~~c. Press #3 for the Quality Tests menu.~~
- ~~d. Press #3 for Calibration verification.~~
- ~~e. Follow the steps for running QC.~~

~~1. **i-STAT Troponin and BNP CALIBRATION VERIFICATION SET and Procedure:**~~

- ~~1. A three level Calibration Verification Set is available to verify the calibration of Troponin and BNP cartridges throughout the reportable ranges.~~
- ~~2. Store at $\leq -18^{\circ}\text{C}$ (-1°F) in a non-defrosting freezer. After thaw, the opened or unopened vial is stable for 4 hours when capped and stored at $2-8^{\circ}\text{C}$ ($35-46^{\circ}\text{F}$).~~
Do not re-freeze. Do not use if arrive thawed or uncapped
- ~~3. Procedure Steps are similar to running QC please follow the QC Steps.~~

1. **CLINICAL SIGNIFICANT:**

Analyte	Some Causes of Increased Values	Some Causes of Decreased Values
Sodium	Dehydration Diabetes insipidus Salt poisoning Skin losses Hyperaldosteronism CNS disorders	Dilutional hyponatremia (cirrhosis) Depletional hyponatremia Syndrome of inappropriate ADH
Potassium	Renal glomerular disease Adrenocortical insufficiency Diabetic Ketoacidosis (DKA) Sepsis <i>In vitro</i> hemolysis	Renal tubular disease Hyperaldosteronism Treatment of DKA Hyperinsulinism Metabolic alkalosis Diuretic therapy
Chloride	Prolonged diarrhea Renal tubular disease Hyperparathyroidism Dehydration	Prolonged vomiting Burns Salt-losing renal disease Overhydration Thiazide therapy

BUN	Pregnancy Severe liver insufficiency Overhydration Malnutrition	
Glucose	Diabetes mellitus Pancreatitis Endocrine disorders (e.g. Cushing's syndrome) Drugs (e.g. steroids, thyrotoxicosis) Chronic renal failure Stress IV glucose infusion	Insulinoma Adrenocortical insufficiency Hypopituitarism/Massive liver disease Ethanol ingestion/Reactive hypoglycemia Glycogen storage disease
Creatinine	Impaired renal function	
HCO₃ and TCO₂	Primary metabolic alkalosis Primary respiratory acidosis	Primary metabolic acidosis Primary respiratory alkalosis
Hematocrit	Dehydration Burns Impaired ventilation Renal disorders	Hemolytic anemias Iron deficiency Marrow depression Blood loss
cTnI	Myocardial Infarction Coronary vasospasm Cardiac contusion/trauma Rhythm disturbance (SVT, AF) Chemotherapy (ex. Adriamycin) Myocarditis/pericarditis Infiltrative diseases (ex. Amyloidosis, sarcoidosis, hemochromatosis, connective tissue disease) Congestive heart failure Heart transplantation Cardiac procedures (PTCA, DC cardioversion) Intracranial hemorrhage/stroke Pulmonary embolism Pulmonary hypertension Chronic renal insufficiency Sepsis Strenuous exercise Certain drug ingestions	Rare antibodies to troponin or its circulating complexes

2. PRINCIPLE OF MEASUREMENT:

1. Sodium, Potassium, Chloride:

14.1.1 Are measured by ion-selective electrode potentiometric.

14.1.2 Concentrations are calculated from the measured potential through the Nernst equation.

2. Urea

14.2.1 Is first hydrolyzed to ammonium ions in a reaction catalyzed by the enzyme urease.

14.2.2 The ammonium ions are measured by an ion-selective electrode and the concentration is calculated from the measured potential through the Nernst equation.

3. Glucose

14.3.1 Is measured amperometrically. Oxidation of glucose, catalyzed by the enzyme glucose oxidase, produces hydrogen peroxide.

14.3.2 The liberated hydrogen peroxide is oxidized at an electrode to produce an electric current which is proportional to the glucose concentration.

4. Creatinine

14.4.1 Is hydrolyzed to creatine in a reaction catalyzed by the enzyme creatinine amidohydrolase.

14.4.2 Creatine is then hydrolyzed to sarcosine in a reaction catalyzed by the enzyme creatine amidohydrolase.

14.4.3 The oxidation of sarcosine, catalyzed by the enzyme sarcosine oxidase, produces hydrogen peroxide.

14.4.4 The liberated hydrogen peroxide is oxidized at the platinum electrode to produce a current which is proportional to the creatinine concentration.

5. Troponin I/cTnI

14.6.1 Is determined amperometrically using a two-site ELISA method. Antibodies specific for human cardiac troponin I (cTnI) are located on an electrochemical sensor fabricated on a silicon chip. 14.6.2 Also deposited in another location on the sensor silicon chip is an antibody/alkaline phosphatase enzyme conjugate specific to a separate portion of the cTnI molecule.

14.6.3 The whole blood or plasma sample is brought into contact with the sensors allowing the enzyme conjugate to dissolve into the sample.

14.6.4 The cTnI within the sample becomes labeled with alkaline phosphatase and is captured onto the surface of the electrochemical sensor during an incubation period of approximately seven minutes.

14.6.5 The sample, as well as excess enzyme conjugate, is washed off the sensors. 14.6.6 Within the wash fluid is a substrate for the alkaline phosphatase enzyme.

14.6.7 The enzyme bound to the antibody/antigen/antibody sandwich cleaves the substrate releasing an electrochemically detectable product.

14.6.8 The electrochemical (amperometric) sensor measures this enzyme product which is proportional to the concentration of cTnI within the sample.

6. TCO2

14.7.1 The measured TCO2 test method is calibrated to the International Federation of Clinical Chemistry (IFCC) TCO2 reference method with an algorithm, based on the Henderson- Hasselbach equation, which uses pH, PCO2, and ionic strength (Na) measurements.

3. FREQUENCY OF REVIEW by NURSING UNIT & POCT COORDINATOR

1. Documentation of daily temperatures and instrument start-up records: each day of patient testing by nursing unit and monthly by POCT Coordinator.
2. Q.C. results of electronic simulator: each day of patient testing by nursing unit and monthly by POCT Coordinator.
3. Q.C. results of normal and abnormal liquid controls: each day of patient testing by nursing unit and monthly by POCT Coordinator.
4. Patient chart results: each day of patient testing by nursing units and monthly by POCT Coordinator.
5. Preventive maintenance log: each day of patient testing by nursing units and monthly by POCT Coordinator.
6. Corrective action log: each day of patient testing by nursing units and monthly by POCT Coordinator.

7. Competency test results: annually and as needed by nursing units and POCT Coordinator.
8. CAP proficiency test results:
 1. Two or three surveys per year by laboratory.
 2. Summary of results are sent to the managers of nursing units along with documentation of investigation of any results that is not acceptable.

~~PROCEDURE FOR POCT COORDINATOR:~~

4. PROCEDURE FOR POCT COORDINATOR:

1. POCT Coordinator will receive copies of the i-STAT Quality Control and Patient Result logs, patient medical chart results, and preventive maintenance logs from the previous month from the nursing units.
2. POCT Coordinator will review the temperature, electronic and liquid control results for "out of range" results monthly.
3. POCT Coordinator will check that all "out of range" results have a corrective action comment written as to what was done.
4. POCT Coordinator will check that all temperature, electronic and liquid controls were in range before patient samples were tested.
5. POCT Coordinator will check that the liquid control lot numbers in use have been validated by the laboratory.
6. POCT Coordinator will document results review with initials and date monthly.
7. POCT Coordinator will review all corrective action comments monthly.
8. POCT Coordinator will check that the policy and procedures were followed.
9. POCT Coordinator will document review with initials and date.
10. POCT Coordinator will review all patient medical chart results monthly.
11. POCT Coordinator will check for proper patient identification documentation.
12. POCT Coordinator will check that results were properly transcribed from the i-STAT Quality Control and Patient Result logs.
13. POCT Coordinator will document all discrepancies with corrected reports on the patient medical chart.
14. POCT Coordinator will complete a UOR (Unusual Occurrence Report) to document all explanations and corrective actions.
15. POCT Coordinator will review & document corrective actions if needed on the preventive maintenance logs monthly.
16. Check for comments "no patient testing done this day" to explain why there is no P.M. (or controls).
17. POCT Coordinator will write a "Statement of Concern" requesting an explanation for missing preventive maintenance data to the Unit Manager and a copy to the Lab Director.
18. POCT Coordinator will document review with initials and date.
19. POCT Coordinator will review operator competency test documentation.
20. POCT Coordinator will check that all operators' names are listed and have been tested following

policy.

21. POCT Coordinator will document review with initials and date monthly. POCT Coordinator will review all CAP proficiency test result documentation within the time frame designated by CAP
5. Check that the proper instrument code and cartridge code is documented.
6. Check that the results are filled in the correct places and are signed and dated by the operator.
7. Complete the original CAP survey test result form.
8. Record on the attestation sheet all the operators who performed the testing.
9. Have another CLS review the completed CAP survey test result forms and compare them with the test result documentation received from the nursing units.
10. Give the completed survey test result form to the laboratory medical director to sign and date.
11. Fax or mail the completed survey documents to the CAP within the appropriate time frame.
12. POCT Coordinator will review the graded CAP results when they are received from CAP.
13. Check for unacceptable results and obtain follow-up action and documentation.
14. Send summary results to the unit managers.
15. Obtain the Point of Care Testing Coordinator's, the laboratory administrative director's, and the laboratory medical director's signatures and dates of review.
16. Keep all documents for a minimum of two years in the clinical laboratory.
17. POCT Coordinator will calculate the mean and standard deviation from at least 10 control results for each level of a new lot number before the lot is put into use.
18. A 6–8-month supply of a lot number should be ordered and kept in a 2-10°C refrigerator.
19. Document the control range validation and distribute a copy to each unit.
20. POCT Coordinator will save all data and documentation for a minimum of two years.
- ~~1. POCT Coordinator will receive copies of the i-STAT Quality Control and Patient Result logs, patient medical chart results, and preventive maintenance logs from the previous month from the nursing units.~~
- ~~2. POCT Coordinator will review the temperature, electronic and liquid control results for "out of range" results monthly.~~
- ~~3. POCT Coordinator will check that all "out of range" results have a corrective action comment written as to what was done.~~
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- ~~5. POCT Coordinator will check that the liquid control lot numbers in use have been validated by the laboratory.~~
- ~~6. POCT Coordinator will document results review with initials and date monthly.~~
- ~~7. POCT Coordinator will review all corrective action comments monthly.~~
- ~~8. POCT Coordinator will check that the policy and procedures were followed.~~
- ~~9. POCT Coordinator will document review with initials and date.~~
- ~~10. POCT Coordinator will review all patient medical chart results monthly.~~

- ~~11. POCT Coordinator will check for proper patient identification documentation.~~
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- ~~13. POCT Coordinator will document all discrepancies with corrected reports on the patient medical chart.~~
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- ~~15. POCT Coordinator will review & document corrective actions if needed on the preventive maintenance logs monthly.~~
- ~~16. Check for comments "no patient testing done this day" to explain why there is no P.M. (or controls).~~
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- ~~18. POCT Coordinator will document review with initials and date.~~
- ~~19. POCT Coordinator will review operator competency test documentation.~~
- ~~20. POCT Coordinator will check that all operators' names are listed and have been tested following policy.~~
- ~~21. POCT Coordinator will document review with initials and date monthly. POCT Coordinator will review all CAP proficiency test result documentation within the time frame designated by CAP.~~
- ~~22. Check that the proper instrument code and cartridge code is documented.~~
- ~~23. Check that the results are filled in the correct places and are signed and dated by the operator.~~
- ~~24. Complete the original CAP survey test result form.~~
- ~~25. Record on the attestation sheet all the operators who performed the testing.~~
- ~~26. Have another CLS review the completed CAP survey test result forms and compare them with the test result documentation received from the nursing units.~~
- ~~27. Give the completed survey test result form to the laboratory medical director to sign and date.~~
- ~~28. Fax or mail the completed survey documents to the CAP within the appropriate time frame.~~
- ~~29. POCT Coordinator will review the graded CAP results when they are received from CAP.~~
- ~~30. Check for unacceptable results and obtain follow-up action and documentation.~~
- ~~31. Send summary results to the unit managers.~~
- ~~32. Obtain the Point of Care Testing Coordinator's, the laboratory administrative director's, and the laboratory medical director's signatures and dates of review.~~
- ~~33. Keep all documents for a minimum of two years in the clinical laboratory.~~
- ~~34. POCT Coordinator will calculate the mean and standard deviation from at least 10 control results for each level of a new lot number before the lot is put into use.~~
- ~~35. A 6-8 month supply of a lot number should be ordered and kept in a 2-10°C refrigerator.~~
- ~~36. Document the control range validation and distribute a copy to each unit.~~
- ~~37. POCT Coordinator will save all data and documentation for a minimum of two years.~~

1. REFERENCE RANGES, REPORTABLE RANGES, AND TEST UNIT CONVERSIONS

1. Reference range means the range of test values expected from 95% of fasting individuals presumed

to be healthy.

2. Reportable range means the range of test values throughout which the measurement system's results have been shown to be valid.
3. Table shows the Reference Ranges (for adult) and Reportable Ranges applicable to the i-STAT System.

ANALYTE	UNIT	REFERENCE RANGE (arterial) (venous)	REPORTABLE RANGE	UNIT CONVERSION
Sodium	mmol/L (mEq/L)	135 – 145 135 – 145 Neonate: 133-155	100 – 180	mmol/L x 1 = mEq/L Example: 140 mmol/L = 140 mEq/L
Potassium	mmol/L (mEq/L)	3.5 – 5.0 3.5 – 5.0 Neonate: 3.5-5.5	2.0 – 9.0	mmol/L x 1 = mEq/L
Chloride	mmol/L (mEq/L)	100 – 109 100 – 109 Neonate: 100-117	65 – 140	mmol/L x 1 = mEq/L
BUN UREA	mg/dL mmol/L	6 – 20 6 – 20 Neonate: 8-34 2.9 – 9.4 2.9 – 9.4	3 – 140 1 – 50	mg/dL BUN x 0.357 = mmol urea/L Example: 20 mg/dL BUN = 7.1 mmol urea/L
Glucose	mg/dL g/L mmol/L	70 – 105 70 – 105 Neonate: D1 50-100 D2: 70-105 0.70 – 1.05 0.70 – 1.05 3.9 – 5.8 3.9 – 5.8	20 – 700 0.20 – 7.00 1.1 – 38.9	mg/dL x 0.055 = mmol/L Example: 100 mg/dL = 5.55 mmol/L g/L x 5.556 = mmol/L
Creatinine	mg/dL	0.0- 1.1 0.5 - 1.1 Pediatric 2-12 years 0.5-1.0	0.2- 20.0 18 - 1768	mg/dL x 88.4 = μmol/L
TCO2 (on the CHEM8+ cartridge only)	mmol/L (mEq/L)	23-27 22-31 Neonates: 22-31	5-50	mmol/L x 1 = mEq/L
Hematocrit	%PCV Fraction	M-40-52 M-40-52 F-34-47 F-34-47 Neonate: 45-64 0.38 – 0.51 0.38 – 0.51	10 – 75 0.10 – 0.75	% PCV x 0.01 = Volume fraction Example: 40% PCV = 0.40 PCV
Hb*	g/dL g/L	M-14.0 – 18.0 M-14.0-18.0	3.4 – 25.5 34 – 255	g/dL x 10 = g/L

	mmol/L	F-12.0- 16.0 F-12.0-16.0 120 – 170 120 – 170 7 – 11 7 – 11	2.1 – 15.8	
Troponin I/cTnI	ng/mL (µg/L)	<0.08 ng/ mL=Negative 0.08-0.6 ng/ mL=indeterminate > 0.6 ng/mL = Positive	0.00 –50.00	ng/mL x 1 = µg/L

2. CRITICAL RESULTS:

1. Critical results are test results that fall outside high and low critical limits that define the boundaries of life-threatening values for a test.
2. Critical results represent an emergency condition and must be reported immediately to the patient's attending physician or nurse

ANALYTE (units)	ADULT	CHILDREN	NEONATES
Sodium (mmol/L)	low high <120 >155	low high <120 >155	low high < OR =130 > or =146
Potassium (mmol/L)	<3.0 >6.0	<3.0 >6.0	<3.0 >6.0
Chloride (mmol/L)	<80 >120	<80 >120	< or = 90 > or = 120
TCO2 (mmol/L)	<10 >40	<10 >40	< or =10 > or =40
BUN (mg/dL)	–	–	–
Glucose (mg/dL)	<50 >450	<50 >450	<50 >150
Creatinine	–	–	–
Hematocrit (%PCV)	<21 >55	<21 >55	<40 >60
Troponin I/cTnI	. 0.6= Positive		

3. LIMITATIONS:

1. The i-STAT test is to be used with fresh venous or arterial whole blood samples.
 1. Poor technique in sample collection may also compromise the results.
 2. Samples drawn from insufficiently flushed catheters or from traumatic venipunctures may be contaminated with interfering substances.
 3. The analyzer should remain on a level surface with the display facing up during testing.
 4. A level surface includes running the handheld in the downloader/recharger.
 5. Hemodilution may affect test results.

1. LIMITATIONS for Troponin Testing:

1. Samples from patients who have been exposed to animals or who have received therapeutic or diagnostic procedures employing immunoglobulin's or reagents derived from immunoglobulin's may contain antibodies, e.g. HAMA or other heterophile antibodies, which may interfere with immunoassays and produce erroneous results.

2. The generation of potentially interfering antibodies in response to bacterial infections has been reported. While this product contains reagents that minimize the effect of these interferents, and QC algorithms designed to detect their effects, the possibility of interference causing erroneous results should be evaluated carefully in cases where there are inconsistencies in the clinical information.
3. Partially clotted samples can result in elevated cTnI results above the reference range, as well as quality check codes. To prevent this from occurring, upon drawing the whole blood sample into a heparinized collection tube, the sample should be inverted gently at least 10 times.
4. Grossly hemolyzed samples can cause a decreased alkaline phosphatase activity, resulting in decreased detection of cTnI, increased assay backgrounds, and/or quality check codes.
5. Heparin at 90U/mL was found to decrease the cTnI level by approximately 20%.
6. Hematocrits in the range of 0-65 %PCV have been demonstrated not to affect Abbott iSTAT Troponin I Method and Sample Collection results. Samples with hematocrit levels above this range have demonstrated increases in the test imprecision and quality check codes.

1. **COMPETENCY TESTING:**

1. Organize a date and time for all trained operators to be tested on the i-STAT instrument, initially, 6 months after and annually or more often if necessary.
2. Test and observe the operator's technique using two levels of a blind commercial control material with an acceptable range not known to the operator.
3. Place documentation of all testing in the POCT Operators Manual under competency testing.

2. **PROFICIENCY TESTING:**

1. The iSTAT operators will be notified by the laboratory when the CAP survey has arrived.
2. The CAP survey testing is to be done within the appropriate time frame from the date received.
3. Refrigerate the CAP survey kit at 4 °C if it is not tested right away.
4. Follow the directions that come with the CAP survey and test all the samples in the kit as assigned to the unit.
5. Test the samples just like a patient sample.
6. Take corrective action for a failed precision check on a sample test.
7. Refer to "Out of Control Values" and Troubleshooting
8. Repeat the survey testing of the sample.
9. If repeat testing fails the result precision check, immediately notify the department supervisor and laboratory Point of Care Coordinator and document.

3. **REFERENCES:**

1. Statland, B.E., Clinical Decision Levels for Lab Tests. Medical Economics Books. 1987.
2. Tietz, N.W., Tietz Textbook of Clinical Chemistry, third edition, ED. C.A. Burtis, E.R. Ashwood, W.B. Saunders Company, Philadelphia, 1999. Table 50 – 20, Appendix.
3. Kost, Gerald J., Using critical limits to improve patient outcome. Medical Laboratory Observer. March 1993; 25(3): 22-27.

Document History

Formulated: Connie B. Ramirez

Adopted: 09/2019

Revised:

Attachments



Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
Medical Director, Lab	Lalaine Berube: Senior Director Clinical Laboratory	01/2024
Policy Committee	Maria Virata: Point of Care Coordinator	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024

Applicability

CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 15096054




Providence

Little Company of Mary
Medical Center
Torrance

Origination: N/A
Effective: Upon Approval
Last Approved: N/A
Last Revised: N/A
Next Review: 2 years after approval
Owner: Maria Virata: Point of Care Coordinator
Policy Area: Lab - Point of Care Testing
References:
Applicability: CA - Providence LCM MC Torrance

POCT QC (Quality Control) Management by the Laboratory

	Laboratory Department Policies and Procedures		TPOC.02.00
Providence Little	Subject:	Point of Care Quality Control Management by the Laboratory	Initial and date
Company of	Section:	Point of Care Testing	POCT Coordinator:
Mary Medical	Author:	Patricia Hess	Laboratory Director:
Center Torrance	Adopted: 06/08 Revised: 07/18		Medical Director:

~~POINT OF CARE QUALITY CONTROL MANAGEMENT BY THE LABORATORY~~

1.0 PRINCIPLE

According to the College of American Pathologists (CAP) regulations for Point of Care testing (POCT), and for good patient care, the laboratory is responsible for monitoring:

- 1.1 Compliance to testing procedures.
- 1.2 Test control results.
- 1.3 Preventive Maintenance of POCT instruments following Manufacturer's recommendations.
- 1.4 Competency testing of operators.
- 1.5 The proficiency testing program.
- 1.6 The POCT instrumentation in use.

2.0 POINT OF CARE TESTS

2.1 Waived Testing include the following POCT:

- 2.1.1 Whole blood capillary glucose.

- 2.1.2 Occult blood - fecal specimens (ICNN only).
- 2.1.3 Dipstick urinalysis by visual interpretation (L&D and WHS only).
- 2.1.4 Dipstick urinalysis by Clinitek Status (ER only).
- 2.1.5 Beta hCG – Urine (ER, GI Lab, ARU and SDS only).
- 2.1.6 HemoCue® Hb201+ Therapeutic Phlebotomy Patient Hemoglobin.

2.2 Non-waived or Moderately Complex POCT:

- 2.2.1 Abbott i-STAT System include Chem 8, BHcg and Troponin (ER).
- 2.2.2 Abbott i-STAT Kaolin Activated Clotting Time (Cath Lab)
- 2.2.3 ROM Plus (L&D only).
- 2.2.4 Avoximeter Test for Whole Blood Oximeter.

3.0 AUTHORITY

3.1 The program is under the direction, authority, jurisdiction, and responsibility of the Medical Director of the Laboratory. The Medical Director of the Laboratory has delegated responsibilities as stated below.

4.0 REVIEWERS

- 4.1 Point of Care Coordinator.
- 4.2 Nurse Unit Manager.

5.0 FREQUENCY OF REVIEW

5.1 A **Documented Review** consists of the date of review and the signature or initials of the reviewer.

5.2 There must be a **Documented Review** of the following parameters:

- 5.2.1 Patient chart results.
- 5.2.2 Patient log sheets (if applicable).
- 5.2.3 Quality Control results.
- 5.2.4 Preventive Maintenance of POCT instruments following Manufacturer's recommendations.

5.3 **Documented Reviews** must be performed:

- 5.3.1 **Monthly** by a Technical Supervisor.
- 5.3.2 Weekly by the laboratory POCT Coordinator and/Unit Manager (when Corrective Action is taken).
~~taken~~).

5.4 There must be a **Documented Review** of:

- 5.4.1 **CAP proficiency test results** by the Technical Supervisor and the laboratory POCT Coordinator.
~~Coordinator~~.
- 5.4.2 **Competency test results** by the Technical Supervisor and the laboratory POCT Coordinator.

5.4.2.1 Waived POCT Competency Assessment.

5.4.2.1.1 Initially after training.

5.4.2.1.2 Annually thereafter.

5.4.2.2 Non-waived POCT Competency Assessment.

5.4.2.2.1 Initially after training.

5.4.2.2.2 Six months after training.

5.4.2.2.3 Annually thereafter.

5.4.2.4 When employee evaluation indicates it or as needed.

~~6.0 RESPONSIBILITIES OF THE LABORATORY POINT OF CARE COORDINATOR~~

6.0 RESPONSIBILITIES OF THE LABORATORY POINT OF CARE COORDINATOR

6.1 Receive and review the Quality Control (Q.C.) log, preventive maintenance (P.M.) log, patient report forms and patient log sheets (if applicable) from the nursing units weekly.

6.1.1 POCT Coordinator and Charge RN/Manager must review, sign & date the QC, PM, and patient logs weekly when any of the following are in question:

~~patient logs weekly when any of the following are in question:~~

6.1.1.1 QC out of range

6.1.1.1 Corrective Action taken & documented on QC log by Charge RN/Manager & POCT Coordinator

~~& POCT Coordinator~~

~~6.1.1.2 Incomplete entries on PM Log without proper documentation (ex: no initial/date,~~

6.1.1.2 Incomplete entries on PM Log without proper documentation (ex: no initial/date, days left blank – no PM done = no documentation, etc.)

6.1.1.3 Corrective Action must be documented on Logs by both POCT Coordinator & Charge RN/Manager stipulating:

~~& Charge RN/Manager stipulating:~~

~~6.1.1.3.1 Employee counseling or education reinforcement if needed with~~

6.1.1.3.1 Employee counseling or education reinforcement if needed with documentation written on the Logs.

6.1.1.3.2 Reason QC was out of range = documentation or corrective action taken (ex: PM done on analyzer, reran/open new control, employee counseling or education reinforcement, etc.)

~~action taken (ex: PM done on analyzer, reran/open new control,~~

~~employee counseling or education reinforcement, etc.)~~

~~6.1.1.4 If no patient was run "NO PATIENT TESTING DONE THIS DAY" must be~~

6.1.1.4 If no patient was run "NO PATIENT TESTING DONE THIS DAY" must be documented on both PM &

QC Log.

6.1.1.2 Continued incomplete entries require a meeting initiated by the POCT coordinator with the lab director, manager, and CNO to specify corrective actions and timeframe.

~~the lab director, manager, and CNO to specify corrective actions and timeframe.~~

6.1.1.2.1 For more than one incomplete log entry in a month, the POCT coordinator notifies the Lab Director, Lab Manager, and CNO in writing (email) with request for improvement plan submitted in writing to coordinator within two weeks of notification.

~~notifies the Lab Director, Lab Manager, and CNO in writing (email) with request for improvement plan submitted in writing to coordinator within two weeks of notification.~~

6.2 Review the instrument maintenance logs.

6.2.1 Check for comments **"no patient testing done this day"** to explain why there is no P.M. (or controls).

6.2.3 Document POCT "reviewed" with initials and date on a weekly/monthly basis depending on POCT analyzer/test.

~~on POCT analyzer/test.~~

6.2.4 Record compliance on the Monthly Compliance Report.

6.3 Review the patient identification results from monthly statistics reports.

6.3.1 All nursing units (except ER, L&D, WHS, and NBN) have mandatory barcode scanning for patient identification.

6.3.2 ER, L&D, WHS, and NBN nursing units may either scan the barcode for patient identification or enter information manually.

6.3.3 Document the number of wrong patient identifications (i.e., billing accounts, wrong patient identification numbers, etc.)

6.3.4 Record compliance for correct patient identification on the Monthly Compliance Report.

6.4 Review patient critical value action comments from monthly statistics reports.

6.4.1 Document the number of critical patient values that have action comments.

6.4.2 Record compliance on the Monthly Compliance Report.

6.5 Review the control results from monthly statistics reports.

6.5.1 Check that the lot numbers in use have been validated by the lab and are within the expiration date.

6.5.2 Check that controls were run according to policy

6.5.3 Document the number of successful controls.

6.5.4 Record compliance on the Monthly Compliance Report.

6.6 Review all out of range control results from the monthly statistics report.

6.6.1 Document the number of failed control results that have action comments.

6.6.1.1 Written Corrective Actions taken & documented on the QC POC log by POC Coordinator & Unit Manager when QC range is "Out of Control".

~~Coordinator & Unit Manager when QC range is "Out of Control"~~.

6.6.2 Record compliance on the Monthly Compliance Report.

6.7 Review patient report forms and QC log sheets (if applicable).

6.7.1 Check that the results were recorded correctly (duplicates within range, results reported per our policy, results reported within the instrument range of linearity and reported with normal ranges).

~~our policy, results reported within the instrument range of linearity and reported with normal ranges~~).

6.7.2 Check that the operator recorded patient's name, medical record number, time, date, and initialed the results.

6.7.3 Check that the QC log sheet, if applicable, is complete.

6.7.4 Record compliance on the Monthly Compliance Report.

6.8 Receive CAP proficiency test results at the specified dates for the current year.

6.8.1 Check that the proper methods and reagents are correctly recorded for the POCT testing performed.

6.8.2 Check that the results are filled in the correct places and that the forms are signed and dated by the person who did the testing. The lab copies should have the nursing unit, the operator and date on each result.

6.8.3 Complete the original survey form using the data from the test result forms.

6.8.3 Record on the attestation sheet all the operators who performed the testing.

6.8.4 Have another CLS review all the test result forms and the original survey form to make sure the results are recorded correctly.

6.8.4 Give the completed original survey form to the laboratory medical director to sign and date.

6.8.5 Fax the signed completed original survey form and the attestation sheet to CAP within the acceptable time frame.

6.9 Review the graded CAP results when they are received from CAP.

6.9.1 Check for unacceptable results and obtain follow-up action and documentation.

6.9.2 Obtain signatures from the POCT Coordinator, the laboratory administrative director and the laboratory medical director along with the date of review.

6.9.3 Keep all documents for a minimum of **two years** in the clinical laboratory.

6.10 Review competency test documentation.

6.10.1 Check that all patient testing and Q.C. was performed by a trained and competency tested staff member.

6.10.2 Review evidence of six month (non-waived POC) and annual competency testing of nursing staff from the Technical Supervisors and update staff certification in the computer.

6.10.3 Verify that all competency testing was done by trained testers.

- 6.10.4 Return all written competency tests and checklists to the Diabetes Education Coordinator.
- 6.10.5 Keep a summary record of all employee competency documentation in the POCT file.
- 6.11 Write a "Statement of Concern" requesting an explanation for any deficiencies noted in daily and monthly reviews and retain a copy in the laboratory for a minimum of two years.
- 6.12 Assay and calculate the mean from at least 5 glucose control results for each level of a new lot number of material.
- 6.12.1 A 6-8 month supply of reagent lot number should be on hand.
- 6.12.2 Check that our assayed control mean is within 10% of Roche Accucheck II assayed mean.
- 6.12.2.1 If it isn't, test the level at least 5 more times and check if the mean of 10 results is within 10% of Roche Accucheck II.
- 6.12.2.2 If not, call Roche Accucheck II to help with troubleshooting.
- 6.12.2.3 Determine the new mean for each control level.
- 6.12.2.4 Review the trend graph (institution) periodically to see if adjustments need to be made.
- ~~made-~~
- 6.13 Check all controls monthly to observe for shifts or trends or evidence a value should have a new mean calculated.
- 6.13.1 Document a new control range (see above).
- 6.13.2 Save all plots in a monthly Q.C. file.
- 6.14 **Save all data for a minimum of 2 years.**

7.0 TECHNICAL SUPERVISOR

7.1 Responsibilities:

- 7.1.1 Compliance to testing procedures.
- 7.1.2 Test Quality Controls.
- 7.1.3 The preventive maintenance of POCT analyzers
- 7.1.4 The proficiency testing.
- 7.1.5 Competency testing of operators.
- 7.1.6 Corrected reports.

7.2 Reviewer

- 7.2.1 Staff Nurse designated by the unit manager.
- 7.2.2 The Technical Supervisor will be trained by the POCT Coordinator to perform the daily and monthly reviews, instrument maintenance, and competency and proficiency testing of staff personnel.

~~daily and monthly reviews, instrument maintenance, and competency and proficiency testing of staff personnel.~~

7.3 Frequency of Review

7.3.1 **Daily** by a Technical Supervisor.

7.3.2 **Monthly** by a Laboratory POCT Coordinator.

7.3.3 Data to be reviewed:

7.3.3.1 Patient chart results.

7.3.3.2 Patient log sheets (if applicable).

7.3.3.3 QC results.

7.3.3.4 Preventive maintenance of POCT instrument.

~~7.3.4 There must be Documented Review of CAP proficiency test results by the POCT area~~

7.3.4 There must be Documented Review of CAP proficiency test results by the POCT area Technical Supervisors and the Laboratory POCT Coordinator.

7.3.4.1 **Annual Proficiency testing.** The Clinical Laboratory will receive unknown specimens from CAP several times a year.

~~specimens from CAP several times a year.~~

7.3.4.2 These specimens will be distributed to POCT sites to be tested in the same manner as patient specimens.

~~manner as patient specimens.~~

7.3.4.3 Results will be compiled and sent to CAP for evaluation.

7.4 Competency waived and non-waived POCT test results upon completion of POCT training and annually thereafter, must be reviewed by the Technical Supervisor and the Laboratory POCT Coordinator.

7.4.1 Competency assessment of all POCT testing personnel must be performed and documented before patient testing:

7.4.1.1 **Waived POCT Competency Assessment.**

7.4.1.1.1 During employment orientation upon completion of POCT training.

7.4.1.1.2 Annually thereafter for waived.

7.4.1.2 **Non-waived POCT Competency Assessment.**

7.4.1.2.1 During employment orientation upon completion of POCT training

7.4.1.2.2 Six months after training.

7.4.1.2.3 Annually thereafter for both waived and non-waived POCT.

7.4.2 All Competency Assessment testing is to be performed only by trained testers.

7.4.2.1 Trained testers are R.N.s, C.L.S. (Clinical Laboratory Scientists), or the POCT Coordinator.

~~Coordinator.~~

7.4.2.2 Trained testers will inform the POCT Coordinator of any employee competency Issues.

~~Issues:~~

7.4.3 Document all Competency Assessment testing.

7.4.3.1 Send a copy to the Education Department to be included in the employee's education file.

~~education file:~~

7.4.3.2 Send verification of Competency Assessment testing to the laboratory POCT Coordinator.

~~Coordinator:~~

8.0 REFERENCES

8.1 Roche Accucheck II Meter Operator's Guide, 2012

8.2 Medtronic Hemotec, Inc., **Quality Assurance Manual**, April, 2004.

8.3 Hemocult SENSE Product Insert, Beckman Coulter, January 2001.

8.4 Quantimetrix Corporation, Dropper Plus Urine Dipstick Control Insert Sheet M044717A-06/95,
2005 Manhattan Beach Blvd., Redondo Beach, CA 90278-1205, (310) 536-0006, (800) 624-8380, Fax (310)
536-9977.

8.5 Quidel QuickVue+ One Step hCG Test Kit Insert, 2003.

8.6 ROM Plus Test package insert 5/16.

8.6.1 Manufacturer recommended QC Reference Sheet and Procedure Manual.

8.7 The Joint Commission, Accreditation Manual for Pathology and Clinical Laboratory Services, 2009.

8.8 College of American Pathologists, Commission on Laboratory Accreditation Inspection Checklist,
Point-of-Care Testing Section:30, 2009.

8.9 ITC AVOXimeter 1000E Whole Blood Oximeter Manual.

8.9.1 Product insert for Co-Oximeter Controls.

8.9.2 Product insert for Multi-4 tm Co-Oximeter.

8.10 HemoCue® Hb201+ Hemoglobin Test.

8.10.1 Product insert for HemoCue® Hb201+.

8.10.2 AABB Technical Manual

8.10.3 AABB Standards for Blood Banks and Transfusion Centers.

This policy was developed in collaboration with the following involved departments: Nursing Services, Education Services, PLCMMCS Laboratory and PLCMMCT Laboratory.

Document History

Formulated: Patricia Hess

Adopted: 06/98

Revised: 06/02, Dennis Hardy

12/03 & 12/09, Diane Doty

01/13 & 04/14, Lalaine C. Berube

07/17, 09/17, 11/17, 03/18 & 07/18 Maria (Connie) Virata

POCT QC MANAGEMENT BY THE LABORATORY

Attachments



Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
Medical Director, Lab	Lalaine Berube: Senior Director Clinical Laboratory	01/2024
Policy Committee	Maria Virata: Point of Care Coordinator	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024

Applicability

CA - Providence LCM MC Torrance



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 05/1994
Effective: Upon Approval
Last Approved: N/A
Last Revised: 04/2021
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Environment of Care
References:
Applicability: CA - PH&S Little Company of Mary Service Area

POM: Acquisition of Flame-Resistant Furnishings and Equipment

Number: LCM-EOC-300

PURPOSE:

It is the purpose of this policy to provide an effective process for reviewing proposed acquisitions of bedding, window draperies and other curtains, furnishings, decorations, wastebaskets and other equipment to identify issues related to fire safety.

POLICY:

It will be the policy of Providence Little Company of Mary Medical Centers (PLCMMC) to review proposed acquisitions of items described above for the purpose of minimizing risks associated with materials that are not appropriately fire-rated for hospital use.

REFERENCES:

- JCAHO, Management of the Environment of Care, and National Fire Protection Association 101, 2012 Life Safety Code (LSC); Title 24.

Materials Management

1. All "Requests for Purchase" requisitions are to be submitted to the Materials Management Department, or through the Director, Facilities Development.
2. The buyer will review and request and act appropriately to assure that the requested item meets the following agency having jurisdiction procurement criteria to assure compliance with the Life Safety Standards:
 - Flame-resistant capability, as required.
 - Wastebaskets are of noncombustible or other approved material.
 - Attention is given to heat-generating combustible material and placement of equipment close to heat sources.
 - Flame-resistant coatings and coverings are maintained as necessary to retain their effectiveness.
 - Furniture is constructed to appropriate standards.

- Equipment is tested and listed for use.
 - All construction materials meet appropriate standards.
3. The buyer will acquire samples, specifications and independent test reports as necessary to assure that they have the Class A rating (*Flame spread 0-25 and smoke development of 0-450*).
 4. Only with the approved specifications and/or test reports will the buyer proceed with the acquisition.
 5. The buyer will be responsible for maintaining the specifications on file for each acquisition.
 6. The buyer will work closely with Environmental Services (EVS), Plant Operations and Maintenance (POM), vendors, and users of department's to assure that this policy regarding acquisitions are followed and enforced.
 7. See Contractor's Handbook for construction material requirements.

All Departments

1. All employees are responsible for paying attention to keeping combustible materials away from heat sources.
2. Attention is to be paid to the maintenance of flame-resistant coating and coverings as necessary to retain effectiveness.
3. Materials are acquired through the proper departments and/or are reviewed for meeting these standards.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
EOC	Salvator Demarti: Accreditation Program Manager	01/2024
EOC	Edgar Flemate: Director Facilities	01/2024

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 15013633



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 12/2012
Effective: Upon Approval
Last Approved: N/A
Last Revised: 04/2021
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Facilities
References:
Applicability: CA - Providence LCM MC
Torrance

POM: Decorations, Receptacles and Heating (General)

Number: LCT-POM-151

POLICY

The purpose of this policy is to provide and maintain operating features that conforms to fire and smoke prevention requirements.

PROCEDURE

1. The hospital prohibits all combustible decorations that are not flame retardant. *(For full text and any exceptions, refer to NFPA 101-2012: 18/19.7.5.6)*
 - A. See attachment A for examples.
2. Soiled linen and trash receptacles larger than 32 gallons *(including recycling containers)* are located in a room protected as a hazardous area. *(For full text and any exceptions, refer to NFPA 101-2012: 18/19.7.5.7.1)*
 - A. See attachment B for specific locations
3. The hospital prohibits portable space heaters within smoke compartments containing patient sleeping areas and treatment areas. *(For full text and any exceptions, refer to NFPA 101-2012: 18/19.7.8)*

Attachments

[Attachment B](#)

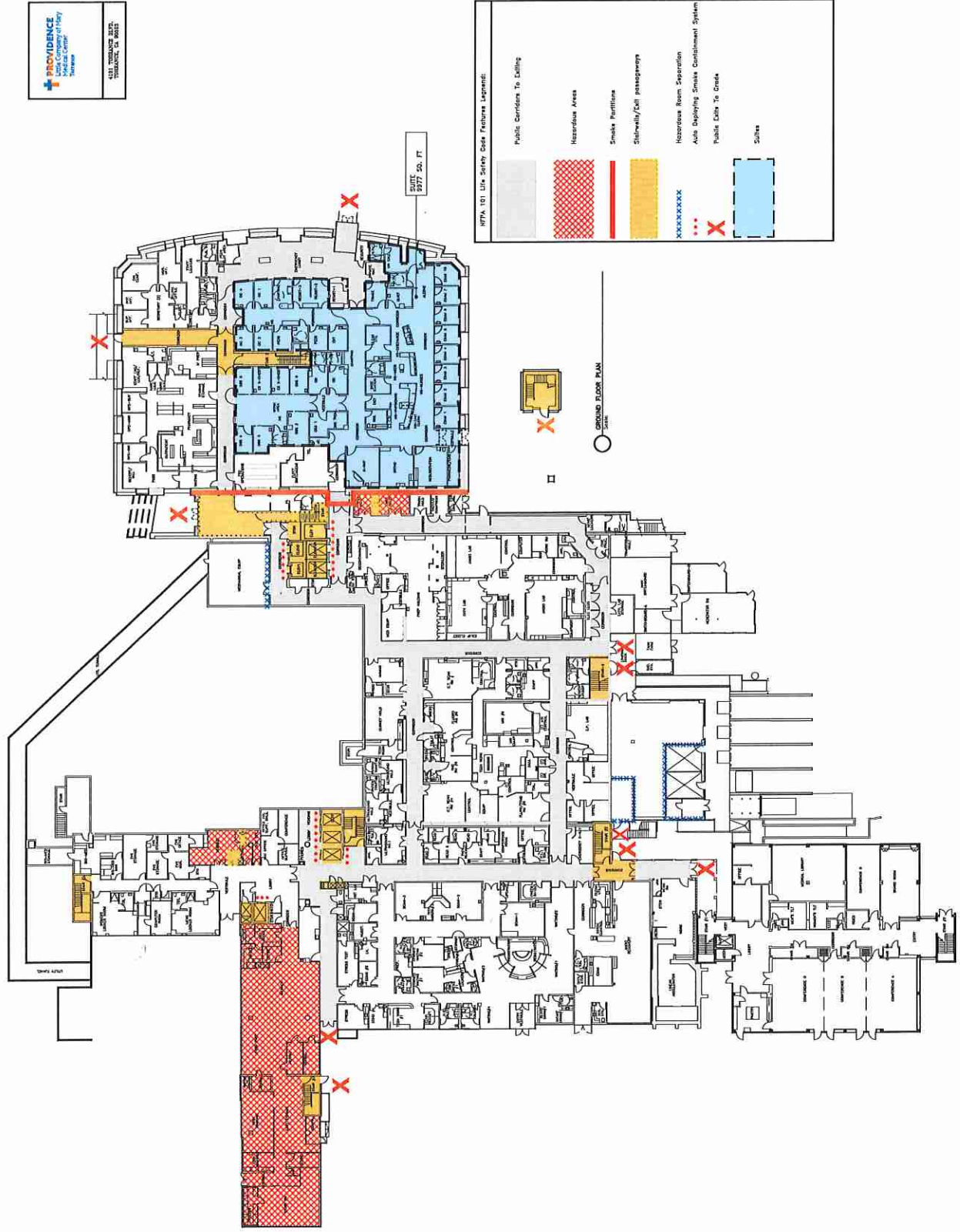
Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
EOC	Salvator Demarti: Accreditation Program Manager	01/2024

Step Description	Approver	Date
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024
Policy Committee	Edgar Flemate: Director Facilities	01/2024
Applicability CA - Providence LCM MC Torrance		

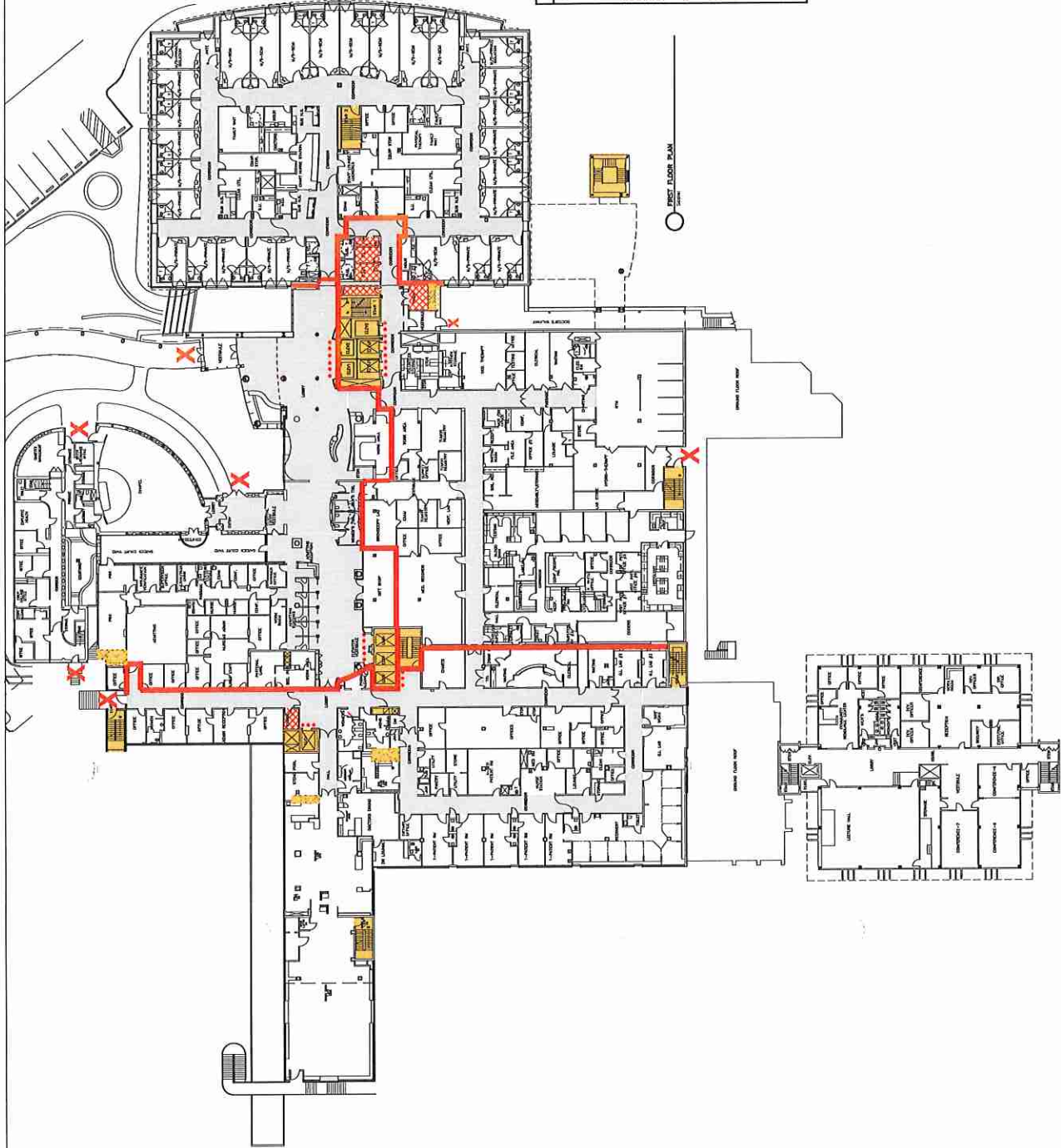
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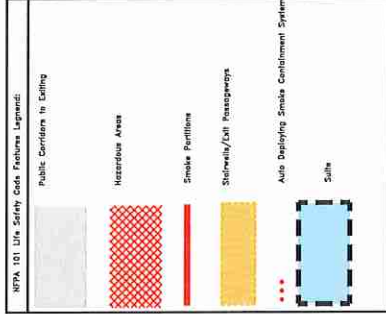
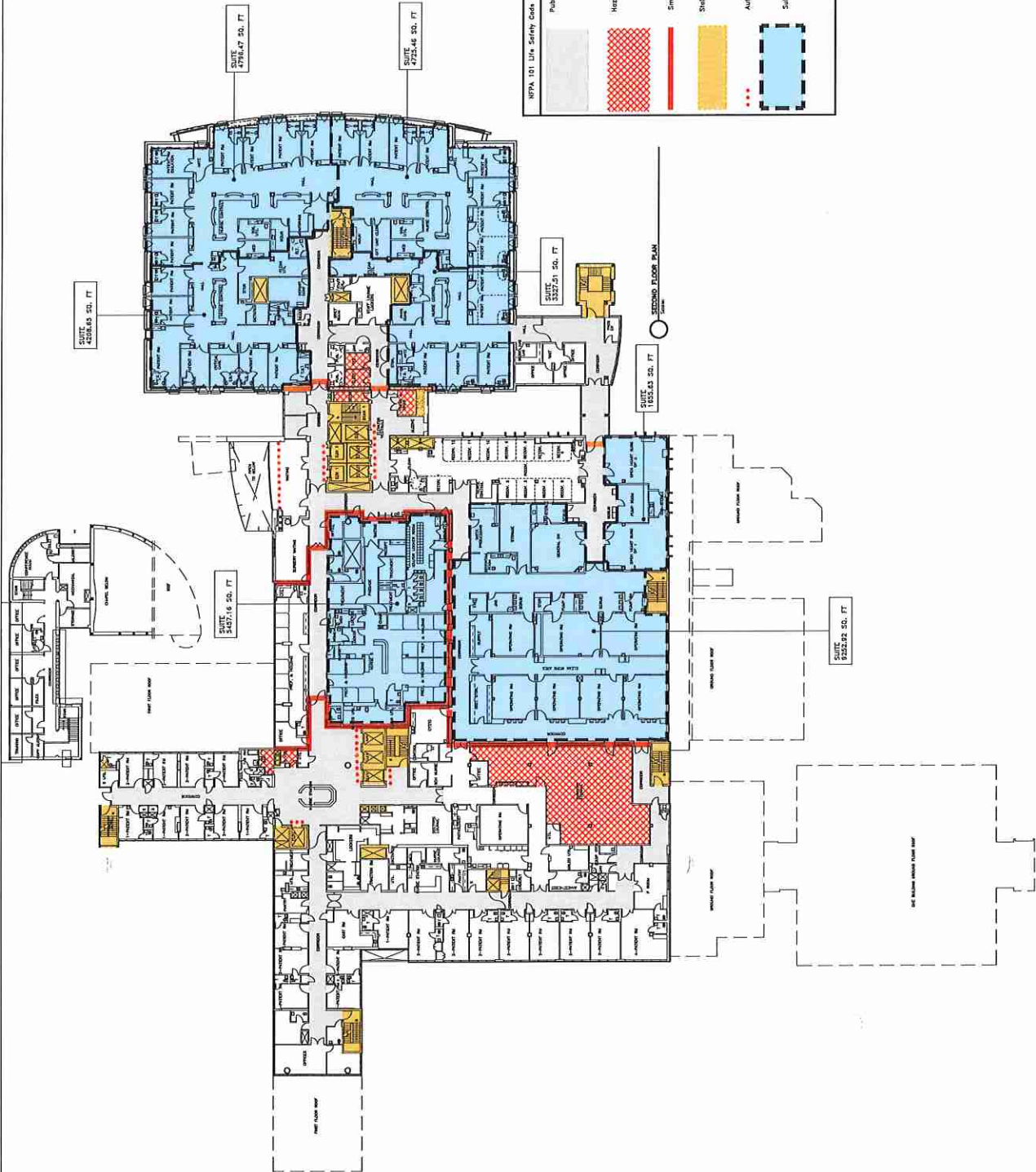
Attachment B LCT-POM-151

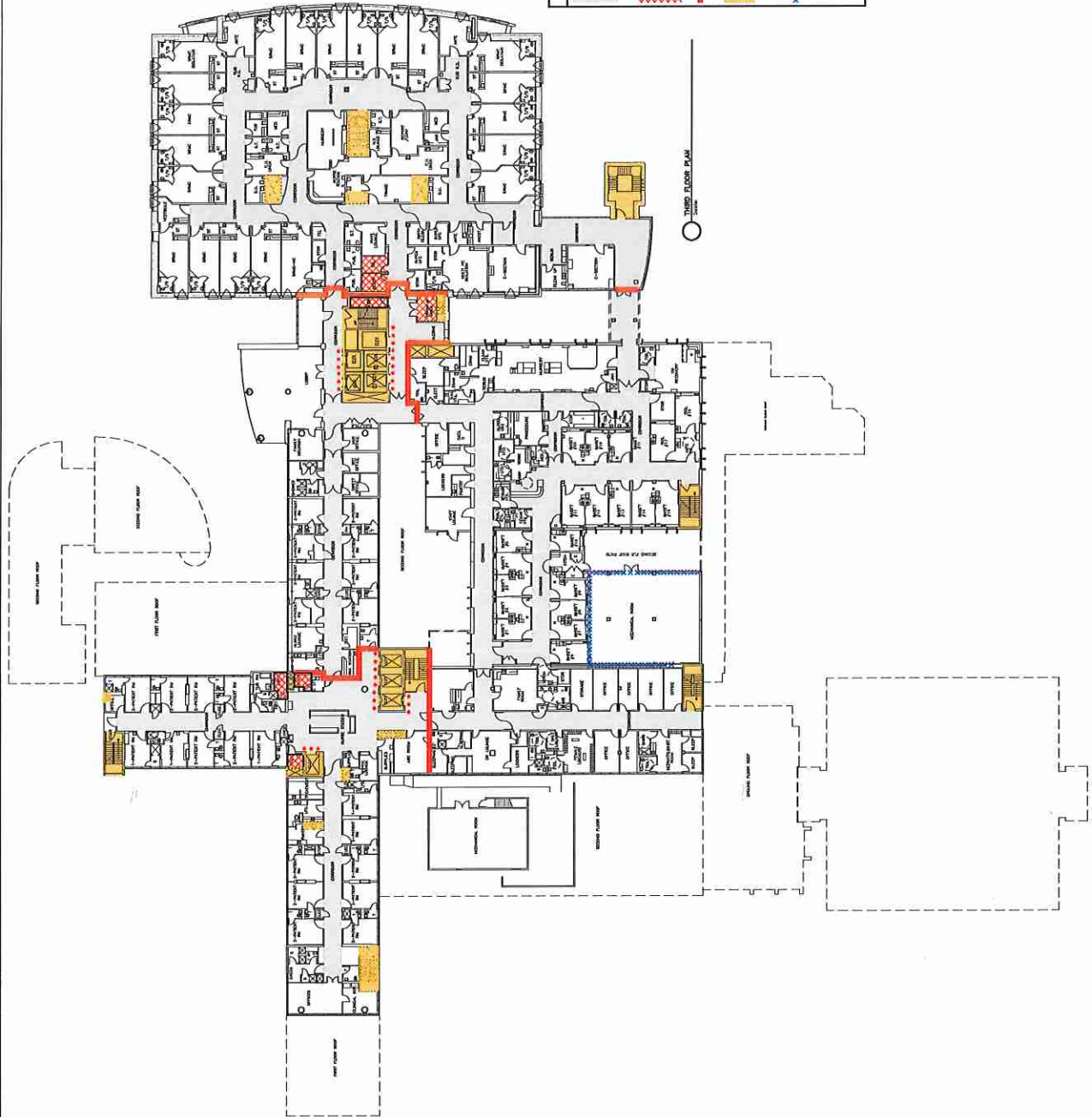


NFPA 101 Life Safety Code Features Legend:

	Public Corridor in Building
	Hazardous Area
	Smoke Partitions
	Stairway/Elevator Enclosure
	Automatic Fire Alarm System
	Public Exit To Street

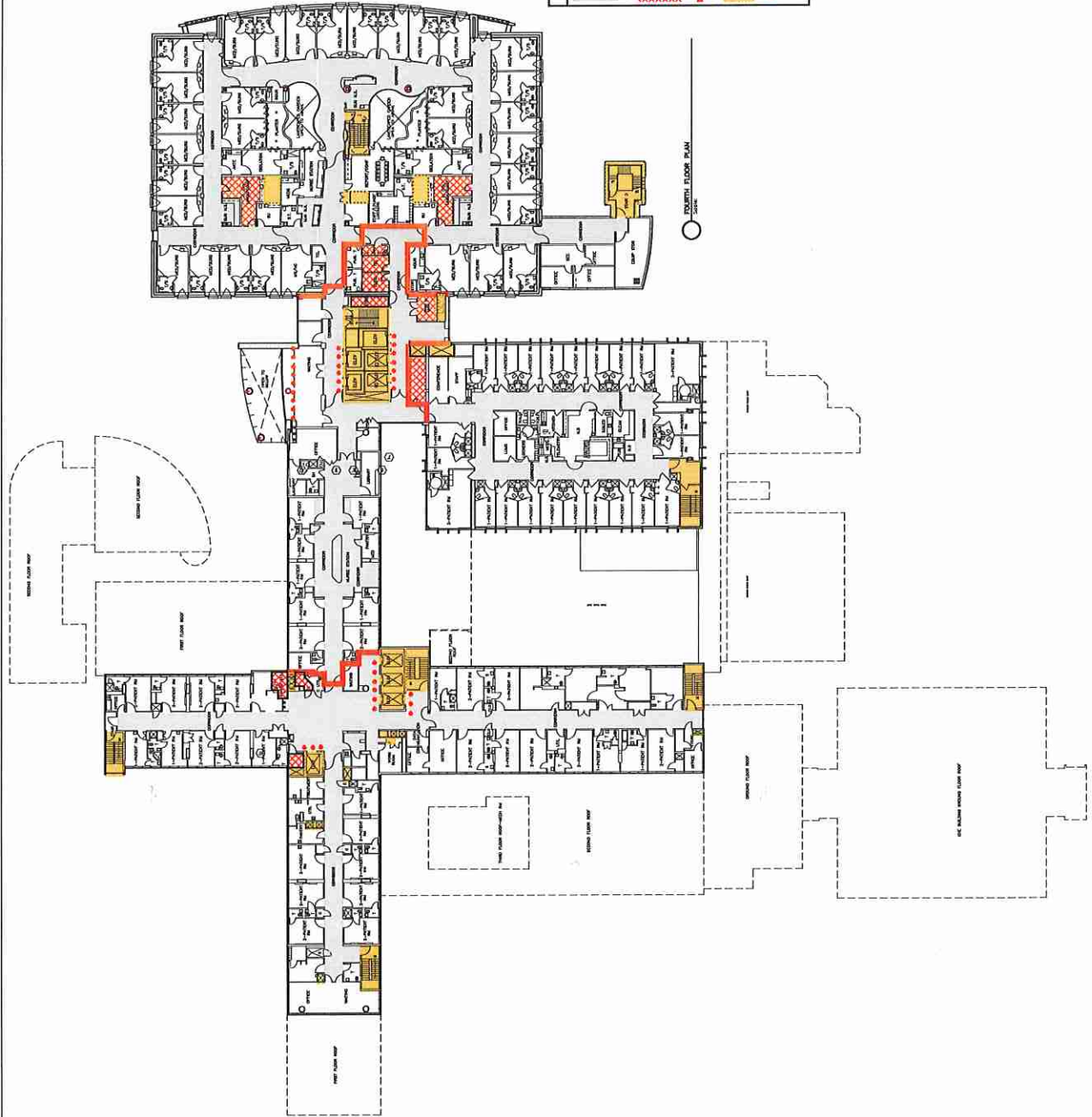






IFPA 101 Life Safety Code Features Legend:

	Public Corridors To Exit
	Hazardous Areas
	Smoke Partitions
	Stairwells/Full Passageways
	Auto Deploying Smoke Containment System
	Hazardous Room Separation



UPA 101 Life Safety Code Features Legend:

	Public Corridors To Ceiling
	Hazardous Areas
	Smoke Partitions
	Stairwells/Elevator Enclosures
	Auto-Deploying Smoke Containment System

FOURTH FLOOR PLAN

Current Status: Pending

PolicyStat ID: 15013636



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 06/2000
Effective: Upon Approval
Last Approved: N/A
Last Revised: 04/2021
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Facilities
References:
Applicability: CA - Providence LCM MC
Torrance

POM: Electrical Safety Guidelines

Number: LCT-POM-013

POLICY

It is the policy of Providence Little Company of Mary Medical Center Torrance (PLCMMCT) to assure operational reliability, assess risks, respond to failures, and train staff for the purpose of providing a safe and healthy environment for patients, staff and visitors, in keeping with their philosophy, values and mission.

PURPOSE

The purpose of this policy is to establish electrical safety guidelines to Plant Operations & Maintenance (POM) staff to provide a safe and healthy environment for patients, staff and visitors.

DEFINITIONS

Plant Operations & Maintenance (POM) – department consist of Plant Operations, Maintenance, Grounds, Fire Life-Safety and Utilities.

PROCEDURE / GENERAL INSTRUCTIONS

General Electrical Safety Practices:

The use of electrical extension cords is limited to the following:

1. For life threatening emergencies.
2. During periods of construction.
3. For demonstrations and/or audio visual equipment.
4. For connecting Personal Computers.

Plugs should be grasped by the body of the plug when removed from the wall socket, the plug should not be removed by pulling on the line cord.

Power cords and patient cables should not be routed across areas of heavy foot or cart traffic.

Power cords or patient/resident cables should not be laid across sinks, or other metal surfaces.

Damaged or worn wall outlets should not be used; if plugs fall out of wall sockets, the sockets should be

reported to the POM department. Tape should never be used to maintain a plug in a socket.

Unauthorized employees should never attempt to modify any piece of electrical equipment including wall plugs.

Electrical equipment should be turned off before plugging or unplugging from a wall outlet.

All incidence of shock or tingling sensation sustained from electrical equipment is to be reported to the Safety Officer and to POM immediately.

Employees should avoid touching electrical equipment with one (1) hand and a metal surface with the other hand, particularly when hands are wet.

All possible hazards should be reported immediately. The following warrant such action:

- Electric shock
- Fluid spilled into electrical equipment
- Equipment that is sparking or a burning smell is noticed.
- Electrical equipment that has been dropped
- Frayed cords

All employees should know the location of electrical panels in the area in which he/she is assigned. Special precautions are required to avoid the possibility of even very small electric currents passing directly to the heart in patients provided with pacemaker leads, internal monitoring leads or pressure lines leading to the heart or major blood vessels.

- All equipment that is connected to these "*invasive pathways*" should be labeled as suitable for this purpose.
- Non-conductive (*plastic*) stopcocks should be used on the pressure lines.
- Staff should only touch the conductive leads with gloved hands.
- All instructions for proper use of invasive devices must be strictly adhered to.

Time:

Extension cords may not be used for more than ninety (90) days except during construction or for use with personal computers.

Specifications:

All extension cords permitted for use shall be constructed of #16 AWG 3 conductor cable not to exceed 25 ft. in length and be UL listed. Only extension cords approved by the POM are permitted for use in the hospital.

Adapters:

The use of adapters or modifying caps is strictly prohibited in the hospital.

Procurement:

Extension cords must be obtained from or approved by the POM Department.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
EOC	Salvator Demarti: Accreditation Program Manager	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024
Policy Committee	Edgar Flemate: Director Facilities	01/2024

Applicability

CA - Providence LCM MC Torrance



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 04/1994
Effective: Upon Approval
Last Approved: N/A
Last Revised: 04/2021
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Environment of Care
References:
Applicability: CA - PH&S Little Company of Mary Service Area

POM: Grounds Maintenance

Number: LCM-EOC-502

PURPOSE

The purpose of this policy is to provide for a safe environment and accessibility for the delivery of patient care services.

POLICY

General Grounds Maintenance:

The grounds will be inspected annually under the Hazard Surveillance Inspection Program. Identification of unsafe or hazardous conditions shall be reported to the Manager of Plant Operations & Maintenance (POM) for appropriate corrective action and the findings of deficiencies will be reviewed by the Safety Committee.

Between the annual hazard surveillances, Public Safety Officers will regularly patrol all parking lots, driveways, and walkways to keep them safe and clear of obstructions, with particular attention to the emergency care area.

Public Safety Officers who observe or receive a report of a safety hazard shall do the following:

1. Make an immediate attempt to correct the problem.
2. Install warning signs and/or barriers to warn of the hazard whenever possible.
3. Report the hazard in writing through the POM on-line Work Order system.
4. Log the hazard in the Security Department Daily Activity Report.

The Providence Little Company of Mary Medical Center (PLCMMC) contracts with an outside gardening service.

Emergency Care Area:

There shall be provisions for a readily identifiable and easily accessible Emergency Department (ED).

Red curbs and "No Parking" signs and markings will be utilized to prevent vehicles from parking or otherwise blocking the emergency driveway. Any vehicle parked or left standing in the emergency driveway should be immediately reported to the Public Safety Department. Public Safety Officers will regularly patrol this area to assure compliance.

Public Safety Officers will attempt to locate the owner of any vehicle found in the emergency driveway. If the owner cannot be located, the vehicle may be towed away, after receiving authorization from the DPS Manager. Security Officers will log all activity in the emergency driveway in their daily activity report.

Lighting:

There will be provisions for adequate lighting for all parking lots, sidewalks, and driveways. All parking lot light poles have been assigned a unique number for identification. DPS Officers finding a defective critical light shall report it, in writing, by creating a Work Request to the Engineering Department for corrective action.

Daily, one (1) hour after darkness, a DPS Officer will inspect the grounds lighting.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
EOC	Salvator Demarti: Accreditation Program Manager	01/2024
EOC	Edgar Flemate: Director Facilities	01/2024

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: *Pending*

PolicyStat ID: 15013681



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 01/2009
Effective: Upon Approval
Last Approved: N/A
Last Revised: 06/2014
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Environment of Care
References:
Applicability: CA - Providence LCM MC
Torrance

Incoming Inspection, Add/Delete Equipment from Inventory

Number: LCT-EOC-701

POLICY:

It is the policy of Engineering and Plant Operations/Maintenance (POM) Department to keep an accurate Equipment Inventory, by creating a process for the inspection of new equipment and updating the inventory for any equipment deletion or addition.

PROCEDURE:

A. INCOMING INSPECTION:

1. Purchasing Department is to inform Engineering Department of any arrival of new equipment.
2. Engineering Department will conduct an inspection and add a Control Number or asset number, and gather the model, serial and manufacturer information and assigning Preventive Maintenance schedule and interval.
3. Conduct Electrical Safety Inspection.
4. In case of Construction or Remodeling, Project Manager will inform Engineering Department of any equipment updates.

B. ADD/DELETE EQUIPMENT FROM INVENTORY:

Should any equipment fail to operate or it becomes necessary to replace a defective equipment with a new one (1):

1. The same procedure will be followed in section A.2.
2. Remove the deleted equipment from the inventory.
3. Properly dispose of the defective equipment.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
EOC	Salvator Demarti: Accreditation Program Manager	01/2024
EOC	Edgar Flemate: Director Facilities	01/2024

Applicability

CA - Providence LCM MC Torrance

COPY

Current Status: *Pending*

PolicyStat ID: 14681177



Provident

Little Company of Mary
Medical Center
Torrance

Origination: 04/2018
Effective: Upon Approval
Last Approved: N/A
Last Revised: 11/2023
Next Review: 3 years after approval
Owner: Munaver Bholat: Senior Director
Pharmacy
Policy Area: Medication Management
References:
Applicability: CA - PH&S Little Company of
Mary Service Area

Methadone Therapy

PURPOSE

The purpose of this policy is to outline safety measures regarding the provision of methadone therapy.

BACKGROUND

Methadone is a synthetic opioid agonist indicated for:

1. Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.
 - a. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-acting opioids, reserve methadone for use in patient for whom alternative treatment options (e.g. non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
 - b. Methadone is not indicated as an as-needed (PRN) analgesic. (This does not preclude the use of PRN orders for dose titration or to provide adequate pain relief in hospice/palliative patients as appropriate)
2. Detoxification treatment of opioid addiction (heroin or other morphine-like drugs), for federally licensed and approved treatment program only.
3. Maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services for federally licensed and approved treatment program only.
4. Opioid treatment programs must be federally certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and approved by the designated state authority. Only oral methadone is dispensed and the Federal Opioid Treatment Standards must be met. (42 CFR 8.12)
 - a. Regulatory exception is allowed during inpatient care when the patient is admitted for any condition other than concurrent opioid addiction, to facilitate the treatment of the primary admitting diagnosis. (21CFR 1306.07(c))

Methadone has unique pharmacokinetic and pharmacodynamic properties and high inter-patient variability in response. Most importantly:

1. Methadone's elimination half-life (8-59 hours) is much longer than its duration of analgesic action (4-8 hours).
2. Methadone's peak respiratory depressant effects typically occur later, and persist longer than its peak analgesic effects.
3. Methadone's full analgesic effect is usually not attained until 3-5 days of initial dosing.
4. Methadone's dosage range is wide and depends on the indication. Indication for use should be included when prescribing.

POLICY

1. The administration of Methadone for the acute treatment of a patient for addiction or for detoxification is prohibited at Providence Little Company of Mary Medical Center.
 - Example: A patient admitted with a diagnosis of Chemical Dependency, Opioid Dependence, Opioid Use Disorder, or Opioid Withdrawal is NOT permitted to receive methadone under any circumstances.
2. Methadone maintenance therapy is permitted only for inpatients and only when the primary diagnosis is medical, surgical or psychiatric, excluding addiction and detoxification. In these cases, methadone therapy is an incidental adjunct to medical or surgical treatment of conditions other than addiction.
 - Example: A patient currently enrolled with a methadone treatment clinic who is hospitalized with pneumonia, may be maintained on their methadone dosing per physician order.
3. Methadone may be administered for pain therapy when deemed necessary by the physician.
 - Example: A cancer patient who is hospitalized for hospice care may receive methadone for pain control.
4. All methadone orders will require indication on the order and all 1st dose order for methadone dose above 20mg will require confirmation with the prescriber.
5. Methadone will not be dispensed to the Emergency Department for any indications.
 - a. Exception for patients who will be admitted.
6. Discharge prescriptions for methadone for patients other than for hospice patients, will only be dispensed for pain indication and only when prescribed by palliative, pain management, or oncology specialists.

PROCEDURE

A. General Procedures:

1. Indication for methadone use should be included with the order. The pharmacist must verify the indication, prior to processing the order.
2. In keeping with the federal regulations, conditions for distribution and use of methadone products for the treatment of opioid addiction will be followed.(42 CFR Section 8)
3. Methadone dose must be prescribed in milligrams (mg).
4. Pharmacy dispenses oral liquid methadone 5mg/5mL or 10mg/5mL for in-patient use as patient specific doses.

- a. For hospice patients unable to swallow or patients on high maintenance doses and unable to swallow, high concentration methadone doses will be dispensed only as unit dose with patient specific labeling.

5. Pharmacists must confirm with the prescriber, all first doses of methadone above 20mg.

B. Methadone Maintenance Therapy for inpatients with medical, surgical, or psychiatric diagnosis excluding addiction and/or detoxification.

1. When a patient who is on a methadone maintenance program is admitted, the admitting physician must establish this fact and advise nursing staff and pharmacy staff of such patients.
2. The nurse and pharmacy staff will obtain the name and telephone number of the licensed methadone clinic at which the patient is registered.
3. The pharmacist, in collaboration with the nurse and the physician will contact the licensed methadone clinic for verification of patient registration and dosage information.
4. Documentation is to be made in the patient's medical record. The prescribing or attending physician will be contacted in the event of denied verification.
5. Methadone will not be administered until verification of patient registration and dosage information is obtained.

REFERENCES

1. Methadone package Insert – FDA approved product labeling including black box warning
2. 42 CFR 8.12 - Code of Federal Regulations, Title 42, Section 8: Certification of Opioid Treatment Programs
3. 21 CFR 1306.07 – Code of Federal Regulations, Title 21, Part 1306.07 – Administering or Dispensing of Narcotic Drugs
4. DATA 2000 – Drug Addiction Treatment Act of 2000
5. SAMHSA – Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Attachments

No Attachments

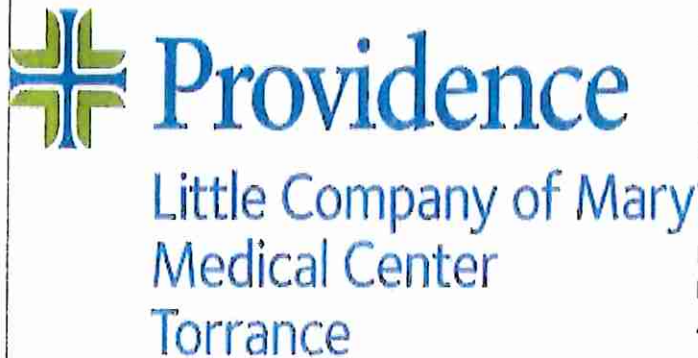
Approval Signatures

Step Description	Approver	Date
Med Staff - Critical Care (T), ED (Both),	Mayra Graves: Medical Staff Coordinator	pending

Step Description	Approver	Date
Medicine (SP), P&T (Both)		
Med Staff - Critical Care (T), ED (Both), Medicine (SP), P&T (Both)	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
CNO	Kathryn Webster: Executive Director Nursing	12/2023
CNO	Jillian Nichols: Director Nursing	11/2023
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Dir	Munaver Bholat: Senior Director Pharmacy	11/2023
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	11/2023
Applicability		
CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance		

Current Status: *Pending*

PolicyStat ID: 14586445



Origination: 03/2018
Effective: Upon Approval
Last Approved: N/A
Last Revised: 10/2023
Next Review: 1 year after approval
Owner: *Treasure Joyce: Clinical Program Manager*
Policy Area: *Patient Care Services*
References:
Applicability: *CA - PH&S Little Company of Mary Service Area*

Neuroscience Interfacility Transfer

POLICY

In keeping with the mission and values of Providence St Joseph Health System, Providence Little Company of Mary Medical Center (PLCMMT) will receive inter-facility transfer of patients requiring a higher level of care from within the Providence Health System or another facility not affiliated with Providence (Outside Hospital). The purpose of this document is to provide guidelines for appropriateness of patient transfer and to outline the standard work in which should take place during decision to transfer patients with complex non-traumatic cerebrovascular conditions requiring a higher level of care.

DEFINITIONS/ACRONYMS

Neuro IR: Neuro Interventional Radiologist

Outside Hospital (OSH): Sending hospital; Primary Stroke Certified, other community hospital or other Providence hospital

Complex Stroke: Any acute stroke requiring surgical or percutaneous intervention, neuro-critical care monitoring, or higher level of care that is not provided by the sending facility.

LVO: Large Vessel Occlusion (Cerebral)

AIS: Acute Ischemic Stroke

CVT: Central Venous Thrombus

SAH: Subarachnoid Hemorrhage

aSAH: Aneurysmal Subarachnoid Hemorrhage

SDH: Subdural Hematoma

EDH: Epidural Hematoma

ICH: Intracranial Hemorrhage

CCT: Transport of a patient, from a scene or clinical setting, whose condition warrants care within the scope of practice of an RN (Registered Nurse) in addition to an EMT (Emergency Medical Technician).

CSC: Comprehensive Stroke Center

MICN: Mobile Intensive Care Nurse (Radio Nurse)

PROCEDURE / GENERAL INSTRUCTIONS

For patients considered for transfer to a CSC for higher level of care. There is physician to physician discussion between the OSH physician and the appropriate accepting physician at PLCMMCT. The accepting physician approves appropriateness of transfer and determines the appropriate level of care for transport. The plan of care is communicated to the ED Physician at PLCMMCT.

APPROPRIATENESS GUIDELINES FOR NEURO TRANSFER

A. Acute ischemic stroke (AIS) with:

- Known or Clinical suspicion of Large Vessel Occlusion (LVO) \leq 24 hours of last known well
- High risk for malignant cerebral edema requiring Neuro-critical Care management
- Large artery anterior circulation stroke or large posterior fossa stroke
- Cerebral venous thrombus (CVT) with: ICH, Seizure, NIHSS $>$ 9 or GCS $<$ 12

*Approval for transfer at the discretion of the Interventional Neuro Radiologist, Neurologist, or Neurocritical Care Physician on call

B. Patients with ~~non-traumatic~~ intracranial hemorrhage including:

- Subarachnoid hemorrhage (SAH)
- Aneurysmal subarachnoid hemorrhage (aSAH)
- Subdural hematoma (SDH)
- Epidural hematoma (EDH)
- Intracerebral hemorrhage (ICH)

* Approval for transfer at the discretion of the Neurosurgeon, Interventional Neuro Radiologist, Neurologist, or Neurocritical Care Physician on call

C. Neuroimaging evidence of unruptured intracranial aneurysm or avm with cranial neuropathy, recent history consistent with sentinel bleed, or other features considered high-risk (e.g., cerebral aneurysm $\geq 15\text{mm}$ or $\geq 2.5\text{cm}$ diameter) per appropriate accepting physician.

D. Transient ischemic attack (TIA) with:

- Imaging evidence of $\geq 50\%$ steno-occlusive lesion in extracranial or intracranial circulation corresponding to symptomatic vascular territory.
- Imaging evidence of occlusive thrombus corresponding to symptomatic vascular territory.

E. Any ~~non-traumatic~~ patient requiring neurological services that are available at PLCMMT and not available at outside hospital. (e.g., brain tumor, spine fracture, hydrocephalus)

** Note: Any patient who has a life expectancy less than one year, is "Do Not Attempt CPR" (DNACPR) status and aggressive treatment or intervention is not pursued, or is comfort measures only status, then the decision not to accept can be made by the transferring provider or PLCMMCT neuro-physician.*

* Above selection guidelines in items A-E are at the discretion of the appropriate neuro-physician on call which can include: Neuro IR, Neurosurgeon, Neurologist, and Neuro-Critical Care, and ICU Intensivist.

1. OSH provider will call ~~Providence Little Company of Mary Medical Center's~~ **STROKE TRANSFER**

~~HOTLINE (310) 4—STROKE (310) 478-7653 for emergent~~Providence Patient Placement Center (PPC) for
transfer requested.

~~2. The MIGN manning the TRANSFER HOTLINE will then connect the referring physician via "conference call" with the appropriate accepting physician based on the reason for patient transfer.~~

~~A. The goal is to establish a ONE CALL/streamlined process for communication and patient transfer.~~

~~B. All calls will be recorded for quality assurance.~~

~~C. If patient is coming from a non-Providence OHS, the HOTLINE MIGN will require a Facesheet to be faxed to the ED Fax 310-303-5609. This will be given to the Registrar ASAP to ensure quick registration of the patient in the EMR.~~

~~1. Upon receipt of the Facesheet the Registrar performs ED-STAT registration and places the patient in "Expected" status.~~

~~D. In the event that the accepting physician does not answer the call within 2 attempts the HOTLINE MIGN will inform the referring physician that an accepting physician will be located and return the call within 10 min. (see "Intake and Receiving Process for Comprehensive Neuroscience Transfers")~~

~~1. The HOTLINE MIGN will then send a text message via the CCT iPhone to the appropriate accepting physician and request a call back to the TRANSFER HOTLINE in order to reinstate the conference call with the referring physician. This will occur in addition to leaving a voicemail with the TRANSFER HOTLINE call back.~~

~~2. In the event that the accepting physician does not call the hotline within 10 min, the MIGN will call the Neurologist on call for direction.~~

~~3. Once an accepting physician is reached the MIGN will then teleconference both sending and accepting physician via the TRANSFER HOTLINE.~~

~~E. During the call the HOTLINE MIGN will obtain and document the following information:~~

- ~~▫ Age~~
- ~~▫ Reason for Transfer~~
- ~~▫ Transport Level of care~~
- ~~▫ ***NOTE: If the patient does not require immediate neurointervention/surgery or admission to ICU the standard direct admission process will be followed (See "Emergent Direct Admit Inpatient" attached.**~~
- ~~▫ Sending physician and facility~~
- ~~▫ Accepting physician~~
- ~~▫ Pertinent treatments performed at sending facility~~
- ~~▫ Plan of care~~
- ~~▫ Additional orders requested by accepting physician who will be receiving patient~~

~~F. Once the decision to transfer is made, the accepting physician will communicate the plan to the Emergency Room Physician who will be initially receiving the patient.~~

~~1. The Emergency Room Physician will identify and notify the appropriate "Admitting Physician" of pending transfer.~~

~~G. The HOTLINE MIGN will then proceed to notify the following personnel:~~

- CCT RN, Ambulance Company EMT, and Respiratory if indicated for airway management. (See "Neuroscience Critical Care Transport Standards of Care")
 - House Supervisor for bed assignment
 - Cath Lab (if requested by Neuro-IR) for intervention
 - OR Team (if requested by Neurosurgeon) for surgery
- H. Upon 10 minutes of return to PLCMMCT the CCT team notifies the HOTLINE MICN of pending arrival.
 - 1. The ED PST notifies PBX of "CODE STROKE TRANSFER" which is paged overhead.
 - 2. HOTLINE MICN writes updated pt information and plan of care on Code Stroke White Board if applicable
- I. Upon arrival the following processes occur in parallel:
 - The Registrar "Arrives" the patient.
 - The CCT RN gives hand-off to the Emergency Room Physician and the ED RN receiving the patient
 - The Emergency Room physician performs a rapid assessment of the patient and implements any orders requested by the accepting neuro-physician.
 - The accepting neuro-physician and appropriate team (ie: Cath Lab or OR) are notified of the patients arrival.
 - If intervention is planned, "Code Stroke Intervention" is paged overhead at this time.
 - The Emergency Department team hand-off to the accepting team.
- J. The accepting neuro-physician is responsible for communicating with the ICU intensivist and Neurohospitalist physician after planned treatment is rendered or plan of care if treatment is other than immediate intervention or surgery.
- K. The "Admitting Physician" will obtain neurology consult if indicated and complete appropriate admission orders.

2. The PPC will then follow the Emergent Neuro/Stroke Transfer process as outlined in the attachment.

3. If transfer is deemed to be EMERGENT the MICN will be connect by the PPC to the 3 way call in order to review the plan of care discussed. At this time the plan of care will also be communicated with the ED MD.

4. If expected thrombectomy transfer, the MICN will activate "Code Stroke Intervention."

5. If the ambulance provider is not able to provide CCT transport with an ETA of 30 min, a CCT RN from PLCMMT may be required for transport.

REFERENCE(S) / RELATED POLICIES

- Schwamm, L.H., Pancioli, A., Acker, J.E. et al. (2005) Recommendations for the Establishment of Stroke Systems of Care: Recommendations from the American Stroke Association's Task Force on the Development of Stroke Systems. *Stroke*, 36,690-703. Retrieved from: <http://stroke.ahajournals.org/content/36/3/690.short>
- Opeolu Adeoye, MD, MS, FAHA, Chair et al. (2019) Recommendations for the Establishment of Stroke Systems of Care: A 2019 Update. *Stroke*, 50, issue 7, e187-e210. Retrieved from: <https://doi.org/10.1161/STR.0000000000000173>
- E. Sander Connolly, Jr, MD, FAHA, Chair et al. (2012) Guidelines for the management of Aneurysmal

Subarachnoid Hemorrhage: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. *Stroke*, 43, Issue 6, 1711-1737. Retrieved from <http://doi.org/10.1161/STR.0b01382587839>

- Powers, J. William, MD, FAHA Chaire et al. (2019) Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Retrieved from: <http://doi.org/10.1161/STR.0000000000000211>
- Acute Stroke Management Policy - PLCMMT
- Stroke Center Operations - PLCMMT

Attachments

[CCT Orders](#)

[Stroke Transfer PPC V2 - Copy.pdf](#)

Approval Signatures

Step Description	Approver	Date
Med Staff - Critical Care (T), ED, Medicine	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - Critical Care (T), ED, Medicine	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	10/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023
Policy Committee	Treasure Joyce: Clinical Program Manager	10/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

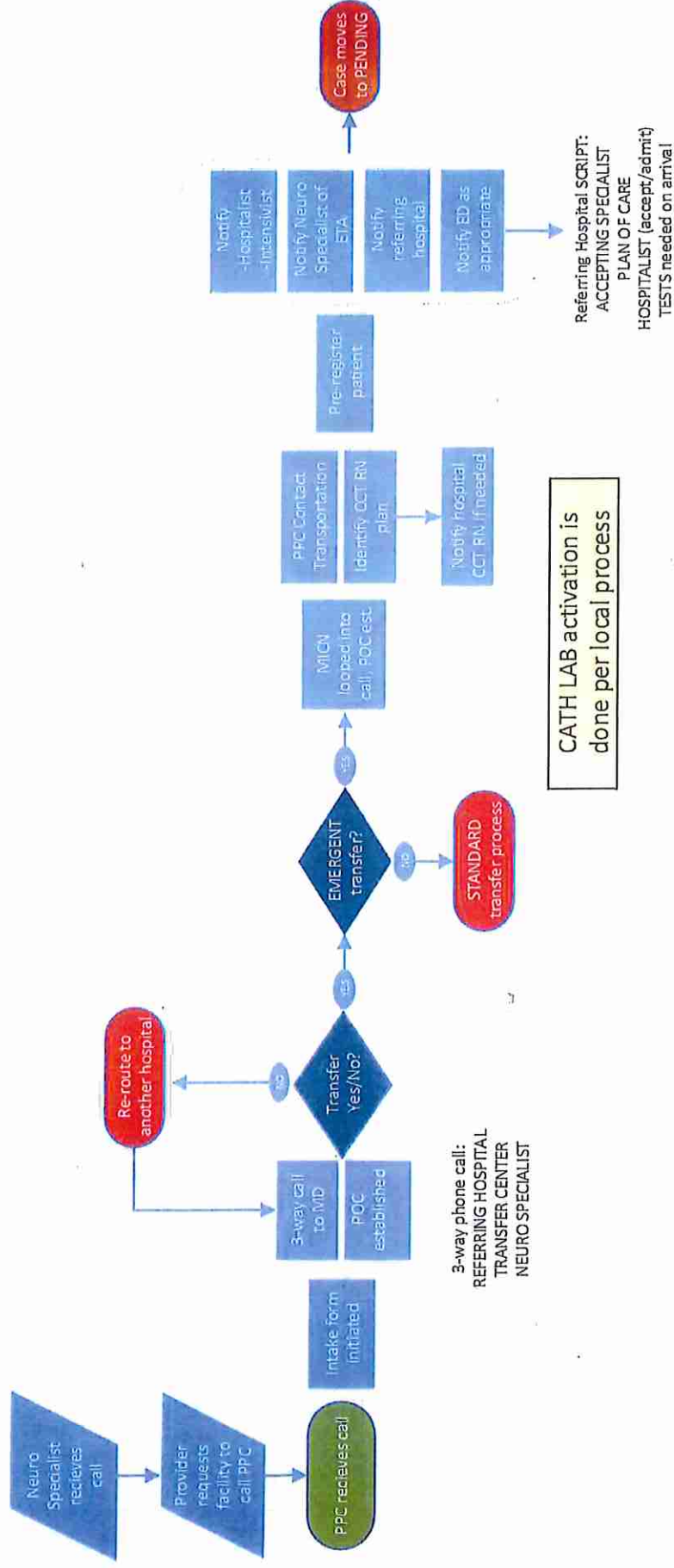
OUTPATIENT EMERGENCY TRANSPORT ORDERS

Revised 04-2019

NURSING	MEDICATIONS
<input type="checkbox"/> Critical Care Transport	<input type="checkbox"/> Adenosine 6mg rapid IVP symptomatic SVT; may repeat 12 mg IVP x's 1 if SVT persists
<input type="checkbox"/> Transport Code 3 "lights and sirens"	<input type="checkbox"/> Albuterol 2.5 mg hand held nebulizer hand nebulizer prn wheezing or basilar rales. <i>Dilute with Normal Saline to a total volume of 3 ml</i>
<input type="checkbox"/> Cardiac Monitor, Oxygen and Pulse Oximetry/Capnography if indicated.	<input type="checkbox"/> Amiodarone 300 mg IVP prn pulseless VT/VF; may repeat 150mg IVP in 3 minutes if VT/VF persist.
<input type="checkbox"/> IV access	<input type="checkbox"/> Amiodarone 150 mg IVPB over 10 min prn wide complex (stable) tachycardia
<input type="checkbox"/> Initiate BLS and ALS measures based on AHA guideline, if necessary for cardiopulmonary or respiratory deterioration or arrest.	<input type="checkbox"/> Atropine 0.5mg IVP prn symptomatic bradycardia; May repeat q 3min, max dose 2 mg
<input type="checkbox"/> Oxygen prn to maintain O2 sats > _____%	<input type="checkbox"/> Diphenhydramine (Benadryl) 50 mg IVP prn allergic reaction or Angioedema; May repeat x's 1 in 15 min for total dose of 100 mg
<input type="checkbox"/> 12 lead EKG prn rhythm change or patient complaint of chest pain	<input type="checkbox"/> Dextrose 50% 25 gms IVP prn ALOC related to hypoglycemia (blood sugar less than 70mg/dl)
<input type="checkbox"/> IO placement for patients requiring emergency medications when a peripheral IV is unable to be accessed after 90 seconds	<input type="checkbox"/> Dopamine (Inotrophin) 5mcg/kg/min. Start if NS bolus completed and ineffective (Keep SBP>90). Max dose 20mcg/kg/min
<input type="checkbox"/> Vital Signs and Neuro checks per protocol	<input type="checkbox"/> Epinephrine 1:1,000 0.3 IM x's 1 PRN allergic reaction
IV FLUIDS	<input type="checkbox"/> Epinephrine 1:10,000 1 mg IVP q 3 min PRN asystole or VF
<input type="checkbox"/> 0.9% Normal Saline 500ml bolus PRN symptomatic hypotension (SBP <90)	<input type="checkbox"/> Prasugrel (Effient) 60mg PO now if able to swallow
STROKE	<input type="checkbox"/> Romazicon (Flumazenil) 0.2mg IVP over 15 secs. IF no improvement in LOC after 45 secs, may repeat to max dose of 1 mg (Not for use with chronic Benzodiazepine patients or those with seizure disorder)
<input type="checkbox"/> Ischemic Stroke without tPA	<input type="checkbox"/> Magnesium Sulfate 2 gms over 15min IVPB PRN Torsades de Pointe
<input type="checkbox"/> Maintain SBP <220 mmHg	<input type="checkbox"/> Aspirin (Chewable) 81mg PO now if PT is able to swallow
<input type="checkbox"/> Vital Signs and Neuro Checks q 15 min or more frequent if indicated	<input type="checkbox"/> Heparin 5000 units/ml SQ now
<input type="checkbox"/> Maintain HOB 30 degrees	<input type="checkbox"/> Narcan (Naloxone) 0.4 mg IVP if suspected narcotic induced respiratory distress. Give diluted in 10 ml of NS; may repeat x's 1 after 2 mins
<input type="checkbox"/> Ischemic Stroke <u>w/tPA</u>	<input type="checkbox"/> Clopidogrel (Plavix) 300mg PO now if able to swallow
<input type="checkbox"/> Continue tPA drip during transport if remaining volume in bag to be infused.	<input type="checkbox"/> Clopidogrel (Plavix) 600mg PO now if able to swallow
<input type="checkbox"/> Maintain SBP < 180 mmHg	<input type="checkbox"/> Nitroglycerin 5 mcg/min and titrate by 10 mcg/min every 5 min PRN chest pain; max does 200 mcg/min – hold if SBP <160mmHg
<input type="checkbox"/> Vital Signs and Neuro checks q 15 or more frequent if indicated.	<input type="checkbox"/> Midazolam (Versed) <u>1mg IVP PRN sedation/agitation</u> ; may repeat x1 in 3 min for a total dose of 2 mg
<input type="checkbox"/> Maintain HOB 30 degrees	<input type="checkbox"/> Midazolam (Versed) <u>2 mg IVP PRN seizure</u> ; may repeat q1min for seizure control, max dose 10 mg
ANTIHYPERTENSIVES	<input type="checkbox"/> Ondasetron (Zofran) 4mg IVP PRN nausea; may repeat x's 1 in 3 min for total dose of 8 mg
<input type="checkbox"/> Nicardipine (Cardene) Start 5mg/min increase by 5 mg/min; max dose 20 mg/min for Hypertension SBP > 160 mmHg	<input type="checkbox"/> Ondansetron (Zofran) 4mg PO PRN Nausea
<input type="checkbox"/> Labetalol 10 mg IVP; May repeat q 10 mins, max dose 80 mg	<input type="checkbox"/> Metoprolol (Lopressor) 5g/5ml IVP for heart rate > _____ or SBP > _____
<input type="checkbox"/> Labetalol 20mg IVP; May repeat q 10 mins, max dose 80 mg	<input type="checkbox"/> Nitroglycerin (Nitrostat) SL tablet 0.4mg q 5min PRN Chest Pain

T.O. _____, MD	_____, RN	Date: _____	Time: _____
MD Signature: _____	<input type="checkbox"/> Read Back verified	Date: _____	Time: _____

EMERGENT STROKE/NEURO TRANSFER PROCESS



It is noted that there may be several different scenarios in which specialists at the comprehensive center are consulted to discuss treatment options for a neurological/stroke patient. It is understood that if the decision to transfer is established, the sending facility is instructed to call the PPC in order to further facilitate the transfer. The PPC will recontact the accepting specialist to confirm the plan of care and the appropriate level of transportation.

Current Status: *Pending*

PolicyStat ID: 14619863



Provident

Little Company of Mary
Medical Center
Torrance

Origination: 12/2020
Effective: Upon Approval
Last Approved: N/A
Last Revised: 12/2020
Next Review: 3 years after approval
Owner: Scott Ciesielski: Chief Nursing Officer
Policy Area: Patient Care Services
References:
Applicability: CA - Providence LCM MC Torrance

Patients Requiring Methotrexate for Ectopic Pregnancy

POLICY

In keeping with the mission and values of Providence Health & Services patients requiring methotrexate administration for treatment of ectopic pregnancy will be treated at Providence Little Company of Mary Medical Center Torrance (PLCMMCT). Methotrexate orders for treatment of ectopic pregnancy are to be written by an OB/GYN physician and administered by a chemotherapy certified RN.

PROCEDURE / GENERAL INSTRUCTIONS

- A. At PLCMMCT ED: The ED MD will complete an exam of the patient and order any studies to be done. If an ectopic pregnancy is determined the ED physician will contact the OB/GYN. If methotrexate is ordered it will be administered in the ED by a chemotherapy certified RN. The ED RN will call the Tele Oncology unit to request a chemotherapy certified RN to go to ED to administer the Methotrexate.
- B. For patients seen in an OB/GYN office, examined, and studies completed to confirm the diagnosis and the need for methotrexate therapy, the OB/GYN office staff will direct the patient to go to PLCMMCT Emergency Department.
 1. The OB/GYN must enter orders into the electronic medical record (EMR) or call in orders for the patient.
 - a. The ED provider does not write orders for methotrexate.
- C. The OB/GYN will dictate an H&P into the patient's EMR including documentation of information provided to the patient enabling an informed consent regarding administration of methotrexate.
- D. For all patients, in order for the patient to receive methotrexate, the pharmacist must be able to verify the following information in the EMR:
 1. Indication for Methotrexate therapy
 2. Accurate patient height and weight
- E. For Emergency Department patients, in order for the patient to receive methotrexate, the pharmacist must be able to verify the following information in the EMR:

1. Labwork including positive bHCG result
2. Documentation of ultrasound confirming an ectopic pregnancy
3. Absence of viable intra-uterine pregnancy

F. In the event of an emergency such as an ectopic that ruptures while the patient is at PLCMMCT ED awaiting methotrexate therapy, the OB/GYN physician will be contacted and the laborist/hospitalist will be called

1. Because the hospitalist's primary role is limited in the L&D unit, treatment is limited to providing emergent care until the primary OB/GYN MD arrives. The primary OB/GYN MD will be the admitting physician for that patient, even if the hospitalist has stabilized the patient and completed the surgical procedures prior to arrival.

CRITERIA FOR METHOTREXATE THERAPY

- Hemodynamic stability
- No severe or persistent abdominal pain
- Commitment to follow-up until the ectopic pregnancy has resolved
- Normal baseline liver and renal function laboratory results

CONTRAINDICATIONS FOR METHOTREXATE THERAPY

- Intrauterine pregnancy
- Evidence of immunodeficiency
- Moderate to severe anemia, leukopenia, or thrombocytopenia
- Sensitivity to methotrexate
- Active pulmonary disease
- Active peptic ulcer disease
- Clinically important hepatic dysfunction
- Clinically important renal dysfunction
- Breast feeding
- Ruptured ectopic pregnancy
- Hemodynamically unstable

Relative Contraindications:

- Embryonic cardiac activity detected by transvaginal ultrasound
- High initial hCG concentration (> 5000 mIU/mL)
- Ectopic pregnancy > 4 cm size by transvaginal ultrasound
- Refusal to accept blood transfusion
- Inability to participate in follow-up

REFERENCE(S) / RELATED POLICIES

- American Society for Reproductive Medicine. (2013). Medical Treatment of Ectopic Pregnancy: A Committee Opinion. *Fertility and Sterility*, 100 (3), 638-644.

Attachments

No Attachments

Approval Signatures

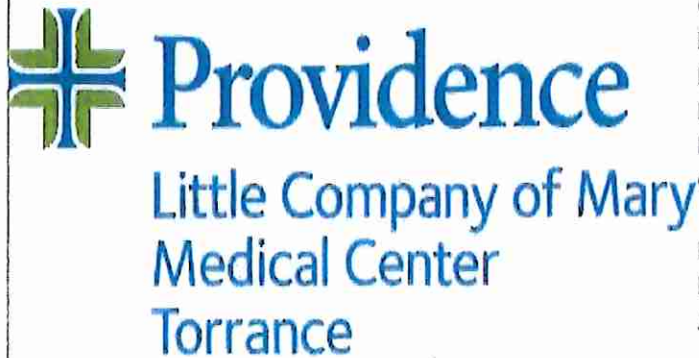
Step Description	Approver	Date
Med Staff - ED, OB/GYN, P&T	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023

Applicability

CA - Providence LCM MC Torrance

Current Status: *Pending*

PolicyStat ID: 14501739



Origination: 01/2000
Effective: Upon Approval
Last Approved: N/A
Last Revised: 12/2020
Next Review: 1 year after approval
Owner: Lisa Yauchzee-Gac: Executive Director Nursing
Policy Area: Pediatrics
References:
Applicability: CA - Providence LCM MC Torrance

Pediatrics: Admission, Discharge and Transfer Criteria

PURPOSE:

The purpose of this policy is to define the patient population for which care will be provided in the pediatric unit.

REFERENCE:

California Children's Services (CCS). Manual of Procedures, 1999.

RESPONSIBILITY:

Medical and nursing staff

POLICIES:

1. Criteria for admission to the pediatric unit include:
 - A. Age 13 years and under, including infants age 30 days or less who do not meet criteria for admission to the Neonatal Intensive Care Unit (NICU).
 - B. Expected length of stay 21 days or less.
 - C. Children up to age 21 may be admitted upon order of the physician, in consultation with the unit manager/supervisor and/or charge nurse, with specific documented indications.
 - D. Children with infectious diseases may be admitted according to the infection control policy.
 - E. Children under age three (3) years will be kept separate from older children.
 - F. Room assignment will consider the patient age, sex and diagnosis.
2. If a pediatric patient less than 14 years of age is admitted to other service/department of the hospital than the Pediatric department, the Chief of Pediatrics will be notified.
3. Criteria for discharge from the pediatric unit include:
 - A. Physician order
 - B. A parent or legal guardian is present to take the child home.

- C. Patients who have undergone a same-day surgical procedure may be discharged when they meet the following criteria:
1. Activity level appropriate to age and surgical procedure.
 2. Awake and oriented to surroundings, as appropriate for age, at pre-procedural level.
 3. Vital signs are stable within patient's normal or pre-procedural limits.
 4. Absence of untoward abnormal signs or bleeding from procedure site.
 5. Adequate circulation.
 6. Pain controlled, as appropriate.
 7. Nausea and vomiting minimal or absent.
 8. Voiding sufficient quantity according to age and procedure.
4. Criteria for transfer from the Pediatric Unit to a CCS approved higher level of care.
1. Order from pediatric hospitalist or attending physician.
 2. Patients requiring 24 hour in-house coverage by a physician.
5. Children with the following conditions shall have care provided and/or coordinated through facilities meeting CCS Standards for Special Care Centers. Upon identification, these children shall, be referred to the appropriate CCS-approved Special Care Center for further diagnostic work-up, treatment services and/or follow-up care as indicated. The conditions include:
- A. Acute hepatic failure.
 - B. Acute renal failure or chronic renal disease.
 - C. Immediate dialysis requirements because of renal failure.
 - D. Complex congenital heart disease.
 - E. Chronic renal disease.
 - F. Craniofacial anomalies.
 - G. Myelomeningocele
 - H. Chronic lung disease and/or the need for ventilator assistance.
 - I. Need for administration of vasoactive, inotropic, or chronotropic agents or anti-arrhythmic medication.
 - J. Need for invasive monitoring
 - K. Burn injuries involving greater than 10% of body surface area in child less than one (1) year of age.
 - L. Burn injuries involving greater than 15% of body surface area in child one (1) year of age or older.
 - M. Anomaly or cardiac disorder requiring specialized diagnostic procedures or surgery.
 - N. Inherited metabolic disorder.
 - O. Malignant neoplasm.
 - P. Hemophilia or hemoglobinopathy, requiring specialized diagnostic procedures treatment and/or follow-up.
 - Q. Endocrine disorder requiring specialized diagnostic procedures treatment and/or follow-up.
 - R. Immunologic or infectious disorder requiring specialized diagnostic procedures treatment and/or

follow-up, including HIV infection.

REFERENCE(S) / RELATED POLICIES:

- Document Central policy number LCT-PEDS-203

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - Peds/NICU, ED	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	10/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023
Policy Committee	Lisa Yauchzee-Gac: Executive Director Nursing	10/2023

Applicability

CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 14182683



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 06/2012
Effective: Upon Approval
Last Approved: N/A
Last Revised: 08/2023
Next Review: 1 year after approval
Owner: Joseph Wolff; Manager Nursing
Policy Area: Emergency Department
References:
Applicability: CA - PH&S Little Company of Mary Service Area

Standardized Procedures for Emergency Department Triage RN

POLICY

It is the policy of Providence Health Service (PHS) Southern California Region that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) without the previous written authorization of the Emergency Department (ED) Physician.

Only RNs that have a documented competency on file for the performance of said standardized procedures will perform these standardized procedures as part of their scope of practice.

PURPOSE

The purpose of this policy is to define designated medical functions that may be performed by the RN as a standardized procedure in the ED.

DEFINITION(S)

1. Emergency Severity Index (ESI) is defined as a simple to use, five (5) level triage algorithm that categorizes ED patients by evaluating both patient acuity and resource needs. Initially, the triage nurse assesses only the acuity level. If a patient does not meet high acuity level criteria (ESI Level 1 or 2), the triage nurse then evaluates expected resource needs to help determine a triage level (ESI Level 3, 4 or 5). The ESI is intended for use by nurses with triage experience (~~United States Department of Health and Human Services, 2012~~); Emergency Nurses Association, 2020).

STANDARD PROCEDURES include all of the following: Abdominal Pain, Chest Pain, Respiratory Distress, Fever in Adult, Pediatric Fever, and Extremity Deformity from Trauma with Pain, ~~and Severe Pain~~.

PROCEDURE/GENERAL INSTRUCTIONS

1. Competency Requirements:
 - A. To be eligible to perform these standardized procedures in the ED, the RN must:
 1. Complete a Standardized Procedure for Emergency Department Triage RN in the ED HealthStream program upon hire and annually, and pass the assigned post-test with 100%

accuracy.

- B. A list of RNs competent to perform standardized procedures in triage is maintained in the Nursing Administrative Office and updated annually.
- C. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

I. Abdominal Pain:

1. Circumstances under which the procedure is performed:
 - A. Any patient in the ED, age 18 and older, presenting with abdominal pain
2. Circumstances under which an ED Physician or Licensed Independent Practitioner (LIP) will be contacted:
 - A. Any patient classified as an ESI Level 1
 - B. Any patient classified as an ESI Level 2
 - C. Any significant change in patient condition
3. Standardized Procedure:

Upon presentation to the ED with complaint of (c/o) abdominal pain, the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

 - A. Places a saline lock
 - B. Obtains an Electrocardiogram (EKG) if greater than 35 years old
 - C. Obtains blood, urine for testing: CBC, Complete Chem Panel, Urinalysis, Urine Pregnancy if female up to age 12-55, hold PT/PTT, hold blood tubes for Lipase
4. Complications:
 - A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category
5. Documentation:
 - A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

II. Chest Pain/Shortness of Breath:

1. ~~Circumstances under which the procedure is performed:~~
 - ~~A. Any patient, age 35 and older, in the ED presenting with chest pain~~

Circumstances under which the procedure is performed:

 - A. All patients, age 14 and older with: chest pain, shortness of breath, palpitations, or syncope.
 - B. Age >30 or diabetic of any age with chest pain, shortness of breath, upper abdominal pain, nausea/vomiting or AMS
 - C. Dialysis patient at any age with any of the above complaints, missed dialysis, or HR <60 or >120, SBP <90 or >160.
2. Circumstances under which an ED Physician or LIP will be contacted:
 - A. Any patient classified as an ESI Level 1
 - B. Any patient classified as an ESI Level 2

- C. Any significant change in patient condition
- 3. Standardized Procedure:

Upon presentation to the ED with c/o chest pain, the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

 - A. ~~Obtains a STAT EKG~~ Obtains a STAT EKG: Obtain STAT EKG if greater than 14 years of age with the complaint of Chest Pain or Palpitations.
 - i. At Providence Little Company of Mary Medical Center Torrance: Obtain STAT EKG if greater than 14 years of age with the complaint of Chest Pain or Palpitations.
 - B. Administers oxygen (O2) via nasal cannula or mask to maintain pulse oximetry greater than ~~94~~92%
 - C. Monitors pulse oximetry continuously
 - D. Places a saline lock

~~Administers Nitroglycerin 0.4 mg sublingual every 5 minutes as needed for chest pain x3 doses if systolic BP greater than 90 (or x3 doses maximum)~~
 - E. Administers Aspirin (ASA) ~~325~~324 mg oral STAT
 - F. Obtains from Radiology: PA/LAT if patient is stable, Portable CXR 1-view Chest X-Ray if patient is unstable.
 - G. Obtains Labs: CBC, Chem Panel, BNP if symptoms of heart failure, Troponin, and PT/INR if patient is on Coumadin
 - H. Notify ED Physician/Provider if patient is experiencing severe chest pain to assess for need of further interventions or medication orders.
- 4. Complications:
 - A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category
- 5. Documentation:
 - A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

III. Respiratory Distress:

- 1. Circumstances under which the procedure is performed:
 - A. Any patient in the ED presenting with respiratory distress and/or wheezing
- 2. Circumstances under which an ED Physician or LIP will be contacted:
 - A. Any patient classified as an ESI Level 1
 - B. Any patient classified as an ESI Level 2
 - C. Any significant change in patient condition
- 3. Standardized Procedure:

Upon presentation to the ED with respiratory distress and/or wheezing, the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

 - A. Monitors pulse oximetry continuously

- B. Administers O2 via nasal cannula or mask to maintain pulse oximetry greater than ~~94~~92%
- C. Obtains a STAT EKG if greater than 14 years of age.
- D. Places a saline lock
- E. Obtains from Radiology: PA/LAT if patient is stable. Portable ~~CXR 1 view~~ Chest X-Ray if patient is unstable.
- F. Obtains Labs: CBC with manual differential, Complete Chem Panel, Troponin, BNP if symptoms of heart failure
- G. Obtains Labs: Blood Cultures x2 and Lactic Acid if temperature greater than or equal to 38.0° C (100.4°F)
- H. For patients greater than 14 years of age, administers acetaminophen ~~1000 mg~~ 1 gram oral or 650 mg ~~oral or 650 mg~~ rectal for temperature greater than or equal to greater than or equal to 38.0° C (100.4°F) if patient has not received acetaminophen within the last 4 hours - NOT to exceed ~~4000 mg~~ 1 gram in a 4 hour period
 - i. ~~Any pediatric patient 3 months to 14 years of age presenting with temperature greater than or equal to 100.4°F:~~
 - a. ~~Administers acetaminophen 15 mg/kg oral or rectal for temperature greater than or equal to 100.4°F if patient has not received acetaminophen within the last 4 hours. NOT to exceed 1000 mg in a 4 hour period~~
 - b. ~~If patient is greater than 6 months old, administers Ibuprofen 10 mg/kg oral only if recent acetaminophen dose ineffective after 1 hour. Dose NOT to exceed 400 mg.~~
- I. Any pediatric patient 3 months to 14 years of age presenting with temperature greater than or equal to 38.0° C (100.4°F):
 - i. Administers acetaminophen 15 mg/kg oral or rectal for temperature greater than or equal to 38.0° C (100.4°F) if patient has not received acetaminophen within the last 4 hours - NOT to exceed 1 gram in a 4 hour period
 - ii. If patient is greater than 6 months old, administers Ibuprofen 10 mg/kg oral only if recent acetaminophen dose ineffective after 1 hour. Dose NOT to exceed 400 mg.
- J. If wheezing or assessed signs of severe respiratory distress (pulse oximetry less than 90%, tripping, diaphoretic), ~~administers~~administer:
 - For patients less than or equal to 35 kg: Albuterol ~~2.5~~2.5 mg with Ipratropium 0.25 mg (1.5 mL of Duoneb) nebulized every 15 minutes x3
 - For patients greater than 35 kg: Albuterol 2.5 mg with Ipratropium 0.5 mg (3 mL of Duoneb) nebulized every 15 minutes x3

4. Complications:

- A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category

5. Documentation:

- A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

IV. Fever in Adult:

1. Circumstances under which the procedure is performed:

- A. Any adult patient in the ED assessed with a temperature greater than or equal to 38.0° C (100.4°F)

2. Circumstances under which an ED Physician or LIP will be contacted:

- A. Any patient classified as an ESI Level 1
- B. Any patient classified as an ESI Level 2
- C. Any significant change in patient condition

3. Standardized Procedure:

Upon presentation to the ED with temperature greater than or equal to 38.0° C (100.4°F), the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

- A. Administers acetaminophen ~~4000~~ 1 gram oral or 650 mg oral or 650-mg-rectal for temperature greater than or equal to greater than or equal to 38.0° C (100.4°F) if patient has not received acetaminophen within the last 4 hours - NOT to exceed ~~4000-mg~~ 1 gram in a 4 hour period
- B. Administers Ibuprofen 400 mg oral *only if recent acetaminophen dose ineffective after 1 hour*
- C. Monitors pulse oximetry
- D. Administers O2 via nasal cannula or mask to maintain pulse oximetry greater than ~~94~~ 92%
- E. Obtains from Radiology: PA/LAT if patient is stable, Portable CXR-1-view Chest X-Ray if patient is unstable.
- F. Obtains Labs: CBC with manual differential, Chemistry Panel, Blood Cultures x2 and Lactic Acid
 - i. At Providence Little Company of Mary Medical Center San Pedro: Sends UA to lab
 - ii. At Providence Little Company of Mary Medical Center Torrance: ~~#~~ Send UA to lab, however if dip is ordered and positive for leukocytes and/or nitrate, sends UA and Urine Culture to lab.

~~Administers Normal Saline intravenous (IV) at 150 mL/hr if no history CHF~~

4. Complications:

- A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category

5. Documentation:

- A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

V. Pediatric Fever:

1. Circumstances under which the procedure is performed:

- A. Any pediatric patient 3 months to 14 years of age presenting with temperature greater than or equal to 38.0° C (100.4°F)

2. Circumstances under which an ED Physician or LIP will be contacted:

- A. Any patient classified as an ESI Level 1
- B. Any patient classified as an ESI Level 2
- C. Any significant change in patient condition

3. Standardized Procedure:

Upon presentation to the ED with temperature greater than or equal to 38.0° C (100.4°F), the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

- A. Administers acetaminophen 15 mg/kg oral or rectal for temperature greater than or equal to 38.0° C (100.4°F) if patient has not received acetaminophen within the last 4 hours - NOT to exceed ~~4000-mg~~ 1 gram in a 4 hour period
- B. If patient is greater than 6 months old, administers Ibuprofen 10 mg/kg oral *only if recent acetaminophen dose ineffective after 1 hour. Dose NOT to exceed 400 mg.*

4. Complications:

- A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category

5. Documentation:

- A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

VI. Extremity Deformity from Trauma with Pain:

1. Circumstances under which the procedure is performed:

- A. Any patient in the ED presenting with extremity deformity from trauma with pain and assessed to have normal circulation, motor, and sensation in the distal extremity

2. Circumstances under which an ED Physician or LIP will be contacted:

- A. Any patient classified as an ESI Level 1
- B. Any patient classified as an ESI Level 2
- C. Any significant change in patient condition

3. Standardized Procedure:

Upon presentation to the ED with an obvious extremity deformity from trauma with pain, the ED nurse performs the following prior to the patient being seen by the ED Physician or LIP:

- A. Contacts the ED Physician or LIP for pain medication order
- B. Places a saline lock
- C. Obtains from Radiology: X-ray of the affected extremity/associated bone structure, 2 view
- D. Elevate affected extremity
- E. Immobilize affected extremity
- F. Cold compress if <24 hours

4. Complications:

- A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category

5. Documentation:

- A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

Severe Pain:

1. Severe pain represents a unique circumstance. If the patient rates their pain as 7/10 or greater and the triage RN feels this patient cannot wait and needs IV analgesia, the patient will be assigned to ESI Level 2 to ensure they are seen by an ED Physician or LIP in a timely manner. The patient's rating is just one part of an assessment. Observations of the patient and behavior are another key element of the assessment. For example: "The patient rates pain as 10/10, with skin warm and dry, laughing with a friend(s) at triage," or "Generalized abdominal pain for 3 days, constant dull ache. Rates pain as 10/10." If the pain level is 7/10 or greater and the patient is an ESI Level 3, the patient will receive a reassessment within 1 hour and will be seen by a ED Physician or LIP to determine if the patient needs immediate pain management. If at any time prior to the reassessment, the patient's pain rating and/or symptoms worsen, the patient will be immediately reassessed and appropriate interventions performed.
2. Circumstances under which the procedure may be performed:
 - A. The patient's rating of pain is 7/10 or higher
3. Circumstances under which an ED Physician or LIP will be contacted:
 - A. Any patient classified as an ESI Level 1
 - B. Any patient classified as an ESI Level 2
 - C. Any significant change in patient condition
4. Standardized Procedure:

Upon presentation to the ED with a pain rating of 7/10 or higher, the nurse may perform the following interventions, if appropriate, in an attempt to decrease the patient's pain:

 - A. The nurse may provide the following comfort measures as appropriate to decrease pain:
 - Apply ice to affected area;
 - Position, support, elevate/mobilize;
 - Provide quiet environment/cover eyes as needed
 - B. Contact ED Physician or LIP for pain medication order
5. Complications:
 - A. Immediate ED Physician or LIP notification for abnormal vital signs and/or change in status to higher priority category
6. Documentation:
 - A. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure

REFERENCE(S)/RELATED POLICIES

Agency for Health Care Research and Quality

- California State and Consumer Services Agency, Board of Registered Nursing. (2011). "An explanation of the scope of RN practice including standardized procedures". Retrieved from: www.rn.ca.gov <https://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf> Section 2725 of California Nurse Practice Act.

Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition. Chapter 2: Overview of Emergency Severity Index. Retrieved from: <http://www.ahrg.gov/research/esi/esi2.htm>.

Joint Statement by the American College of Emergency Physicians, American Pain Society, American

~~Society for Pain Management Nursing, and the Emergency Nurses Association: Optimizing the Treatment of Pain in Patients with Acute Presentations. Retrieved from: www.aacnp.org.~~

- ~~Implementation Handbook 2020 Edition: Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care. Content last reviewed 2020. Emergency Nurses Association. Retrieved from: https://media.emscimprovement.center/documents/esi-implementation-handbook-2020_1592279717486_edvzqe5cc.pdf~~
 - Sullivan, J., Farrar, H., & the Section on Clinical Pharmacology and Therapeutics and Committee on Drugs (2011, Reaffirmed 2016, 2023). Clinical Report - Fever and Antipyretic Use in Children. *American Academy of Pediatrics*, 127(3), 580 - 587. doi: 10.1542/peds.2010-3852.
- ~~United States Department of Health and Human Services,
Document Central Policy Number: LCS-ED-425~~

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - ED (Both), Interdisciplinary (SP), P&T (Both), RN/MD (Torr)	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - ED (Both), Interdisciplinary (SP), P&T (Both), RN/MD (Torr)	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	10/2023
CNO	Scott Ciesielski: Chief Nursing Officer	10/2023
Policy Committee	Catrice Nakamura: Executive Director Nursing	09/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	08/2023
Policy Committee	Joseph Wolff: Manager Nursing	08/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



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Owner:	Glenn Van Houten: Senior Director Respiratory Care
Policy Area:	Respiratory Care Services
References:	Policy
Applicability:	CA - PH&S Little Company of Mary Service Area

Respiratory Care Services: Adult High Flow Nasal Cannula System

POLICY

- The High Flow Nasal Cannula will be instituted by a Physician order.
- The Respiratory Care Practitioner (RCP) will set-up and monitor the High flow humidification system.
- The order should contain the saturation, flow and FIO2 parameters.
- All patients placed on the High Flow Nasal Cannula MUST have continuous pulse oximetry.

For San Pedro: Initiation of High Flow Nasal Cannula for worsening acute hypoxic respiratory failure or pending respiratory failure may be done for a patient admitted to the intensive care unit (ICU). Once patient has been stabilized in ICU and upon the written order of the Physician, patient can be transferred outside of the ICU with the High Flow still in use for continued care.

PURPOSE

The purpose of this policy is to provide guidelines for setting up, instituting and monitoring of the High Flow Nasal Cannula Humidification System. The High Flow Nasal Cannula Humidification System is designed to comfortably deliver high flow, heated humidified oxygen through a nasal cannula.

RATIONALE:

High flow nasal cannula (HFNC) systems are offered but not limited to:

- Possible alternative to traditional BIPAP/CPAP.
- Extubation support.
- Airway secretion and pulmonary hygiene tool.
- Improved patient comfort.
- Oxygen delivery.

CONTRAINDICATIONS:

- Upper airway abnormalities that make high flow nasal cannula ineffective or dangerous (i.e. Tracheosophageal fistula)
- Severe cardiovascular instability and impending arrest or respiratory failure.
- Unstable respiratory drive with frequent apneic episodes resulting in desaturation and/or bradycardia.

- Patients that may not be candidates of HFNC include, but are not limited to:
 - a. Patients that are obtunded.
 - b. Patients in severe respiratory acidosis.
 - c. Patients with epistaxis.
 - d. Patients with skull/facial fractures.
 - e. Patients with pronounced physical shunting (i.e. pulmonary edema, atelectasis).

EQUIPMENT:

1. High Flow Nasal Cannula (HFNC) System
2. High Flow circuit
3. Sterile Water Bag
4. Correct Size Nasal Cannula Interface
5. Continuous pulse oximetry monitor

PROCEDURE / GENERAL INSTRUCTIONS

1. Verify physician's order for HFNC and O2 titration.
2. Review patient information. **NOTE:** If the patient is not a candidate for HFNC therapy the RCP will inform the patient's nurse and contact the ordering physician with alternative recommendations for therapy.
3. Identify yourself to patient/family. Use two patient identifiers to verify patient.
4. Educate patient/family on the uses and purpose of High Flow Therapy.
5. Assemble HFNC device per manufacturers' guidelines and set temperature to 37°C.
6. Allow temperature to reach at least 32°C before attaching cannula to patient and attach alligator clip to patient's gown for comfort.
7. Titrate FIO2 to desired saturations while adjusting liter flow to exceed patient's demands. Initial flow rate is 25-35 L/m for adults.
8. FIO2 and flow are to be adjusted as necessary to maintain ordered saturations.
9. High Flow Therapy and patient response will be evaluated every 4 hours and PRN. Documentation and billing will be done in the patient's electronic medical record.

HAZARDS / COMPLICATIONS:

Hazards and complications associated with equipment include the following:

- Obstruction of nasal prongs from mucus plugging may interfere with delivery of flow and result in a decrease in FIO2 through entrainment of room air via opposite nares or mouth.
- Improper placement of prongs causing fluctuation or reduced flow.

Hazards and complications associated with the patient's clinical condition include:

- Gastric insufflation and abdominal distention potentially leading to aspiration.

Monitoring

- All patients shall be on continuous pulse oximetry monitor.
- ABGs MUST be obtained within 1-2 hours of initiation of therapy.
- Patients must be assessed daily to determine efficacy of therapy.

REFERENCE(S) / RELATED POLICIES

- Wilkins, R. L., Stoller, J. K., & Kacmarek, R. M. (2013). *Egan's Fundamentals of Respiratory Care*. (10th ed.). St. Louis: Mosby Elsevier.
- Roca, O., Riera, J., Torres, F., & Masclans, J. R. (2010). High-Flow Oxygen Therapy in Acute Respiratory Failure. *Respiratory Care*, 55(4), 408-413.
- CRCE Clinical Foundations ▪ L-1111-0601, *High Flow Oxygen Delivery*

Board Approved:	12/09
Reviewed:	12/09, 7/31/11, 9/14, 4/16
Revised:	12/09

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
Med Staff - Medicine	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
Med Staff - Medicine	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023
Policy Committee	Glenn Van Houten: Senior Director Respiratory Care	11/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



Provident

Little Company of Mary Medical Center Torrance

Origination: 06/2021
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Owner: Glenn Van Houten: Senior
Director Respiratory Care
Policy Area: Respiratory Care Services
References:
Applicability: CA - PH&S Little Company of
Mary Service Area

Respiratory Care Services: Arterial Blood Gases (ABG)

PURPOSE:

To establish guidelines for arterial blood gas (ABG) collection, handling and resulting including STATS, next days, routines, inpatient and outpatients.

RESPONSIBILITY:

1. A written order from a physician is required.
2. The ABG is drawn by a Respiratory Care Practitioner who is hospital certified.
3. All NICU samples are drawn by NICU staff and then analyzed by Respiratory staff.
4. All Surgical samples are drawn by Operating Room staff and then analyzed by Respiratory staff.
5. The Respiratory Care Practitioner is responsible for obtaining pertinent patient data and accurate handling and resulting of the ABG.
6. All ABG samples ~~MUSAT~~Must be labelled with the patient identification sticker or information in the patient's room before leaving patient room.

GUIDELINES:

1. Routine requests are considered non-urgent and will be prioritized appropriately.
2. All timed requests are done at specified times.
3. STAT requests need immediate response to take no longer than ten (10) minutes for immediate analysis and reporting of results to appropriate person.
4. ~~All next-day requests are done in the A.M. round. They are processed and resulted as quickly as possible.~~ All AM ABGs in the Intensive Care Unit are to be drawn by the Respiratory NOC shift unless otherwise specified by physician order.
5. All patient results are entered into the computer system.
6. All critical value results are processed in accordance with the critical value policy.
7. All Samples are run at 37 degrees Celsius. If requested, samples may be temperature corrected. Patient

temperature is needed prior to analysis.

PRECAUTIONS:

1. In the event of an adverse reaction to the procedure the physician is immediately notified.
2. Possible hazards and symptoms may include:
 - Arteriospasm
 - Hypotension
 - Hematomas
 - Cardiac Arrhythmias
 - Severe anxiety
 - Thrombosis
 - Pain

REFERENCES:

Document Central Policy Number: LCT-RSP3-101

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
Med Staff - Critical Care, Medicine	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
Med Staff - Critical Care, Medicine	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023
Policy Committee	Glenn Van Houten: Senior Director Respiratory Care	11/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 14786976



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Owner: Glenn Van Houten: Senior
Director Respiratory Care
Policy Area: Respiratory Care Services
References:
Applicability: CA - Providence LCM MC
Torrance

Respiratory Care Services: Oxygen Therapy for the Patient with Carbon Dioxide (CO₂) Retention

Number: LCT- RSP-102

PURPOSE:

Patients who are carbon dioxide (CO₂) retainers are at risk of developing oxygen induced hypercapnia. The purpose of this policy is to outline the care of this patient receiving oxygen therapy.

RESPONSIBILITY:

Physician, Respiratory Therapist and Registered Nurse

POLICY:

For those patients identified or suspected as being CO₂ retainers:

1. The Physician will:
 - A. Write the order for oxygen therapy (e.g., "Titrate oxygen to maintain arterial oxygen saturation 88-92%").
2. The Respiratory Therapist will:
 - A. Place the CO₂ retainer signage at the head of the patient's bed, on the oxygen flowmeter, and outside the patient's door.
 - B. Administer the oxygen as ordered. When possible, use a Venturi mask to ensure accurate dosages are given.
 - C. Monitor the patient's respiratory status (oxygen saturation, respiratory rate, effort, level of consciousness).
 - D. Use compressed air to administer nebulizer therapy. When not being used, the **AIR** flowmeter will be removed from the wall and placed in holding place within the patient's room.
 - E. Notify the Physician with abnormal findings.
 - F. Document assessments and interventions.
3. The Registered Nurse will:

- A. Notify the Physician with abnormal findings.
- B. Notify the Respiratory Therapist for changes in oxygen therapy.
- C. Monitor the patient's respiratory status including oxygen saturation to maintain the oxygen saturation within the desired parameters every four (4) hours and PRN.
- D. Document assessments and interventions.
- E. Assist in transporting/removing signage and **AIR** flowmeters from the patient's room (*bedside*) when the patient is transferred to another unit or discharged from the hospital.

Attachments

No Attachments

Approval Signatures

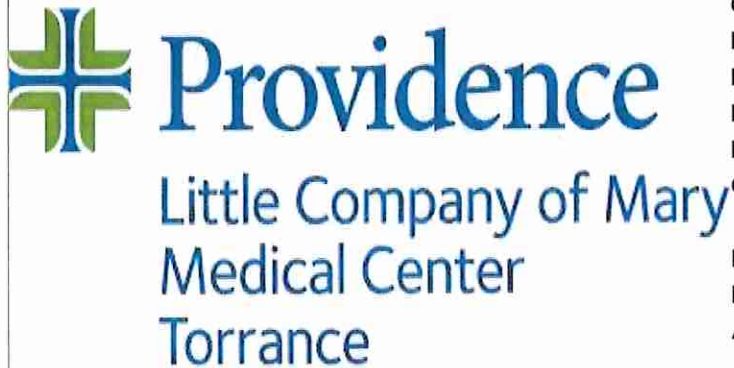
Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - Critical Care, Medicine	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	12/2023
Policy Committee	Glenn Van Houten: Senior Director Respiratory Care	11/2023

Applicability

CA - Providence LCM MC Torrance

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Owner: Maria Aoki: Director
Rehabilitation Services
Policy Area: Therapy Services
References:
Applicability: CA - Providence LCM MC
Torrance

Therapy Services: Dysphagia

POLICY

In keeping with the mission and values of Providence St. Joseph Health, the Speech Language Pathology department will evaluate patients with signs and symptoms of dysphagia and make clinical diet recommendations.

OBJECTIVES

The objective for the Speech-Language Pathologists (SLP) with regard to managing a patient with dysphagia include but are not limited to:

- Assess the presence or absence of a swallowing difficulty via objective and/or subjective measures
- Recommend the most appropriate and safe diet and/or fluid consistency in order to prevent or minimize the risk of aspiration
- Determine appropriateness for ongoing swallowing intervention in order to optimize patient outcomes
- Educate patients, family, caregivers and staff on swallowing disorders and safe swallowing practices
- Document all matters as it relates to management of dysphagia within the electronic medical record (EMR)

PROCEDURE/GENERAL INSTRUCTIONS

1. Prior to the initiation of services, an electronic order must be obtained from a qualifying medical provider (MD, DO, PA, NP). The SLP will be responsible for confirming receipt of the referral
2. Once a referral has been received, the SLP will complete a detailed pre-clinical assessment. This will involve a thorough chart review, including information related to patients' pre-morbid function, pertinent past medical history, relevant diagnosis, lab findings and imaging results
3. When indicated, a bedside swallow evaluation will be carried out. Information obtained during the bedside swallow evaluation will aid in determining the extent and nature of the swallowing impairment, as well as the identification of intervention methods to maximize safety of swallowing through either consistency modifications and/or individualized therapeutic techniques. Components of a bedside swallow evaluation are as follows:
 - a) Assessment of the patients' general cognitive status, which may include level of arousal, orientation, communication status (verbal or nonverbal), and ability to follow commands and answer questions. The

patient may be deemed unsafe to continue the bedside swallow evaluation at any point during this portion of the assessment. It is at the discretion of the SLP to move forward with the exam. If the patient is deemed unsafe to continue then the assessment will be completed at a later time or date, based on the patient's ability to participate and SLP availability

b) Oral Mechanism exam (OME) in order to assess oral integrity and mechanism

c) Administering of food/liquid trials to evaluate oral and pharyngeal phases of the swallow. The consistency type and quantity of the trials administered will be patient-dependent and up to the discretion of the evaluating SLP

4. Determination of need for instrumental assessment of the swallow function may be recommended at the discretion of the SLP and be a result of either a thorough pre-clinical assessment and/or bedside swallow evaluation. Instrumental assessments include Video Fluoroscopic Swallow Study (VFSS) and Fiberoptic Endoscopic Evaluation of Swallowing (FEES). Please see appropriate Policy and Procedure related to instrumental assessments for details

5. The SLP will use their knowledge and expertise related to the understanding of dysphagia in order to provide the appropriate recommendations related to least restrictive diet, with lowest risk of aspiration. If an oral diet is recommended, the qualifying provider will enter the diet order through the EMR (electronic medical record), taking into consideration the SLP's recommendations. If it is recommended that the patient be nothing by mouth (NPO), then it will be up to the qualifying provider's discretion to initiate an alternate mode of feeding, when indicated

6. Based on the standards set-forth by International Dysphagia Diet Standardization Initiative (IDDSI), the following food consistencies may be considered:

- a) Regular
- b) Easy to Chew
- c) Soft and Bite-sized
- d) Minced and Moist
- e) Pureed
- f) Liquidized

Based on the standards set-forth by the International Dysphagia Diet Standardization Initiative (IDDSI), the following liquid consistencies may be considered:

- a) Thin
- b) Slightly Thick
- c) Mildly Thick
- d) Moderately Thick

7. The SLP will be responsible for educating and training the patient, family, caregiver and relevant team members as they are available. This may include details regarding recommended diet consistencies, aspiration precautions/safe swallow strategies, and any other information pertinent to the understanding and management of the individuals swallowing impairment. If a modified diet has been recommended diet consistency and individualized precautions to adhere to during all oral feedings. Additional written or visual

aids will be provided, as needed

8. Ongoing follow-up will be provided on an as-needed basis until deemed suitable for discharge from the SLP caseload or until discharged from the hospital/Subacute. ~~discharge~~Discharge from the SLP's caseload may occur when the patient has reached their premorbid status as it relates to swallow function, is tolerating a least restrictive diet, or if directed by the medical team. Criteria for discharge may also be met if the patient is non-compliant, is frequently refusing services, or is not medically stable enough to safely participate in services over the course of multiple attempts. A qualifying medical provider may re-order services when clinically indicated

REFERENCE(S)/RELATED POLICIES

International Dysphagia Diet Standardization Initiative 2016 (IDDSI)

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - Medicine	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023
Policy Committee	Maria Aoki: Director Rehabilitation Services	11/2023

Applicability

CA - Providence LCM MC Torrance

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PolicyStat ID: 14081910



Providence

Little Company of Mary
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Torrance

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Owner: Lisa Yauchzee-Gac: Executive
Director Nursing
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References:
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Mary Service Area

Discharge Planning Process-Role Delineation- Referral and Follow-up for Neonatal and Pediatric Patients



Providence
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Center Torrance

Discharge Planning Process / Role Delineation / Referral and Follow-Up for Neonatal and Pediatric Patients

Number: LCT-WH-353

POLICY:

- In keeping with the philosophy and mission of Providence Little Company of Mary Medical Center Torrance (PLCMMCT) and to abide by Californian Childrens' Services Standards (CCS); discharge planning, is a multidisciplinary process which will begin on admission, continues throughout the hospitalization until discharge and post- hospital care until appropriate hand off to the outpatient pediatrician has been established and confirmed.
- All services provided are family-centered, culturally competent, and linguistically appropriate.
- Each member of the multidisciplinary team providing care for the infant is responsible for integrating discharge planning into every phase of the delivery of that care, and for documenting the process accordingly.
- This process will also ensure a successful transition to home and follow-up care.
- The goals of discharge planning are to prepare the patient, the parent(s) and/or the caretaker(s)

for discharge through a coordinated, collaborative, multidisciplinary process.

- This process will ensure that the patient and family have the specific skills, knowledge, and resources to meet the ongoing health care needs beyond the hospital setting.

PURPOSE:

- To identify the roles of the multidisciplinary team in discharge planning.
- To clarify the responsibility of the multidisciplinary team in discharge planning and after care.

Scope of Responsibility:

1. This policy applies to all PLCMMCT Pediatric and Neonatal patients, including those that are CCS eligible.
2. There shall be an organized discharge planning program for Neonatal Intensive Care Unit (NICU) and the department of Pediatrics.
3. The **Multidisciplinary Team** is comprised of:
4. Case Manager/Discharge Coordinator

- CCS paneled social service staff
- Staff nurse
- Charge Nurse
- Neonatal and Pediatric Respiratory Therapist
- CCS paneled Dietician
- CCS paneled Occupational Therapist / CCS paneled Physical Therapist
- Pediatric Pharmacist
- Spiritual care team
- CCS paneled Neonatologist and/or Pediatrician
- Clinical nurse specialist

1. Each week, the needs of each family will be evaluated and updated at the weekly multidisciplinary discharge rounds.

- A. There shall be, at a minimum, weekly NICU multidisciplinary team conferences (*rounds*).
- B. The NICU multidisciplinary team conferences shall include representation of the NICU medical, nursing, medical social service, Respiratory Care Practitioner staff, and other specialists, i.e., the Clinical Registered Dietitians, Occupational Therapist and Physical Therapist, when appropriate.
- C. The case manager will lead these rounds.
- D. The case manager, social worker, clinical nurse specialist, Neonatologist, Respiratory Therapist, charge nurse, and dietician will attend weekly rounds.
- E. The case manager will coordinate, collect and document all patient clinical information as it relates to discharge on the Multidisciplinary Discharge Rounds record.
 1. This information will include all pertinent clinical information on hospitalized NICU patients; patients discharged the prior week, and completed follow up phone calls.
- F. Documentation:
 1. The case manager will be responsible for documentation of the weekly Multidisciplinary Discharge Rounds. This information will be shared with the entire team.
 2. A plan of care and estimated date of discharge will be discussed and documented.

3. Team members will also document the developed plan of care on the Electronic Medical Records (EMR).
 4. This information will then be communicated to the respective nurse taking care of each baby. During the hospital stay, every family will be offered the opportunity to meet individually with the attending Neonatologist and individually with members of the multidisciplinary team to discuss plan of care, ask questions, and develop a plan for discharge.
- G. On admission, throughout the hospital stay until discharge, and beyond the hospital setting after discharge; members of the multidisciplinary team will **participate in discharge planning activities based on their role and responsibility as described below**.

PROCEDURE/GENERAL INSTRUCTIONS:

The **Multidisciplinary Team** is responsible for the following:

1. Educate and document any teaching of patients and family according to your discipline.
 2. The Multidisciplinary Team will modify plan as patient progresses through the continuum of care based on their continued assessment and evaluation of the effectiveness of the plan.
 3. Provision for teaching the parent, legal guardian, and/or primary caretaker about the medical needs of the patient; this will include the use of necessary technology to support the patient in the community.
- A. **The Case Manager/Discharge Coordinator:** Discharge planning at a minimum, shall include but not be limited to the following: Designation of a coordinator for discharge planning who shall be responsible:
1. Collaborating with the Clinical Nurse Specialist to ensure the implementation of a coordinated and effective discharge planning program.
 2. Ensuring collaboration between the NICU multidisciplinary team members and communication with the Primary Care Physician (PCP), community agencies, CCS programs, CCS Special Care Centers, Medi-Cal In-Home Operations Unit, and the Early Start Program whose services may be required and /or related to the care needs of the infant after hospital discharge.
 3. And also ensures that each infant discharged from the NICU shall have follow-up by a PCP and a program specialized in the follow-up care of the high-risk infant.
 - a. Parent will be given the names and phone number of all consultants for follow-up after discharge, and appointment(s) will be made before discharge by the case manager and/or the parent and /or the staff nurse.
 - b. Additionally, ensures that all follow-up eye appointments are done prior to discharge. The case manager will make these appointments. See NICU Ophthalmology Policy and Procedure.
 4. Assists with the coordination of and leads weekly multidisciplinary discharge rounds. See above.
 5. Identification of the responsibilities and involvement of the NICU multidisciplinary team members in discharge planning activities on an on-going basis.
 6. The Case Manager and Social Worker review the discipline specific assessments, the patient profile, and other chart information in order to assess the patient's needs and to assess available resources.

7. Ensuring culturally and linguistically appropriate written discharge information shall be given to the parent(s) or primary caretaker(s) participating in the infant's care at the time of discharge and shall include, but are not limited to the infant's diagnoses, medications, follow-up appointments, including community agencies and High-Risk Infant Follow-up program appointments and instructions on any medical treatment(s) that will be given by the parent(s) or primary caretaker(s). A copy of this written discharge information shall be sent to the PCP and as applicable, agencies involved in providing follow-up care.
8. Ensuring that infants, who are determined by a neonatologist, to be discharged from a Community NICU to a facility closer to the home of the parent or primary caretaker shall:
 - a. be transferred to a CCS-approved NICU for those who continue to require NICU care,
 - b. be transferred to a CCS-approved hospital appropriate for those who no longer require NICU care but require continued hospitalization for the CCS-eligible condition.
9. Provision for teaching the parent, legal guardian, and or primary caretaker about the medical needs of the infant, including the use of necessary technology to support the infant in the community, when appropriate.
10. As part of the discharge plan, coordinates outpatient/follow-up services including home health, high-risk infant clinic, referral to Synagis program, and specialty clinics.
11. The case manager will oversee the RSV program for the NICU. Prior to the start of RSV season, reminder letters will be sent to " *at risk* " infant's Primary Care Provider to assist in recognition and treatment of previous NICU patients.
12. Participates in the discussion of a daily plan of care.
 - a. The case manager will have frequent follow-up on the discharge planning needs of each individual patient.
13. Will identify **CCS patients** and their needs. Then implements an initial plan of care for these vulnerable patients.
 - a. Will assist parents with the CCS Application form and the High Risk Infant Follow-up referrals.
 - b. The case manager will make appropriate CCS approved referrals as specified in child's diagnosis and plan of care.
 - c. Refers all neonates/infants/children with potentially eligible CCS conditions to the CCS program for review of CCS program eligibility.
 - d. Assists families with the CCS referral and enrollment process by providing CCS application forms, phone numbers, and office locations.
 - e. Offers all available services to all patients, including CCS eligible clients regardless of race, color, religion, national origin or ancestry.
14. Ensures that patients who are determined to be stable, be transferred to a CCS appropriate facility closer to the home of the parent or primary caretaker.
15. All patients, including CCS eligible patients:
 - a. Provides the family with information about hospital and community resources. These may include, but are not limited to:
 - a. WIC program

- b. Breast pump rentals/lactation consultants
 - c. Name and number of financial counselor
 - d. CCS, Regional Center, High-Risk Infant Follow-up Program
- 16. In the event of a transport: notifies the local CCS program office, in a timely manner, of specialized transport methods for potentially eligible patients.
- 17. Is responsible for coordinating all multidisciplinary care plans in concert with the physician, multidisciplinary team and with patient/family input in order to formulate a discharge plan that best fits the patient's needs and available resources.
- 18. Follows up with Regional Center on patients that have been referred out.
- 19. A discharge summary will be sent to the primary Pediatrician at discharge and a copy of the discharge instructions and discharge summary will be given to the family at the time of discharge.
- 20. Orders any necessary supplies or durable medical equipment (*apnea home monitor, gavage tube, syringes tee.*). Equipment will be ordered prior to discharge so family will have time to work with and troubleshoots equipment prior to discharge.

B. Social Worker

- 1. Provides psychosocial assessments to all NICU families within two (2) working days of admission.
 - a. Provides psychosocial assessment to all patients under the age of 21 years, regardless of service department, who remain inpatient for three (3) days or more.
 - b. Assists to set up a multidisciplinary family care conference with parent(s)/caretaker(s) as deemed appropriate to provide a forum in which to develop a plan with the parent(s)/caretaker(s).
 - c. Verifies family address, phone number and identify patient's primary caregiver for discharge, assess patient/family support system and needs and addresses those needs.
 - d. Provides a comprehensive psychosocial evaluation which includes a complete needs assessment for each patient/family and documents in the EMR.
 - e. Evaluates the need for discharge education prior to discharge.
 - f. Provides the family with hospital and community resources, which may include, but are not limited to:
 - a. Counseling services
 - b. Taxi vouchers
 - c. SSI, Disability information
 - d. Hospital and community CPR classes
 - e. Support groups
 - f. Doula and nanny services
 - g. Regional Center information.
 - h. WJC Program
 - g. Evaluate the patient and family for emotional support and reinforces healthy coping

strategies.

h. Attends weekly multidisciplinary

i. **Staff Nurse:**

1. Utilizes the nursing process to initiate and continue discharge planning from admission to discharge.
2. Within 48-hours of admission, the bedside nurse will determine if there are any barriers to learning (*language, cognitive, physical, etc.*) and note them on the discharge teaching sheet.
3. The RN identifies potential discharge planning problems and communicates with the case manager and the appropriate discipline regarding the same.
4. Identifies teaching and readiness for learning with the parent(s)/caretaker(s) and implements a plan of patient education. This plan is documented on the EMR.
 - a. Encourages parents/caregivers to be active participants in their infants care.
 - b. Parent teaching of the family begins at admission and continues until discharge.
5. Includes the multi disciplinary team in educating the parents(s)/caretaker(s) when specific needs are identified.
6. Ensures that the appropriate test/procedures have been completed or scheduled to be done prior to discharge.
7. Facilitates cultural and linguistically appropriate tools. Offers interpreter services to assist in ensuring discharge instructions are culturally and linguistically appropriate.
8. Completes the Discharge Instruction Sheet, reviews with family/caretaker(s) and provides a signed copy of them at time of discharge.
 - a. Information can be provided by any health care team member.
 - b. It is the responsibility of the Staff RN to verify completeness and accuracy.
 - c. In NICU, if the infant is scheduled for a " *Diagnostic Hearing Evaluation Referral* " the appointment date and time and location will be recorded on the NICU Discharge Instruction sheet.
9. Upon discharge, the PLCMMCT discharging nurse will verify that the infant and the parent(s)/caretaker(s) have matching Baby Identification Band numbers and document on the Discharge Instruction Sheet, and staple one infant band to the chart copy of the Discharge Instruction Sheet.
10. Parents will have any prescriptions for home use filled prior to discharge. They will be instructed to bring the filled prescriptions up to the hospital prior to discharge so that the nurse can review medication administration guidelines with the family, followed by a return demonstration by the parent/caregiver.
11. The patient will be discharged in the computer and the chart disassembled.
12. A discharge focus note will be written, noting the patient's health status at the time of discharge.
13. When appropriate, the patient will be discharged via the mother's/father's/caregiver's arms, in a wheelchair, and escorted by hospital personnel.

14. Charge Nurse:

1. Utilizes the nursing process to initiate and continue discharge planning from admission to discharge.
2. The Charge Nurse identifies potential discharge planning problems and assists the staff nurse and case manager with any problem solving needs.
3. Attends weekly multidisciplinary discharge rounds.

C. The Respiratory Care Practitioner:

1. Evaluates the need for discharge education for patients and families on pulmonary lung disease/disorders and respiratory treatments.
2. Evaluates the need for discharge education prior to discharge.
3. Treatment, equipment and techniques are instructed with a return demonstration to determine understanding. Assessment and education plans are documented in the EMR.
4. Attends weekly multidisciplinary discharge rounds.
5. Documents accordingly in the EMR.

D. The Pediatric Dietitian:

1. Evaluates the need for discharge education prior to discharge.
2. Completes parent teaching on all patients per CCS requirements on applicable topics.
3. Coordinates care with outside agencies for ongoing monitoring of nutrition needs and for procurement of nutritional supplements/special formulas needed at home.
4. Attends weekly multidisciplinary discharge rounds.
5. Documents accordingly in the EMR.

E. The Occupational Therapist, Physical Therapist or Speech Language Pathologist:

1. May assist families with liaison, linkage, and referrals for services throughout the medical center, other community based agencies, programs, or providers including the Regional Center outpatient therapy and CCS MTU.
2. Advocates on behalf of the family for needed services.
3. Attends weekly multidisciplinary discharge rounds.
4. Documents accordingly in the EMR.
5. After discharge, communication will be continued with parent(s)/caretaker(s) at home through an Occupational Therapy letter and/or Ages and Stages Questionnaire and/or Outpatient follow up visit.

F. Pharmacist:

1. Monitor drug therapy on all patients in the NICU and Pediatrics.
2. Provide professional education regarding clinical pharmacology, including individual consultation to the physicians and nurses.
3. Documents all interaction and teaching in EMR

G. Spiritual Care: .

1. Document all interaction and teaching in EMR.

2. Attends weekly multidisciplinary discharge rounds.

H. The Neonatologist / Pediatrician / Pediatrician Hospitalist:

1. Responsible for the discharge planning for the infant, including but not limited to:
 - a. Works with Case Management and Social Worker for discharge planning.
 - b. Works with the Clinical Nurse Specialist and Staff RN for discharge education and teaching.
 - c. Identifies the responsibilities and involvement of the NICU multidisciplinary team members in discharge planning activities on an on-going basis.
 - d. Must develop a discharge plan of care.
 - e. Ensures that the patient's discharge needs have been addressed by the appropriate health care team member .
 - f. Providing for teaching the parent, legal guarding, and/or primary caretaker about the medical needs of the infant, complex diagnoses, and the use of necessary technology to support the infant in the community, when appropriate.
2. Attends all weekly multidisciplinary discharge rounds.
3. Documents accordingly in the EMR.

I. The Clinical Nurse Specialist:

1. Has oversight of comprehensive parent and or primary caretaker education activities.
2. Is responsible for ensuring the implementation of a coordinated and effective discharge planning program.
3. Provide professional education regarding clinical care, including individual consultation to the physicians and nurses.
4. As overseen by the CNS, all NICU staff will have the on-going education.
5. Attends all weekly multidisciplinary discharge rounds.

J. Immunizations in the NICU

1. Daily, the team will assess whether each infant is ready for their Hepatitis B vaccine and/or their 60-day vaccinations and any other immunizations.
2. The AAP policy will be referred to in each case, and decisions about administration will be made on a case by case basis in conjunction with the Neonatologist and the Multidisciplinary team.
3. Once the team has decided that an infant will receive a vaccination, the process will be as follows:
 - a. An MD order will be obtained.
 - b. The parent will be given a VIS form and a CONSENT form to take home and review.
 - c. Parents will be given an opportunity to ask questions of the NICU Multidisciplinary Team.
 - d. Once the consent is signed, the vaccination will be administered accordingly
 - e. Documentation:
 - a. The RN will document the day the VIS was given to the parent.
 - b. The immunization will be documented in the EMR.

- c. In addition to the medication administration documentation, the RN will document the LOT number of the vaccine, the expiration date of the vaccine, the site of the injection.
- d. A yellow Immunization Record will be filled out and given to the parents.

Special Considerations

- For all NICU patients, immunizations (*with the exception of hepatitis B*) are not to be given within 72-hours of discharge.
- Parents that refuse immunization, the physician will be notified and the parents will be asked to fill out the AAP refusal to vaccinate form.
- For specifics regarding the Hepatitis B, please refer to the Hepatitis B policy.
- **REFERENCES:**
- Core Curriculum for Neonatal Intensive Care Nursing, AWHONN, W.B. Saunders, 6th Edition, 2021
- Guidelines for Perinatal Care, 8th Edition, 2017

COPY

Attachments

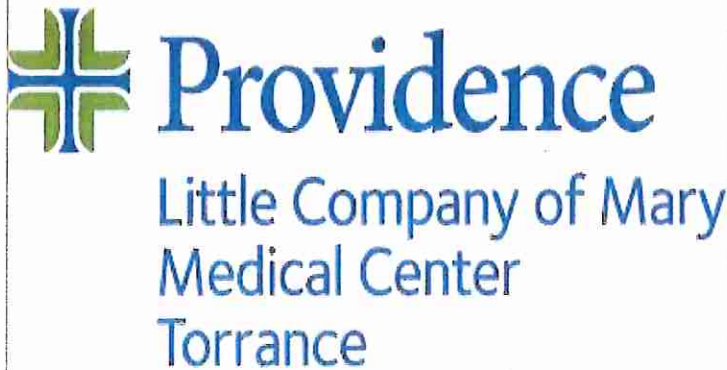
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Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
Med Staff - Peds/ NICU	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	11/2023
Med Staff - Peds/ NICU	Mayra Graves: Medical Staff Coordinator	09/2023
CNO	Scott Ciesielski: Chief Nursing Officer	08/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	07/2023
Policy Committee	Lisa Yauchzee-Gac: Executive Director Nursing	07/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



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Capnography: Exhaled CO2 Monitoring

PURPOSE

The purpose of this policy is to provide guidelines for capnography monitoring. Capnography is supported by evidence to be a useful assessment tool in many patient situations including but not limited to: early detection of respiratory depression, assessment of compression quality during cardiopulmonary resuscitation (CPR), and recognition of return of spontaneous circulation (ROSC) during CPR.

SCOPE

This policy defines roles and responsibilities for Nurses, Respiratory Therapists, and Pharmacists coordinating care for patients for whom capnography measurement or monitoring is advised. This includes all patient care areas where procedural sedation occurs, where patients receive narcotic analgesia, and where CPR and intubation may be utilized.

DEFINITIONS

Partial Pressure End-tidal CO2 (PETCO2): Peak concentration of carbon dioxide occurring at the end of exhalation. Normal range is between 35 and 45 mm Hg. This is different than arterial partial pressure of CO2 (PaCO2).

Color-metric CO2 Detector: A device to 'spot check' exhaled CO2 that can be used to confirm initial endotracheal tube (ETT) placement and validates the presence of CO2 by changing color after a minimum number of breaths recommended by the manufacturer.

Continuous Capnography: Bedside monitoring in real time of PETCO2 that provides waveform and numeric data to the caregiver. Mainstream and side-stream configurations are typical.

Mainstream Capnography: Uses an adapter between the breathing circuit and the ETT and measures using infrared light. This can only be used with intubated patients.

Side-stream Capnography: Can be used with intubated or non-intubated patients. A long tube leads from the patient (either a T adapter for intubated patients or a specialized nasal cannula for non-intubated patients) to the monitor. This tube carries exhaled gas to the monitor device for analysis. As such, troubleshooting includes assessing for moisture in the line interfering with accurate measurements.

NORMALS AND LIMITS

- Normal ETCO₂ reading is 35-45 mmhg
- Alarm limits are set at:
 - ETCO₂ High – 60mmhg
 - ETCO₂ Low – 20mmhg
 - High Respiratory rate – 35 bpm
 - Low respiratory rate – 7 bpm
 - ~~No-breath~~Apnea alarm – ~~30~~20 seconds
 - Pause limit – 6 bpm
 - If there are changes in patient condition, please follow the normal procedure (RRT, Direct call etc.) to call for help.

POLICY

Capnography is a required element of patient assessment in the following situations:

1. Immediately following endotracheal intubation
2. During Cardiopulmonary Resuscitation (CPR)
3. During procedural sedation and in the recovery period immediately following the sedation
4. Patients with specific narcotic analgesia orders involving medications, doses, or modalities at high risk for respiratory depression, including:
 - a. Patient Controlled Analgesia (PCA)
 - b. Narcotics via Epidural / Neuraxial Analgesia with continuous drips or patient controlled epidural analgesia (PCEA)
 - c. Continuous narcotic intravenous infusions
 - d. Hydromorphone (Dilaudid) via IV, IM, or SC routes, with a dose ≥ 2 mg

Capnography monitoring may also be initiated by order of a Physician or a Licensed Independent Practitioner (LIP).

Important Considerations

1. Patients at end of life receiving comfort care do not require capnography monitoring.
~~Patients on ventilator support do not require capnography monitoring except during CPR.~~
2. Patients who receive a single dose epidural injection/ neuraxial analgesia do not require continuous capnography.
3. Due to the general health and age of the patient population in Labor and Delivery, capnography for epidurals in this population is optional only.
4. An arterial blood gas (ABG) may be considered to validate the exhaled carbon dioxide (EtCO₂) value.

PEtCO₂ Monitoring and Assessment Responsibilities

1. Immediately following endotracheal intubation:
 - a. CO₂ detection will be used to validate correct placement at the bedside.

- b. A spot check with a color-metric device or capnography using mainstream or side-stream configurations are all acceptable methods of assessment.
- c. Continuous capnography can identify tube misplacement or displacement and will show a flat line or zero reading.
- d. The Respiratory Therapist is responsible to connect the device, obtain a reading, and communicate that result to the primary nurse or Physician. If no Respiratory Therapist is present, the primary nurse assumes responsibility to perform or delegate those tasks.
- e. The CO2 validation does not eliminate the need for a post intubation X-ray.

2. During Cardiopulmonary Resuscitation (CPR):

- a. Continuous Capnography is required during chest compressions, and should be initiated as early as possible.
- b. **Caregivers should not wait for the patient to be intubated to start PETCO2 monitoring. Utilize a side-stream T-adaptor with the bag-valve-mask until the patient becomes intubated.**
- c. Mainstream or side-stream configurations are acceptable methods of assessment during compressions. (Colormetric devices are not appropriate for monitoring and assessment during CPR.)
- d. Respiratory Therapy is responsible to initiate monitoring, obtain waveform and numeric data, and communicate that data to the rest of the code team including initial readings and any clinically significant changes or trends.
- e. All code team members should offer peer checks and speak up if monitor is not connected or if significant numeric values or trends are observed but not verbalized.
- f. PETCO2 values should be recorded in the Code Blue documentation.
- g. Per the American Heart Association, PETCO2 readings less than 10 mm Hg correlate with poor quality of compressions. Readings less than 10 should prompt the team to improve the quality of compressions through coaching or rotating the compressor. Values of 15-20 mm Hg are consistent with high quality CPR.
- h. The use of continuous capnography during CPR allows assessment for Return of Spontaneous Circulation (ROSC) **without the need to stop compressions**. A sudden, sustained increase of PETCO2 readings (typically 40mm Hg or greater) may indicate ROSC. Recommended actions for such readings are to perform reassessment of patient, check for pulses, analyze cardiac rhythm, and continue care according to American Heart Association algorithms.

3. During Procedural Sedation:

- a. Continuous Capnography is required (with the exception of ventilated patients, unless specified by the physician) during procedural sedation and the immediate post procedure phase of care.
- b. Capnography readings will be evaluated and documented with each set of vital signs.
- c. Initiation and monitoring are the responsibility of the Primary Nurse or Respiratory Therapist.
- d. Alarms or deteriorating trends should prompt interventions such as stimulating the patient, opening the airway, further assessment, adjustment of sedation medications, or activation of the Rapid Response Team.

4. Patients with *specific narcotic analgesia orders* involving medications, doses, or modalities at high risk for respiratory depression. This includes:

- a. Patient Controlled Analgesia (PCA)
 - For PCA, epidural, and continuous narcotic infusions, the continuous capnography must be initiated before the narcotic administration begins.
 - If the PCA is paused by ETCO2 module, turn off infusion and contact the physician.
 - b. Narcotics via Epidural / Neuraxial Analgesia with continuous drips or patient controlled epidural analgesia (PCEA)
 - c. Continuous narcotic intravenous infusions
 - d. Hydromorphone (Dilaudid) via IV, IM, or SC routes, with a dose ≥ 2 mg
 - For PRN injections of Hydromorphone (Dilaudid), Respiratory will set up the device promptly after the medication order is received, and monitoring should start if/when the patient received the first dose of ≥ 2 mg.
 - Note:
 - A reminder that Palliative / 'Comfort Care' patients do not require capnography monitoring
 - Upon receiving the initial order for any of the above, Pharmacy will enter a Respiratory order for capnography. The purpose of this order is to facilitate notification of the Respiratory Therapy team.
 - Respiratory will respond promptly to the patient's bedside with the appropriate equipment for monitoring. This may include portable monitors and tubing, or they may utilize wall mounted monitors in areas equipped with them. In either case, Respiratory will collaborate with nursing, discuss plan of care, and set up the capnography monitor.
5. Discontinuing Capnography
- a. Capnography monitoring may be discontinued by an order from the LIP who is managing the narcotic. Capnography is typically discontinued after the narcotic is discontinued AND the peak time of the last dose has expired.
 - b. Capnography continuation after discontinuation of a narcotic related to an adverse event should be considered. Collaboration between RN and LIP is recommended.
 - c. RN can monitor more often than is required if indicated by nursing judgment .
6. **Capnography monitoring may also be initiated with an order from the LIP.** Nursing and Respiratory should collaborate with LIP to identify patients who might benefit from continuous capnography, for example:
- a. Post-operative patients with a pre-existing diagnosis of obstructive sleep apnea (OSA) or who have been identified as at risk for OSA using the Sleep Apnea Risk Assessment tool.
 - b. Patient on opioids and concomitant sedatives, medication stacking/other sedating medications.
 - c. Patient receiving unplanned administration of reversal agents.

Equipment

1. Capnography monitoring devices:
 - a. Color-metric devices are stocked on all crash carts BUT are only reliable for a single spot check, NOT continuous monitoring. They should not be used during compressions to evaluate cardiac output.

- b. The Zoll Series R defibrillators have capnography as a built in feature.
 - c. Crash carts equipped with the Zoll Series M defibrillator (which does not have built-in capnography) are equipped with a portable capnography monitor.
 - d. Portable capnography monitors for bedside use are stored in the Respiratory Department.
 - e. Wall mounted monitors with capnography modules could be used for continuous capnography in locations/units that have them installed.
 - f. Some IV pumps are capable of monitoring ETCO₂ and are in different units.
2. Capnography sampling line as appropriate for patient condition:
 - a. Mainstream for ETT, or side-stream for nasal or T adapter.
 - b. All crash carts are stocked with appropriate sampling lines compatible with their monitoring type.
 - c. Sampling lines are stored in the Respiratory department and LUMS areas.
 3. Pulse oximeter probe

Setup and Documentation

1. When in use, EtCO₂ will be documented with each set of vital signs.
2. Monitors will be set up by a Respiratory Therapist as instructed by manufacturer.
3. Supplemental oxygen does not interfere with accuracy of PetCO₂ readings. If required for non-ventilated patients, supplemental oxygen may be utilized.
4. When administering nebulizer therapy, place monitor in standby/pump off mode.
5. Condensation in the line may cause false readings. If patient assessment leads you to believe there is an equipment problem, collaborate with Respiratory partners to troubleshoot.
6. Alarms are set by Biomedical Engineering Department. An order is needed to make any changes to alarms.

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Reviewed: 8/14, 8/17

Revised: 8/14, 5/18, 4/19

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Med Staff - Anesthesia (Both), Critical Care (T), Medicine (SP), P&T (Both)	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - Anesthesia (Both), Critical Care (T), Medicine (SP), P&T (Both)	Mary Guglielmo: PD Continuing Med Educ Coord	05/2022
CNO	Scott Ciesielski: Chief Nrsing Officer South Bay	04/2022
CPC	Cindy Wishon: Clinical Educator	04/2022
CPC	Wendy Lu: Asst Mgr Nrsng Med Surg/Tlmtry	03/2022
Policy Committee	Scott Ciesielski: Chief Nrsing Officer South Bay	03/2022
Policy Committee	Patti Hamaguchi: Dir Qual Imprvmt Data Anlyts	03/2022

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



*Providence Little Company of Mary Medical Centers San Pedro and Torrance
Policies and Procedures*

Subject: PHARMACIST PROTOCOL TO DISCONTINUE INACTIVE INFUSIONS	
Board Approved: 10/26/21 Torrance	Category: General
Reviewed: 9/21 Torrance, 2/22 SP	Number:
Revised: 4/23, <u>11/23</u>	

Policy

The purpose of this policy is to define and establish guidelines for pharmacists to discontinue inactive medication infusions in the intensive care unit (ICU).

Procedure

- 1) Pharmacists reviewing medication profiles in ICU may discontinue infusions based on the criteria specified below.
- a. Providers will be notified of the change via progress note in EPIC.

Sedatives and analgesics (*either criteria below*)

- Discontinue if inactive for 36 hours or more
- Discontinue after extubation (excludes dexmedetomidine)
- Agents include propofol, opiate analgesics, benzodiazepines, ketamine

Vaso-active agents

- Discontinue if inactive for 36 hours or more
 - Vasopressors (norepinephrine, epinephrine, vasopressin, phenylephrine, dopamine)
 - Antihypertensive agents (nicardipine, esmolol, diltiazem)
 - Inotropic agents (dobutamine, milrinone, isoproterenol)

Neuromuscular blocking agents (*either criteria below*)

- Discontinue if inactive for 36 hours or more
- Discontinue after Targeted Temperature Management Protocol discontinued ~~used~~ for post cardiac arrest care

- 2) If patient transfers out of ICU, pharmacist may discontinue an INACTIVE infusion if the infusion is continued on transfer to a unit that is not an appropriate phase of care for that medication.

- a. Pharmacist will contact physician to notify them of the change and place a progress note in EPIC.

Role/Responsibility

- Critical Care Pharmacist

Collaboration

This policy was developed in collaboration with the following involved Departments

- Critical Care Committee
- Cardiothoracic Surgery
- Pharmacy Departments

Reference

N/A

RESPONSIBILITY FOR REVIEW AND MAINTENANCE OF THIS POLICY IS ASSIGNED TO: Pharmacy Director

Reviewed and Approved: Muno Bholat, Pharm.D

Date: 04/202311/23

Current Status: Pending

PolicyStat ID: 14975245



Providence

Little Company of Mary Medical Center Torrance

Origination: 02/1997
Effective: Upon Approval
Last Approved: N/A
Last Revised: 01/2024
Next Review: 3 years after approval
Owner: Munaver Bholat: Senior Director
Pharmacy
Policy Area: Medication Management
References:
Applicability: CA - PH&S Little Company of
Mary Service Area

Investigational Drug Use

Number: LCM-PC-310

PURPOSE:

To define the policy of handling investigational medication in the hospital for the following:

1. Patients enrolled in the investigational drug study while in the hospital.
2. Patients already enrolled in Providence Little Company of Mary Medical Center (PLCMMC) approved investigational drug study ~~and~~ including those treated with investigational drug as out-patients and required continuation of the drug during hospitalization.
3. Patients enrolled in an investigational study outside of the PLCMMC approved study who require continuation of the drug during the hospitalization.

POLICY:

1. As specified under **PURPOSE**, Item #1, the investigational study and physician are approved to prescribe the drug by the ~~PLCMMC~~ Providence St. Joseph Health Institutional Review Board (~~IRB~~ PSJH IRB).
 - A. Investigational drug may be used only if the physician is on the medical staff of the facility and complies with the policy governing use of investigational drugs and secures IRB approval.
 - B. All investigational drugs must be stored in the pharmacy and dispensed on an individual order under the patient's name.
 - C. All investigational drugs shall be labeled as "**INVESTIGATIONAL**" or "**STUDY**" ~~DRUG~~.
 - D. A list of physicians and the study approved to use an investigational drug shall be kept in the pharmacy.
 - E. A pharmacist must review the list prior to dispensing drug to verify that the physician is approved to prescribe the investigational drug.
 - F. PSJH IRB approved "Patient Informed Consent" is signed by the patient and placed in their medical record.
2. As specified under **PURPOSE**, Item #2, the investigational study and the physician are approved to prescribe the drug by ~~PLCMMC~~ PSJH IRB.
 - A. All new orders for enrollment in the study require that a copy of the investigational study "Patient

Informed Consent-Form"-accompany the order.

3. As specified under **PURPOSE**, Item #3, investigational study drugs not approved by PSJH IRB shall not be used at PLCMMC ~~IRB shall not be used at PLCMMC~~ unless the following conditions are met:

A. Primary Investigator is on staff at PLCMMC Facility

1. The Primary Investigator **MUST** provide a copy of the investigational drug study protocol and the signed "~~Patient Informed Consent~~" "Patient Informed Consent".
2. The Primary Investigator **MUST** obtain the approval of the IRB Chair or Vice-Chair on an individual case basis.
3. The protocol and use will be reviewed at the next scheduled IRB meeting.

B. Primary Investigator is **NOT** on staff at PLCMMC facility

1. The Primary Investigator **MUST** secure temporary privileges from the Medical Staff to prescribe the investigational study drug.
2. The Primary Investigator **MUST** provide a copy of the investigational drug study protocol and the signed "Patient Informed Consent".
3. The Primary Investigator **MUST** obtain the approval of the IRB Chair or Vice-Chair on an individual case basis.

PROCEDURE:

1. For an unapproved study, the pharmacist shall request from the Primary Investigator the copy of the drug study protocol and the "Patient Informed Consent".
2. For unapproved study where Primary Investigator is a member of the medical staff, the pharmacist receiving the order shall direct the requesting physician to contact the Chair or Vice-Chair of the IRB or their designee during absence for approval or disapproval of use of the investigation study drug.

~~For unapproved study where Primary Investigator is NOT a member of the medical staff, the pharmacist receiving the order shall direct the requesting physician to contact the Medical Staff Services Department during regular business hours and the Nursing Supervisor after hours for Temporary Privileges, in addition to #2 above.~~

~~The Medical Staff Services Department or Nursing Supervisor will notify the pharmacist regarding the approval or denial of Temporary Privileges.~~

3. ~~Pharmacist will confirm with the IRB Chair or Vice Chair and~~ For unapproved study where Primary Investigator is NOT a member of the medical staff, the pharmacist receiving the order shall direct the requesting physician to contact the Medical Staff Services Department ~~or~~ during regular business hours and the Nursing Supervisor after hours for Temporary Privileges, where appropriate if the request for use is approved, and will document the following: in addition to #2 above.

~~The date and time of the chairman's order for approval or denial shall be logged on the pharmacy copy and forwarded to the Pharmacy Manager.~~

~~The date and time of the Chief of Staff or designee order for approval or denial of Temporary Privileges shall be logged on the pharmacy copy and forwarded to the Pharmacy Manager.~~

~~If approved by the IRB Chair and Chief of Staff where appropriate, the drug shall be handled as in the procedure below.~~

- A. The Medical Staff Services Department or Nursing Supervisor will notify the pharmacist regarding the

approval or denial of Temporary Privileges.

- B. Pharmacist will confirm with the IRB Chair or Vice Chair and the Medical Staff Services Department or Nursing Supervisor, where appropriate if the request for use is approved, and will document the following:
1. The date and time of the chairman's order for approval or denial shall be documented and provided to the Pharmacy Manager or Director.
 2. The date and time of the Chief of Staff or designee order for approval or denial of Temporary Privileges shall be documented and provided to the Pharmacy Manager.
 3. If approved by the IRB Chair and Chief of Staff where appropriate, the drug shall be handled as in the procedure below.
4. Pharmacist receiving the order shall enter the drug in the patient profile in the ~~computer~~ electronic health record (e.g. use ~~miscellaneous oral solid~~ non-formulary medication and document in the comment section the protocol study, or select the STUDY drug from the Epic drug database if available). The pharmacist shall document quantity dispensed in the investigational study drug log ~~the quantity dispensed in the investigational study drug log book~~ where appropriate.
- A. A maximum of 24-hour dose shall be dispensed at a time.
- B. Pharmacist will send information on the investigational drug for the nursing staff, including any safe handling procedures when appropriate.
- a. Basic information concerning the dosage form, route of administration, strength, actions, uses, side effects, adverse effects, interactions and symptoms of toxicity of the investigational drug shall be available to nursing where the drug is being administered, and in the pharmacy.
- C. Pharmacist is responsible for proper labeling, storage, and distribution of the investigational drug being dispensed from the pharmacy.
5. All unused drug shall be returned to the pharmacy for proper disposal.
- A. Unused non-unit dose drugs shall be disposed properly (*per manufacturer's instructions*).
- B. Unused unit dose and injectables drugs shall be logged and added into the investigational drug inventory.
1. If the patient is to use own stock of study drug, the drug is to be stored in the pharmacy and dispensed as above. Follow the policy and procedure on storage in the pharmacy of patient medications brought from home.

REFERENCES:

California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, Section 70263 (o)

Code of Federal Regulations, Title 21, Chapter 1, Subchapter A, Part 56 - Institutional Review Boards

Code of Federal Regulations, Title 21, Chapter 1, Subchapter D, Part 312, Section 312.59 - Disposition of unused supply of investigational drug

Code of Federal Regulations, Title 21, Chapter 1, Subchapter D, Part 312, Section 312.62 - Investigator recordkeeping and record retention

The Joint Commission Standards, Medication Management MM.06.01.05

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	01/2024
Med Staff Comm - P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	01/2024
Med Staff Comm - P&T	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
Dir	Munaver Bholat: Senior Director Pharmacy	01/2024
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	01/2024

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



Provident

Little Company of Mary Medical Center Torrance

Origination: 11/2017
Effective: Upon Approval
Last Approved: N/A
Last Revised: 10/2020
Next Review: 3 years after approval
Owner: Munaver Bholat: Senior Director
 Pharmacy
Policy Area: Medication Management
References:
Applicability: CA - PH&S Little Company of
 Mary Service Area

Self Administration of Medication

PURPOSE

To establish the policy and procedure for patients to safely self-administer medications.

POLICY

1. Self-administration of medications by patients may be allowed when ordered by a physician/provider and for medications deemed appropriate for safe self-administration.
 - a. Patients' designated caregivers (e.g. parents of pediatric patients) may also administer the medication to the patient if so ordered by the physician/provider and deemed appropriate by licensed patient care providers.
2. Patients or designated caregivers must be assessed by licensed patient care providers and felt to be competent to be allowed to self-administer medications. Patients must be able to understand and properly perform self-administration procedures.
3. Patients admitted on home based infusions/implantable pumps will be identified and managed.
4. All self-administered medications must be documented on the patient's Medication Administration Record (MAR) by the nurse or other licensed care provider.

RESPONSIBILITY

1. It shall be the responsibility of the physician/provider to specify in the medication order that the patient or a designated patient caregiver may self-administer that medication.
 - a. Self-administration shall not be ordered on patients who may be mentally or physically incompetent or incapable of properly understanding and performing self-administration procedures.
 - b. Drug name, dose, frequency, route and other precautions desired by the physician/provider must be included in the order.
 - c. If a medication is to be stored at bedside it must be stated in the physician/provider order. (see Policy: **Patient Bedside Medications and Storage**)
2. It shall be the responsibility of the pharmacist to:
 - a. Review the physician/provider medication order and ensure that self-administration of the medication is appropriate.

- b. Enter the medication order on the patient's medication profile/medication administration record (MAR).
 - c. Ensure that the medication dispensed to the patient has proper labeling.
 - i. Self-administered medications that will be kept at bedside must include clear administration instructions on the label. (see Policy: **Patient Bedside Medications and Storage**)
 - ii. Medications that will be self-administered under the direct supervision of a licensed patient care practitioner do not require labeling provided that proper administration instructions are provided by the observer.
 - d. If patient will be administering his/her own medication brought from home, a pharmacist must verify medication, container and proper labeling. (see Policy: **Patients Taking Their Own Medication**)
 - e. Provide drug information and patient counseling as required.
3. It shall be the responsibility of the nurse or other licensed care provider (e.g. respiratory therapist) to:
- a. Ensure the patient is capable of understanding and following directions and procedure for self-administration.
 - i. Assessment shall be documented in the patient's electronic health record (EHR) (e.g. using the standard cognitive, neuro, behavioral assessment documentation).
 - b. Provide instructions and education to the patient (or designated caregiver) about the medication prior to self-administration.
 - i. Education shall be documented in the patient's EHR.
 - c. Supervise/observe the self-administration of medication doses by the patient/designated caregiver.
 - d. Record all doses of medication that are self-administered onto the MAR.
 - e. Monitor the patient for any adverse effect as well as comprehension and capability with self-administration of the medication. Education will be reinforced as needed.
 - f. Notify physician/provider of any adverse events involving self-administration or any change in the patient's ability to safely self-administer the prescribed medication.

PROCEDURE

1. Physician/provider to order the medication and specify that the patient or a designated patient caregiver may self-administer that medication.
2. Upon receipt of an order for self-administration:
 - a. The pharmacist will review the medication order and ensure that the medication is appropriate for safe self-administration. Pharmacist-verified orders will be entered onto the patient's medication profile/MAR.
 - b. The nurse or other licensed care provider will assess and ensure that the patient is capable of understanding and following directions and procedure for self-administration. Assessment and education shall be documented in the patient's EHR.
3. Medication dispensed to the patient for self-administration must have proper labeling.
4. For patient's self-administering their own supply of medications, the policy **Patients Taking Their Own Medication** must additionally be followed.

5. For medications ordered by the physician/provider to be stored at the bedside, the policy **Patient Bedside Medications and Storage** must be followed.
6. Medications not ordered and/or approved by pharmacy to be stored at bedside will be stored in the proper medication storage area on the patient's nursing unit (e.g. Pyxis) and will be accessed by nursing or another authorized licensed patient care provider. Medication will be obtained and provided to the patient for self-administration and observation of each dose.
7. Nurse and other licensed care providers will continue to monitor the patient/caregiver for comprehension and capability with self-administration of the medication. Education will be reinforced as needed.
8. Patients (and/or designated caregivers) will be educated about the medication by the physician/provider, nurse, pharmacist, or other licensed care provider within their scope of practice. Written instructions and education will be provided when needed. Education will include:
 - a. Medication name, type, and reason for use
 - b. How to administer the medication including timing, route, and dose
 - c. Actions and side effects of the medication
 - d. Monitoring effects of the medication
9. Nurse or licensed care provider will supervise the self-administration of medications. If the patient or designated caregiver has administered the medication without supervision, the staff member will check the medication container(s) to assess if the medication was in fact taken and will query the patient or designated caregiver to assure the medication was taken properly.
10. All doses self-administered or administered by an approved designated caregiver will be documented on the MAR.
11. The patient will be monitored for any adverse events and untoward effects of the medication.
12. Physician/provider will be notified of any adverse events or any change in the patient or caregiver's ability to safely self-administer the prescribed medication.
13. Patients admitted on home-based infusions/implantable pumps (e.g. insulin, epoprostenol, intrathecal pain pump, chemotherapy pump) have the following additional requirements and considerations:
 - a. The medication infusion pump may be continued in the hospital if a member of the medical staff orders to continue the POM infusion pump while in the facility. The order shall include the medication(s) and concentration(s) contained in the solution/pump, and the dose.
 - i. Clinical considerations to continuing therapy should include but are not limited to:
 - A. Duration and necessity during acute admission; potential alternative therapy available in the hospital
 - B. Emergency management of the pump (how to turn it off and/or remove it)
 - C. Device compatibility with MRI and other procedures
 - b. The provider, nurse, and/or pharmacist will identify that the patient is already receiving the ordered medication via a home infusion device at the correct dose.
 - c. For insulin pumps: see policy **Continuous External Insulin Pump Therapy**.
 - d. For chemotherapy pumps: see policy **Chemotherapy and Biotherapy Administration**.
 - e. The patient must be able to manage the pump appropriately before allowing them to use it.

- f. If a refill of medication is required during hospitalization, pharmacy will supply the medication. If possible. Alternately, the patient's own medication supply may be used if available and identifiable by a pharmacist.
- g. If the infusion may need to be titrated/adjusted, held, discontinued or needs to be replaced, the care team shall determine whether to continue infusion. Vendor support may be required. Alternately, if possible, convert the infusion to a hospital supplied medication and infusion device so that hospital staff can manage the therapy.
 - i. The discontinued device and drug will be returned to the patient, family or patient designee, provider managing the therapy, or vendor. If necessary, the device and drug may be stored together in the pharmacy as per policy **Patient Medications Brought from Home**.
- h. If, for technical reasons, it is necessary to utilize a device to deliver a drug that is not available in the hospital, the provider will be notified. The patient, family/patient designee, provider, vendor, and care team including pharmacy/nursing shall determine and implement a plan to continue therapy in the safest method.

1. Policy: Patients Taking Their Own Medication
2. Policy: Patient Bedside Medications and Storage
3. Policy: Continuous External Insulin Pump Therapy
4. Policy: Chemotherapy and Biotherapy Administration
5. CCR Title 22 Section 70263 (g)(2), (l), (m), (q)
6. Joint Commission Accreditation Manual for Hospitals MM.03.01.05, MM.03.01.01, MM.06.01.01, MM.06.01.03, et al

Attachments

No Attachments

Approval Signatures

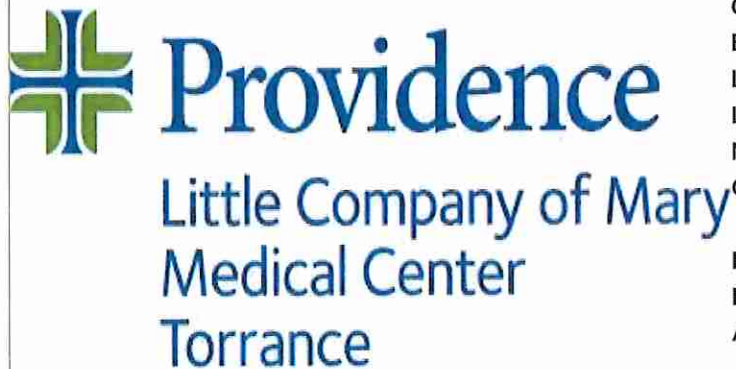
Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	01/2024
Med Staff - P&T (Both)	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	01/2024
Med Staff - P&T (Both)	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
CPC	Cindy Wishon: Nurse Educator [PH]	12/2023
CPC	Wendy Lu: Manager Nursing [PH]	12/2023

Step Description	Approver	Date
Dir	Munaver Bholat: Senior Director Pharmacy	11/2023
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	10/2023
Applicability CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance		

COPY

Current Status: Pending

PolicyStat ID: 14712168



Origination: 12/2013
Effective: Upon Approval
Last Approved: N/A
Last Revised: 11/2023
Next Review: 3 years after approval
Owner: Asiya Djalilova: Diabetes Educator RN
Policy Area: Diabetes/Glycemic Management
References:
Applicability: CA - Providence LCM MC Torrance

[Regional] IV Insulin Infusion (Columnar) - Adult (Pregnant & Non-Pregnant), Obstetric and Heart Surgery

In keeping with the mission and values of Providence Saint Joseph Health & Services, Providence Little Company of Mary Medical Center Torrance adopts the ~~"IV Insulin Infusion (Columnar) - Adult (Pregnant & Non-Pregnant), Obstetric and Heart Surgery"~~ IV Insulin Infusion (Columnar) - Adult (Pregnant & Non-Pregnant), Obstetric and Heart Surgery" regional clinical standard for use in the following*:

Providence Little Company of Mary Medical Center Torrance:

x	Acute Care
	Transitional Care Center
	Providence Little Company of Mary Home Health

*An "x" identifies inclusion and the absence of an "x" indicates exclusion or exception.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
Med Staff (P&T)	Mayra Graves: Medical Staff Coordinator [TA]	01/2024
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023

Applicability

CA - Providence LCM MC Torrance

COPY



Providence

Little Company of Mary
Medical Center
Torrance

Origination: 02/1997
Effective: Upon Approval
Last Approved: N/A
Last Revised: 11/2023
Next Review: 3 years after approval
Owner: Edgar Flemate: Director Facilities
Policy Area: Environment of Care
References:
Applicability: CA - PH&S Little Company of Mary Service Area

Oxygen Handling

PURPOSE:

The purpose of this policy is to ensure that guidelines are established for the proper handling, storage and safety of oxygen and for the prevention of fire. The "psi" levels mentioned in this policy do not relate to Crash Carts or other emergency response equipment. For information on Oxygen and Crash Carts, refer to Crash Cart policy for Torrance Ministry or Code Blue Policy for San Pedro Ministry.

DEFINITIONS:

E-Cylinder – Oxygen tank holding a maximum of 2200 psi at 25 standard cubic feet

H-Cylinder – Oxygen tank holding a maximum of 2200 psi at 251 standard cubic feet

Oxygen Dewars - liquified oxygen

Full E-Cylinder – Oxygen tank with a gauge showing the needle in the Green section on the gauge.

Partial E-Cylinder – Oxygen tank with a gauge showing the needle between the Green and Red section on the gauge.

Empty E-Cylinder – Oxygen tank with a gauge showing the needle in the Red section on the gauge.

In-Use E-Cylinder – Oxygen tank attached to wheelchairs, gurneys, etc.

In-Storage – Oxygen tanks, either full or partial kept in a rack for future use

Storage Room – Location in a department designated for Full, Partial and Empty tanks

Smoke Compartment – An area of the facility which automatically closes during a Fire Alarm event, designed to contain and prevent the spread of smoke and fire.

POLICY:

1. Smoking is strictly prohibited inside the Hospital and offsite facilities. (See Non-Smoking Policy)
2. Smoking materials found should be removed from any patient/resident room that has oxygen in use.
3. All patients/residents and their visitors must adhere to the hospital's/TCC/ SACC smoking policy.
4. All electrical cords must be grounded.
5. Only electrical devices which have been inspected by facility's Engineering Department may be used by patients/resident for personal care (e.g., razors, radios, hair dryers).
6. All electrical medical equipment in the room should be kept three (3) feet from the oxygen equipment, if possible. Combustible material is to be kept five (5) feet from oxygen storage.

7. All therapeutic gas cylinders within the facility must be strapped securely to walls or stored in an approved tank rack and inspected periodically. Cylinders must be strapped to carts or appropriate holders during transportation from departments and/or units.
8. Cylinders are not to be laid down at any time when in use or during storage.
9. Oxygen cylinders are to be transported in the designated oxygen carts for type "E" and "H". They must be strapped or chained securely to the cart with the valves completely closed.
10. Cylinder valves should be closed at all times except when gas is in use.
11. Oxygen cylinders should be handled only by properly trained personnel.
12. Trans-filling of one (1) gas cylinder from another is expressly prohibited in any patient care room/ area.
13. Trans-filling to liquid oxygen portable containers may only occur in approved area that meets the following criteria:
 1. well ventilated area with posted "No smoking" signs and noncombustible floor (not in patient care area/room)
 2. Performed by individuals that have been properly trained in transfilling procedure
 3. Containers PSI 50 or under only
14. No part of any cylinder containing compressed gas should be subjected to a temperature above 130 degrees Fahrenheit. A flame should never be permitted to come in contact with any part of a compressed gas cylinder.
15. Never drop cylinders or permit them to strike each other violently.
16. Patients/residents using portable oxygen cylinders must be instructed in the care, use, and safety of the cylinder.
17. The combined total of "Full" and "Partial" E-Tanks may not exceed twelve (12) tanks in a single smoke compartment. "In-Use" tanks, e.g., on wheelchairs or gurneys, do not apply to the twelve (12) total and may be in a smoke compartment. Additionally, empty tanks waiting for replacement do not apply to the twelve total tanks. Questions on smoke compartment size/perimeters are to be directed to the Engineering Department. "Empty" tanks must be stored in a separate rack from "Full" and "Partial" tanks. Signs will be placed to assist caregivers as a guide.
18. ~~For Torrance:~~ Tanks that are full, indicated by the gauge needle pointing in the Green section of the gauge face, ~~may or tanks that are considered to be stored in the "Full/Partial" tank storage rack. Tanks, once opened, and with the gauge needle showing between the Green (full) and Red (empty) sections on the gauge face, are to~~ may be considered "Partial" and moved to the "Partial" tank Rack. "Empty" tanks with gauge needle in the red section must be stored in "Empty" tank together in the same rack or section of rack. ~~For San Pedro/ Torrance TCC/ SACC: Tanks that are full, indicated by the gauge needle pointing in the Green section of the gauge face or tanks that are considered to be "Partial" with gauge between Green (full) and Red (empty) may be stored together in the same rack (Full/Partial rack). "Empty" tanks with gauge needle in the red section must be stored in "Empty" tank rack or section of rack.~~
19. Tanks attached to wheelchairs or gurneys are considered "In-Use". These tanks are to be checked prior to each use and replaced as necessary for the needed transport time, refer to the "estimated E-Cylinder Flow/Time" chart. Tanks with the gauge needle showing in the Red (empty) section of the gauge face are considered empty and should be placed in the empty rack.

REFERENCE(S) / RELATED POLICIES:

- Please refer to the attached "*Estimated E-Cylinder Flow/Time*" chart to determine tank usage based on pressure. Chart approved by Respiratory Therapy.
- NFPA 99-2012 11.3,11.5

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	01/2024
EOC Committee	Salvator Demarti: Accreditation Program Manager	12/2023
Policy Committee	Edgar Flemate: Director Facilities	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 14619870



Providence

Little Company of Mary Medical Center Torrance

Origination: 04/2012
Effective: Upon Approval
Last Approved: N/A
Last Revised: 10/2023
Next Review: 3 years after approval
Owner: Scott Ciesielski: Chief Nursing Officer
Policy Area: Patient Care Services
References:
Applicability: CA - Providence LCM MC Torrance

Response to Surge in Patient Volume

Number: LCT-ED-114

PURPOSE

The purpose of this policy is to provide a description of the defined process and procedure to manage patient admission, transfer, and rapid discharge in the event of significant bed shortages or Emergency Department (ED) overcrowding. The defined process/procedure will:

1. Provide a mechanism that focuses on appropriate and timely patient placement, especially during times of high census, critical bed needs, or staffing emergency or ED overcrowding.
2. Define roles of support departments during times of peak/over capacity.
3. Establish a systematic notification to physicians, hospital departments, and hospital personnel, and administration.

REFERENCES

- Emergency Nurses Association. Position Statement 2017. Crowding in the Emergency Department <http://www.ena.org/>.
- Proposed leadership standard revisions emphasize resolution of conflicts among leaders. (2007). *ED Management: The Monthly Update on Emergency Department Management*, 19(5), 1-3.
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- Policy: Diversion Request Requirements for Emergency Department Saturation LCT-ED-212
- Policy: Response to Surge in Patient Volume (ED) LCT-ED-114

POLICY STATEMENT

The nursing supervisor, as the designee of hospital administration, is to initiate actions to address significant shortages of available beds, regardless of the cause.

The nursing supervisor is responsible to evaluate the critical nature of patients awaiting bed placement.

Consideration is given to number of holds and boarding patients in the Emergency Department (ED), transfers, ED acuity, ED influx of patients, requests for direct admits, and surgical/procedural patients in need of placement. Analysis is done throughout the day to determine need for additional or changed times of bed huddle.

The hospital utilizes a tiered response to manage increasing hospital census, contributing saturation levels of key departments, diversion of EMS, staffing adequacy, and inpatient length of stay

The EMR is the primary vehicle by which the nursing supervisor tracks patient census by unit, pending admissions, pending discharges, and ED activity (*including patients waiting for triage, medical screening examinations, and treatment*). Should additional information be needed for decision-making, the nursing supervisor contacts appropriate charge nurses and/or department managers and directors.

PLCCMCT uses an adapted NEDOCS score to more accurately reflect the specific needs of the facility.

DEFINITIONS

Bed Huddles act as the forum for validating alert levels and identifying other patient care needs.

ED Hold: Any patient in the ED longer than 2 hours past the request to admit without inpatient orders

ED Boarding: Any patient in the ED with written inpatient admit orders exceeding 2 hours from the request to admit. *For purposes of this policy, ED holds and ED boarding patients are totalled together as "admits".*

ICU Competent RN: An RN with ACLS and experience in caring for critical patients, such as an ICU RN, ED RN, PACU RN, or ARU RN.

NEDOCS (National Emergency Department Overcrowding Score) - An objective measure of emergency department and hospital overcrowding.

The PLCCMCT Torrance NEDOCS website is available at <http://nedocs.providence.org/lcmt/>

The calculator is available at http://hsc.unm.edu/emered/nedocs_fin.shtml and uses the equation:

$$\text{Score} = -20 + 85.8(c/a) + 600(f/b) + 13.4 (d) + 0.93 (e) + 5.64 (g)$$

The institutional constants are:

- A. Number of ED beds: (*as of 9/2015: 36 including 8 in overflow*)
- B. Number of Acute (*Adult and Peds*) Hospital Beds 220*

ICU	28
4MC	35
PCU	34
4 West Medical	24+3 Infusion27
Tele Onc	56
1SO	37
PEDS	7
1MS Overflow	12

excludes NICU, Women's Health, and TCC/TCU

The situational variables are:

- A. Total Patients in the ED
- B. Number of Ventilators in use in ED
- C. Longest Admit Time (*in hours*)
- D. Total Admits in the ED
- E. Wait Time for the Last Patient Called from Triage

NEDOCS Score	0-50	51-100	101-140	141-180	>180
Condition	Not Busy (Green)	Busy (Yellow)	Overcrowded (Orange)	Severely Overcrowded (Red)	Dangerously Overcrowded (Black)

PROCEDURE

Criteria will be measured in the Emergency Department (ED) every four (4) hours or more frequently as needed. Once a decision to admit a patient from ED has been made, the patient will be admitted to a virtual bed within one hour of admission order or moved to the inpatient bed.


Bed huddle occurs at regular schedules but times may be altered and additional bed huddles called during escalation procedures

The nursing supervisor, in conjunction with the CNO, evaluates potential areas for patient placement such as Angio Recovery Unit (ARU), Post-Anesthesia Care Unit (PACU), and Mother Baby Unit (MBU)

At all levels, procedural area bed placement needs must be taken into consideration.

Health Care Emergencies for the Purposes of Staffing

As stated in the California Code of Regulations, Title 22 (CCR, T22), 70217 (q): "The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care".

- A. Hospitals are not required to seek prior approval from the California Department of Public Health Services (CDPH) Licensing and Certification (L&C) to decrease staffing levels below required ratios during a health care emergency. Hospitals are expected to respond ~~to~~ immediately to emergency situations in the unsuccessful attempts to decompress patient saturation events. **They will not be found in violation of the nurse-to -patient ratio regulations during a health care emergency, provided they can demonstrate they took steps to try to maintain staffing levels.**
- B. Healthcare emergencies may be reportable to CDPH, L&C if they result in a "disruption of services as defined in CCR, T22 § 70746 and/or meet the criteria of a "reportable disease or unusual occurrence" as described in CCR T22 § 70737(a). If this healthcare emergency constitutes a reportable event, it must be reported immediately or as soon as reasonably practical. If a reportable event occurs outside of business hours, the Hospital Compliance Officer or Administrator on Call will notify the Office of Emergency Services (OES) Warning Center at 916-845-8911  and ask that they notify the CDPH Duty officer.

- C. Should the hospital census exceed 10% above the total licensed beds, the following steps will be followed:
1. Notify Senior Leadership
 2. House Supervisor/Administrator on Call will notify the Compliance Office
 3. The Compliance Officer or designee will formally notify CDPH.
- D. Should patients need to be held in a department not normally assigned for their level of care for more than 24 hours, the following steps will be followed:
1. The Administrator on Call will notify Senior Leadership
 2. House Supervisor/Administrator on Call will notify the Risk Manager on call.
 3. The Risk Manager or designee will formally notify CDPH.
 4. All staffing ratios and competency for the level of care will be maintained.
 5. If an ICU patient is being cared for out of the ICU environment (such as in PACU), 2 ICU-competent RNs will be available to provide care for that patient.

Not Busy (Green)

- A. Routine bed huddles
- B. Nursing Supervisor communicates with ED and Inpatient Nurse Leadership to ensure patient placement.

Busy (Yellow)

- A. Routine bed huddles
- B. Charge Nurses, case managers, and nursing leadership to facilitate discharges and transfers

Overcrowded (Orange)

- A. Routine bed huddles
- B. Nursing supervisor, in conjunction with ED Director, Director Case Management, and CNO determine the need to activate any or all of the following.
- C. Nurse Director/Clinical Manager/charge nurse and Case Manager on each unit review current patients on the unit and identify the patients most appropriate for discharge or transfer from the facility.
 1. Identify the number and identity of patients (and each patient's most appropriate physician) who could be discharged with care needs met in the home setting (e.g. awaiting discharge).
 2. Identify the number and identity of patients (and each patient's most appropriate physician) who could be discharged to another setting with care needs met with assistance by others (home or transitional care).
 3. Input information into EMR system for bed tracking.
- D. The nursing supervisor facilitates review with the Nursing Directors/Managers to identify potential discharges, or transfers to another level of care based upon the types of beds needed.
- E. The Nurse Directors/Managers and Case Managers facilitate calls to physicians as appropriate to obtain discharge / transfer orders. Results of these efforts are communicated directly to the Nursing Supervisor via telephone or EMR.
- F. Overflow Criteria is implemented to house inpatients holding in the ED in the following locations in listed

priority, taking into account patient acuity and staff competency

- 1st Overflow
- Tele North
- Angio Recovery Unit (ARU)
- PACU/Same Day Surgery

Pediatrics

- G. The nursing supervisor is responsible for communicating need for additional staff to Nursing Directors and CNO as needed
- H. The nursing supervisor may call additional bed huddles as needed

AFTER HOURS/WEEKENDS

- I. The nursing supervisor may choose to initiate any or all of the following actions:
 - 1. Contact the Administrator on Duty (AOD) to apprise him/her of the situation. The AOD may choose to join bed huddles
 - 2. The on-duty case managers oversee discharge efforts and assist as needed with difficult situations
 - 3. The nursing supervisor is responsible for communicating the need for additional staff to nursing directors and managers as needed

Severely Overcrowded (Red)

In Addition to Above:

- A. At the time of escalation, an ad hoc meeting can be convened with the following leaders: CNO, Director of Emergency Services, Director of Care Management, Director of Radiology, Director of Laboratory, Director of Surgical Services, Director of Care Experience, and Chief Medical Officer (CMO).
- B. Charge Nurses and Nurse Managers identify and act on opportunities to increase patient load by utilizing the Charge RN and/or re-evaluate RN:Pt ratio to reflect actual acuity level of care.
- C. Determine appropriate communication to Medical Staff to facilitate patient discharges and admissions.
- D. The CNO and CMO shall review bed status with the nursing supervisor and identify a call priority list based upon information provided by charge nurses and the specific type of beds needed.
- E. The senior administrative staff member identifies an individual to place calls to physicians and assist with discharges. Charge nurses shall be available with relevant information when physicians are contacted. Every attempt is made to place a single call to a physician for all of his/her potential discharges.
- F. If sufficient discharges are not obtained and additional contact with physicians is needed, the CMO in conjunction with the appropriate department chair/vice-chair may be contacted to enhance cooperation. The Chief of Staff may be involved as needed.
- G. The CNO evaluates scheduled meetings to determine if they should be cancelled or postponed.
- H. Potential areas to be considered for use as overflow areas include ARU, PACU, and 1st floor, as well as hallways in nursing units. Appropriate supplies and equipment should be available to readily prepare these areas for use.

Dangerously Overcrowded (Black)

In Addition to Above:

- A. An ad hoc bed huddle convenes comprised of: nursing supervisor, unit directors and managers, charge nurses, designees from departments of radiology, laboratory, peri-operative services, care experience, and supply chain, as appropriate
- B. The medical director of record (Dept Chair, Chief of Staff) consults with at least one of the following (CEO, CNO, CFO, CMO) regarding the possibility of cancellation of same or next day elective surgical and invasive procedures. Affected physicians and departments are notified.
- C. **AFTER HOURS/WEEKENDS**
 - 1. The AOD is expected to come to facility and conduct reassessment as requested by nursing supervisor
 - 2. Directors and/or managers are called in as needed
 - 3. During Red or Black NEDOCS status when the above measures have not provided for sufficient capacity, the nursing supervisor consults with at least one of the following: CEO, CNO, CFO, CMO. In collaboration, these individuals can make a decision as to appropriate expansion into patient care areas not usually used for this function. (See potential areas in Severe section). Patients will receive the level of care as determined by the physician regardless of location.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023

Applicability

CA - Providence LCM MC Torrance

Current Status: *Pending*

PolicyStat ID: 14619844



Provident

Little Company of Mary
Medical Center
Torrance

Origination: 06/1983
Effective: Upon Approval
Last Approved: N/A
Last Revised: 02/2021
Next Review: 3 years after approval
Owner: Patti Hamaguchi: Executive
Director Quality
Policy Area: Patient Care Services
References:
Applicability: CA - PH&S Little Company of
Mary Service Area

Policy and Procedure Management

PURPOSE:

The purpose of this policy is to define the process for development, maintenance and approval of Providence Little Company of Mary Medical Center Service Area, Providence Little Company of Mary Medical Center Torrance and San Pedro Policies and Procedures.

POLICY:

1. Department Directors/Managers are responsible for development of required policies and procedures specific to their department and services and for maintenance of them including periodic review and revisions as indicated.
2. All policies and procedures will be reviewed in their entirety by the Director/Manager and approved by the Administration and Board of Directors at intervals not to exceed three (3) years.
3. Clinical policies and procedures will be approved by the Medical Staff as appropriate.
4. Policies and procedures are approved by the appropriate disciplines and are included in the approval workflow process.
5. Department Directors/Managers are responsible for maintaining their Policies and Procedures between formal approval dates, including the development of new policies, revision of existing policies and deletion of policies and for keeping records of these activities.
6. Department Directors/Managers (policy owners) are responsible for archiving any policies that are no longer current.
7. Policies are available in the following locations: PolicyStat (Providence intranet) and in department manuals.

Policy Format:

1. Policies and Procedures will utilize the appropriate templates and formatting as follows:
 - a. PolicyStat Policies and Procedures:
 - i. Subject/title – The title by which the policy is known
 - ii. Implementation Date – The month/year the policy went into effect

- iii. Last Reviewed – The month/year the policy was last reviewed
- iv. Last Revised – The month/year the policy was last revised
- v. Next Review – The month/year the policy is due to be reviewed
- vi. Owner – Name of policy owner
- vii. Policy Area – Major category that the policy is assigned to
- viii. Applicability – Entity that the policy applies to

Procedure for Policy Approval:

1. Templates for policies and procedures are located in PolicyStat.
2. The Policy Owner is responsible to ensure that all stakeholders (e.g. Physicians, Nursing, Subject Matter Experts, Administration, Ancillary and Support departments, etc.) are part of the approval process, as applicable, and have the opportunity to review and comment on the policy.
3. The policy is implemented when all stakeholders have approved it.
4. Emergent policy approval process:
 - Clinical policies - Approval process to include MEC (Medical Executive Committee) and the Board.
 - Non-clinical policies - Approval process to include the Board.
5. The PolicyStat Administrator can override policies if there are no major content changes (e.g. formatting, correcting typos, clarifying a statement, etc.).

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	11/2023
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

Current Status: Pending

PolicyStat ID: 14292716



Providence

Little Company of Mary Medical Center Torrance

Origination: 08/1996
Effective: Upon Approval
Last Approved: N/A
Last Revised: 10/2017
Next Review: 1 year after approval
Owner: Jaymie Felipe: Manager
Facilities
Policy Area: Environment of Care
References:
Applicability: CA - PH&S Little Company of Mary Service Area

Safety Management Plan

Number: LCT-EOC-510

MISSION, VISION AND VALUES.

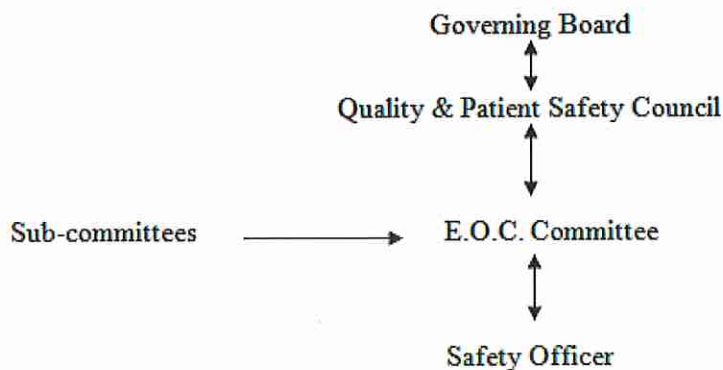
Providence Little Company of Mary Medical Center (PLCMMC), in support of the organization's mission, core values, and vision, is dedicated to the promotion of a safe and healthy environment for patients, employees, volunteers, visitors, medical staff and the surrounding community. The goals of the hospital's safety management program are to emphasize safety in all aspects of care, to promote health and safety awareness as a means of prevention, and to comply with all federal, state and local laws on safety and health. The safety management program is designed to continuously monitor PLCMMC's environment for health and safety risks, identify hazards, recommend appropriate corrective action, and evaluate corrective actions taken.

AUTHORITY:

The authority for the establishment of a *Management Plan for Safety* is with The Joint Commission (TJC). The authority for overseeing and monitoring the safety management program lies in the Environment of Care (EC) Committee, for the purpose of ensuring that safety management activities are identified, monitored and evaluated, and for ensuring that regulatory activities are monitored and enforced as necessary. The Safety Officer, in conjunction with the EC Committee, develops and oversees implementation of the Safety Management Plan. Whenever possible, regulatory requirements are integrated with accreditation standards to avoid duplication of efforts, and to assist in meeting or exceeding the requirements or the accreditation standards.

ORGANIZATION

A. The following represents how the Safety Management Program's reporting structure is organized.



B. RESPONSIBILITIES

Responsibilities and accountabilities of the Governing Board, administrative staff, management staff, employees and medical staff are outlined in the safety management program. All individuals are recognized as having varying levels of accountability and responsibility.

Governing Board: The Governing Board will support the Safety Management Program by:

- Review and feedback if applicable of the quarterly EC Committee summary reports presented by the Safety Officer or an appointed representative.
- Supporting implementation of policies, which are required to assure the health and safety of each individual in the hospital environment.
- Endorsing budget support, which is needed to implement a safety or health improvement identified through the activities of the Safety Management Program.

Administrative Staff: Administrative Staff will support the Safety Management Program by:

- Active representation at the safety committee meetings.
- Setting an expectation of accountability for compliance with all Safety Management Program policies.
- Providing leadership and budgetary support during the process of developing, implementing and maintaining the Safety Management Program.

Management Staff, including Directors and Department Managers: These individuals will support the Safety Management Program by:

- Communicating recommendations of the EC Committee to affected staff in a timely manner.
- Developing systems within each department, which insure compliance with the policies of the Safety Management Program.
- Complying with corrective action activities for all identified hazards or unsafe work practices.
- Supporting required employee safety education and training by monitoring employee participation and setting clear expectations for employee participation to include a disciplinary policy for employees who fail to meet the expectations.
- Cooperating with the Safety Officer in the elimination of work site hazards as soon as possible after identification.
- Cooperating with the EC Committee during times of department safety surveys.
- Serve as a resource for staff on matters of health and safety.

Employees. Employees will support the Safety Management Program by:

- Actively participating in all required safety education and training.

- Practicing safe work practices at all times to include use of required personal protective equipment.
- Reporting any observed or suspected unsafe conditions to department management as soon as possible after identification.
- Participation, when possible, in safety promotion programs or activities.

Medical Staff: Medical Staff will support the Safety Management Program by:

- Practicing safe work practices while performing procedures at the medical center.
- Actively supporting the policies of the Safety Management Program by becoming informed of the various activities directed toward the promotion of a safe and health environment (*e.g., reading the physician periodical, receiving EC information*).

Participating, when possible, in health and safety promotion programs or activities, including receiving safety-related information as it may relate to the EC Standards, or regulatory requirements, participating in fire or disaster drills, assisting in the care of employees who receive a work-related injury.

SCOPE

The scope of this management plan applies to PLCMMC, and offsite areas. During the evaluation process, the scope will be reviewed in terms of major accomplishments made throughout the year.

GOALS AND OBJECTIVES:

The program's goals are to provide a physical environment wherein patient care can be optimized, and by creating an environment that is free from physical harm and hazards for the patient-care population, staff, volunteers, physicians and visitors. It is an accreditation/ standards-based and regulatory driven program. The safety management plan provides processes for the following components to meet the stated goals and objectives, and to meet or exceed accreditation and regulatory standards.

The hospital plans for a safe environment. The hospital identifies how it establishes and maintains a physical environment free of hazards and manages staff activities to reduce the risk of injuries.

Establishing an orientation and education program. The facilities orientation and education program will address:

- General safety processes
- Area specific safety processes
- Specific job-related hazards

Education

The EC Committee monitors compliance with educational requirements, and acts as a resource, when requested, or through a needs assessment or special investigations. All of the organization's new employees receive general hospital-wide safety training at their initial orientation, and annual continuing education sessions, which are coordinated through the HealthStreams interactive computer software program. Department-specific orientation and on-going training for departmental safety requirements and specific job-related hazards are the responsibility of the individual department manager.

Educational sources.

Various types of experience at PLCMMC provide sources from which educational material will be developed. These include, but will not necessarily be limited, to the following:

1. **Safety surveillance trends.** Through trending of surveillance results, it may be determined that staff

need additional education. The survey process itself may be an educational tool for staff, for example, when staff are asked specific questions relating emergency codes or obtaining SDS, or relating to their responsibilities with respect to defective equipment.

2. **Fire and Disaster drills.** When staff performance is evaluated during fire and disaster drills, educational topics may be developed if a knowledge deficit exists, or if staff performance was not at the expected level.
3. **Changes in Operational Practices.** Whenever changes occur within the hospital that require additional safety education, the education will be determined by the safety officer and/or EC Committee.
4. **Needs Assessment.** Another source of education is determined from periodic needs assessment tools. These can be gathered from educational evaluations wherein the staff may be asked, "*What other types of educational topics would you like to see?*" Or it may be done at the unit level, for example, with the use of medical equipment any subsequent education given to staff by the equipment's vendor.
5. **Illness and Injury Trends.** When illness and injury trends demonstrate an unusual trend, the trend may be the catalyst for further education. Increasing back or needle stick injuries, or falls are examples of using injury trends to substantiate the need for additional education.
6. **Consequential Events or Risk of Consequential Events.** An incident may occur that results in an adverse patient, visitor or employee injury. This would warrant investigation, and the possibility of additional education.
7. **EC Committee.** The EC Committee may impose education upon staff due to various regulatory and/or accreditation agencies that require annual updating.

A non-smoking policy is developed, communicated and enforced throughout all buildings. Patients, visitors, and staff are prohibited from smoking in any of the hospital's buildings.

A non-smoking policy is developed and in place and is enforced throughout all buildings by management, vigilant employees and Security staff. The smoking policy identifies designated smoking areas for employees and visitors who desire to smoke. The smoking policy is addressed with all new employees upon hire and new patients upon admission. Smoking must take place only with the designated out-side areas, and not within proximity to doors or windows wherein smoke may migrate into the medical center.

Conducting a risk assessment that proactively evaluates the impact of buildings, grounds, equipment, occupants and internal physical systems on patients and public safety

Internal and external activities that support risk assessment at PLCMMC include: **[Risk Assessment]**

1. **Policies.** These are developed for various aspects of the Environment of Care, and provide structure to safety at the hospital.
2. **Inspections.** Safety inspections are conducted throughout the facilities, for the purpose of maintaining a proactively safe environment. These may include special reviews of construction areas and maintenance projects.
3. **Grounds Safety.** Surveillance of the premises and grounds is conducted by Security to contribute to a proactive stance with respect to maintaining a safe environment.
4. **Safety Information Collection and Evaluation.** Through the collection of a wide body of information from various hospital sources, the EC committee will monitor trends and activities that will have a positive impact on risk assessment.
5. **Regulatory inspections** (e.g., DHS, local agencies having jurisdiction, such as the fire department, and

OSHPD, Cal-OSHA consulting, TJC accreditation mock and actual surveys).

6. Vendor inspections (*e.g., insurer surveys*), use of consultants as necessary, and investigations recommended by the EC committee or requested by internal/external sources.

Reporting and investigating all incidents of property damage, and patient or visitor injury.

Internal processes and activities that support this component include: **Reporting and Investigating Incidents**

1. There are reporting and investigating mechanisms in Security that addresses incidents of property damage, thefts, vandalism, burglary, assault, battery and any violent incidents.
2. There is a reporting and investigating mechanism in Risk Management, which addresses patient and visitor incidents, including incidents on the grounds and premises.
3. There is a reporting and investigating mechanism in Employee Health, which addresses employee incidents and injuries within the premises and on the grounds.
4. There is a reporting and investigating mechanism in Infection Control that addresses the surveillance of infections.
5. There is a reporting and investigating mechanism in Supply Chain Management that addresses product recall trends and outcomes.
6. There is a reporting and investigating mechanism in Clinical Engineering that addresses product recall trends and outcomes.

Ongoing hazard surveillance, including response to product safety recalls.

Internal processes that support this component include:

Hazard Surveillance

1. Department safety surveys are conducted throughout the year in accordance with a schedule. If a department demonstrates an unusually high number of injuries, inspections will be initiated to determine the cause for the trend.

Product Recalls

1. Product safety recall reports to the EC committee occur, with follow-up and outcome(s).

Examining safety issues by appropriate hospital representatives.

Activities that support this component include:

Examination of Safety Issues

1. The establishment of the EC Committee reviews information that comes from the following sources:
 - a. Summary statistics regarding ongoing safety educational training.
 - b. Employee/visitor incident reports
 - c. Information relating to hazardous materials and wastes management
 - d. Surveillance data relating to construction sites, and building and grounds surveys.
 - e. Any exposures to hazardous materials and wastes.
 - f. Fire alarm system testing

- g. Fire and disaster drill reporting and evaluations of drills,
 - h. Preventive maintenance and testing data for medical and utility equipment.
 - i. Information and evaluations relating to utility and medical equipment failures and user errors.
 - j. Reports from Risk Management, Infection Control, and other pertinent safety-related information, (e.g., *Product Recalls*).
 - k. Reports from security that include, but are not limited to property loss incidents, thefts, vandalism on the property, violent incidents.
 - l. Reports from relevant regulatory agencies.
 - m. Special or unusual occurrences related to safety not identified above.
2. **Integration of OSHA (*regulatory*) with TJC (*accreditation*):** In an effort to remain at a very high level of compliance with respect to regulatory and accreditation standards, key personnel from the hospitals are not only responsible for accountability with TJC standards compliance, but also are accountable to ensure compliance with OSHA regulations. Whenever possible, the accreditation standards are integrated with OSHA regulatory requirements. A good example of this is the Employee Illness and Injury Prevention Program. This is an OSHA-mandated program, but it additionally supports the Safety Management Program as part of the overall plan for safety management. Whenever possible, all relevant and pertinent data derived from OSHA and other regulatory requirements (e.g., *DHS, local agencies with jurisdiction*) are compiled to show support of TJC standards compliance.

Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:

- Staff knowledge and skills
- Level of staff participation
- Monitoring and Inspection activities
- Emergency and Incident reporting, and
- Inspection, preventive maintenance, and testing of equipment

Performance Standards

Performance standards are identified that measure effective outcomes in the area of safety management. The standards are approved and monitored by the safety officer and the EC Committee, with appropriate actions and recommendations made. The criteria for the selection of performance standards includes the following:

- The performance standard measured represents a high-volume activity.
- The performance standard could represent a sentinel event activity (e.g., *infant abduction*).
- The performance standard represents an activity that needs improvement.
- The performance standard represents an activity that is not problematic, but could be enhanced, to establish a new threshold.
- The performance standard represents a key indicator of the activity being measured (e.g., *measuring illness and injury trends represents a key indication with respect to the effectiveness of the overall illness and injury program*).

The EC Committee approves performance standards, along with thresholds for particular performance standards.

Safety policies and procedures that are distributed, practiced, enforced and reviewed as frequently as necessary, but at least every three (3) years.

The plan requires a hospital safety policy and procedure manual, be developed, distributed, practiced and enforced under the direction of the affected department manager, or the manager who has assumed functional responsibility for the affected department. The EC Committee, in cooperation with the department manager will review the hospital safety policies and Fire manual at least once every three (3) years, or if a situation warrants a more frequent review (*such as a change in a process or procedure, or a new operation, etc.*). Department specific safety policies and procedures for high-risk areas are contained at the unit level.

Appointment of a qualified individual(s) to oversee development, implementation, and monitoring of safety management.

Internal processes that support compliance includes:

A Qualified Individual Oversees Implementation and Monitoring of the Safety Program

1. The Safety Officer role is established, with a job description. The Safety Officer receives ongoing education, and keeps current with professional organizations and references, sources, etc.
2. An administrative position is established that oversees the safety officer function(s).

Individual(s) to intervene whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings.

Safety Officer Appointment

The *Safety Officer Appointment* identifies the authority for the Safety Officer, as well as an alternate in the event of his/her absence, to intervene whenever conditions pose an immediate threat to life or health or threaten damage to equipment or buildings. Additionally, the engineer and/or Public Safety Officer(s) that is on duty for the evening and night shifts may intervene in the event conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings.

Maintenance and supervision of all grounds and equipment.

Internal activities that support this component include:

1. **Ongoing safety surveillance.** Semi-annual Hazard Surveillance surveys are done ongoing, in accordance with a schedule, by safety representatives from the EC committee, or by the appointed department safety officer. Additionally, routine and varied security patrols are conducted, during routine patrols and when conducting Fire Drills, wherein any safety hazards would be brought to the attention of the Safety Officer or EC Committee if warranted. Special investigations by the safety officer and other designated staff, when requested, are conducted. All of these activities contribute to an overall monitoring plan for the grounds and any safety-related equipment.
2. **Risk Management surveillance.** Risk Management reviews data from reported incidents that may identify patterns, trends and opportunities for improvements. The data involves all patient and visitor incidents related to accidents or other unusual events, which are not consistent with routine patient care and treatment.

Annual evaluation of the safety management's program's objectives, scope, performance and effectiveness will occur

The EC Committee will evaluate the effectiveness of the overall program and plan on an annual basis, and based upon its findings, determine goals and objectives for the following year. An overall report will be written, which will ultimately be forwarded to the Governing Board. The Safety Management Program will be evaluated on the following:

1. **The objectives.** Previous goals will be evaluated, i.e., the following questions will be asked: was the goal completed? If not, why not? What is the continuing plan? Will this goal be included in the following year? Will new goal(s) be identified?
2. **The scope.** The following indicators will be used to evaluate the effectiveness of the scope of the safety management program:
 - Illness and injury trends, hazard surveillance trends.
 - Regulatory inspection outcomes will be used to determine if the scope of the management program is effective.
 - Additionally, a summary of each component will be completed to determine if key components of the TJC EC accreditation standards have been met.

If a key component has not been met, causation will be determined, with a plan for continuing action established.
3. **Performance Standards.** Specific performance standards for each component of the EC standards will be monitored for achievement. Thresholds will be set for the performance standard identified. If a threshold is not met, an analysis will be in effect to determine the possible reasons. Some performance standards will be monitored without thresholds established. A plan for improvement, or continued monitoring will be noted with each evaluation.
4. **Effectiveness.** The overall effectiveness of the objectives, scope and Performance Standards will be evaluated, and recommendations made to continue monitoring, add new indicators if applicable, or take specific actions for ongoing review.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
EOC	Jaymie Felipe: Manager Facilities	10/2023
EOC	Salvator Demarti: Accreditation Program Manager	09/2023

Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance