Emergency Department Policies and Procedures
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Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Emergency Department Triage</td>
<td>4</td>
</tr>
<tr>
<td>II. Admission of Patients to the Emergency Department</td>
<td>8</td>
</tr>
<tr>
<td>III. Admission Orders</td>
<td>9</td>
</tr>
<tr>
<td>IV. Emergency Treatment of Minors</td>
<td>10</td>
</tr>
<tr>
<td>V. Patient Rights and Responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>VI. Informed Consent</td>
<td>13</td>
</tr>
<tr>
<td>VII. Implied Consent</td>
<td>14</td>
</tr>
<tr>
<td>VIII. Physician’s Certificate of Emergency and Necessity</td>
<td>15</td>
</tr>
<tr>
<td>IX. Patient Leaving Against Medical Advice (AMA)</td>
<td>17</td>
</tr>
<tr>
<td>X. Patient Elopement from the Emergency Department</td>
<td>18</td>
</tr>
<tr>
<td>XI. Procedures and Treatment Not to be Performed in the Emergency Department</td>
<td>19</td>
</tr>
<tr>
<td>XII. Emergency Medical Screening Procedures</td>
<td>20</td>
</tr>
<tr>
<td>XIII. Do Not Resuscitate (DNR)</td>
<td>22</td>
</tr>
<tr>
<td>XIV. Release of Information – Patient Privacy</td>
<td>23</td>
</tr>
<tr>
<td>XV. Anatomical Donations</td>
<td>24</td>
</tr>
<tr>
<td>XVI. Brain Death Guideline</td>
<td>29</td>
</tr>
<tr>
<td>XVII. Death of a Patient Checklist</td>
<td>31</td>
</tr>
<tr>
<td>XVIII. Death of a Patient</td>
<td>32</td>
</tr>
<tr>
<td>XIX. Medical Examiner’s Cases</td>
<td>36</td>
</tr>
<tr>
<td>XX. Dead on Arrival (DOA)</td>
<td>37</td>
</tr>
<tr>
<td>XXI. Standard of Practice or Care</td>
<td>38</td>
</tr>
<tr>
<td>XXII. Assessment of the Emergency Department Patient</td>
<td>49</td>
</tr>
<tr>
<td>XXIII. Assessment of the Trauma Patient</td>
<td>50</td>
</tr>
<tr>
<td>XXIV. Emergency Room Psychiatric Assessment – Psychiatric Emergency</td>
<td>63</td>
</tr>
<tr>
<td>XXV. Suicide Precautions/Constant Precautions/Attempted Suicide</td>
<td>65</td>
</tr>
<tr>
<td>XXVI. Care of Emotionally Ill and Chemical Dependent Patients</td>
<td>69</td>
</tr>
<tr>
<td>XXVII. Patient Awaiting Psychiatric Evaluation</td>
<td>70</td>
</tr>
<tr>
<td>XXVIII. Management of a Patient Under the Influence of Drugs</td>
<td>71</td>
</tr>
<tr>
<td>XXIX. Legal Alcohol Testing</td>
<td>72</td>
</tr>
<tr>
<td>XXX. Waived Testing Requirements</td>
<td>76</td>
</tr>
<tr>
<td>XXXI. Bedside Glucose Monitoring</td>
<td>78</td>
</tr>
<tr>
<td>XXXII. Blood Transfusion</td>
<td>80</td>
</tr>
<tr>
<td>XXXIII. Transfusion Reaction</td>
<td>86</td>
</tr>
<tr>
<td>XXXIV. Suspected Rape Guidelines</td>
<td>89</td>
</tr>
<tr>
<td>XXXV. Rape Trauma Syndrome Standard of Care</td>
<td>91</td>
</tr>
<tr>
<td>XXXVI. Cervical Traction or C-Spine Immobilization</td>
<td>94</td>
</tr>
<tr>
<td>XXXVII. Chest Tubes of Pleur-Evac</td>
<td>95</td>
</tr>
<tr>
<td>XXXVIII. Conscious Sedation Policy</td>
<td>96</td>
</tr>
<tr>
<td>XXXIX. Crash Cart Policy</td>
<td>109</td>
</tr>
<tr>
<td>XL. Emergency Delivery</td>
<td>111</td>
</tr>
<tr>
<td>XLI. Intubation of Patients in Emergency Situations</td>
<td>112</td>
</tr>
<tr>
<td>XLII. Code Blue Policy and Procedure</td>
<td>114</td>
</tr>
<tr>
<td>XLIII. Resuscitation/Life Sustaining Measures</td>
<td>115</td>
</tr>
<tr>
<td>XLIV. Poison Control Management</td>
<td>116</td>
</tr>
<tr>
<td>XLV. Poison Control: Ingestion of Poison (Adult and Child)</td>
<td>117</td>
</tr>
<tr>
<td>XLVI. Medications in the Emergency Department</td>
<td>119</td>
</tr>
<tr>
<td>XLVII. Medication Reconciliation</td>
<td>120</td>
</tr>
<tr>
<td>XLVIII. Latex Sensitive Patients</td>
<td>121</td>
</tr>
<tr>
<td>XLIX. Intravenous Therapy</td>
<td>124</td>
</tr>
</tbody>
</table>
Emergency Department Triage

Effective: 07/2014

POLICY

To provide a standardized system whereby patients presenting to the Emergency Department are treated in order of priority based upon acuity utilizing the Emergency Severity Index Five Level triage system (Gilboy, Tanabe, Travers, Eitel and Wuerz, 2003).

DEFINITIONS

**Triage** - Triage is the process by which patients are sorted and/or classified according to the type and urgency of their medical conditions.

**Acuity** - Acuity refers to the severity of the illness or injury, as well as the potential for complications.

**Emergency Severity Index** - The Emergency Severity Index (ESI) is a five-level triage scale developed as a triage instrument to help facilitate the prioritization of patients based on the urgency of the patients’ conditions.

PROCEDURE

1. An RN will triage all patients arriving to the Emergency Department to identify life-threatening conditions and to “sort” or prioritize patients according to acuity.

2. The process of acuity determination is accomplished by using a five-tiered system of triage acuity categories.

3. Only the assessment necessary to accurately assign a triage level based on the ESI system should be performed in triage and the patient appropriately assigned to a location.

4. The following steps should occur when making the triage decision (ENA, 1995, p. 37):

   1) The triage assessment may include the incorporation of at least one of the following to help assign an appropriate ESI level:
      a) *Across the room assessment*: General appearance, airway status, breathing status, circulatory status and disability (neurological) status.
      b) *Chief complaint*: Generally a brief one-line statement or phrase in the patient’s own words describing the reason for seeking emergency care.
      c) *Triage assessment*: Perform focused assessment of chief complaint. Includes the collection of subjective and objective data.
**Subjective data which may include but is not limited to:** onset and progression of symptoms, location and description of problem, mechanism of injury, treatment prior to arrival and response and pain assessment.

**Objective data which may include data observed (appearance), data measured (vital signs), and data discerned (localized examination).**

**Collection of in depth medical/surgical, TB and/or Infectious disease history, along with a detailed medication list, to include names of medications, routes, dosages and last dosage administered, and allergies.**

d) **Consider worst case scenarios.** Pose hypotheses, collect data to narrow the range of possibilities. Consider current condition, potential for deterioration, speed of flow within the department, and the availability of resources.

e) **Determine the acuity category**

**f) Reassess and reassign acuity as necessary.**

**2) Determine the amount of resources needed.** The list of CRH approved resources is as follows: (please note that each bullet point is considered an individual resource)

- Labs
- ABG’s
- Respiratory Treatments
- EKG
- X-rays
- CT/MRI/Ultrasound
- IV fluids
- IV/IM medications
- Specialty Consultations
- Simple procedures: laceration repair, foley catheter insertion
- Complex procedures (2 points awarded): conscious sedation

**5 Tier Acuity Categories and Reassessment Objectives**

1. **Level 1 – Imminent (Lavender):**
   a. Definition: any condition presenting an immediate threat to life or limb requiring immediate interventions to save a life or prevent irreversible damage.
   b. Time to Treatment: Immediate
   c. Reassessment: Continuous
   d. Presentation: Unresponsive, intubated, apneic, pulseless

   ***When Level I condition is identified, the triage process stops, the patient is taken directly to a room and immediate physician intervention is requested.***

2. **Level 2 – Emergent (Red):**
   a. Definition: potentially life or limb threatening and could worsen without intervention
   b. Time to treatment: Immediate
   c. Reassessment: Every 15 – 30 minutes, and as needed
d. Presentation: High risk situations, new onset confusion, lethargy or disorientation, severe pain or distress, patients requiring two or more resources, HR, RR or Oxygen Saturation in the danger zone.

***When Level II condition is identified, the triage process stops, the patient is taken directly to a room and immediate physician intervention is required.

3. Level 3 – Urgent (yellow):
   a. Definition: Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
   b. Time to treatment goal: Less than 2 hours
   c. Reassessment: Every 1 to 2 hours, and as needed
   d. Presentation: Patients requiring two or more resources with vital signs not in danger zone.

4. Level 4 Semi-Urgent (Green):
   a. Definition: Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
   b. Time to treatment goal: 2 – 24 hours
   c. Reassessment: Every 2 – 4 hours, and as needed
   d. Presentation: Patients requiring 1 resource only

5. Level 5 Non-Urgent (Blue):
   a. Definition: Any condition that requires minimal interventions and will not worsen if treatment delayed several hours to days.
   b. Time to treatment goal: 2 – 24 hours
   c. Reassessment: 2 – 4 hours, and as needed
   d. Presentation: Patients requiring no resources

A. A triage level must be obtained and recorded on all patients, during all shifts. This includes all ambulance patients. Triage is generally done at bedside, except during peak census periods, then the triage room will be utilized.

B. The triage assessment and triage category must be documented in the appropriate area of the EHR Triage Clinical Note.

C. Only the assessment necessary to accurately assign a triage level based on the ESI system should be performed in triage and the patient appropriately assigned to a location.

D. If in doubt about a category, choose the higher acuity to avoid undertriaging a patient.

E. After determining the ESI level for each patient, he/she will escort the patient to the appropriate bed and give report to the receiving nurse who will be caring for the patient.

F. If all beds are full and the patient’s condition is stable enough to wait in the ER Lobby, reassessment at appropriate intervals must be done according to the reassessment guidelines. Any significant symptoms should be reassessed for change and the acuity category increased if
G. necessary. Triage is a dynamic process; a patient’s condition may improve or deteriorate during the wait for entry to the treatment area.

H. The primary nurse caring for each patient is responsible for reviewing the triage documentation and performing the ED Primary RN assessment with a goal of 15 minutes of the patient’s arrival to the room; if this cannot be done due to other patient care related priorities, the primary nurse must delegate this task to another registered nurse and document accordingly.

I. Full patient assessments should not be done in the triage area; only the information required to assign a triage level should be recorded. A primary survey (rapid assessment A, B, C, D) should be used when there is one or more patients waiting to be triaged. The primary nurse is responsible for completing the remaining assessment.

J. Nurse triage is performed by Registered Nurses who have successfully completed the triage course/orientation offered by the Emergency Department.

REFERENCES

Emergency Nurses Association (1992): Triage: Meeting the Challenge
Admission of Patients to the Emergency Department

Effective. 07/2014

POLICY

The Emergency Department staff will evaluate chief complaint of patient prior to being seen by the Emergency Department Registration Clerk.

All patients will have the appropriate demographic information obtained by an Emergency Department Registration Clerk.

If the patient is taken directly back to the Emergency Department after triage, the Emergency Department Registration Clerk may obtain the information from a relative or from the patient in the Emergency Department.

All Emergency Department patients must sign a “Consent For Treatment in the Emergency Department” form. If the patient is unable to sign, the significant other may sign. If no one available is authorized to sign the consent, document the reason patient is unable to sign. The Emergency Department physician may sign the Emergency Consent form is a medical emergency exists.
Admission Orders  
Effective. 07/2014

POLICY

Admission orders (to include 24 hour observations) will be written per the procedure listed below.

PROCEDURE

• ALL patients admitted to Cochise Regional Hospital (CRH) should be admitted to the onsite doctor.

• Tele-Hospitalist team will oversee the medical care of all patients admitted to the Acute Care Floor, and will also be available for consultation 24/7 upon request.

• The onsite doctor will be responsible for the entire admission process including:
  
  A) H&P AND Admission orders (Tele-Hospitalist can and will assist on a per case basis and upon request).
  
  B) Daily Rounds.
  
  C) Evaluation of an Unexpected or Rapid deterioration of a patient’s condition including but not limited to “Rapid Response” and “Code Blue”.
  
  D) The onsite MD can and should request a Tele-Hospitalist consultation at ANYTIME 24/7 if any concerns arise regarding a patient admitted to Cochise Regional Hospital.
Emergency Treatment of Minors
Effective. 07/2014

POLICY

All attempts will be made to contact the parent or guardian of an unemancipated minor prior to treatment. If unable to obtain permission from parent or guardian, the Child Protective Services or the local law enforcement agency will be contacted to assume responsibility. In the event of a life-threatening condition, treatment will not be delayed; the Emergency Department physician will sign for treatment.

PROCEDURE

Pregnant minors with complaints related to the pregnancy may sign for treatment.

Emancipated minors, minors living away from home and being responsible for payment, may sign for treatment.

Minors presenting with a signed note from parent or guardian giving permission to a named adult, may have the adult sign for treatment.

When phone consent has been obtained for treatment of the minor, arrangements should be made to discharge the minor to an adult.
Patient Rights and Responsibilities

POLICY

COCHISE REGIONAL HOSPITAL and medical staff have adopted the following statement of patient rights. This list shall include but not be limited to the patient’s right to:

• Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.

• Exercise these rights without regard to sex or culture, economic, educational or religious background or the source of payment for care.

• Considerate and respectful care, provided in a safe environment, free from all forms of abuse and harassment.

• Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

• Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.

• Receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

• Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

• Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.

• Formulate advance directives regarding his or her healthcare, and have hospital staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state law and regulations).

• Have a family member or representative of his or her choice notified promptly of his or her admission to the hospital.
• Have his or her personal physician notified promptly of his or her admission to the hospital.

• Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.

• Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the hospital/ His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.

• Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of request).

• Reasonable responses to any reasonable request he/she may make for service.

• Leave the hospital even against the advice of his/her physician.

• Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.

• Be advised of the hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the hospital contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.

• Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

• Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the hospital.

• Examine and receive an explanation of his/her bill regardless of source of payment.
Informed Consent

Effective. 07/2014

POLICY

The patient will be informed of procedures, potential adverse reactions and potential outcomes.

PROCEDURE

The patient shall sign a written consent outlining invasive procedures and/or surgery.

The patient shall have all questions answered by the physician concerning the invasive procedure or surgery.

The patient shall be informed of the name of the physician or practitioner responsible for performing the procedure/surgery.

The patient has the right to refuse any invasive procedure or surgery.
Implied Consent  
Effective. 07/2014

POLICY

The patient that presents to the Emergency Department unconscious and unresponsive shall be deemed to give “Implied Consent”. By the definition of “implied”, the emergency itself will justify emergency care.

PROCEDURE

Physician’s Certificate of Emergency and Necessity form will be completed by treating ER physician and placed in chart.
Physician’s Certificate of Emergency and Necessity

Effective. 07/2014

POLICY

In emergencies, when it is not feasible to obtain consent, good health care shall be given immediately, except in cases of competent refusals. The nature of the emergency, including the significant facts relating to the patient’s condition, shall be recorded in the medical record, by the attending physician or qualified medical person. Full documentation is of prime importance.

PROCEDURE

1. If feasible, consent shall be obtained after emergency care has been given.

2. Any treatment beyond treatment of the emergency condition shall require additional consent.

3. The attending physician or qualified medical person has the discretion to determine that an emergency exists and hence, to act without consent.

4. Physician’s Certificate of Emergency and Necessity shall be completed to document presence of emergent condition (see attached).
ATTACHMENT 1

PHYSICIAN’S CERTIFICATE OF EMERGENCY AND NECESSITY

Patient _________________________ Date ____________ Time ____AM/PM

I am a duly licensed physician. On _______________ (date), I was in attendance on ______________________________________ (name of patient).

Upon examination, I found the patient to be:

________ unconscious

________ incapable of signing

________ a minor

________ other (explain below)

I hereby certify that the patient’s condition was emergent and the treatment rendered was necessary for proper care to the patient before consent could be obtained from the patient or the patient’s legally authorized representative.

Explanation:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Physician

______________________________

Witnesses: ______________________

______________________________
Patient Leaving Against Medical Advice (AMA)
Effective. 07/2014

POLICY

All patients indicating the desire to leave against medical advices shall be documented in the patient’s chart and patient shall sign an AMA form.

PROCEDURE

The Registered Nurse and/or physician shall discuss, with the patient and/or family, the potential complications that may occur if the patient leaves prior to the physician discharging the patient.

The AMA form shall state the possible consequences.

If after explanation of potential consequences, the patient still wishes to leave AMA, request that the patient sign the AMA form and give a copy to the patient.

The Registered Nurse shall instruct the patient to follow up with his/her family physician or return if his/her condition worsens.

Document the patient’s desire to leave AMA, conversations on potential complications and patient’s condition prior to leaving the Emergency Department.

In the event the patient leaves prior to an evaluation by the physician and does not notify any staff member, the Registered Nurse shall document the elopement of the patient in the nursing notes. The chart will be reviewed by the ER Manager or designated staff and follow up as needed or indicated.
Patient Elopement from the Emergency Department

Effective. 07/2014

POLICY

Any person presenting to the Emergency Department that has not been seen by the triage nurse and leaves prior to a medical screening exam is deemed as an elopement.

PROCEDURE

The following will be documented in patient chart:

• Registration face sheet

• If observed, time patient left ER

• Documentation of patient leaving without having medical screening exam and inability to obtain reason
Procedures and Treatment Not to be Performed in the Emergency Department
Effective, 07/2014

POLICY

The following procedures and treatments shall not be performed in the Emergency Department:

• Dilation and curettage
• Chemotherapy/antineoplastic drug administration
• Any procedure requiring general or spinal anesthetic (i.e., endoscopy, colonoscopy, bronchoscopy)

Repair of:
• Open fracture
• Flexor tendons
• Nerves and blood vessels
Emergency Medical Screening Procedures  
Effective. 07/2014

POLICY

All persons presenting to the Emergency Department will receive a medical screening exam.

PROCEDURE

The following procedure is to be followed when any patient presents to the Emergency Room (ER) seeking attention.

1. Patient/family is greeted by Admitting Personnel. If the condition is stable, the admitting personnel will obtain basic demographic information and baseline insurance information after medical screening exam performed. NO PREAUTHORIZATION WILL BE OBTAINED AT THIS TIME! If an emergent condition exists, for example, chest pain, shortness of breath, severe pain, active labor, seizures, etc., the admitting personnel will notify the nurse immediately. Emergency treatment will not be delayed for purposes of obtaining demographic information. Admitting personnel may obtain basic information at the patient’s bedside if the patient’s condition permits or per family member.

2. The ER RN will take the patient into the triage area. If more than one patient has presented to the ER, the RN will triage all patients to determine the order which patients will be seen by the physician, who will perform the Medical Screening Exam. (Please refer to Triage policy which follows.) This triage process will involve taking a brief history of the current complaint, a brief physical assessment, and taking vital signs and allergies. This information will be immediately reported to the physician on duty.

3. The ER physician will perform a Medical Screening Exam on all patients presenting to the ER. Patients will be seen in the order determined by the RN during the triage process. The Medical Screening Exam is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an Emergency Medical Condition (EMC) does or does not exist. Depending upon the patient’s presenting symptoms, the Medical Screening Exam may range from a brief history and physical performed by the physician to excessive ancillary tests and procedures.

4. If the physician determines that an EMC does not exist, the physician may contact the patient’s PCP to discuss treatment options and patient’s disposition. Once the medical screening exam has been performed, the Admitting Personnel can obtain any necessary information from the patient/family, contact the patient’s health plan to request prior authorization for any medically necessary services, and/or collect any fees due for services rendered.
5. If the physician determines that an EMC does exist, the patient will immediately be treated and receive stabilizing treatment for the EMC. After this stabilizing treatment is rendered, the Admitting Personnel may proceed as outlines in #4 above.

6. The patient is discharged from the ER when: 1) the EMC has resolved; b) the EMC is stabilized and further care, including diagnostic work-up and/or treatment, could be reasonably performed on an outpatient basis; c) the patient is admitted to the inpatient facility; or d) the patient is transferred to a high level of care.
Do Not Resuscitate (DNR)
Effective. 07/2014

POLICY

“Do Not Resuscitate” means the patient does not want chest compressions, artificial ventilations or advanced cardiac life support measures. There is a written statement signed by the patient prior to cardiac arrest.

PROCEDURE

The patient may have a medical alert bracelet or necklace which states “Do Not Resuscitate”.

The pre-hospital personnel will bring a copy of the DNR with the patient from the convalescent facility.

If no DNR is available, CPR and ACLS will be initiated until:

• A DNR is found;
• Death is established by the Emergency Department physician;
• Successful resuscitation is reached;
• Arrival of spouse;
• Arrival of the conservator or Durable Power of Attorney for Health Care of the patient.
Release of Information – Patient Privacy
Effective. 07/2014

POLICY

All patients are guaranteed the right to privacy.

PROCEDURE

Patient will be given the opportunity to express whether the area provided meets their privacy expectations, and if not, will be provided with a secluded area.

Information on patient care is limited to only those healthcare professional directly responsible for the patient’s care.

Any outside agency requesting information on a patient’s condition shall be routed to the Medical Records Department following HIPAA regulations.

Information on patient status or condition will NOT be given out over the telephone.
Anatomical Donations  
Effective. 07/2014

POLICY

In compliance with State and Federal laws, JCAHO requirements, and the philosophy of COCHISE REGIONAL HOSPITAL, all families will be presented with the option of organ, tissue, and eye donation for transplantation and/or research at or near the time of patient’s death.

DESIRED OUTCOME

1. Comply with the Uniform Anatomical Gift Act and Organ, Eye, and Tissue Procurement Statute and Medicare Conditions of Participation.

2. Meet the needs of organs and tissues to individuals awaiting transplantation.

3. To support the family through the process of informed consent.

4. Support the humanitarian benefits of transplantation and research.

5. Notification of appropriate agency and obtaining appropriate consents for organs, tissue, and eye donations.

SUPPORTIVE DATA

The State of Arizona and HCFA (Health Care Finance Administration) have enacted Organ Procurement Statutes in an effort to meet the needs of patients awaiting organ and tissue transplants. The statute (A.R.S. 36-849, et seq.) requires each local hospital establish organ procurement for transplant protocol which addresses the notification of an appropriate organ procurement agency and the obtaining of appropriate consent for organ and tissue donation. The Medicare Conditions of Participation (42 CFR Part 482) requires that an agreement with the local organ procurement organization (OPO) be established, that the OPO be contacted by phone on each death, and that the family of each potential donor be given the option to donate (consent/decline).

PROCEDURE

1. COCHISE REGIONAL HOSPITAL has an agreement with Donor Network of Arizona (1-800-447-9477) for organ and eye procurement. In addition, CRH maintains an agreement with RTI Donor Services (1-877-733-3700) to provide the option for tissue recovery. Both agencies are available at all times to assist the staff in this process.

2. At or near the time of death, hospital personnel should make a reasonable effort to find evidence of a person’s consent to donate. Such evidence comes in many forms, including a donor card,
living will, advance directives, power of attorney, or other Document of Gift. The driver's license is not a Document of Gift, but an indicator of the person's wishes.

3. The Donor Network of Arizona (DNA) should be called (1-800-447-9477) with each death that occurs in the facility for the evaluation and determination of the type of donation possible for that patient and concurrently notifies RTI Donor Services. In compliance with standards, DNA should be called with every death, before speaking to the family. The Donor Network of Arizona will provide further instructions about approaching the family. Deaths that should be included are deaths due to impending cardiac cessation or impending brain death.

4. If there is no potential for donation, this is documented on the Arizona Record of Donation of Anatomical Gift form and placed in the chart. RTI Donor Services then evaluates the patient for options regarding tissue donation.

5. If a person has not executed a Document of Gift nor legally refused to make an anatomical gift before his/her death, a trained requestor (defined as either a representative of the OPO or a hospital employee trained by the OPO) will give the next of kin (NOK) the option to consent/decline donation. The hospital as well as the recovery agencies encourages discretion and sensitivity regarding religious/cultural beliefs, and individual families' unique circumstances surrounding the death. However, using discretion does NOT mean that certain families should not be informed of donation options or approached regarding donation.

Approach should be attempted from the following persons in the stated order of priority:

- The person’s designated agent in a health care power of attorney
- The person’s court-appointed guardian
- Person’s spouse unless legally separated
- The person’s adult child
- The person’s parent
- Domestic partner
- The person’s adult brother or sister
- The person’s close friend

Document acceptance of declination on the Arizona Record of Donation of Anatomical Gift.

6. Hospital personnel must determine if the patient is a Medical Examiner’s case, in accordance with A.R.S. 11-593, and report this to Donor Network of Arizona (medical examiner’s cases can be organ and tissue donors). The permission from the Medical Examiner for donation will be obtained by DNA or RTI Coordinator.

7. Site of organ, tissue and eye recovery

- Organ recovery takes place in the sterile operating room environment of the hospital where the donor is located. While patient’s vital signs are maintained with ventilator and appropriate drips.
Eye recovery may take place at the bedside, hospital morgue, medical examiner’s office, or the mortuary.

References:
Donor Network of Arizona (1-800-447-9477)
Title 36, Chapter 7, Article 3 of Arizona Revised Statutes
A.R.S. 11-593
A.R.S. 36-849
43 CFR, Part 482, Subpart C
## Sources and Applications of Donated Tissue for Transplantation

<table>
<thead>
<tr>
<th>DONOR TISSUE</th>
<th>TRANSPLANTED TISSUE</th>
<th>TYPICAL APPLICATIONS</th>
<th>BENEFITS TO RECIPIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EYE TISSUE</strong></td>
<td>Sclera</td>
<td>Repair eyelid, reinforce wall of eye</td>
<td>Prevents blindness, restores vision</td>
</tr>
<tr>
<td>Eye</td>
<td>Cornea</td>
<td>Replace diseased or damaged cornea</td>
<td>Prevents blindness, restores vision</td>
</tr>
<tr>
<td><strong>BONE TISSUE</strong></td>
<td>Whole, proximal, distal, shaft</td>
<td>Reconstruction related to trauma, tumors, degenerative diseases and fractures</td>
<td>Prevents amputation, accelerates, promotes and allows healing</td>
</tr>
<tr>
<td>Humerus</td>
<td>Humeral Head</td>
<td>Total hip revision</td>
<td>Restores mobility</td>
</tr>
<tr>
<td><strong>BONE TISSUE</strong></td>
<td>Whole, Proximal, Distal, Shaft</td>
<td>Reconstruction related to trauma, tumors, degenerative diseases and fractures</td>
<td>Prevents amputation, accelerates, promotes and allows healing</td>
</tr>
<tr>
<td>Femur</td>
<td>Femoral Head</td>
<td>Reconstruction of damaged acetabulum, supplement for small defects</td>
<td>Restores mobility</td>
</tr>
<tr>
<td></td>
<td>Dowel</td>
<td>Cervical spinal fusion</td>
<td>Prevents collapse of bone, reduces pain, reduces chance of nerve damage</td>
</tr>
<tr>
<td></td>
<td>Cancellous Chips</td>
<td>Filling defects, augments prosthetic device implant</td>
<td>Accelerated, promotes and allows healing</td>
</tr>
<tr>
<td>Tibia</td>
<td>Whole, Proximal, Distal, Shaft</td>
<td>Reconstruction related to trauma, tumors, degenerative diseases and fractures</td>
<td>Prevents amputation, accelerates, promotes, and allows healing</td>
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<tr>
<td></td>
<td>Cortical strut</td>
<td>Augments large grafts and prosthetic implants</td>
<td>Restores mobility, promotes healing</td>
</tr>
<tr>
<td>Fibula</td>
<td>Fibular Shaft</td>
<td>Repair of traumatic bone loss</td>
<td>Restores mobility, promotes healing</td>
</tr>
<tr>
<td></td>
<td>Fibular wedge</td>
<td>Cervical spinal fusion</td>
<td>Prevents collapse of bone, reduces pain, reduces chance of nerve damage</td>
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## DONOR NETWORK OF ARIZONA

### THE REFERRAL PROCESS

<table>
<thead>
<tr>
<th>Impending Death or Death</th>
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<tbody>
<tr>
<td>Call to Donor Network of Arizona</td>
<td>1-800-447-9477</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Accepted as donor</td>
<td>Not accepted as donor</td>
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<tr>
<td>Family Approach by trained requester</td>
<td>No need to approach family</td>
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<tr>
<td>Family Documents Consent/Decline</td>
<td>Document DNA’s response on hospital form</td>
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<tr>
<td>Notify DNA of family decision</td>
<td>Place completed form on chart</td>
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<td></td>
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<tr>
<td>If consent: recovery process begins</td>
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Brain Death Guideline
Effective. 07/2014

POLICY

To establish guidelines for determination of patient death when circulatory and respiratory functions are being maintained by artificial means of support. To set criteria with which Donor Network of Arizona will accept brain death documentation from all hospitals within Arizona.

CRITERIA FOR BRAIN DEATH

The determination for brain death remains the clinical judgment of the primary treating physician, or another physician within the hospital that is capable of performing the necessary tests to determine brain death.

A. The following minimal parameters of brain resuscitation must be established:
   1. PaO2>90 for at least 30 minutes
   2. Systolic BP>90 for at least 30 minutes
   3. Negative serum/urine drug and toxic screens (Barb level <5.0g/ml)
   4. Temperature 35.0 degrees C or greater
   5. Rule out causes of reversible coma (hepatic, diabetic, uremic)

B. The clinical neurological examination must reflect the following:
   1. Pupils fixed/dilated
   2. Absent corneal reflexes
   3. Unresponsiveness to intensely painful stimuli
   4. Absent response to upper and lower airway stimulation (i.e., pharyngeal and endotracheal suctioning).
   5. Absent ocular response to vertical and horizontal head turnings (i.e., Doll's eyes).
   6. Absent ocular response to bilateral irrigation of the ears with 50 mls of ice water (Cold Calorics)
   7. Absence of respirations

C. In addition to the clinical exam, an apnea test or adjunctive diagnostic testing must be performed to adequately determine brain death.
   1. Apnea Test Procedure
      a. Place on 100% oxygen and normalize CO2 to >35mmHg
      b. Draw baseline ABG after 20-30 minutes
      c. Place on 100% T-piece (or 6 liters O2 cannula in the end of ET tube
      d. Observe for respiratory efforts
      e. Draw ABG at 5, 8, and 10 minutes, if needed, until the PCO2 reaches 60 or greater.
f. When the patient has no spontaneous respiratory effort after ten minutes, or after three minutes with a PCO2>60; this constitutes failure and the patient may be declared brain dead.

2. In the event that the patient suffered from a cervical spine fracture, an apnea test cannot be performed to determine brain death. Alternatives might include:
   a. Flow study test (Absence of blood flow to brain)
   b. Angiogram (Absence of blood circulation within the brain)
   c. EEG (Flat line)

Documentation of brain death shall include the following entries with regard to brain death determination:
   A. Document the pronouncement of brain death.
   B. Document each diagnostic test performed as part of this procedure.
   C. Time and date of declaration of death.

REMOVAL OF DONOR ORGANS/TISSUES

When the primary physician decides that irreversible neurological death has occurred or is imminent, and the family and Medical Examiner (if necessary) have given their consent, the AOB will make the final arrangements for removal of the donor organs. An organ procurement team may come to the hospital for the donor organ excision in the operating room as soon as possible after all consents have been obtained, or they may arrange for transportation of the donor to Tucson. Brain death must be pronounced by a physician independent from the transplant or procurement team and this must be done before the patient is moved to the operating room. The pronouncement of death must be well documented on the patient’s chart along with the family’s consent to donate and the Medical Examiner’s permission to do so, if necessary.

REMOVAL OF DONOR EYES

When a potential donor of eyes as been identified, the Donor Network of Arizona will be notified. DMA will provide transportation of the eyes to the Tucson eye bank. In most cases, the Medical Examiner will remove the eyes. All materials necessary for this are kept in the Emergency Room and are replaced by the eye bank. Eye tissue should be recovered within sixteen (16) hours after cardiopulmonary arrest.

Following the evaluation by the recovery agency, the nurse will document the patient’s donor status on the Arizona Record of Donation of Anatomical Gift and place in the patient’s medical record.

Documentation necessary: Arizona Record of Donation of Anatomical Gift

References:
• Donor Network of Arizona (1-800-447-9477)
• Title 36, Chapter 7, Article 3 of the Arizona Revised Statutes
• A.R.S. 11-593
DEATH OF A PATIENT CHECKLIST  
Effective. 07/2014

Please note: If we have a patient that is being shipped and is NOT doing well, pending death cases can be called to the Donor Network of Arizona.

1. Notify Donor Network of death and fill out the appropriate form (two fold with carbon page) prior to death and BEFORE consulting family.

2. Donor Network of Arizona will provide you with instructions about approaching the family. IF YOU DO NOT FEEL COMFORTABLE ABOUT THIS, LET DONOR NETWORK KNOW WHILE YOU ARE ON THE PHONE.

3. Find out from the family their preference about choice of mortuary.

4. Nursing staff will notify the mortuary when the family is ready.

5. In the case of doctor or family wanting medical examiner’s exam, then the appropriate police service will be contacted to “red tag” the patient.

6. Nursing staff will fill out the death certificate information sheet, it will be copied and given to the mortuary personnel when they pick up the patient’s remains. PLEASE HAVE THE MORTUARY STAFF SIGN RECEIPT BOOK.

7. We cannot release a body to return to Mexico. A Douglas mortuary must make arrangements with Mexican authorities.
Death of a Patient

Effective. 07/2014

If death is imminent, nursing staff shall refer to the Anatomical Donation policy for direction. In the event that resuscitative measures fail and/or resuscitative measures are withheld and/or withdrawn and the patient expires with no consent regarding organ donation, the time of death will be pronounced by the physician or qualified medical provider and recorded in the medical record. Family members shall be allowed to remain with the body if they so desire as long as is practical/possible.

The family or person legally responsible will be contacted first for the choice of mortuary. The name of the individual contacted and their decision will be documented in the patient’s medical record. The nursing staff will notify the mortuary selected and a member of the family will be instructed to make further arrangements with the mortuary. If no family member or individual responsible for the patient can be contacted within two hours, the nursing staff will designate the mortuary. This arrangement will be in effect for all deaths, including coroner’s cases, indigents, unidentified persons, and those patients who will be interred outside the United States.

In cases of fetal demise, if the fetus has completed the 20th week of gestation, or moves, or weighs 500 grams or more, it is sent to the mortuary properly identified. If not, the fetus is sent to the laboratory unless the physician or family specifically requests that other arrangements be made. A fetal death certificate must be filled out and signed by the attending physician. The “Death Certificate Information” form with identification information form the admission sheet only shall be given to the mortician. The mortician will sign on the nurse’s notes and in duplicate a “Receipt for the Body”. All details will be documented in the patient’s medical record.

Death shall be considered a Coroner’s case if:

1. the death occurred within 24 hours post-admission when not previously attended by a physician.
2. the death is the result of an accident, suicide, poisoning, or any cause in which there is evidence of foul play.
3. any case in which the physician is unable to give the cause of death.

PROCEDURE


2. If the Primary Care Physician is not available or is uncomfortable to sign the Death Certificate, the Emergency Department Physician should call the Medical Examiner to discuss the patient’s death.
3. The Emergency Department Physician may, in consultation with the Medical Examiner, decide to sign the death certificate. If this is the case, the mortuary will be notified. If the Emergency Department Physician’s shift is over at 0800, and the Emergency Department Physician will not be on duty for an extended time frame, the mortuary must be notified of the time restraints of the Emergency Department Physician and every possible effort should be made to have the Death Certificate completed prior to the Physician’s departure.

4. If the Medical Examiner and the Emergency Department Physician determine that the case is a Medical Examiner case, the body will be red tagged by the Sheriff’s department of the Police Department and the body will be picked up by the local mortuary for transportation to the Medical Examiner. All invasive procedures such as IV's, central lines, chest tubes and endotracheal tubes must be left in place for assessment by the Medical Examiner.

5. Do not ask the family about organ donation prior to checking with the organ donor network. There may be a possibility that the body will not be accepted for organ donation. Notify the Organ Donor Network about the death and complete the Arizona Record of Anatomical Gift Form to ensure that the family has been approached regarding their wishes. Written permission or denial must be documented by the next of kin. Be certain to document the name of the Organ Donor personnel who gives the direction whether the donor is an Organ Donor candidate.

6. The Organ Donor Network will refer the case to the tissue donation network. The organ donor network will allow you to release the body to the mortuary before any decision from the tissue network is made.

7. Check with the family to ascertain which mortuary they prefer. If the body is to be a Medical Examiner’s case, notify the family of this decision.

8. The mortuary must sign CRH’s receipt book for the body before taking the body. Please note in the receipt book if any personal belongings are sent with the body to the mortuary (i.e., jewelry, wallet, dentures, etc.) Please note in deceased patient’s medical record if family members took the deceased patient’s belongings home.

9. According to the Arizona Department of Health Services, hospitals must complete a Human Remains Release Form whenever they are to release a deceased person’s remains to a funeral home. A funeral home is not authorized to accept a deceased person’s remains without this form.
ATTACHMENT 1

HUMAN REMAINS RELEASE FORM

FACILITY NAME: ____________________________________________

FACILITY ADDRESS: ________________________________________

RELEASED TO: ____________________________________________

DECEASED PERSON'S NAME: _________________________________

DATE OF BIRTH: ___________________ SOC. SEC. NO: ____________

DATE OF DEATH: ___________________ TIME OF DEATH: ___________

EXPECTED TO SIGN: ___________________ PHYSICIAN OR NURSE PRACTITIONER

MEDICAL:

CERTIFICATE OF DEATH:

NAME: __________________________________ PHONE: __________

PERSON AUTHORIZING RELEASE TO FUNERAL ESTABLISHMENT OR RESPONSIBLE PERSON:

NAME: __________________________________ PHONE N: __________

DECEASED PERSON: __________________________________ RELATIONSHIP TO


IF DECEASED IS A FETUS, PROVIDE INFORMATION BELOW:

NAME OF MOTHER:

DATE OF DELIVERY: ESTIMATED GESTATIONAL AGE: (OR) WEIGHT OF HUMAN REMAINS:

S OF A PEP ON WHO DIES UNDER ANY OF THE FOLLOWING CIRCUMSTANCES AS LISTED IN A.R.S 11-503(A) ARE REQUIRED TO BE REFERRED TO THE Medical Examiner

DID THIS PERSON (OR FETUS): CHECK ALL THAT APPLY:

☐ Die while not under the care of a physician or nurse practitioner for a potentially fatal illness
☐ Die and the attending physician or nurse practitioner is not available to sign the death certificate.
☐ Die because of violence.
☐ Die suddenly when in apparent good health
☐ Die in a prison.
☐ Die while a prisoner.
☐ Die in a suspicious, unusual, or unnatural manner.
☐ Die from a disease or an accident that may be related to the person’s occupation or employment.
☐ Die and may present a public health hazard.
☐ Die during an anesthetic or surgical procedure

WERE THE DECEASED PERSON’S HUMAN REMAINS REFERRED TO THE MEDICAL EXAMINER AS REQUIRED IN A.R.S. 11-593?

YES ☐ NO ☐ N/A ☐ ME ACCEPTED ☐ ME RELEASED

THE MOST RECENT DIAGNOSIS IN THE PERSON’S MEDICAL RECORD IS:

PROVIDE THE FOLLOWING INFORMATION IF THE DECEASED PERSON’S HUMAN REMAINS ARE BEING RELEASED TO (1) A FUNERAL HOME ESTABLISHMENT, OR (2) A PERSON AUTHORIZED UNDER A.R.S. 36-664 TO RETRIEVE THE DECEASED PERSON’S COMMUNICABLE DISEASE RELATED INFORMATION.

INDICATE WHETHER THE DECEASED PERSON (or fetus) HAD BEEN DIAGNOSED WITH OR WAS SUSPECTED OF HAVING ANY OF THE FOLLOWING AS STATED IN THE DECEASED PERSON’S MEDICAL RECORD AT THE TIME OF DEATH (PLEASE CHECK ALL THAT APPLY):

☐ Infectious tuberculosis
☐ Human Immunodeficiency virus
☐ Creutzfelds-Jacob deceased
☐ Hepatitis B
☐ Hepatitis C
☐ Rabies

For a death that occurs in a “hospital” (not require( I for nursing or In-patient hospice facility): if the deceased individual’s human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 38, Chapter 7, Article 3, and the person authorized in A.R.S 38-843 has not made or refused to make an anatomical gift, indicate whether the organ procurement organization has been notified that the deceased individual’s human remains are being removed from the hospital.

Yes ☐ No ☐

PERSON REPRESENTING THE HOSPITAL, NURSING CARE INSTITUTION, OR HOSPICE INPATIENT FACILITY WHO RELEASED THE HUMAN REMAINS

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
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<tr>
<th>Person Accepting Human Remains</th>
<th>Signature</th>
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Medical Examiner’s Cases  
*Effective. 07/2014*

The attending physician or medical practitioner in charge is responsible for notifying the medical examiner in the following:

a. Patient deaths occurring within 24 post-admission hours when not *previously* attended by a physician.

b. Deaths caused by accident, suicide, poisoning, any case in which there is evidence of foul play and any case in which the physician is unable to give the cause of death.

c. Under circumstances affording reasonable grounds to suspect death was caused by the criminal act of another.

d. If in doubt whether Medical Examiner’s case or not, call Medical Examiner’s office in Sierra Vista at (520) 459-1984.

e. If the patient’s PCP is unwilling to sign the death certificate and the ER physician also refuses to sign, the Medical Examiner must be notified.
Dead on Arrival (DOA)
Effective. 07/2014

POLICY

A. The medical examiner must be notified in the event of death on arrival (DOA). The medical examiner is to be called regardless of the community from which the DOA came.

PROCEDURE

1. If the death has occurred inside the Douglas City Limits, the Medical Examiner is notified by the ER personnel; then the City Police are notified to tag the body.

2. If the death has occurred in Cochise County, the Medical Examiner is notified by ER personnel. Then the Cochise County Sheriff’s Department is called.

3. The appropriate authority then advises the hospital where to release the body and if there will be an autopsy.

4. The Charge Nurse is to record on the Emergency Room Record the authorities who were notified and the time they were notified.

5. Obtain all information possible regarding circumstances, time and place of occurrence, etc., record information obtained on the ER record.

6. Minister or Priest should be called as soon as feasible and preferably after consultation with family.

7. Register an ER Admission.

8. Death Certificate shall be filled out and sent to mortuary with remains. Notify mortician if autopsy is pending.

Standard of Practice or Care

Effective. 07/2014

POLICY

Standards of practice or care shall be observed.

PROCEDURE

STANDARD I:

The Registered Nurse performs a comprehensive nursing assessment and develops and implements patient treatment consistent with the objectives of multidisciplinary treatment. The patient and family members are included in patient care planning and planning for discharge.

Important Aspects of Patient Care:

Data collection is systematic and comprehensive. Data is obtained through the following:

• Interview process (patient, family, significant other)
• Patient health history
• Observation
• Physical examination
• Record review
• Diagnostic reports
• Consultation reports

The patient assessment is completed within 15 minutes after admission to the treatment area and includes:

• Chief complaint and present physical and emotional status;
• The presence or absence of pain;
• Focused review of affected systems and medical history, including current medications and chief complaint and allergies;
• Family, social, cultural and predisposing factors, as necessary or pertinent;
• Economical and environmental factors affecting patient's health and equilibrium, as necessary or pertinent;
• Home care options, if relevant;
• Evaluation of patient's educational needs;
• Alcohol and/or drug history in patient or significant family members, if relevant;
• Tetanus and LMP status, if applicable.
The patient is evaluated according to Triage Categories:

Class I – Emergent:
- Airway and breathing difficulties
- Cardiac arrest
- Chest pain/acute Dyspnea/cyanosis
- Uncontrolled seizure status
- Severe head injury/comatose/altered LOC (Level of Consciousness)
- Drug overdose
- Open chest/abdominal wounds
- Severe shock/trauma
- Obvious multiple injuries
- Excessively high temperature: (104 degrees F oral, 105 degrees F rectal)
- Emergency childbirth, complications of pregnancy
- Allergic reactions
- Testicular pain
- Chemical/foreign substance in eye or eye trauma
- Third degree burns (over large area)
- Chest trauma
- Dysrhythmia, irregular pulse with symptoms of lightheadedness
- CVA/TIA
- Bleeding, hemorrhage from a wound, hematemesis/melena/hematochezia/ severe epistaxis, profuse vaginal bleeding

Class II – Urgent:
- Burns
- Obvious fractures (not femur)
- Open wounds (not minor lacerations)
- Back injuries without spinal cord damage
- Persistent nausea, vomiting, diarrhea
- Severe pain
- Temperature: 102 degrees F
- Acute pain status and drug overdose (including alcohol) and apparent or suspected poisoning
- Lacerations
- Abdominal pain – less than 36 hour duration
- Headaches that are different, severe or sudden

Special Classifications for Class II. Patients with the following conditions should be classified at least as Class II (Urgent) no matter how insignificant the complaint because they are a high-risk population:
- Patients with organ transplants
- Patients on renal dialysis
- Patients with cancer
- Patients who are paraplegics or quadriplegics
• Patients who are insulin-dependent diabetics
• Patients with lupus erythematous
• Patients with severe kyphoscoliosis (hunchback)

Class III – Non Urgent:
• Chronic back pain without neuron deficit
• Moderate headache of non-acute onset
• Minor fractures or other injuries of a minor nature
• Medication refills
• Upper respiratory complaint, except SOB
• Minor burns
• Sprains/strains
• Suture removal
• Minor complaints of pain, non-specific
• Minor lacerations, with controlled bleeding

Assessments and supportive data are thoroughly documented, property stored and retrievable in the:
• Emergency Department Nursing Notes
• Laboratory results
• Progress Notes
• History and Physical
• Nursing flow sheets
• Radiology results

Assessments are consistent with the overall treatment plan coordinated by the multidisciplinary team:
• Patient care planning is initiated upon admission.
• Assessment reflects changes in patient’s condition and are appropriately charted and communicated; plan of treatment is changed accordingly.
• Patient’s response to treatment and interventions is reflected in the patient progress notes/ nursing notes.

Assessment and patient needs are communicated to the healthcare provider(s) who are responsible for the care and treatment of the patient:
• Members of the multidisciplinary team
• Shift reports
• Progress/nursing notes

The nursing process is used on an ongoing basis to reflect the patient’s current condition and treatment plan:
• Assessment
• Identification of patient needs and problems
• Delineation of patient expected outcomes
• Selection of related interventions
• Evaluation of patient response to interventions and outcome

Patient assessments are used to identify patient care needs:
• Assessment contributes to determination of patient acuity or classification;
• Staffing assignments are based on patient assessments and needs for treatment;
• The patient and family members are included in the assessment process and ongoing patient care as appropriate.

Discharge assessments completed by the Registered Nurse include:
• Physical, mental and/or emotional status upon discharge or transfer to inpatient unit;
• Patient’s knowledge and understanding of his/her plan of care, instructions, medications and follow-up care;
• Patient’s response to treatment;
• Patient or family’s perception and knowledge of health status upon discharge or transfer after the patient is provided with health education. (See Standard II of this section);
• Identification of self-care abilities, need for assistance and possibly home care service.

Age appropriate care will be delivered, utilizing the pediatric staff when assistance with developmental stages is necessary.

Related Standards of patient care:
• All patients receive initial triage assessment within fifteen (15) minutes of arrival to the Emergency Department based on their chief complaint(s).
• The patient will receive treatment based on the nursing assessment and all members of the multidisciplinary team will coordinate efforts to plan, identify and meet patient outcome goals.
• The patient will receive appropriate nursing care and emergency interventions to meet his/her assessed needs.
• The patient will be continually assessed for changes and progress towards meeting outcome goals and discharge objectives.
• The patient and family members will be encouraged to contribute to the assessment process, and plan activities and treatments to meet discharge objectives.
• All patients are seen, treated and stabilized as appropriate without regard to ability to pay.

STANDARD II:

The nurse provides health education to the patient and family members from admission through discharge. Patient and family education includes basic physiological, psychological and psychosocial factors affecting health.

Important Aspects of Health Care:

Patient care goals include teaching-learning needs of the patient and his/her family regarding basic knowledge of:
• Diagnostic, physical condition, laboratory and other diagnostic studies, etc.
• Therapeutic interventions and other treatment modalities
- Normal/abnormal coping behaviors and emotional responses
- Medications and intravenous therapy used for treatment
- Nutritional considerations and any potential food-drug incompatibilities
- Self-care responsibilities, in the hospital and at home
- Adaptive behaviors or conditions affecting recuperation
- Physical limitations during recuperation
- Activities and healthcare goals to promote wellness
- Appropriate referrals to community and other resources are used in meeting these educational goals.
- Patient’s home environment is addressed and referred to Social Services, as appropriate.
- Instructions will be given, if possible, in the primary language of the patient or to a reliable/responsible caretaker for the individual.

Related Standards of Patient Care:

- The patient will receive education to promote understanding of his/her diagnostic conditions.
- As appropriate, the patient’s family members will receive education on the patient’s condition, interventions appropriate for therapy, and relationship and communication within the family structure which may improve patient recovery.
- The patient will receive discharge instructions or referral to community resources to supplement educational goals, ongoing treatment or home healthcare.

STANDARD III:

Nursing interventions identified in multidisciplinary patient treatment are delivered by skillful and competent providers of care, who utilize current standards of practice.

Important Aspects of Patient Care:

Nursing interventions are based on identified needs or problems as determined from the patient assessment and initiated within 15 minutes after admission to the treatment area:

- Evaluation of self-care potential is considered;
- Emergency multidisciplinary protocols for management of care are the basis for interventions;
- Procedures applicable to patient care needs are current;
- Nursing interventions are consistent with collaborative multidisciplinary treatment goals.

Physiological, psychological and psychosocial factors are assessed and evaluated to determine interventions and therapeutic goals:

- Physical examination includes identification of conditions which affect the patient and his/her care.

Psychological assessment may include:

- Current emotional state of awareness, stress self-concept, anxiety, aggression, loss, grief or anger.
- Alterations in thinking, perceiving, communicating and decision making
- Impaired ability to relate to others
• Indicators of potential for self-harm or harm to others
• Influence of alcohol or drugs
• Physical assessment includes a complete review of systems, family history, alcohol usage, substance abuse, previous hospitalization, surgery and other relevant data pertaining to chief complaint/diagnosis.
• Multidisciplinary interventions are individualized.

Nursing interventions are carried out by competent healthcare providers:

Personnel engaged in clinical practice undergo a credentialing process, which documents individual competency to practice:
• Nursing interventions are provided by personnel who have received education, training and evaluation of their ability to implement interventions specific to emergency nursing practice;
• Personnel administering medications and intravenous therapy will have the skills and knowledge of indicators, side effects, contraindication, and related documentation;
• Registered Nurses supervise and are accountable for the healthcare delivery of all non-Registered Nurse personnel assigned to work with them.

Nursing interventions are identified in the patient's record and are based on established standards of practice:
• Emergency Department Record
• Nursing evaluation
• Protocols, guidelines and procedures for practice
• Reflect individualized needs of the patient
• May include community resources
• Are consistent with multidisciplinary team

Fundamental Emergency Department nursing interventions include, but are not limited to the following:

• Vital signs every 30 minutes on Class I patients, unless ordered more frequently
• Vital signs every 2 hours on Class II patients, unless ordered more frequently
• Vital signs on admission on PRN on Category III patients, unless ordered more frequently

Vital signs will be repeated if not within normal limits, as follows:
• Temp” 96 degrees – 101 degrees F
• BP: 100/60 – 140/90mm/Hg
• Pulse: 60-100 bpm
• RR: 12-23/min
  o Postural vital signs will be done on all patients with potential hypovolemia or dehydration
  o Vital signs will be repeated after administration of medications with potential side effects
  o IV hydration or IV access, if needed
  o Shock prevention
  o Resuscitation
- Stabilization
- Basic comfort measures
- Timely administration if medications
- Respiratory therapy as needed
- Pain management
- Close evaluation
- Prevention or stabilization of hemorrhage
- Infection Control
- Trauma support

Patient response to medical and nursing interventions is evaluated, documented and pertinent findings communicated to the appropriate healthcare provider:

- The patient’s care is evaluated and based on a current assessment including laboratory data and radiologic studies;
- The patient’s response to therapy, medications, treatments, diagnostic procedures, etc., are evaluated and documented;
- Healthcare providers (physicians, social workers, respiratory therapists, etc.) are kept abreast of changing patient status or adverse outcome, as appropriate.

Nursing interventions are consistent with discharge planning objectives:

- Discharge planning begins upon admission;
- Discharge planning includes the patient and significant others;
- Discharge planning includes evaluation for admission to inpatient services or transfer to an appropriate facility;
- Discharge planning may include social work, private referral and community support services.

Nursing interventions are consistent with structure, planning, process and outcome standards set by Nursing Services:

- Policy manuals are kept current and available for easy reference;
- Process (protocols, procedures, guidelines) standards are kept current and available for easy reference;
- Outcome standards are monitored and evaluated to determine if nursing interventions are effective in patient care.

Related Standards of patient care:

- The patient will receive age appropriate care by competent providers, consistent with diagnostic condition, assessment and treatment goals.
- The patient will receive treatment or therapy which is current, age appropriate and meets the standards of practice for the community.
- The patient’s treatment and interventions are individualized, evaluated and updated on an ongoing basis.
• The patient and family will be included in the planning of the patient's care and interventions whenever possible.
• The patient and/or family will receive verbal and written instructions regarding aftercare, follow-up and/or referral.

STANDARD IV:

Nursing care is provided in a safe and therapeutic environment.

Important Aspects of patient care:
• Unsafe environmental conditions are surveyed and measures are initiated to correct them.
• Safety concerns are addressed with the patient and family members.
• Standard Precautions are used as the basis for all patient care delivery.

Related Standards of patient care:
• The patient will be properly oriented to his/her environment.
• The patient will be evaluated for any potential items of harm.
• The patient will be provided with adequate staff supervision to ensure safety and therapeutic results.
• The patient’s environment will be structured or altered to be consistent with the patient’s treatment plan.
• The patient will receive safe administration of medications and treatments prescribed.
• The patient will be provided with adequate staff supervision to ensure safety and therapeutic results.

STANDARD V:

The nurse serves as a patient advocate, preserving the basic rights of the patient for independence of expression and decision with regard to healthcare and personal dignity, within compliance to ethical standards set forth by the hospital.

Important Aspects of patient care:
• The nurse supports the patient’s bill of rights.
• The nurse collaborates with the patient and communicates the patient’s concerns and goals or needs to other members of the multidisciplinary team.
• The nurse counsels or provides counsel (chaplain, etc.) for the patient and family members whenever necessary.
• The nurse informs the patient or family of their rights and responsibilities in cases where they leave (AMA) from the Emergency Department before an assessment is made or treatment is complete.
• The nurse extends courtesy and privacy at all times.
• The nurse ensures confidentiality and adheres to the privacy act.
• The nurse demonstrates awareness of and compliance with current federal, state and local laws governing the delivery of care to the emergency patient.
• The nurse provides an opportunity for the patient to have all questions or concerns regarding the patient’s healthcare plan answered.
• The nurse provides an opportunity for the patient to express advance directives regarding resuscitation and organ donation.

Related Standards of patient care:

• The patient will be entitled to privacy, confidentiality and freedom of expression.
• The patient and family will be informed of his/her bill of rights and methodology for registering complaints.
• The patient will be provided an environment to meet individual needs, rights and therapeutic goals.

STANDARD VI:

Nursing practice is reviewed and evaluated in a systematic manner to validate compliance to standards. Nursing staff are all levels will engage in the continuous quality improvement process.

Important Aspects of Performance Improvement Activity:

• Ongoing Performance Improvement (PI) in nursing practice is comprehensive in scope and implementation. Performance improvement activities determine compliance to standards (structure, process and outcome). JCAHO’s Ten Step Process is used for monitoring and evaluation (M&E) activities.

Nursing practice standards related to important aspects of care associated with high-volume, high-risk conditions are monitored and evaluated. An annual calendar outlines indicators of monitoring and evaluation activities related to:

• Structure Standards (policy)
• Process Standards (protocols, procedures, guidelines, position descriptions)
• Outcome Standards (patient discharge goals, morbidity, risk management, case management, patient satisfaction, volume indicators)
• Focused reviews of specific problems identified from monitoring and evaluation activities

Staffing standards are monitored and evaluated to determine if they are consistent with current workloads (patient care) and technologic requirements:

• Patient acuity classification
• Staffing requirements for specific populations
• Staffing allocation/assignments

Methodologies for monitoring and evaluating nursing practice may include:

• Concurrent chart reviews when the patient is still in the hospital;
• Retrospective chart reviews and telephone interviews when the patient has already been discharged;
• Collection of data for identification of volume indicators;
• Focused reviews to closely monitor specific problems.

Nursing participates in collaborative meetings with multidisciplinary staff to plan, evaluate and discuss results of CQI activities:

• The Emergency Department Clinical Leader meets with the Nursing Performance Improvement Coordinator and participates in Critical Care and Emergency Committee meetings;
• Action plans may be coordinated with multidisciplinary input and participation;
• Actions for improvement or problem resolution are reported to the Nurse Executive, Emergency Department and ICU Medical/Nursing staff and Special Care Committee;
• The Nurse Executive meets monthly with the Medical Executive and Performance Improvement Committees of the hospital to present and discuss nursing monitoring and evaluation activities.

Nursing practice issues and monitoring and evaluation activities needing improvement are identified and communicated to personnel:

• Clinical Leaders communicate issues and problems with staff in monthly staff meetings or via written communication (memos, etc.);
• Inservice education programs are provided for staff whenever knowledge deficit is identified from monitoring and evaluation activities;
• Performance improvement education is addressed at monthly staff meetings.

Nursing practice deficiencies and opportunities for improvement are reported, recorded, trended and re-evaluated after corrective intervention:

• Performance improvement monitoring and evaluation activity reports are completed for each indicator;
• Department clinical leaders document results and action plans;
• Monthly Performance Improvement reports are given by the nurse managers at the Nursing Performance Improvement meeting. These reports are then presented by the Nursing Performance Improvement Coordinator at the monthly Medical Staff Performance Improvement meetings;
• Trends are identified for evaluation of improvement at all levels;
• Monitors are repeated for re-evaluation to document improvement or verify adherence to standards.

Related Standards of patient care:

• The patient will receive quality patient care verified through monitoring and evaluation of the important aspects of patient care.
• The patient will be asked to report any problems related to his/her care to any member of the staff for evaluation and action.

STANDARD VII:

Provisions for staff development and education are available for all levels of nursing personnel.

Important Aspects of Professional Staff Development:

• Professional staff is continually evaluated for competence to practice. Sub-specialty training to care for various populations is provided to personnel who deliver care (i.e., emergency, disaster, hazardous materials, etc.)
• Skill verification packets are completed on all levels of staff and are annually updated to confirm and document personnel competency to practice.
• Opportunities for in-service education and continuing education are provided for all nursing personnel, especially related to problems identified in monitoring and evaluation activities.
• Annual courses for recertification in BLS, ACLS, PALS, fire safety and infection control or other specialty-specific courses are provided or opportunities for attendance elsewhere are considered.
• Individualized training opportunities exist for personnel requiring special instruction.

Emergency Department Policies and Procedures

• Credentialing records of personnel and continuing education are current.

Related Standards of patient care:

• The patient will receive care from competent staff who maintains current education and training requirements.
Assessment of the Emergency Department Patient

Effective. 07/2014

PURPOSE

Establish assessment criteria for all Emergency Department patients.

POLICY

All patients presenting to the Emergency Department will be triaged and categorized as either Emergent, Urgent or Non-Urgent.

All patients admitted to the Emergency Department will have the following documentation:

- Chief complaint
- Subjective data
- Objective data
- Assessment of psychological status
- Initial vital signs
  - Additional vital signs shall be obtained depending on patient’s condition
  - Critical patients every 5-15 minutes, as needed
  - Intermediate every 1 hour
  - All other patients every 2 hours or prior to discharge
- Allergies and medications
- Medical history
- Response to medication
- Condition prior to discharge
- Tetanus status
- Patient education

In addition, the pediatric patient shall have the following information documented:

- Weight and height
  - If less than one year:
    - Birth weight
    - Head circumference, or as per hospital and medical staff criteria
    - Activity for age
    - Inoculations
    - Behavior or LOC
    - Referrals to pediatrician or specialist
Assessment of the Trauma Patient
Effective. 07/2014

POLICY

The trauma patient shall be assessed and treated according to Emergency Nursing Association/Trauma Nurse Care Course criteria.

PROCEDURE

Use the ENA/TNCC criteria to assist the nurse with the complete initial assessment of a trauma patient.

A systematic process or initial assessment of the trauma patient is essential for recognizing life-threatening conditions, identifying injuries, and for determining priorities of care based on assessment findings. The initial assessment is divided into two phases, primary and secondary assessments. Both phases can be completed within several minutes unless resuscitative measures are required. Within an organized team approach to trauma care, this first step of the nursing process (assessment) is often simultaneously conducted with the identification of nursing diagnoses that require immediate intervention. Utilizing an organized, systematic approach when assessing each trauma patient also helps to ensure that injuries will not be missed and that priorities can be set for each intervention based on the life-threatening potential of each injury.

Adherence to “Standard Precautions” (precautions for care of all patients in hospitals) and “Transmission-Based Precautions” for care of patients who are known or suspected of being infected or colonized by certain pathogens transmitted by contact with skin, airborne, or droplet are indicated for use by the trauma team. The term “Standard Precautions” encompasses “Universal Precautions” used to protect against transmission of pathogens from moist body surfaces. Use of lead aprons by the trauma team during radiologic procedures is necessary and can often be initiated prior to the patient’s arrival.

Initial assessment provides the nurse with subjective and objective data that are analyzed, interpreted, and documented. During this initial encounter with the patient, initiate the health care team’s protocol for informing family members of the patient’s arrival and condition.

A GUIDE TO INITIAL ASSESSMENT

The following mnemonic may assist nurses during the initial assessment of a trauma patient:

- Primary Assessment
  - A – Airway with simultaneous cervical spine stabilization and/or immobilization
  - B – Breathing
  - C – Circulation
  - D – Disability (neurologic status)

- Secondary Assessment
  - E – Expose/environmental control (remove clothing and keep patient warm)
o F – Full set of vital signs/five interventions (electrocardiographic monitor, pulse oximeter, urinary catheter, gastric tube, and laboratory studies) facilitate family presence
o G – Give comfort measures (verbal reassurance, touch)
ô H – History and Head-to-toe assessment
ô I – Inspect posterior surfaces

PRIMARY ASSESSMENT AND RESUSCITATION

Airway, with simultaneous cervical spine stabilization and/or immobilization, breathing, circulation, and disability (neurologic status) are the A-B-C-Ds of the primary assessment. Remove only those clothes necessary to expose the patient in order to conduct the primary assessment. If any life-threatening compromises or injuries are determined, implement interventions to correct them immediately. Additional assessment steps are not taken until measures to ensure an adequate airway, effective breathing, and effective circulation have been instituted.

In the presence of potentially life-threatening injuries, begin assessment immediately on the patient’s arrival to collect objective assessment information. The extent and timing of obtaining information related to both the injury event and the patient’s past medical history depend on the severity of the patient’s condition. Subjective information from pre-hospital personnel, family, or the patient at this point of the assessment process is limited to a brief statement composed of the patient’s major injuries or chief complaints and the mechanism of injury. A more detailed history is obtained during the secondary assessment.

AIRWAY

Assessment
Inspect the patient’s airway while maintaining cervical spine stabilization and/or immobilization. Since partial or total airway obstruction may threaten the patency of the upper airway, observe for the following:
• Vocalization
• Tongue obstructing airway in an unresponsive patient
• Loose teeth or foreign objects
• Bleeding
• Vomitus or other secretions

INTERVENTIONS

Airway Patent

• Maintain cervical spine stabilization and/or immobilization.
• Any patient whose mechanism of injury, symptoms or physical findings suggest a spinal injury should be stabilized or remain immobilized.
• If the patient is awake and breathing, he or she may have assumed a position that maximizes the ability to breathe. Before proceeding with cervical spine stabilization, be sure interventions do NOT compromise the patient’s breathing status.
Airway Totally Obstructed or Partially Obstructed

- Position the patient in a supine position. If the patient is not already supine, logroll the patient onto his or her back while maintaining cervical spine stabilization. Remove any head gear, if necessary, to allow access to the airway and cervical spine; removal of such gear should be done carefully and gently to prevent any manipulation of the spine.
- Stabilize the cervical spine.
  - If the patient has not been stabilized, manually stabilize the head. Stabilization includes holding the head in a neutral position.
  - If the patient is already in a rigid cervical collar and strapped to a backboard, do NOT remove any devices. Check that the devices are placed appropriately.
- Complete spinal immobilization with a backboard and straps should be done at the completion of the secondary assessment, depending on the degree of resuscitation required and the availability of team members.
- Open and clear the airway.
  - Techniques to open or clear an obstructed airway during the primary assessment include:
    - Jaw thrust
    - Chin lift
    - Removal of loose objects or foreign debris
    - Suctioning
  - Maintain the cervical spine in a neutral position. Do not hyperextend, flex, or rotate the neck during these maneuvers.
  - Suctioning and other manipulation of the oropharynx must be done gently to prevent stimulation of the gag reflex and subsequent vomiting and/or aspiration.

- Insert an oropharyngeal or nasopharyngeal airway. Consider endotracheal intubation (oral or nasal route). Ventilate the patient with a bag-valve-mask device prior to endotracheal intubation. For patients requiring control of the airway with an endotracheal tube, the decision must be made to use the oral versus the nasal route.
- Oral endotracheal intubation is done with the patient’s cervical spine in a neutral position and without any extension or flexion of the cervical spine. This requires a second person to hold the patient’s head in this position.
- Blind nasotracheal intubation is NOT indicated when the patient is apneic or when there are signs of major midface fractures (e.g., maxillary fractures (LeFort II or III). Basilar skull fractures or fractures of the frontal sinus or cribriform plate are considered relative contraindications.
- The use of neuromuscular blocking agents alone or in combination with other drugs administered before intubation is usually dictated by institutional protocols.
- Consider needle or surgical cricothyroidotomy. Ventilate the patient with a bag-valve-mask device prior to these procedures. In rare circumstances, the patient’s condition may restrict passage of an endotracheal tube. To establish an airway, a needle cricothyroidotomy may be performed with an over-the-needle catheter placed into the trachea through the cricothyroid membrane. Another method is a surgical cricothyroidotomy. An incision is made in the cricothyroid membrane, and a tube is placed into the trachea. Both of these approaches to a cricothyroidotomy should be performed by skilled physicians. In some settings, advanced life support (ALS) personnel (e.g., flight nurses or advanced practice nurses) may also be trained and qualified to perform cricothyroidotomies.
If there are any life-threatening compromises in airway status, stop and intervene to correct the problem before proceeding to breathing assessment. Examples of life-threatening airway conditions are partial or complete obstruction of the airway from foreign bodies or debris (blood, mucus, vomitus) and/or obstruction by the tongue. Penetrating wounds may cause disruption of the integrity of the airway, and blunt trauma may lead to injury of the larynx and/or other upper airway structures.

**Breathing**

**ASSESSMENT**

Life-threatening compromises may occur with a history of any of the following:

- Blunt or penetrating injuries of the thorax
- Patient striking the steering column or wheel
- Acceleration, deceleration, or a combination of both types of forces (e.g., motor vehicle crashes, falls, crash injuries)
  
  Once the patency of the airway is assured, assess for the following:

- Spontaneous breathing
- Chest rise and fall (depth and symmetry)
- Skin color
- General respiratory rate
  - Normal
  - Slow
  - Fast
- Pattern of breathing
  - Regular
  - Irregular
  - Cheyne Stokes
- Integrity of the soft tissue and bony structures of the chest wall
- Use of accessory and/or abdominal muscles
- Bilateral breath sounds
  - Auscultate the lungs bilaterally at the second intercostal space midclavicular line and at the fifth intercostals space at the exterior axillary line.
- Jugular veins and position of trachea

**INTERVENTIONS**

**Breathing Present: Effective**

Administer oxygen via a *nonbreather mask* at a flow rate sufficient to keep the reservoir bag inflated; during inspiration, usually requires a flow rate of at least 12 liters/minute and may require 15 liters/minute or more.
Breathing Present: Ineffective
When spontaneous breathing is present but ineffective, the following may indicate a life-threatening condition related to breathing:

- Altered mental status (i.e., restless, agitated)
- Cyanosis, especially around the mouth
- Asymmetrical expansion of the chest wall
- Use of accessory and/or abdominal muscles
- Sucking chest wounds
- Paradoxical movement of chest wall during inspiration and expiration
- Tracheal shift from the midline position. To inspect and palpate the anterior neck region (i.e., jugular veins and trachea), remove the anterior portion of the cervical collar. Another team member must hold the patient’s head while the collar is being removed and replaced.
- Distended external jugular veins
- Absent or diminished breath sounds
- Auscultate breath sounds to determine if present, diminished, or absent
- Administer oxygen via a nonbreather mask or assist ventilations with a bag-valve-mask device, as indicated
- Assist with endotracheal intubation as previously described.

Breathing Absent
- Ventilate the patient via a bag-valve-mask device with an attached oxygen reservoir system
- Assist with endotracheal intubation; ventilate with oxygen via a bag-valve-mask device attached to an oxygen reservoir system

If there are any life-threatening injuries that compromise breathing, stop and intervene before proceeding to circulation assessment. Examples of life-threatening injuries that may compromise breathing are tension pneumothorax, open pneumothorax, flail chest with pulmonary contusion, and hemothorax. These conditions may require simultaneous assessment and immediate intervention (e.g., needle thoracentesis or covering an open chest wound).

Circulation

ASSESSMENT

- Palpate a central pulse (e.g., femoral or carotid) initially if there is any question as to whether the patient has adequate circulation
- Palpate the pulse for quality (i.e., normal, weak, or strong); and rate (i.e., normal, slow, or fast)
- Inspect and palpate the skin for color, temperature, and degree of diaphoresis
- Inspect for any obvious signs of external bleeding
- Auscultate blood pressure
- If there are other members of the trauma team available, auscultate the blood pressure. If not, proceed with the primary assessment and auscultate the blood pressure at the beginning of the secondary assessment.
INTERVENTIONS

Circulation: Effective
If the circulation is effective, proceed with assessment and intervene according to interventions for ineffective circulation, as indicated.

Circulation Present: Ineffective
Although the pulse is present, other signs may indicate inadequacy of the circulation such as:

- Tachycardia
- Altered level of consciousness or mental status (e.g., agitated, confused, decreased arousability)
- Uncontrolled external bleeding
- Distended or abnormally flattened external jugular veins
- Pale, cool, diaphoretic skin
- Distant heart sounds

Circulation: Effective or Ineffective
• Control any uncontrolled external bleeding by:
  o Applying direct pressure over the bleeding site
  o Elevate the bleeding extremity
  o Applying pressure over arterial pressure points
  o The use of a tourniquet is rarely indicated; however, if the above interventions do not control the bleeding and operative bleeding control is not readily available, a tourniquet may be the last resort.
• Cannulate two veins with large bore 14- or 16-gauge catheters, and initiate infusions of lactated Ringer’s solution or normal saline
  o Use warmed solutions
  o Use plastic bags to facilitate pressurized infusion
  o Use “Y” tubing for possible administration of blood
  o Use rapid infusion device, as indicated
  o Use normal saline (0.9%) in intravenous tubing through which blood is administered
  o Venous cannulation may require a surgical cutdown and/or central venipuncture
  o Consider use of a pneumatic antishock garment (PASG) for intra-abdominal and/or pelvic bleeding with hypotension
  o Obtain a blood sample for typing to determine the ABO and Rh group
  o Administer blood, as prescribed.

Circulation: Absent
If a patient does not have a pulse, cardiopulmonary resuscitation (CPR) is indicated. However, it is possible to have electrocardiographic activity even when the pulse and blood pressure cannot be auscultated. The term electromechanical dissociation (EMD) refers to one example of pulseless electrical activity (PEA), whereby the patient has no pulse but has narrow complexes indicating depolarization of the myocardium with no mechanical contraction. Pseudo-EMD, a newer term, described a patient who has no blood pressure by auscultation, but may have some degree of myocardial muscle contraction, albeit too weak to generate a blood pressure. If there is no palpable carotid pulse:
• Initiate cardiopulmonary resuscitation (CPR)
• Initiate advanced life support measures
• Administer blood, as prescribed
• Prepare for and assist with an emergency thoracotomy, as indicated, in the emergency department or resuscitation area; open thoracotomies should only be done in facilities with the resources to manage post-thoracotomy patients.
• Prepare patient for definitive operative care after thoracotomy, if indicated.

If there are any life-threatening conditions compromising circulation, stop and intervene before proceeding to the neurologic assessment. Examples of life-threatening conditions that may compromise circulation are uncontrolled external bleeding, shock because of hemorrhage or massive burns, pericardial tamponade, or direct cardiac injury.

Disability – Brief Neurologic Assessment

ASSESSMENT

After the primary assessment of airway, breathing and circulation, conduct a brief neurologic assessment to determine the degree of disability (D) as measured by the patient’s level of consciousness.

• Determine the patient’s level of consciousness by assessing the patient’s response to verbal and/or painful stimuli using the AVPU mnemonic as follows:
  o A – Speak to patient. The patient who is alert and responsive is considered A for Alert.
  o V – The patient who responds to verbal stimuli is considered V for Verbal.
  o P – Apply a painful stimulus. The patient who does not respond to verbal stimuli, but does respond to a painful stimulus is considered P for Pain.
  o U – The patient who does not respond to painful stimulus is considered U for Unresponsive.

• Assess pupils for size, shape, equality, and reactivity to light.

Interventions

• If the disability assessment indicated a decreased level of consciousness, conduct further investigation during the secondary focused assessments.
• If the patient is not alert or verbal, continue to monitor for any compromise to airway, breathing, or circulation.
• If the patient demonstrates signs of herniation or neurologic deterioration (e.g., unilateral or bilateral [papillary] dilation, asymmetric papillary reactivity, or motor posturing) consider hyperventilation.

SECONDARY ASSESSMENT

After each component of the A-B-C-D of the primary assessment has been addressed and life-saving interventions initiated, start the secondary assessment. This assessment is a brief, systematic process to identify ALL injuries. Exposure/environmental control (E) is necessary to assess the patient adequately. It may be necessary to cut away clothing in certain circumstances. Timing of the removal of clothing will depend on the number of trauma team members available.
Once clothing has been removed, it is important to prevent heat loss by using overhead warmers, warming blankets, and warmed intravenous fluids. The F of the assessment mnemonic stands for full set of vital signs/five interventions/facilitate family presence.

Prior to initiating the head-to-toe assessment to identify other injuries, obtain a full set of vital signs, including blood pressure, pulse rate, respiratory rate, and temperature. If chest trauma is suspected, auscultate the blood pressure in both arms.

After completing the A-B-C-D-E of the assessment, intervening for life-threatening conditions, and obtaining a complete set of vital signs (F), critical decision-making will determine whether to continue with the secondary assessment or to perform additional interventions. The availability of other trauma members to perform these five interventions will influence the decision. If the patient sustained significant trauma and required life-saving interventions during the primary assessment, perform the following interventions before proceeding with the secondary assessment:

• Assign another trauma team member to attach leads and monitor the patient’s cardiac rate and rhythm.
• Assign another trauma team member to attach a pulse oximeter, if available, to monitor the patient’s arterial oxygen saturation (SpO2). The normal SpO2 is greater than 95%, meaning hemoglobin is 95% saturated with oxygen. SpO2 readings may not be accurate if the patient has inconsistent blood flow, vasoconstriction, or altered hemoglobins such as carboxy-hemoglobin. Even if the patient has only a slight change in SpO2 readings, the change in arterial partial pressure of oxygen (PaO2) is significant, especially of the PaO2 changes between 100 and 60 mm Hg. The percent of hemoglobin saturated with oxygen has a relationship to the partial pressure of oxygen as demonstrated by the oxygen-hemoglobin dissociation curve. The curve plateaus when PaO2 levels are high but the SpO2 will not significantly change at these higher ranges especially the hemoglobin is 100% saturated; however, at lower ranges of PaO2 where the curve is more sigmoidal-shaped; the changes in SpO2 are extremely significant. For example, a 100mm Hg drop in PaO2 form 90 to 80 represents only a drop in SpO2 from 96.5% to 94.5%. However, if the PaO2 drops from 50 mm Hg to 40, the drop in SpO2 is from 83.5% to 75%. The clinical significance is that patients who have pulse oximetry readings above 90% could have varying levels of PaO2, and, therefore, pulse oximetry alone should not be used to predict PaO2. Oxygen saturation measurements can also be calculated from an arterial blood sample (SaO2).
• Insert an indwelling catheter to monitor urinary output. Suspected injury to the urethra is a contraindication to catheterization through the urethra. Indications of a possible urethral injury are:
  o Blood at the urethral meatus
  o Palpation of a displaced prostate gland during a rectal examination
  o Blood in the scrotum
  o Suspicion of an anterior pelvic fracture
• Insert a gastric tube. In the presence of severe facial fractures, insert the gastric tube through the patient’s mouth. Gastric decompression and emptying of gastric contents will reduce the risk of aspiration, reduce the risk of respiratory compromise, reduce the risk of vagal stimulation and bradycardia, and prepare the patient for possible operative intervention. Test gastric contents for blood. The tube must be passed carefully while:
  o Maintaining cervical spine stabilization and/or immobilization
o Minimizing the stimulation of the patient’s gag reflex
o Having suction equipment available
  • Facilitate laboratory studies
o Blood typing the highest priority. Depending on the severity of the patient’s condition, blood typing studies may also include screening and crossmatching.
  o Frequently ordered studies are blood typing, hematocrit (Hct), hemoglobin (hgb), blood urea nitrogen (BUN), creatinine, blood alcohol, toxicology screen, arterial partial pressure of oxygen (PaO2), arterial partial pressure of carbon dioxide (PaCO2), pH, base deficit, lactate, electrolytes, glucose and clotting profile (platelets, prothrombin time (PT), partial thromboplastin time (PTT), and beta human chorionic gonadotropin or urine test for pregnancy.

The F of the mnemonic also represents family presence. Facilitate the presence of the family in the treatment area and their involvement in the patient’s care.

• Assess the family’s desires and needs
• Facilitate and support the family’s involvement in the care
• Assign a health care professional to provide explanations about procedures and to be with the family in the emergency department
• Utilize resources to support the family’s emotional and spiritual needs, such as a social worker or chaplain.

The G of the mnemonic is a reminder to the trauma team to give comfort measures. Such measures may include, but are not limited to, consideration of pain management (e.g., pharmacologic analgesia); alternative pain control such as touch, positioning, distraction, relaxation techniques; and general comfort measures such as verbal reassurance, stimuli reduction, listening to the patient, and developing a trusting nurse/patient relationship.

History
The H of the mnemonic stands for history which can be obtained from the following:
• Pre-hospital information. Obtain information from pre-hospital personnel as indicated by the circumstances of the injury event. The mnemonic MIVT – which stands for Mechanism of injury, Injuries sustained, Vital signs, and Treatment – can be used as a guide to obtaining pre-hospital information.
  o Mechanism and pattern of injury. Knowledge of the mechanism of injury and specific injury patterns (e.g., type of motor vehicle impact) will help to predict certain injuries. If the patient was transported by pre-hospital personnel, have them describe the pertinent on-scene information to the trauma team. Such information includes the location of the patient on their arrival, length of time since the injury event, and extent of extrication or reasons for extended on-scene time.
  o Injuries suspected. Ask pre-hospital personnel to describe the patient’s general condition, level of consciousness, and apparent injuries.
  o Vital signs
  o Treatment initiated and patient responses
  • Patient-generated information. If the patient is responsive, ask questions in order to evaluate the patient’s level of consciousness and for the patient to describe discomforts or other complaints. Elicit patient’s description of pain (i.e., location, duration, intensity, and character). If domestic
• violence is suspected, ask appropriate questions while providing comfort and a sense of security. Talking to the patient provides reassurance and emotional support and provides the patient with information regarding upcoming procedures.
• Past medical history. Gather information from the patient or family regarding:
  o Age
  o Pre-existing medical conditions
  o Current medications
  o Allergies
  o Tetanus immunization history
  o Previous hospitalizations and surgeries
  o Recent use of drugs and alcohol
  o Smoking history
  o Last menstrual period.

**Head-To-Toe Assessment**
The H stands for head-to-toe assessment. Information from this assessment is collected primarily through inspection, auscultation, and palpation. In specific circumstances, percussion may be indicated. The patient may focus on the more obvious distracting injury and have a decreased response to other injuries. While systematically moving from the patient’s head to the lower extremities and the posterior surface, complete the assessment as described on the following pages.

**General Appearance**
Note the patient’s body position, posture, and any guarding or self-protection movements. Observe for stiffness, rigidity, or flaccidity of muscles. Characteristic positions of limbs (flexion or extension), trunk, or head may indicate specific injuries. Note and document any unusual odors such as alcohol, gasoline, chemicals, vomitus, urine, or feces.

**Head and Face**
• Soft tissue injuries
  o Inspect for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, *ecchymosis*, and edema
  o Palpate for cracking association with subcutaneous emphysema
  o Palpate for areas of tenderness
• Bony deformities
  o Inspect for exposed bone
  o Inspect for loose teeth or other material in the mouth that may compromise the airway
  o Inspect and palpate for depressions, angulation, or areas or tenderness
  o Inspect and palpate for facial fractures resulting in loss maxillary and/or mandibular or structural integrity
• Observe for asymmetry of facial expressions. Also inspect the area for any exposed tissue that may indicate disruption of the central nervous system (CNS) (i.e., CNS tissue from open wounds).
• Eyes
  o Determine gross visual acuity by asking the patient to identify how many of your fingers you are holding up
Inspect for periorbital ecchymosis (*raccoon’s eyes*), subconjunctival hemorrhage, and/or edema. Determine whether the patient is wearing contact lenses.

- Assess pupils for size, shape, equality, and reactivity to light
- Assess eye muscles by asking the patient to follow your moving finger in six directions to determine *extraocular eye movements* (EOMs)

**Ears**
- Inspect for ecchymosis behind the ear (*Battle’s sign*)
- Inspect for skin avulsion
- Inspect for unusual drainage, such as blood or clear fluid from the external ear canal. Do **NOT** pack the ear to stop drainage as it may be cerebrospinal fluid (CFS).

**Nose**
- Inspect for unusual drainage, such as blood or clear fluid. Do **NOT** pack the nose to stop clear fluid drainage as it may be CSF. If CSF or drainage is present, notify the physician and do not insert a gastric tube through the nose.
- Inspect position of nasal septum.

**Neck**
- Inspect for signs of penetrating or surface trauma, including presence of impaled objects, ecchymosis, edema, or any open wounds
- Observe position of trachea and appearance of external jugular veins
- Palpate trachea to determine position (i.e., midline, deviated)
- Palpate neck area for signs of subcutaneous emphysema and/or areas of tenderness.

**Chest**
- **Inspection**
  - Observe breathing for rate, depth, degree of effort required, use of accessory and/or abdominal muscles, and any paradoxical chest wall movement
  - Inspect the anterior and lateral chest walls, including the axillae for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema, and scars
  - Inspect the expansion of the chest and excursion during ventilation
  - Observe for expressions or reactions that may indicate the presence of pain (e.g., facial grimace).
- **Auscultation**
  - Auscultate lungs for breath sounds and note presence of any adventitious sounds, such as wheezes, rales or rhonchi
  - Auscultate heart sounds for presence of murmurs, friction rubs, and/or muffled sounds.
- **Palpation**
  - Palpate for signs of subcutaneous emphysema
  - Palpate the clavicles, sternum, and the ribs for bony *crepitus* or deformities (e.g., step-off, areas of tenderness).

**Abdomen/Flanks**
- **Inspection**
  - Inspect for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema, and scars
  - Observe for evisceration, distension, and scars
- **Auscultation**
Auscultate for presence or absence of bowel sounds. Auscultate before palpating because palpation may change the frequency of bowel sounds.

- **Palpation**
  - Gently palpate all four quadrants for rigidity, guarding, masses, and areas of tenderness; begin palpating in an area where a patient has not complained of pain or where there is no obvious injury.

**Pelvis/Perineum**
- Inspect for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema, and scars
- **Bony deformities**
  - Inspect for exposed bone
  - Palpate for instability and tenderness over the iliac crests and the symphysis pubis
- Inspect for blood at the urethral meatus (more common in males than females because of length of urethra), vagina, and rectum
- **Altered neurologic function**
  - Inspect penis for *priapism* (persistent abnormal erection)
  - Palpate anal sphincter for presence or absence of tone
- Ensure that an appropriate trauma team member has performed a rectal examination to determine if there is any displacement of the prostate gland in males (this may also be done in the posterior assessment)
- Note pain and/or the urge, but inability, to void

**Extremities**
- Inspect previously applied splints and do **NOT** remove if applied appropriately and if neurovascular function is intact
- **Circulation**
  - Inspect color
  - Palpate skin temperature
  - Palpate pulses. In lower extremities, palpate femoral, popliteal, dorsalis pedis; in upper extremities, palpate the brachial and radial pulses.
- **Soft tissue injuries**
  - Inspect for bleeding
  - Inspect for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema, angulations, deformity, and any open wounds

- **Bony injuries**
  - Inspect for angulation, deformity, open wounds with evidence of protruding bone fragments, edema, and ecchymosis
  - Note bony crepitus
  - Palpate for deformity and areas of tenderness

- **Motor function**
  - Inspect for spontaneous movement of extremities
o Determine motor strength and range of motion in all four extremities; use range of motion (ROM)/muscle strength scale 0-5.
   5 = complete ROM or active movement against gravity and full resistance
   4 = complete ROM or active movement against gravity and some resistance
   3 = complete ROM or active movement against gravity
   2 = complete ROM or active body part movement with gravity eliminated
   1 = barely detectable contraction
   0 = no detectable contraction
\[ [image: undefined] \]

• Sensation
  o Determine patient’s ability to sense touch in all four extremities.

**Inspect Posterior Surfaces**

The I of the mnemonic stands for inspection of the patient’s posterior surfaces.

• Maintain cervical spine stabilization.
• Support extremities with suspected injuries.
• Logroll patient with the assistance of members of the trauma team. This maneuver keeps the vertebral column in alignment during the turning process. Do not logroll the patient onto his or her side with an injured extremity. Logroll away from you (if possible) to inspect the back, flanks, buttocks, and posterior thighs for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema, or scars.
• Palpate the vertebral column including the costovertebral angles (CVA) for deformity and areas of tenderness.
• Palpate all posterior surfaces for deformity and areas of tenderness.

**FOCUSED SURVEY**

After the primary and secondary assessments and any simultaneous interventions are completed, a more detailed, focused assessment will be necessary for each area or system injured. This will further direct the priorities of care.

Frequently ordered radiographic studies are of the chest, pelvis, and cervical spine (C-1 through T-01 must be visualized). Follow cervical spine clearance procedures as indicated by individual hospital protocols. These radiographic studies may be performed during any phase of the primary or secondary assessment, depending on the patient’s condition and the availability of resources.

**PAIN MANAGEMENT**

The patient’s perception of pain may originate from a number of sources because of injury (e.g., the actual injury, procedures, the environment). Trauma patients will have their pain managed per the nursing policy – Pain Management.
Emergency Room Psychiatric Assessment- Psychiatric Emergency

Effective. 07/2014

POLICY

The psychiatric patient shall be assessed.

DEFINITION

Psychiatric emergency is a sudden serious disturbance of behavior, affect or thought which makes the patient unable to cope with his life situation or interpersonal relationships.

A. Manifestations
   1. Overactive
      a. Disturbed, uncooperative
      b. Anxiety and panic-like status
      c. Assaultive and destructive impulses or behavior
   2. Underactive
      a. Depression
      b. Fearfulness
      c. Slowing of responses
      d. Sad facial expression

B. Emergency Management
   1. Overactive
      a. History – illness, injury, alcoholic or drug use
      b. Control behavior
         1. Calm approach
         2. Show interest
         3. Explain, be truthful
      c. Sedate as ordered
      d. Restrain as last resort
      e. Admit or refer for outpatient therapy
   2. Underactive
      a. Listen
      b. Use antidepressants with anti-anxiety agents
      c. Determine, if possible, thoughts or attempts at suicide
      d. Notify relatives about a depressed patient
   3. Suicidal
      a. Treat the emergency caused by suicidal attempt
         i. Airway
         ii. Shock
b. Prevent further self-injury

c. Admit

If patient is not a direct threat to themselves or others and insists on going home, be sure there is a competent family group to clearly assume responsibility. Let patient go with proper notation on chart, including the advice to consult psychiatrist or family mental health clinic.

Medical – legal procedure call for notifying police that you have treated a possible suicide. If you decide to notify police, tell the patient that you are going to inform the authorities. This sometimes deters the patient from leaving.

In Arizona, it is not necessary to notify police regarding suicide attempts.

PROCEDURE

Patients may be referred for a Tele-Psychiatry consultation.

Patient must be referred to a Behavioral Health Service for Psychiatric evaluation and follow-up.

If patient is deemed to be suicidal or harmful to self or others, Cenpatico Crisis Counselor should come to the ER for a psychiatric evaluation. The C.I.A. counselors will determine whether the patient is safe to go home.
Suicide Precautions/Constant Precautions/Attempted Suicide

Effective. 07/2014

POLICY

To prevent injury to patient by maximizing environmental safety.

PROCEDURE

This procedure is instituted by the RN. The LPN and NA may monitor and observe the patient.

SUPPORTIVE DATA

Suicide Precautions are ordered for patients who have either harmed themselves, verbalized intent to do so, or indicated, in an overt or covert manner, a wish to do so. If the nurse is concerned about the patient’s potential for suicide, institute Suicide Precautions then contact the patient’s physician for an order and a psychiatric consult. If a psychiatric consult is ordered, it should be completed the same day as the request. The evaluator will evaluate the patient for suicide potential and may recommend Suicide Precautions or Constant Precautions. If this procedure is implemented, then the Self Harm Behavior protocol must also be implemented.

Constant Precautions are ordered for patients who suicide potential appears extremely high (any patient who has just made an attempt or who is believed to be planning an attempt).

The nurse will institute Constant Precautions following a suicide attempt or gesture regardless of the severity.

If the RN believes the gesture to be a self-mutilating or self-injurious behavior, Constant Precautions may not be appropriate. In this case, the patient’s physician should be notified immediately and asked to evaluate and/or recommend the appropriate level of observation.

Patients who are at increased risk of suicide are those who:

• Are experiencing severe anxiety or agitation
• Are depressed and/or psychotic
• Have a history of previous suicide attempt
• Are experiencing intense feelings of hopelessness or abandonment
• Have sleep disturbance
• Are actively abusing alcohol or substances
• Verbally express suicidal thoughts
• Have a family history of suicide
• Have a suicide plan, with the intent and means to carry out the plan
• Have sustained a recent loss (including death of a loved one, divorce, separation, loss of a job, or financial loss)
• Say goodbye with finality (e.g., tell staff “I won’t be here when you return”)
• Are unwilling to make a no-harm/no-suicide contract with staff (i.e., patient is not willing to inform staff if he feels like harming himself).

Times of increased risk of a patient attempting suicide are: change of shift, early morning hours, night time, weekends, holidays, after visitors leave, after phone calls, after disturbing/depressing news, either shortly after admission, and near or at discharge from hospital.

SUICIDE PRECAUTION STEPS:

1. Place the patient in a room which affords the best observation and protection. (If possible, move the patient to a private room close to the nurses’ station.)

2. Search the patient’s belongings, clothing, luggage and packages at the time precautions are instituted. Tell the patient of your concern for safety and the reason for the search. Remove all medications and other items considered unsafe, including glass or sharp items, nail polish remover or other alcohol-containing solutions, matches or lighter, and any aerosol spray cans (i.e., hairspray). Similar items belonging to the patient’s roommate must also be removed. (The patient may be allowed to keep eyeglasses, non-breakable toiletry items, or a cordless electric razor. Patient’s belongings not in daily use should be sent home or to the Motel Unit. Document disposition of belongings on the Valuables/Belongings Inventory and place this in patient’s chart.)

3. Monitor items brought onto the unit by visitors. Remove any item considered unsafe (as above) and return it to the visitor when they leave the unit. (Check all bags and packages upon entry to the unit. This pertains to only those items brought to the patient who is on precautions or to the patient’s roommate).

4. Supervise patient when he/she is using sharp/glass articles, toxic solutions, aerosol sprays, lighter or razor. (Neither the patient nor his roommate may keep these articles in the room. These items must be secured at the nurses’ station.)

5. Restrict patients on Suicide Precautions to the unit unless it’s absolutely necessary to leave the unit for testing or procedures that cannot be delayed. (Maintain a minimum staff ratio of 1 to 1 when off the unit.)

6. Stay with the patient while he/she is taking prescribed medication to make sure he/she swallows the medication. (Check to see that patient has swallowed medication. If you have reason to believe the patient may be “checking” the medication, ask the patient to open his mouth, stick out his tongue, and to touch his tongue to the roof of his mouth while you check for “checked” medication.

7. Assess the patient’s physical/emotional condition and suicide potential every 8 hours. NOTE: The patient’s attending physician must document the patient’s suicide potential in the Progress Notes of the patient’s medical record, at least every 24 hours. (Refer to Self Harm Behavior protocol. Ask the patient if he is having thoughts of suicide. If yes, ask him if he has a
plan as to how he would do it and ask him to share that plan with you. Ask if he can agree to tell a staff member if he is thinking of harming himself, rather than acting on it. Place on “Constant Precautions if patient is unable or unwilling to agree to this. NOTE: The patient’s willingness to contract in this way does not mean the patient can be trusted not to attempt suicide. An unwillingness to make such an agreement may indicate the patient is at risk of suicide.

8. Make a visual observation of the patient every 15 minutes throughout all shifts and document. Observe for any potentially unsafe behavior. (Stagger the 15 minute checks so that they are not made at predictable times. Checks may not exceed 15 minute intervals. Observation frequency and supervision of the patient may be intensified at the discretion of the charge nurse. Notify the physician of intensified observations.)

CONSTANT PRECAUTION STEPS:

FOLLOW STEPS 1 THROUGH 7 AS ABOVE.

9. Keep the patient within sight and within reach at all times. (Patients are observed at all times, which include: bathroom and bathing times, procedures, tests off the unit, and when visitors are present.)

10. Instruct Dietary Department to use disposable products on trays including plastic flatware. No cans or glassware are permitted. (Count flatware before and after use. If anything is found missing from the tray, the patient an immediate surroundings must be searched until lost item is accounted for.)

11. Obtain sitter if need exists for supplemental personnel. Have sitter read these procedures and verbalize to the charge nurse his understanding of the meaning and requirements of Constant Precautions.

12. Obtain a physician’s order to take the patient off the unit if the patient wishes to smoke. (The physician must write an order allowing the patient to be escorted by staff to the courtyard to smoke. When off the unit, maintain a minimum staff ratio of 1 to 1.)

13. Make every attempt to verbally convince the patient to stay if the patient tries to leave the unit or hospital without physician authorization. (Contact Police immediately if assistance is needed to prevent patient from leaving. If the patient leaves without authorization, immediately do the following:
   • Call Police with a description of the patient and instructions to return patient to the unit
   • Search for the patient and attempt to verbally convince the patient to return to the unit
   • Notify the patient’s physician
   • Notify Nursing Supervisor
OBTAINING SITTER FOR SUICIDAL PATIENT IN CONSTANT PRECAUTIONS:

1. Notify the covering House Supervisor that a sitter is needed. (Constant Precautions observations are provided by hospital staff. When the nursing staff cannot provide sufficient hours of care, the charge nurse notifies the covering House Supervisor to call in needed staff. If the patient has not yet been admitted, the admitting unit is responsible for completing the request form. The assigned sitter should be made aware of why the patient requires constant supervision, have read this procedure, and they must verbalize their understanding of these responsibilities to the charge nurse.

ATTEMPTED SUICIDE:

1. Initiate “Constant Precautions” (see above). (Remain with the patient while calling for assistance via emergency call light. Provide any emergency care, as situation requires. Initiate constant 1:1 supervision assuring patient safety.)

2. Notify the patient’s physician, the covering nursing supervisor, Risk Management. (The covering nursing supervisor will notify the hospital director on call.)

3. Document incident in the patient’s chart and complete an incident report.

DOCUMENTATION:

Document every 15 minute checks of the patient. This should include the specific location (patient room, nursing station, etc.) and the behavior of the patient. Document RN assessment of physical/emotional condition and suicide potential of patient in the Progress Notes or Patient Care Record. Document attempted suicide in Progress Notes.

REFERENCES:

PRACTICE

Cooperative Services do not admit patients for the purpose of involuntary psychiatric evaluation.

PROCEDURE

Such persons are referred to a designated psychiatric referral agency. This agency has been designated as the screening agency for involuntary psychiatric evaluations in Cochise County. Staff from the agency will arrange to evaluate the patient and will arrange for hospitalization if indicated.

Evaluation resources are available on a 24 hour basis. The appropriate person can be contacted in accordance with the information below.

Patients who are admitted to this hospital for care and treatment of an emotional illness or a medical condition related to an emotional illness or a medical condition in accordance with the general admitting policies of this hospital.

PSYCHIATRIC RESOURCES

Evaluations and Consultation (be telephone)

Cenpatico 1-866-495-6735
Patient Awaiting Psychiatric Evaluation
Effective. 07/2014

POLICY

Once the Emergency Department physician has evaluated the patient and has determined the need for a psychiatric evaluation, the following criteria shall be assessed and documented.

PROCEDURE

All medical complaints shall be stabilized.

Patient must be medically cleared prior to transfer to appropriate facility. ETOH, drug of abuse screen and medically necessary labs will be drawn prior to calling SEABHS counselor.

If the patient is a danger to self, staff or others, remove potentially dangerous items from the room.

Call the SEABHS Counselor.

Maintain patient safety. Utilize restraints only if patient is a danger to self, staff or others (refer to Restraint policy).

Call local law enforcement agency if there is a potential danger to patient, staff or others.

Assessment and documentation shall include:

• Patient history
• Patient complaint
• Medications and allergies
• Observation of signs and symptoms of mental, emotional, behavioral or suspected substance abuse
• Vital signs
• Documentation of potential danger to self, staff or others
• Ongoing assessment of patient and vital signs of patient has been given any sedatives, etc.
Ongoing monitoring of patient’s vital signs.
Management of a Patient Under the Influence of Drugs
Effective. 07/2014

POLICY

The patient arriving at the Emergency Department under the influence of drugs will receive a drug work-up.

PROCEDURE

• Obtain IV access;
• Draw blood to screen for alcohol and other drugs;
• Monitor airway and give respiratory support, as necessary;
• Administer intravenous Narcan either as bolus, intramuscular or continuous intravenous infusion drip;
• Assume other mixed drug intoxications;
• Monitor heart rate on cardiac monitor;
• Monitor vital signs;
• Monitor LOC.

GENERAL INFORMATION

For any toxic drug ingestion, emesis should NOT be initiated if:

• The patient is comatose, convulsive or without a gag reflex;
• The patient has ingested a strong acid or base;
• The patient has ingested a petroleum distillate.
• Gastric lavage is used if the patient is comatose or has an absent gag reflex, use a cuffed endotracheal tube.
• Lavage with an Ewald tube with the patient in the left lateral decubitus Trendelenburg position. Use a tidal wash volume of 300 cc in adults and 10 cc/kg in children.

Documentation shall include but is not limited to:

• Initial assessment
• Initial vital signs
• Initial LOC with changes
• Response to treatments and medications
Legal Alcohol Testing  
**Effective. 07/2014**

Drawing blood for legal Alcohol Testing is a courtesy service of the hospital to local law enforcement agencies. Hospital staff is required to obtain patient consents and law enforcement request on the forms provided in the forms drawer in the emergency room. These forms may be copies from the Arizona Consent Manual if not available anywhere else. After the blood is drawn in the manner prescribed on the kit provided by the law enforcement officer, the forms will be forwarded to the laboratory for record-keeping and will remain there for three (3) years.

A lot has been placed in the laboratory for documentation of all legal alcohol tests drawn and must be completed including name of individual from whom blood is drawn, name of officer requesting blood and name of tech or nurse or doctor who draws specimen. An indication that consent/request forms were completed and sent to lab and any comments should also be entered.

**GENERAL GUIDELINES**

Hospitals are under no obligation to take blood samples at the request of law enforcement officers. The statute which permits chemical tests for Blood Alcohol, A.R.S. 28-691, also provides “if person under arrest refuses to submit to a chemical test designated by the law enforcement agency…none shall be given.” Legislation in Arizona grants physicians, hospital and their employees immunity from all liability other than for gross negligence arising out of obtaining blood samples pursuant to a police officer’s request.

Although hospitals are not required to draw blood for testing purposes, hospitals are required to provide on request by law enforcement officers portions of any blood samples which might be reasonable cause to believe have violated the drunk driving laws. This is true regardless of whether the patient consents to have blood samples taken for testing purposes.

Hospital personnel may, at the request of law enforcement officers or of a patient, withdraw or make available blood samples from a patient for purposes of alcohol testing when the following conditions are met:

a. One, the patient consents, or two, blood is taken for a purpose other than testing for alcohol. A portion of blood taken in the hospital for other than blood alcohol testing purposes must be provided upon the written request of an officer certifying probable concern.

b. Doctor’s orders

c. The officer’s written request

When the sample is taken at the request of an officer, the officer should sign the special request form (following pages) provided by the hospital to confirm that the applicable legal requirements are met.
TEST BY POLICE PERSONNEL

When law enforcement personnel undertake themselves to secure a blood sample or to administer a breath test to a patient, hospital personnel should not obstruct such officers in their performance of their duties. In such cases the legal responsibility to respect the rights of the patient will rest with the officers. In some instances the police officers may be unable or unwilling to communicate with the patient’s physician to determine whether their proposed contact with the patient is medically contraindicated. Although the officers should not be obstructed, hospital personnel should not hesitate to inform the officers of those situations where the doctor has ordered that no visitors be permitted or where it appears that the patient is in such distress that contact with the officers might jeopardize his health. Police officers ordinarily will want such information so that they may avoid detriment to the patient. When hospital personnel have advised law enforcement officers against disturbing the patient, this fact should be noted on the patient’s chart.

TEST BY HOSPITAL PERSONNEL

Hospital personnel may, at the request of law enforcement officers or of a patient, withdraw blood samples from a patient when the following conditions are met:

1. **The Patient Consents**
   Under the law, the patient has the absolute right to refuse any sort of alcohol test. The patient should therefore be required to sign the special consent form provided by the hospital so that his consent will be a matter of record. (Sample attached)

2. **Doctor’s Order**
   The order or approval of the attending physician, if any, should be obtained and noted on the patient’s record.

3. **The Officer’s Written Request Should be Obtained**
   When the sample is taken at the request of an officer, the officer should be required to sign the special request form provided by the hospital to confirm that the applicable legal requirements are met. (Sample attached)
BLOOD OR BODILY FLUID SAMPLE REQUEST
BY LAW ENFORCEMENT OFFICER

Patient________________________________ Date____________ Time________am/pm

I, the undersigned, being a duly authorized law enforcement officer of________________________
________________________(law enforcement agency) hereby state:

Check one:

☐ That I have arrested the above-named patient for DUI or an offense involving the operation of a vehicle while under the influence of intoxicating liquor or drugs.

☐ The above-named patient is not under arrest, but I have probable cause to believe that he or she has violated A.R.S. § 28-692.

I request the personnel of _________________(provider) to proceed as follows: Check ALL applicable:

☐ That a physician, registered nurse or technician obtains a blood sample from the above-named patient (see attached consent form).

OR

☐ That if provider personnel refuse to take a sample, the provider personnel allow law enforcement personnel to take a sample.

AND (IF APPLICABLE)

☐ I have informed this patient that his or her license or permit to drive will be suspected or denied if he refuses to submit to the test I have designated. This patient has consented to such test (see attached consent form) or is unable to consent or to refuse for the following reason:

________________________________________________________________________

________________________________________________________________________

Date: ______________ Signature (of law enforcement officer)

__________________________

Time: _______ Badge or Serial #___________ Law enforcement report #

__________________________

Witness: ____________________ Witness: ____________________
CONSENT TO A TEST FOR BLOOD, URINE OR OTHER BODILY SUBSTANCES

Patient: ______________________________ Date: ___________ Time: ______________________________ am/pm

MARK PARAGRAPH THAT APPLIES

☐ (Use if patient is arrested for violation of A.R.S. § 28-692 (DUI).

The undersigned hereby consents to the taking from him/her of a sample of blood, urine or other bodily substance to be used for law enforcement purposes. I specifically authorize the provider, its agents, and employees to cooperate, permit, and participate in the taking of the same and agree that neither the provider, its agents, nor employees will incur any civil liability arising from the taking of the sample. I also authorize the provider to release a copy of the consent form and the sample to the law enforcement officer named below or any other designated officer. I understand I have the right to refuse to submit to the test but that such refusal will result in the suspension of my driving privileges. I am not afflicted with hemophilia and I am not using an anticoagulant.

OR

☐ (Use if patient is not under arrest for violation of A.R.S. § 28-692 (DUI) or is arrested for any offense other than DUI).

The undersigned hereby consents to the taking from him/her of sample of blood, urine or other bodily substance to be used for law enforcement purposes. I specifically authorize the provider, its agents, and employees to cooperate, permit, and participate in the taking of the sample and agree that neither the provider, its agents, nor employees will incur any civil liability arising from the taking of the sample. I also authorize the provider to release a copy of the consent form and the same to the law enforcement officer named below or any other designated officer. I am not afflicted with hemophilia and I am not using an anticoagulant.

Date: ______________________________

Time: ______________________________

Signature of patient

Signature of law enforcement officer

Badge or serial no. ___________ Law Enforcement Report No. ___________

Witness: __________________________________________

Witness: __________________________________________
Waived Testing Requirements  
*Effective. 07/2014*

**POLICY**

It is the policy of COCHISE REGIONAL HOSPITAL to instruct and train appropriately licensed personnel to perform specified types of clinical laboratory specimen testing at the point of care rendered (or at the patient’s bedside). This type of testing will be referred to as Waived Testing and is understood to be performed by those individuals who have the clinical expertise and licensure to perform, interpret and take appropriate action on waived tests.

**REQUIREMENTS**

Any test required for inclusion in the Waived Testing Index (list of those tests that may be performed at the point where care is rendered) must be approved by the medical staff and Clinical Laboratory and must meet FDA and CLIA requirements for Waived Testing.

Any individual performing approved tests listed on the Waived Testing Index must meet the following requirements:

- Level of licensure required by the State Board of Nursing
- Level of licensure required by the State Department of Health Services
- Successful completion of instruction and training course on specific test for which the individual will perform Waived Testing
- Successful completion of competency evaluation on specific test for which the individual will perform Waived Testing.

Competency evaluation will always consist of:

- Written evaluation of theory
- Direct observation of test performance by a qualified proctor
- Direct observation of quality control methodology (QC = equipment calibration, outdating, troubleshooting, etc.)

Competency evaluation, in addition to the above, may consist of:

- Blind (unknown source) test performance and resulting
- Simulation of test performance with training equipment/materials for Waived Testing performed infrequently
• Demonstrate, via documented written evaluation and/or verbal assessment by supervisor, familiarity of the COCHISE REGIONAL HOSPITAL’s policies, procedures, scope of services and patient population needs

Pursuant to the patient care unit’s scope of services, licensure, expertise and training of clinical staff and frequency of Waived Testing procedures, the unit manager will determine the frequency of competency evaluation for any Waived Testing procedures performed on that unit.

Any test listed on the Waived Testing Index will be specifically detailed in written policy and procedure format:

• The policy and procedure will indicate the extent to which the test results are to be used in the care of the patient, noting whether the result is of screening value only or if the result is to be deemed definitive for diagnosis and treatment.

• The policy and procedure will indicate whether the nurse is to provide treatment/intervention based on the test result, and pursuant to a physician’s order, or in accordance with an approved COCHISE REGIONAL HOSPITAL protocol.

• The policy and procedure will indicate documentation requirements in the medical record.
Bedside Glucose Monitoring
Effective: 06/2014

PURPOSE

To provide consistent procedure for performing and monitoring hospital bedside testing of patients whole blood glucose.

POLICY

Qualified persons may perform point of care bedside glucose testing with the Blood Glucose Testing System. Patient’s results are to be recorded in the nursing clinical notes under the blood glucose field in the Empower EHR.

PROTOCOL

All personnel must be qualified as operators by a certified trainer before performing patient blood glucose monitoring at the bedside and bi-annually thereafter. A list of current certified operators will be maintained by Nursing Administration and the Laboratory.

Quality controls are performed every 24 hours during the night shift. Quality control log is kept on the front clear lid of the glucometer case. Weekly downloading of data is performed on each Precision Xceed Pro Blood Glucose Testing Unit (download of data to be performed every Tuesday in the morning). Each certified operator will be trained to perform blood glucose testing according to the approved Infection Control Policy and Procedures in place at the Hospital.

Whole blood glucose monitoring measurements above 400 MG/DL or below 50 MG/DL are outside the measuring range of the Precision Xceed Pro System and should be repeated by the clinical laboratory. Critical whole blood glucose concentrations are defined, and all measurements outside clinical ranges are confirmed with testing performed by the clinical laboratory.

EQUIPMENT

| Precision Xceed Pro Glucose Testing System | Precision Xceed Pro Glucose Test Strips |
| Med dispense lancing device or equivalent control solutions | Precision Xceed Pro, low and high |
| Capillary tubes and bulb | Soap and water (or alcohol wipe) |
| Precision Xceed Pro Operator’s Manual |
PROCEDURE

Obtaining a Capillary Blood Sample Procedure:
1. Choose the lateral surface of the ring finger as a site for the capillary puncture. Other fingers may be used; however, the surface chosen should be free of callous, hematoma, burns or scar tissue.
2. Disinfect the chosen area with an alcohol swab. Soap and water may be used to disinfect the area if multiple punctures are needed to prevent the drying and cracking of the skin layer.
3. The puncture site may be allowed to air dry or a sterile gauze pad may be used.
4. Remove the circular top of the supplied lancets to expose the needle. Do not touch the needle end.
5. Using the needle end of the lancet, puncture the disinfected area of the finger. The puncture should provide a drop of blood at the site without squeezing the finger excessively.
6. Wipe the first drop of blood with a sterile gauze pad to remove any leftover alcohol or cleansing agent and any tissue fluid.
7. The finger may be gently “milked” by gently squeezing down the finger towards the puncture site until a hanging drop of blood is obtained. Avoid aggressive squeezing of the finger.

Glucose Monitor Procedure:
1. Press ON/OFF to turn on the monitor.
2. Press “1” to select PATIENT TEST.
3. Manually enter the OPERATOR ID via the keypad, and then press ENTER.
4. Manually enter the PATIENT ID via the keypad, and then press ENTER.
5. Press SCAN to scan the test strip bar code and press ENTER.
6. Open the foil strip packet at the notch and tear up or down to remove the test strip.
7. With the contact bars facing up, insert the test strip into the test strip port until it stops.
8. Apply a drop of blood directly from the patient’s finger (as obtained by the above procedure) to the target area on the test strip.
9. The monitor beeps when the sample is accepted and the SAMPLE ACCEPTED screen appears. If the test fails to start, a second drop of blood may be applied to the target area within 30 seconds of the first blood drop. If the test fails to start after the second drop is applied or if more than 30 seconds have passed, discard the test strip and repeat the test.
10. Wait for the monitor to analyze the sample and display the test result.
11. Test results are displayed on the monitor screen after 20-30 seconds.
12. Remove the test strip from the monitor when finished testing.
13. The operator then has the choice of performing a new test, or repeating the previous test or recalling the patient’s history.
14. Document glucose monitor results in the nursing clinical notes under the blood glucose field in the Empower EHR.
Blood Transfusion
Effective: 06/2014

POLICY

It is the policy of Cochise Regional Hospital to administer blood in a safe and effective manner.

PROCEDURE

A physician’s order is necessary to administer blood or blood products. An order to cross-match does not constitute an order to transfuse blood products. An informed consent shall be obtained prior to the administration of blood or blood product which include: Whole Blood, Packed Red Blood Cells, Fresh Frozen Plasma, Platelets, Cryoprecipitate, White Blood Cells, Albumin, and Factor 8. A refusal of consent for transfusion of blood or blood products shall be obtained on all refusals for transfusion of blood or blood products.

An RN shall not sign out blood products for more than one (1) patient at a time. An RN shall not sign out more than one (1) blood product per patient at a time. (Exception will be made for surgery or emergency patients when two (2) units are to be transfused simultaneously).

In the event that cross-matched blood is no longer needed, it shall be the responsibility of the nursing staff to notify the laboratory so that the blood may be released for use in other individuals. In the event of a life-threatening emergency, the laboratory may release blood on a patient that is not using it to meet the requirements of the emergency situation. All blood will automatically be released 48 hours after it is cross-matched. Do not remove blood product from lab until IV is established, patient consent obtained, and assessment completed.

Assessment should be documented in the Empower system and shall focus on the following:

A) Baseline vital signs; circulatory and respiratory status, skin status (e.g., rash),
B) Doctor’s orders for type, amount, and rate of blood administration,
C) Size of IV catheter or need for catheter insertion,
D) History of blood transfusions and reactions, if any,
E) Religious or other personal objections to client’s receipt of blood.

Equipment Needed

Blood transfusion tubing (blood Y set with in-line filter),
250 to 500 ml bag/bottle normal saline,
Blood administration/Transfusion record
Non-sterile gloves
Biohazard bag (to return blood container to lab),
IV start supplies
Packed cells or other blood product.
Implementation

Wash hands and organize equipment to reduce microorganism and transfer and promote efficiency. Explain procedure to client, particularly the need for frequent vital sign checks, to decrease client anxiety.

Prepare tubing:

- Open tubing package and close drip regulator (which may be clamp, roller, or screw); prepare for infusion of saline before and after transfusion.
- Remove tab from normal saline bag/bottle and insert tubing spike.
- Remove cap from end of tubing, open saline line regulator, prime dip chamber with saline, and flush tubing to end. Prevents air entering tubing and clears air from tubing.
- Close fluid regulator.
- Replace cap on tubing end and place on bed near IV catheter to retain sterility. (If infusing blood rapidly, connect to warming equipment and flow procedure specific to our device. This prepares medium for warming blood before infusing and prevents infusion of cold blood and lowering of body temperature.)

Don gloves and insert IV catheter or if IV catheter is present and is of adequate size (catheter should be 20 gauge or larger, preferred size is 18 gauge), remove dressing enough to expose catheter hub. This permits access for connection of blood tubing, decreased hemolysis and allows free flow of blood.

Connect blood tubing directly to catheter hub.

Open fluid regulator fully and regulate to a rate that will keep vein open (30 ml/hour) until blood is available. This verifies and maintains patency of catheter.

Obtain baseline vital signs.

RN or physician obtains blood from laboratory.

When the blood product is released from the Blood Bank during routine lab hours, the technologist and RN/physician:

1. At the time of an order for blood, a Transfusion Requisition stamped with the patient’s name and medical record number must be sent to the Lab for completion.
2. At the time the RN retrieves the unit from the lab, the Transfusion Record will be matched against the tag attached to the unit and the sign-out book to ensure the name and MR match correctly.
3. The unit number of the blood will be matched against the unit number listed on the Transfusion Record Form.
4. The unit will be inspected visually for hemolysis or abnormal appearance.
5. The Blood Bank Record Log sign-out sheet will be used in issuing the unit. Complete date, time, patient name, MR number, type and Rh and inspection of unit, opposite the unit number in the log book. The RN taking the unit is to sign as person taking blood. A witness must sign signifying they have witnessed the entire issuing process. Normally, the witness is a Lab Tech. If the laboratory is closed, blood can only be issued to the Nursing Supervisor. In this case, a RN must act as witness.

6. RN may take the unit to the floor for transfusion.

When the blood product is to be delivered by the lab technologist to another location within the hospital (in STAT situation only), the technologist:

* Completes Steps 1 -5 above.
* Delivers product to an RN, verifying patient’s name, blood type, and product number with the RN.

When the blood product is released from the Blood Bank after routine lab hours, the RN or House Supervisor:

* Completes Steps 1 -3 above.
* The RN House Supervisor issuing the blood product is to indicate the type of blood product issued, verify its inspection, initial date and time of blood product sign-out log.

**Note:** Blood cannot be out of the lab Blood Bank refrigerator more than 30 minutes prior to initiating transfusion.

Prior to transfusion initiation, check for correct identification information. Check blood and client information with a second RN or a LPN in the presence of the patient. Compare blood package with:

1) Blood Transfusion Record and flowsheet, checking client name, hospital number, blood type, expiration date to verify that the client name, blood type, and unit number match.

2) Client’s name band: Patient’s name, Date of Birth, Medical record number, and account number. This ensures transfusion to correct client.

**Note:** If discrepancies are noted notify the blood bank immediately and postpone transfusion until problems are resolved.

Complete blood transfusion record on the Transfusion Requisition form with date and time of transfusion initiation and nurses’ checking information. This provides legal record of blood and client identification verification.
Initiating transfusion: Remove cap to reveal spike on other side of blood tubing and push spike into port on blood bag. Close regulator on normal saline side of tubing and open regulator on blood side of tubing to fill with blood.

Regulate drip rate to deliver: A maximum of 30 ml of blood within the first 15 minutes; this is 75ml/hour x 15 minutes. Entire blood volume is infused in 2 to 4 hours from time of release from lab.

Reassess patient every 15 minutes throughout transfusion. Transfusion record required documentation of vital signs prior to start and again at 15 minutes, 30 minutes, and one (1) hour thereafter.

*Note:* Most severe reactions occur within the first 15 minutes.

When blood transfusion is complete:

- Clamp off blood regulator.
- Turn on normal saline. Flush tubing of blood. Blood tubing may be used for maximum of two (2) units of packed cells.
- Disconnect blood tubing from IV site.
- Remove empty blood bag. Package in biohazard bag and return to lab.
- Place other copy of transfusion record on chart.

During and after transfusion, monitor client closely for signs of a transfusion reaction (prevents severe complications from undetected reactions) which include the following:

**Allergic Reaction:** Evidenced by rash, chills, fever, nausea, or severe hypotension (shock) Indicates incompatibility between transfused red cells and the host cells.

**Pyrogenic Reaction:** (Usually noted toward end or after transfusion), evidenced by nausea, chilling, fever, and headache. Indicates sepsis and subsequent renal shutdown.

**Circulatory Overload:** Evidenced by cough, dyspnea, distended neck, veins, and rales in lung bases. Indicates acute pulmonary edema or congestive failure.

If allergic or pyrogenic (fever) reaction is noted:

1) Turn off blood transfusion. This decreases further infusion of incompatible or contaminated blood.
2) Remove blood tubing and replace with tubing primed with normal saline. This maintains catheter patency.
3) Turn on normal saline at slow rate.
4) Check blood bag, labels, transfusion records, and patient I.D. for clerical errors.
5) Contact doctor immediately.
6) Notify lab or lab on-call person of suspected reaction regardless of physician orders.
7) Take vital signs frequently every 10 - 15 minutes until stable and perform emergency treatment as needed or ordered.

8) Remove and send remaining blood **and blood tubing** to blood bank with complete blood transfusion discontinued.

**If fluid overload is noted:**

- Slow blood transfusion rate and contact doctor.
  - * Decreases workload of the heart and avoids further overload.
- Monitor input and output (particularly urinary output).
  - * Detects renal shutdown secondary to reaction.

Discard supplies remove gloves and wash hands to prevent spread of microorganisms.

**Special Considerations**

Clients with a history of previous transfusions must be watched carefully for a transfusion reaction - use micro filter. The transfusion must be started within half an hour after getting the blood from the blood bank. The maximum transfusion time for packed cells or whole blood is four (4) hours from release from the blood bank.

**Geriatric:** Fluid sensitive clients may not tolerate a rapid change in blood volume; they must receive the transfusion as slowly as possible.

**Pediatric:** Small children tolerate less circulatory volume change. Assess carefully, as children do not communicate well.

**Confused or comatose clients** must be watched closely for a transfusion reaction because they often cannot communicate discomfort.

**Documentation**

1) **Record on Blood Transfusion Record:**
   - Date
   - Time Started
Time Completed
Vital Signs (as indicated on transfusion record)
Unit Number
Blood Type
Rh Factor
Other Pertinent Information

2) Record on patient’s transfusion flow sheet to include:

*Data:* Subjective (complaints, emotional status, etc), Objective (vitals, urine output, rashes, etc).

*Action:* Nurse action starting the IV, patient education about risk/benefit of transfusion, initiation of transfusion.

*Response:* Patient response to procedure and infusion of blood, including adverse reaction(s).

*Note:* Record in the Empower EHR, under the nursing notes, any notation of a possible adverse reaction, who was notified, and actions taken.

**Care of Equipment**

Take empty blood bag to lab. Enclose blood bag in biohazard labeled zip-lock plastic bag received from lab. Change IV tubing upon completion of transfusion or maximum of two (2) units through tubing. Arm boards are to be cleaned with hospital approved disinfectant. Tubing, needle and tape are disposed of appropriately in covered wastebasket with red bio-hazardous plastic liner. All needles to be discarded in needle boxes in patient's room. **DO NOT** recap or remove from syringes if possible.
Transfusion Reaction
Effective: 06/2014

POLICY

It is the policy of Cochise Regional Hospital that nursing staff will monitor patients receiving blood transfusion for possible signs and symptoms of a transfusion reaction.

PRINCIPLE

Transfusion of blood and blood components is ordinarily a safe and effective way to correct hematologic deficits, but untoward results may occur. These adverse effects are commonly called “Transfusion Reactions” and may manifest at any time during or after the transfusion process. When a reaction is suspected the following protocols should be followed.

PROCEDURE

1. If a transfusion reaction is suspected, STOP THE TRANSFUSION, change the patient’s IV tubing and keep the IV open with the 0.9 percent Normal Saline.

2. Report the reaction to the patient’s physician and to lab personnel.

3. Complete “Suspected Transfusion Reaction” form and send the unit of blood and attached administration set and labels to the lab.

4. Recheck the patient’s identification numbers and blood bag numbers for accuracy.

5. Treat all symptoms per physician’s order and monitor patient vital signs. Stay with the patient until stable.

6. Immediately collect blood and urine samples if directed by physician or lab.


8. An Incident Report must also be filed for review by Risk Management.

SEE SIGNS AND SYMPTOMS OF A TRANSFUSION REACTION ON THE NEXT PAGE
Symptoms of a Transfusion Reaction

**General**
- Fever (rise of 1 C or 2 F)
- Chills
- Muscle aches, pain
- Back pain
- Chest pain
- Headache
- Heat at site of infusion or along a vein
- Color: Cyanosis, Facial flushing, Temperature Cool/Clammy, Hot/Flushed/Dry, Edema

**Cardiovascular System**
- Heart rate
- Bradycardia
- Tachycardia
- Blood pressure
- Hypotension, shock
- Hypertension
- Peripheral circulation

**Gastrointestinal System**
- Vomiting
- Nausea
- Pain, abdominal cramping
- Diarrhea (may be bloody)

**Integumentary System**
- Rashes, Hives (urticaria)
- Itching
- Diaphoresis
- Sweling

**Respiratory System**
- Respiratory rate
- Tachypnea
- Apnea
- Dyspnea
- Cough
- Wheezing
- red, brown, amber

**Renal System**
- Changes in urine volume
- Oliguria, anuria
- Renal failure
- Changes in urine color
- Dark, concentrated shades of brown, amber

**Signs of Transfusion Reaction in an Unconscious Patient**
- Weak Pulse
- Fever
- Hypotension
- Visible Hemoglobinuria
- Increase Operative Bleeding
  - (Oozing at surgical site)
- Vasomotor instability
- Tachycardia
- Bradycardia
- Hypotension
- Oliguria/Anuria
Reactions from different causes can exhibit similar manifestations therefore every symptom should be considered potentially serious and transfusion discontinued until the cause is determined.

References


American Red Cross, 1994, Circular of Information for the Use of Human Blood and Blood Components.

Suspected Rape Guidelines

Effective. 07/2014

POLICY

An Arizona statute (A.R.S. 13-1413) permits a minor who is twelve (12) years of age or older and who is alleged to be a rape victim to give consent "to hospital, medical, and surgical examination, diagnosis and care in connection with such violation."

Under that statute the consent of a parent or a legal guardian is not necessary “when it is not possible” to contact them within the short time span in which the examination should be conducted. Neither the parents nor the legal guardians are legally responsible, under the statute, to pay for pelvic examinations.

When such examination is requested by a law enforcement officer, the hospital should have the officer sign a statement certifying that he has attempted diligently to contact the parents or legal guardian and that it is not possible to contact them within the period of time in which the examination should be conducted.

Necessary emergency medical care should be given without delay to adults and minors who are rape victims. Forensic rape examinations are a service to the public. The Arizona Hospital Association urges all hospitals which can do so to provide such examinations on a regular and prompt basis. Regardless of whether the hospital does forensic rape examinations, emergency medical care should be given to alleged rape victims without delay.

DEFINITION

1. Rape is assaultive sexual attack on any unwilling victim.

2. Statutory Rape is carnal knowledge of any girl or boy below a legally set age (16-18 om most states) with or without consent.

PROCEDURE

1. Obtain history of alleged rape act in patient’s own words.

2. Obtain written consent, Special Diagnostic Permit, for pelvic examination (Female 12 years or age or older may sign consent). Where possible, obtain parental or guardian consent.

3. Examination requested by laws enforcement officers requires completion of form: “Law Enforcement Request for Examination”.

4. Document following assessment on Nurse’s Notes:
   A. Appearance of patient
   B. Evidence of bruises, lacerations, secretions, torn or bloody clothing
C. Disposition of any or all evidence (i.e., clothing). All clothing should be in paper bags.

5. Assist physician with vaginal examination:
   A. Sex Investigation Kit available
   B. Use water moistened specimen – not lubricant.

6. Follow directions of the Sex Crime Evidence Kit.

7. Refer to laboratory guidelines for processing “wet mount” slides.

8. Administer prophylactic antibiotics as ordered by physician.

9. Refer to Victim Witness or physician for counseling needs.
Rape Trauma Syndrome Standard of Care

Effective. 07/2014

POLICY

To provide quality physical and emotional care to the patient who has been sexually victimized. All patients who present to the Emergency Department with rape trauma syndrome will be considered a priority and treated with sensitivity and adherence to Public Health Law, section 2805.

PROCEDURE

The nurse will provide the following interventions during the immediate phase of management of a rape trauma victim.

Immediate Phase

All patients presented to the Emergency Department with complaints of sexual abuse will be accompanied to a private room and a Rape Crisis Counselor from Victim Witness will be called pending patient approval.

- Police will be notified only when consent is given by the patient or when there is a legal obligation on the part of the hospital to do so (see ED Policy Treatment of Victims of Sexual Assault).
- The appropriate physician will be called (see ED Policy Treatment of Victims of Sexual Assault).

STANDARD II

A sensitive interview will be conducted with the patient regarding the sexual assault.

Intermediate Phase

A. Perform physical assessment of patient as follows:
   1. History of present condition
      a. Time, place, and circumstances of assault
      b. For sexual assault or incest involving child; same as adult, plus interview child and parent/significant other separately
   2. Past medical history
      a. date of LMP
      b. date and time of last consensual intercourse
   3. Physical examination
      a. Assess for physiological stability related to physical injury
      b. Prior to physical exam:
         - establish trust relationship
         - explain all procedures
         - obtain consents for procedures and/or photographs
c. Assist with collection of evidence and physical examination – see guidelines for use of NYSDOH Sexual Offense Evidence Kit
d. For sexual assault or incest involving child, assess for signs and symptoms of child abuse (see child abuse).
e. Assist with diagnostic procedures

B. Psychosocial Intervention
Consider that the patient is going through a traumatic acute phase or may experience a delayed or long-term phase. The possibility of these reactions needs to be discussed with the patient so he/she is prepared.

There may also be feelings of powerlessness related to inability to prevent or control the situation.

C. Interventions
• Offer immediate assistance
• Develop trust relationship
• Focus on facts and immediate problem solving
• Accept all types of responses
• Assist with problem solving and decision making
• Offer assistance in calling friends or support
• Encourage patient to make decisions (i.e., now or in 30 minutes)
• Discuss usual post-traumatic reactions
• Discuss reactions of significant others
• Provide available resources for unresolved anger and rejection
• Arrange for transportation to safe environment
• Refer to mental health counselor if patient unable to progress with direct problem solving assistance.

For pediatric victims of sexual assault or incest:
1. Notify parent if not with child; consider if child is incest victim.
2. Adult interventions are all applicable but must be modified to accommodate development level of child.
3. Notify proper authorities which may include police and child protective services.
4. Refer family for counseling.

STANDARD II

Evaluation

The victimized patient has just undergone a most traumatic event. The sensitive care that has been provided should result in a positive outcome for the patient at time of discharge.

The patient:
• Exhibits decreased anxiety with relaxed body posture and acceptance of help
• Cooperates and participates in verbal dialogue
• Makes decisions and follows through with plan
• Demonstrates coping reactions that are appropriate for event and is aware of own responses
• Accepts offer to call supportive person
• Relates appropriate telephone numbers
• Accepts and understands reason for referral
• Comprehends and repeats types of reactions that may occur
• Decides to inform others based on usual coping behaviors and cites available referral resources
• Leaves Emergency Department with escort

For children: as for adult, plus:
• Child is emotionally secure; parent, significant other or adult advocate is present
• Authorities are notified
• Child leaves Emergency Department to return to safe environment
Cervical Traction or C-Spine Immobilization

Effective. 07/2014

POLICY

Standard application of manual in-line cervical traction/c-spine immobilization is used on a potential c-spine injury arriving to the Emergency Department by private transportation.

PROCEDURE

Indication for Manual Cervical Traction:
• Suspected or known c-spine injury:
  o Traffic collision
  o Falls
  o Assault to head or neck
  o Change in LOC with unknown mechanism of injury.

Action Steps for Manual Traction:
• Apply cervical neck collar.
• Rescuer moves to the top of the patient’s head. Reassure victim verbally.
• Axial stabilization is maintained by staff member placing his/her hands on either side of the patient’s head with the palms over the patient’s ears.
• Staff member maintains a steady forward pull to implement cervical traction until c-spine is cleared by x-ray or replaced by full immobilization equipment. Do not hyperextend neck.

Application of Back Board to Maintain C-Spine Immobilization:
• Log roll patient, utilizing three or more staff members, onto long back board to maintain manual traction and alignment.

Cervical Collars:
• Hold cervical collar (Aspen or Newport collar), following directions on collar.
Chest Tubes of Pleur-Evac

Effective. 07/2014

POLICY

Indications on insertion of chest tubes and use of Pleur-Evac are Pneumothorax, Hemothorax, or Empyema.

PROCEDURE

Pleur-Evac set-up:

Prepackaged Pleur-Evac

Sterile water 1000 cc

Piston syringe

Suction setyp

Via the short rubber tubing on the Pleur-Evac, fill the water seal chamber to the 2 cm level (approximately 70cc). The water seal will turn blue once filled. Fill the open area next to the short tube with sterile water, as physician directs, or to the line.

The long tube will be connected from the collection chamber to the patient’s thoracic catheter, once chest tube has been inserted.

The short suction tubing is connected to the suction source.

Turn on the suction gently and increase it until the orange float appears in the suction control indicator window. The setting of the suction control dial determines the approximate amount of suction imposed, regardless of the amount of source suction, as long as the orange float appears in the indicator window.

Documentation shall be included in patient chart.
Conscious Sedation Policy

Effective. 07/2014

POLICY

The COCHISE REGIONAL HOSPITAL’s Conscious Sedation Policy provides guidelines for administration, patient selection, monitoring and discharge of patients receiving conscious sedation. Conscious sedation is administered by physician order and in the presence of a licensed, trained and approved physician/dentist. Conscious sedation, for adult patients can be administered and monitored by licensed, trained and approved Registered Nurses on patients assigned an ASA I or II classification, who are undergoing invasive, manipulative or constraining procedures in the OR, ER, Labor and Delivery or CAT Scan room. Administration of Conscious Sedation will not be permitted in the Long Term Care Unit or the Medical Surgical Unit.

Conscious sedation is defined as a medically controlled state that does not normally lead to a loss of protective reflexes for the purpose of providing relaxation, amnesia and/or control of pain during diagnostic and surgical procedures (especially endoscopies, closed reductions of fractures, minor suture repairs and radiology procedures). Conscious sedation does not refer to medications given for pain relief, premedication for surgery, pain control during Labor and Delivery or Monitored Anesthesia Care (MAC) delivered by anesthesia providers in the operating or procedure rooms. The definitions for levels of sedation: minimal, moderate, deep, and general anesthesia, are listed in the appendix. Deep sedation is restricted to administration by anesthetist, physician, or dentist. A registered nurse may not administer deep sedation. Patients undergoing conscious sedation are at risk for aspiration, respiratory depression, apnea, hypoxemia, hypotension and paradoxical responses such as agitation, confusion and combativeness. Special monitoring care will be taken to ensure the safety of the patient.

Regardless of the site of administration of conscious sedation, the same safety precautions must be followed, and emergency equipment and appropriately trained personnel should be readily available. In situations where complete abolition or consciousness may be needed an anesthesia provider (CRNA/Anesthesiologist) must be called.

The purpose of this policy is to ensure a safe and consistent process for the administration and management of patients receiving conscious sedation at the COCHISE REGIONAL HOSPITAL.

*The ability to independently maintain a patient airway and respond appropriately to verbal commands and physical stimulation are important distinguishing features of conscious sedation.

II. Administration:

All staff ordering or administering Conscious Sedation at Cochise Regional Hospital shall have training in the administration of Conscious Sedation, and be certified, and approved prior to the administration of Conscious Sedation. This process includes current ACLS Certification, attending a conscious sedation course offered at the center annually, (by Anesthesia Department) and by demonstrating written competency and skills proficiency in the clinical area prior to being approved to administer Conscious Sedation. A list of all approved providers is maintained by the Nursing Office (RN’s) and in the Credentialing File (Physicians). The COCHISE REGIONAL HOSPITAL is

96
committed to educating, certifying and approving all providers of Conscious Sedation to ensure safe patient outcomes.

Medical Staff – Physician
- Physician must be privileged for conscious sedation
- Physician must be updated and evaluated in conscious sedation annually and demonstrate competency
- Physician must obtain informed patient consent for procedure, including conscious sedation and the risks involved
- Physician must assign an ASA status prior to the start of the procedure
- Physician must determine and document type of conscious sedation to use
- Physician must be present during the administration of Conscious Sedation

Registered Nurses
- RN must be currently certified in ACLS
- RN must be updated and evaluated in conscious sedation annually and demonstrate competency
- RN must perform and initial assessment and history of the patient
- RN may be responsible for pre, intra, and post procedure monitoring for patients assigned of ASA class of I or II on adult patient
- RN administering conscious sedation will be unencumbered with other Duties during procedure.

Certified Registered Nurse Anesthetist — Anesthesiologist
- CRNA or Anesthesiologist will be responsible for the monitoring of all patients with an ASA classification’s III-IV, or for situations determined by the attending physician.

III. Patient Selection:
Adults - patients sixteen (16) years or older
(Pediatric patients under the age of 16 years will be referred to the CRNA/Anesthesiologist for procedures requiring conscious sedation; if the anesthesia provider is unavailable (in surgery) then the physician will administer the conscious sedation.)
Only patients classified as ASA I or II are appropriate for administration of Conscious Sedation by a licensed, trained and approved RN
Patients classified as ASA III or IV, will be monitored by anesthesia providers (CRNA/Anesthesiologist).
Patients undergoing elective Conscious Sedation will be NPO for a period of eight (8) hours prior to the administration of Conscious Sedation. The necessity of performing emergency procedures requiring sedation, such as emergency intubation, cardioversion etc., will be determined by the ER or attending Physician, taking into consideration the NPO status and severity of systemic disease.
In emergency situations, the Physician will determine the necessity of sedation for an ASA III/IV, and those patients not NPO for the recommended period of time; if the anesthesia provider is unavailable (in surgery) then the physician will administer the conscious sedation.
IV. Policies:
A. Conscious sedation, for patients over 16 years of age, cannot be given without a written order from the attending or consulting licensed, trained and approved physician/dentist.
B. Conscious sedation may be used outside of the OR (ER, Labor and Delivery, CAT Scan Room) for diagnostic and minor surgical procedures where general anesthesia is not required. Regardless of the site of administration, the same safety precautions must be followed, and emergency equipment and appropriately personnel must be readily available.
C. The physician(s) will review the need for conscious sedation using information gathered by the completion of a history and physical examination.
D. The physician will review and discuss with the patient, guardian, and/or significant other about the risks, benefits, options and potential complications involved in the procedure, to include conscious sedation, and document that informed consent was obtained prior to the sedation and procedure.
E. All patients receiving conscious sedation will be appropriately monitored by a licensed, trained and approved RN from the time of administration of sedation until discharge criteria has been met. The ordering physician and administering RN will both be present during the administration of conscious sedation.
F. All documentation for patients receiving conscious sedation will be done on the approved Conscious Sedation Flow sheet. (see appendix)
G. The department in which the patient receives conscious sedation as well as the department where the procedure is done shall have the following equipment:
   • Pulse oximeter
   • Cardiac monitor, including blood pressure measuring apparatus
   • Oxygen and delivery devices (nasal cannula, face mask)
   • Appropriate oral and nasal airways
   • Positive pressure breathing device (manual resuscitator)
   • Suction at bedside
   • Reversal agents’ naloxone (Narcan) and flunazenil (Romazicon)
   • Intubation Equipment-with laryngoscope/endotracheal tubes checked regularly
   • IV supplies
   • Emergency cart and Defibrillator
H. Minimum personnel during the procedure shall be two qualified professionals with one patient.
   • The care of all patients receiving conscious sedation will be supervised by a physician/dentist privileged both for the specific procedure and conscious sedation.
   • The RN (trained in conscious sedation) managing the care of the patient receiving conscious sedation shall have no other responsibilities that would leave the Patient unattended or compromise continuous monitoring.
   • All personnel involved in monitoring or ordering conscious sedation should be Certified in ACLS. This includes RN staff and physicians.
   • The plans of care shall be developed and documented in the patient’s medical record before the procedure is performed. There shall be written
documentation of all aspects of care rendered to the patient inclusive of
but not limited to teaching/education and referrals.

Transfer or Discharge home after Conscious Sedation will occur after a minimum of 30 minutes
of recovery. Transfer for inpatients and Discharge for outpatients will occur only after
discharge criteria have been met.

V. Procedure:

A. Pre-procedure

Physician Assessments

All patients requiring conscious sedation will have a pre-procedure assessment, including, but
not limited to:

- Selection and documentation of sedation plan prior to sedation.
- History and physical examination performed by a physician/dentist which should include:
  - past medical history, present medical history, drug history, drug or food allergies, previous anesthesia
  experience, (including any history of adverse or allergic drug reactions to anesthesia or sedation),
  - current medications and assignment of *American Society of Anesthesiologists (ASA) Physical
  Status as well as baseline vital signs and pre-procedure level of consciousness. NPO status
  shall be determined.

*American Society of Anesthesiology Patient Classification Status

<table>
<thead>
<tr>
<th>ASA Classification</th>
<th>Medical Description of Patient</th>
<th>Comments</th>
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<tbody>
<tr>
<td>ASA I</td>
<td>No known systemic disease</td>
<td>May have conscious</td>
</tr>
<tr>
<td>ASA II</td>
<td>Mild or well controlled systemic disease(s)</td>
<td>May have conscious sedations without other consultatation</td>
</tr>
<tr>
<td>ASA II</td>
<td>Multiple or moderate systemic disease(s)</td>
<td>Considers Medical</td>
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<td>ASA V</td>
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<td>E</td>
<td>Connotees Emergency</td>
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NPO

Sedation and analgesic medications tend to impair airway reflexes in proportion to the level of
sedation achieved: therefore patients may be at risk for aspiration should regurgitation occur.
For elective procedures, allowing sufficient time for gastric emptying before the sedation begins
may decrease this risk. To minimize these risks adults should be **NPO for eight hours prior to sedation.**
In urgent or emergency situations where gastric emptying maybe incomplete, the potential for pulmonary aspiration of gastric contents should be considered in determining the
timing of the procedure and the degree of sedation/analgesia to be achieved. NPO recommendations should not be modified unless thoroughly documented by the physician.
The anesthesia provider must be called for situations where deep sedation may be needed for patients not meeting the NPO recommendations.
Consent

Informed written consent, documenting consent for Conscious Sedation and risks involved must be obtained by the ordering Physician prior to administration of Conscious Sedation.

Emergency Equipment, Intravenous Access and Monitors

Emergency airway equipment, drugs and resuscitation equipment should be prepared and placed at the patients’ bedside. Working suction must be present at the bedside. A crash cart must be available in the department where Conscious Sedation is administered.

All patients receiving conscious sedation should have continuous intravenous access. For patients who have received sedation by non-invasive route, determination of the need for intravenous access will be made on a case-by-case basis. Skilled personnel should be available if need arises. Patient should be placed on telemetry and a pulse Oximeter prior to beginning sedation.

Nursing Assessments

• Vital Signs: Heart rate, blood pressure, respiratory rate, oxygen saturation and temperature should be recorded prior the administration of conscious sedation.
• Level of consciousness and responsiveness should be assessed and recorded prior to the administration of conscious sedation.
• Verification of proper documentation of informed consent will be made prior to the initiation of conscious sedation.
• For menstruating patients, the last menstrual period shall be determined and documented. A Pregnancy test should be recommended to the physician if there is any question of pregnancy.
• All ordered pre-sedation laboratory/radiology results will be checked prior to the sedation, as well as assessment of emotional, development age, psychological and safety needs of the patient.

B. Intra-procedure

All patients will have continuous monitoring by an unencumbered, licensed, trained, approved RN. All data will be recorded on the Conscious Sedation Flow Sheet from initiation of conscious sedation to the completion of procedure including, but not limited to:

• Vital Signs: Heart rate, blood pressure, respirations; recorded a minimum of every 5 minutes.
• Level of consciousness and responsiveness: monitored continuously and documented every 5 minutes.
• EKG: continuous cardiac rhythm monitoring during the procedure and recovery period.
• Oxygenation: Continuous pulse oximetry monitoring and documentation at a minimum of every 5 minutes.

• Medications: All drugs administrated will be documented on the Conscious Sedation Flow Sheet, noting: 1) site, 2)time, 3)drug, and 4)dose, including 5) oxygen therapy in liters/min. and means of delivery.

Acceptable drugs to be used for conscious sedation include:

1) valium,
2) versed,
3) morphine,
4) Demerol,
6) reversal antagonists: Romazicon and Narcan
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All drugs administered for Conscious Sedation should be titrated to effect. Drug doses are not to exceed the institution's maximum doses. Drugs used for the induction of anesthesia are not permitted for conscious sedation. These drugs include induction agents (Thiopental sodium, etomidate, propofol). Muscle relaxants (succinivicholine, Mivacron, Zemuron vecuronium, etc.) are never to be used for conscious sedation.

- If an adverse drug reaction occurs the RN will notify the attending physician and implement orders. An adverse reaction form will be sent to the Pharmacy and Performance Improvement Department.
- If a reversal agent is used, a drug reaction form must be completed and sent to the Pharmacy and Performance Improvement Department.
- *

*Caution should be used in the administration of reversal agents. Potential adverse reactions include; nausea and vomiting, sweating, excitement, agitation, headache, flushing, hypotension, hypertension, tachycardia, fibrillation, pulmonary edema, and seizures.

C. Post-procedure

1. Recovery
   a) Staffing is based on patient acuity, census and physical facility.
   b) Monitoring and documentation on the Conscious Sedation Flow Sheet in the recovery unit by an ACLS certified RN. Vital signs and oxygen saturation initially every 5 minutes, x3, then every 15 minutes until discharge to a responsible adult. All patients will be recovered for a minimum of thirty minutes prior to discharge.
   c) Continuous cardiac rhythm monitoring until patient is transferred or transfer or discharge.
   d) Administer medications as ordered, document administration and record patient response or results.
   e) Airway patency and level of consciousness is assessed and documented frequently.
   f) Provide for safety, side rails are in the up position
   g) Provide for confidentiality of information and records
   h) Position patient gradually from supine to Fowler’s position, if not contraindicated. Encourage fluids by mouth, if not contraindicated
   i) Ambulate with assistance, if not contraindicated
   j) Monitor surgical site and documented if applicable
k) Body temperature monitored and documented (as appropriate)
l) Pain intensity scale monitored and documented (see appendix)
m) Patients who receive a reversal agent should be continually observed for 30 minutes longer for return of respiratory depression prior to transfer.

Inpatient Transfer
An RN or LPN may assume care of the patient with a normal patient load when inpatient transfer criteria have been met. Transfer orders must be written by the physician ordering the Conscious Sedation. A report will be given to the receiving nurse or unit consisting of:
1. Preprocedure history
   • Intraprocedure factors, including total medication given.
   • Postprocedure instructions.
   • Any additional test and special care needs

The patient may be transferred to the receiving unit when the following criteria have been met:
1. Temperature above 97(ax.) or below 100(ax) and approaching normal.
2. Blood Pressure within 20% of normal or pre-sedation value.
3. Pulse not below 60 or above 100 (except where pre-sedation values are below 60 or above 100).
4. Respirations not below 12 or above 30.
5. Patient is awake, can call for assistance, and is oriented if so disposed prior to sedation.

Outpatient Transfer
An RN or LPN may assume care of the patient with a normal patient load when outpatient transfer criteria have been met. Transfer orders must be written by the physician ordering the Conscious Sedation. A report will be given to the receiving nurse or unit consisting of:

If patient is being transferred to floor prior to discharge, a report will be given to the nurse or unit consisting of:
1. Pre-procedure history
   • Intraprocedure factors, as above
   • Post-procedure recovery factors
   • Post-procedure instructions
   • Any additional test and special care needs

The patient may be transferred to the receiving unit when the following criteria have been met:
1. Temperature above 97(ax.) or below 100(ax) and approaching normal.
2. Blood Pressure within 20% of normal or pre-sedation value.
   • Pulse not below 60 or above 100 (except where pre-sedation values are below 60 or above 100).
3. Respirations not below 12 or above 30.
4. Patient is awake, can call for assistance, and is oriented if so disposed prior to sedation.
5. Post Sedation Aldrete score of 7-10, considering baseline. (see appendix)

The patient may be discharged to home from the unit after Discharge Criteria have been met.

Discharge Criteria for Patient Being Discharged Home -
The discharge criteria for a patient being sent home are not the same as those for inter-faculty transfer.

The patient may be discharged home with an adult when the following discharge criteria have been met:

1. Discharge orders must be written by the physician ordering the Conscious Sedation.
2. Vital signs are stable for 30 minutes within 20% of pre-procedure value.
3. Patient is awake, and is oriented if so disposed prior to sedation.
4. Patient demonstrates the ability to ambulate, unless inappropriate for age or condition
5. No signs or symptoms that may jeopardize the safety of recovery (e.g., bleeding, swelling, extreme pain).
6. No evidence of nausea, vomiting or dizziness.
7. Patient has voided as indicated by procedure (gynecologic urologic)

Patient is tolerating clear liquids unless otherwise indicated

Discharge planning is reviewed with patient, family/accompanying responsible adult as appropriate; written home care instructions are given to patient or accompanying family member.

The written discharge instructions will be given to the patient or family and documented in the patient’s chart. Discharge instructions will be verbalized to the patient/family and will include instructions for limitations on activity and behavior including dietary. Written aftercare instructions will include instructions for signs and symptoms for which the patient should contact his/her physician or return to the emergency room.

Discharging RN will provide for follow-up for extended care as indicated: A follow-up phone call is recommended to evaluate status of the patient the day after discharge. A 24-hour call back number will be provided for the patients use.

A score of > 9 on the Post-anesthesia Discharge Scoring System (PADSS) must be achieved prior to discharge home.

Patients are never to be allowed to drive themselves home form the hospital. Patients are to be discharged to an adult only. The name of the accepting adult is to be documented on the Conscious Sedation Flow Sheet.

VI. Risk Management and Performance Improvement

A. Conscious sedation practices throughout COCHISE REGIONAL HOSPITAL shall be monitored and evaluated by the Department of Anesthesiology according to the policy outline and performed in such a way as to assure optimal patient outcome.

B. The Chairperson of each department administering conscious sedation shall be responsible for ensuring that this policy and procedure is followed.
C. The professional/Unit responsible for monitoring/management of patients receiving conscious sedation will complete a Conscious Sedation Flow sheet (see appendix) for each patient and forward to the Anesthesia Department at the end of each quarter. Audit findings will be reported at the Emergency Room Committee / Performance Improvement Committee.

Post Sedation Aldrete score of 7-10, considering baseline. (see appendix)

QI MONITORING
A QI assessment will be ongoing with concurrent and/or retrospective monitoring of any sedation procedure outside the OR. 100% of the conscious sedation procedures outside the OR will be reviewed, and 20% of the conscious sedation procedures in the OR/Procedure room will be assessed.

The result will be communicated through the unit-based quarterly anesthesia QI reports.

QUALITY INDICATORS
1) Appropriate ASA was assigned
2) Appropriate sedation drugs/dosages were used
3) Throughout the procedure being performed and for at least 30 minutes after medication administration, the following will be documented and monitored as noted under procedure:
   a. Monitoring continuously as per procedure.
      BP
      Pulse and rhythm
      Respirations
      Pulse Oximeter
4) Appropriate D/C or transfer procedure was followed:
   a. D/C instructions given-or
   b. Report given to appropriate personnel
Appendix
“Levels of Sedation”
The standards for sedation and anesthesia care apply when patients receive, in any setting, for any purpose, by any route, moderate or deep sedation as well as general, spinal, or other major regional anesthesia. Definitions of four levels of sedation and anesthesia include the following:

1. Minimal sedation (anxiolysis)
   A drug-induced state during which patients responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. Moderate sedation/analgesia (“conscious sedation”)
   A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep sedation/analgesia
   A drug-induced depression of consciousness during which patients cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained: and deep sedation may be administered by the anesthesia provider or physician in the ER, operating or procedures room.

4. Anesthesia
   Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. General anesthesia is to be performed in the operating or surgical procedure rooms only.

   **LEVEL OF SEDATION: CONSCIOUS**
   1= Patient is anxious and agitated or restless or both.
   2= Patient is cooperative, oriented, and tranquil.
   3= Patient responds to commands only.

   **LEVELS OF SEDATION: DEEP**
   4= Patient exhibits brisk response to light glabellar tap or loud auditory stimulus.
   5= Patient exhibits a sluggish response to light glabellar tap or loud response.
   6= Patient exhibits no response.

Appendix
COCHISE REGIONAL HOSPITAL
Approved Medications and Reversal Agents for Use with Conscious Sedation
Agents that may be administered by the licensed, certified, approved RN for Conscious Sedation include:
Midazolam/Versed — a short acting benzodiazepine, central nervous system depressant
Diazepam/Valium — a long acting benzodiazepine, central nervous system depressant
Morphine, Demerol, and Fentanyl are opiate agonists
Romazicon and Naloxone are Reversal agents

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APPENDIX

Aldrete Scoring System

Activity

- Able to move voluntarily or on command -
  - 4 extremities: 2
  - 2 extremities: 1
  - 0 extremities: 0

Respiration

- Able to deep breathe and cough freely: 2
- Dyspnea, shallow or limited breathing: 1
- Apneic: 0

Circulation

- Preoperative blood pressure mm
  - BP ± 20 mm of preanesthesia level: 2
  - BP ± 20 to 50 mm of preanesthesia level: 1
  - BP ± 50 mm of preanesthesia level: 0

Consciousness

- Fully awake: 2
- Arousable on calling: 1
- Not responding: 0

Color

- Normal: 2
- Pale, dusky, blotchy: 1
- Cyanotic: 0


An Aldrete score of 7-10, considering baseline, must be achieved prior to an interfaculty transfer from the recovery area to the ward.
APPENDIX

Postanesthesia Discharge Scoring System

1. Vital signs
   2 = within 20% of preoperative value
   1 = 20-40% of preoperative value
   0 = 40% of preoperative value

2. Ambulation and mental status
   2 = Oriented x 3 AND has a steady gait
   1 = Oriented x 3 OR has a steady gait
   0 = Neither

3. Pain, or nausea/vomiting
   2 = Minimal
   1 = Moderate
   0 = Severe

4. Surgical bleeding
   2 = Minimal
   1 = Moderate
   0 = Severe

5. Intake and output
   2 = has had P0 fluids AND voided
   1 = has had P0 fluids OR voided
   0 = Neither

* The total score is 10. Patients scoring 9 are considered fit for discharge.
Crash Cart Policy

PURPOSE:

1. To ensure that all crash carts and Defibrillators are constantly ready for use in case of life threatening conditions, such as cardiopulmonary arrest.

2. To establish a standard practice, which is required to maintain and utilize the crash cart and defibrillator.

   The crash cart policy will assist nursing staff to:
   a. Describe the role of nursing staff in maintaining crash cart medications and equipment.
   b. Establish a uniform method of documentation and inspection of emergency medications and equipment.
   c. Establish a procedure for re-supplying the crash cart.
   d. Describe the exact locations of the crash carts.

DEFINITIONS:

1. Crash Cart – is a cart that facilitates coordination of emergency equipment. It contains those emergency drugs and equipment needed when a cardiac or pulmonary arrest occurs.

2. Code Blue – the designated term used to announce a cardiopulmonary arrest. It also encompasses the immediate pre-code situation for a critical, unstable patient who requires the intervention of a Code Team.

POLICY:

1. All RN’s will be familiar with the contents and locations of all medications and equipment in the crash cart.

2. A Licensed staff member (RN, LPN, RT, CAN or EMT), as designated by the patient care area Charge Nurse or Manager, will be responsible for checking the crash cart, oxygen cylinder levels, defibrillator, and documenting compliance on crash cart checklist.

3. Each emergency cart is equipped with a numbered lock and kept locked unless in use. The lock number will be recorded at each shift on the crash cart documentation form.

4. If the lock is not intact, or is opened, the cart is to be checked and restocked according to the crash cart list. A new numbered lock shall be replaced by the Charge Nurse or the Nursing Supervisor.

5. All carts will be opened and checked for contents twice monthly (1st and 15th of each month) and following each use. Sterile items will be checked for package integrity and
expiration dates. Items with expiration dates expiring within the month will be replaced. The medication drawer will not be opened, if sealed and intact.

6. During routine checks, all items will be removed and the interior drawers of the code cart cleaned and wiped out with facility approved disinfectant.

7. The defibrillator shall be kept plugged in at all times, except during battery testing and transportation.

8. Defibrillator load checks will be performed at each shift with the defibrillator plugged in and unplugged. Test strips will be initialed and given to the Charge Nurse for documentation purposes.

9. The department managers will keep a log of the crash cart checklists and the test load strips for a period of 1 year.

10. Laryngoscopes and blades will be checked for proper working condition at each bi-monthly inspection and whenever the code cart is opened.

11. Oxygen cylinders (1) will be on each cart. The tank will be replaced when the tank has <500 psi. Full tanks are obtained from the Respiratory Therapy Department.

12. The drawers of carts should be clearly labeled to identify contents in general categories e.g. medication, cardiac/arrest, airway, etc.

Responsibility:

1. The list of medications and equipment to be maintained in the crash cart should be determined by the individual unit committee’s, then the Pharmacy and Therapeutics committee and on to the Medical Staff for approval.

2. The Pharmacy staff will be responsible for inspection and maintenance of expired drugs in the crash cart.

3. All nursing staff will be aware of the crash cart contents and locations to prevent any delay during cardiac arrest.

4. The Charge Nurse will ultimately be responsible for ensuring crash carts are checked and stocked every shift.

5. The Charge Nurse will notify Maintenance Department of any defibrillator problems.
Emergency Delivery
Effective. 07/2014

POLICY

Establish criteria for the emergency delivery of the pregnant women in active labor on arrival in the Emergency Department.

PROCEDURE

Notify the Sierra Vista Regional Health Center Maternity Department or receiving facility of patient arrival and pending transfer.

Any patient who is not in active labor on arrival to the Emergency Department will be evaluated by the Emergency Department physician.

If birth is imminent, prepare for delivery.

Request infant warmer be brought to the Emergency Department.

Contact the patient’s obstetrician or, if patient has no obstetrician, contact the obstetrician on call at Sierra Vista Regional Health Center.

Prepare for possible resuscitation.

Documentation shall include, but is not limited to:

Time of delivery

APGAR score 1 minute and 5 minutes after delivery

Sex of infant

Birth weight
Intubation of Patients in Emergency Situations

POLICY

Intubation of patients in emergency situations is performed when a patient has acute respiratory failure, CNS depression, neuromuscular disease, pulmonary diseases, chest wall injuries, upper airway obstruction, and/or an anticipated upper airway obstruction from edema or soft tissue swelling due to head or neck trauma. This can include some postoperative head and neck procedures, facial or airway burns, and decrease level of consciousness with possible aspiration complications.

PROCEDURE

1. Intubation shall be preformed by the licensed physician, qualified respiratory therapy staff, or the qualified nursing personnel, including medical helicopter qualified personnel, after a thorough evaluation and assessment of the patient’s condition.

2. Remove loose fitting dental appliances or dentures.

3. Prepare equipment for intubation:
   a. Check function of resuscitation back with mask
   b. Check suctioning apparatus
   c. Check laryngoscope blade and light
   d. Obtain correct sized endotracheal tube, checking balloon
   e. Attach 10 cc syringe to endotracheal tube
   f. Insert the stylet into the tube
   g. Lubricate the end of the E.T. tube
   h. Get CO2 cap ready for use
   i. Get tube holder ready for use.

4. Prepare patient with appropriate sedation medication.

5. Hyperventilate the patient prior to attempting intubation, 100% oxygen via bag-valve-mask.


7. Remove laryngoscope, inflate the balloon of E.T. tube, and check for bilateral expansion of lung by auscultation while bagging with resuscitation bag.

8. Apply CO2 cap to end of tube and observe for color change to yellow to indicate proper placement achieved.

9. Tape endotracheal tube in place securely and continue bagging patient appropriately.

11. Depending upon the length of patient’s stay, the patient will be attached to the ventilator for continue ventilation.

12. Follow up ABGs will be performed for evaluation of proper ventilation and oxygenation.

13. Sedation medications will be given to the patient for patient comfort and therapeutic management of an open airway.
Code Blue Policy and Procedure

Effective. 07/2014

POLICY

All cardiac arrests within the Emergency Department will be treated according to the standards established by the American Heart Association and Advanced Cardiac Life Support.

PROCEDURE

All Emergency Department and Acute Care staff will be ACLS certified. All physicians and nursing staff within the Emergency and Acute Care Departments will be ACLS certified within first year of department employment. Upon identification of an arrest or a pre-arrest condition, a code blue should be paged overhead throughout the CRH building in order to mobilize the Code Blue team (Primary RN, Secondary RN or LPN, and House Physician). ACLS protocol should follow.
Resuscitation/Life Sustaining Measures  
*Effective. 07/2014*

**POLICY**

CRH utilizes the designation “DNR” (DO NOT RESUSCITATE) to indicate that resuscitative measures will not be taken for a given patient.

**PROCEDURE**

The patient’s attending physician shall be responsible for determining and documenting decisions about the withdrawal or withholding of resuscitative or life support measures from individual patients.

The physician shall discuss the plan of care with patient and appropriate family/guardian as soon as possible and seek their input in the decision making process. Should the family or patient request withdrawal or withholding of life support measures, the physician shall clearly document this request on the Empower EHR as a physician’s order. If the patient has made his wishes known in a formal/legal document, a copy of the document shall be included in the medical record.

If no Order of Life Support Measures is present, complete CPR measures will be done. Once resuscitation measures are initiated, only a physician or qualified medical provider, physically present, can stop the process. It shall be nursing responsibility to assure that code status appears on: Empower EHR, and Resident Arm Band.
Poison Control Management

Effective: 07/2014

POLICY

COCHISE REGIONAL HOSPITAL uses the Poison Control Center in Tucson for all up to date information on treating patients who have ingested poison or taken a drug overdose. The phone number for Poison Control is 1-800-362-0101. The service is a resource and all treatment must be accomplished under the orders of the ER physician COCHISE REGIONAL HOSPITAL has the drugs, antidotes, appliances, and equipment necessary for the treatment of poisoning.

PROCEDURE

1. Identify Product (if possible)
   A. Information from patient or family
   B. Information from container
   C. Exposure to fumes (example: carbon monoxide poisoning)

2. Acute Poison
   A. Call Poison Control Center – Tucson: 1-800-362-0101

3. Ingested Poisons
   A. Perform gastric lavage using NG tube or oral gastric tube as ordered
   B. Ipecac as prescribed
   C. Give charcoal and cathartic as ordered

4. Equipment
   A. Gastric lavage equipment
   B. Stomach tubes or Levin tubes
   C. Irrigation tray
   D. Suction unit
   E. Antidote per Poison Control Unit

5. Gastric Lavage
   A. Have patient in semi-fowlers to guard against aspiration.
   B. Remove foreign objects, dentures from mouth.
   C. Insert tube. Irrigate with saline or whatever solution is ordered to remove the stomach contents.
   D. Specific solution and amount, duration of lavage according to ER physician.
Poison Control: Ingestion of Poison (Adult and Child)  
Effective. 07/2014

POLICY

COCHISE REGIONAL HOSPITAL uses the Poison Control Center in Tucson for all up to date information on treating patients who have ingested poison or taken a drug overdose. The phone number for Poison Control is 1-800-362-0101. The service is a resource and all treatment must be accomplished under the orders of the ER physician COCHISE REGIONAL HOSPITAL has the drugs, antidotes, appliances, and equipment necessary for the treatment of poisoning.

PROCEDURE

I. Administer Life-Saving Measures and Stabilize the Patient
   A. Establish an airway and support respirations and cardiovascular functioning if they are deteriorating.
   B. Intubation and mechanical ventilating assistance may be necessary.
   C. Establish an intravenous line.
   D. Monitor vital signs frequently, EKG, cardiac monitor.
   E. Insert Foley catheter.
   F. Blood samples:
      1. Electrolytes
      2. Glucose
      3. BUN
      4. Toxicology Screen
      5. PH and blood gas analysis
      6. Barbiturate and salicylate levels, Tylenol levels, drug of abuse screen
   G. Suction equipment on hand.

II. Unidentified Poisons
   A. Romazecon for suspected Diazepam ingestion or Narcan may be given to aid in the negative identifications of the poison as well as to combat respiratory depression. Failure to respond indicates something other than narcotic.
   B. Do not induce vomiting in victim with deteriorating level of consciousness.
   C. Place a cuffed endotracheal tube before lavaging unconscious patient according to ER provider.
   D. Lavage unconscious victim while they are in semi-fowlers position, guard against aspiration.
   E. Observe aspirate for particle matter.

III. Inducing Emesis (not used as often in the ED setting)
   A. Syrup of Ipecac 15-30 cc for children or adults.
   B. Follow with 2-3 glasses of warm water (large amounts of water may be needed to enhance effectiveness of Ipecac).
C. Repeat if not effective, then lavage if still not effective.

IV. Lavage
   A. Ewald tube Fr 34/46, or larger size nasogastric tube.
   B. Normal Saline, Oral route for infants and small children, nasal route for adults.
   C. 100 cc/kg per wash for children until clear, avoid forceful instillation that may cause stomach concerns to be propelled into small intestines.

V. Absorbants
   A. Activated charcoal powder 25 gm in 8 ounces of Sorbitol (premixed from pharmacy).
   B. When it appears in the stool, there is minimal possibility that any poison remains in the G.I. tract.
   C. Drugs absorbed by charcoal include:
      1. Amphetamines
      2. Alcohol
      3. Ipecac
      4. Barbiturates
      5. Atropine
      6. Salicylates
      7. Sulfonamides

VI. Cathartics
   A. Citrate of Magnesium
   B. Magnesium Sulfate
Medications in the Emergency Department
Effective. 07/2014

POLICY

All medications will be stocked in the Emergency Department per par levels established between the Emergency Department and the Pharmacy.

PROCEDURE

Med-Dispense machine will be stocked by Pharmacy.

Staff shall be assigned access codes to the Med-Dispense machine by Pharmacy.

Narcotics locked in Med-Dispense will be counted per Pharmacy protocol.

Medication cabinets will be stocked by Pharmacy.

Pharmacy will monthly check for outdates.

Emergency ACLS drugs are locked in Crash Cart.

Discrepancies are documented in the Med-Dispense computer and will be followed-up by Pharmacy and Emergency Department Clinical Team Leader.
Medication Reconciliation

Effective: 06/2014

PURPOSE

Medication reconciliation is an effort of CRH to identify and prevent medication errors.

POLICY

Medication reconciliation is an effort of CRH to identify and prevent medication errors by providing a current list of medications for each patient. The list should include all prescribed medications, herbal products, vitamins, and over-the-counter medical preparations being taken by the patient.

PROCEDURE

The nursing staff admitting the patient to the facility will compile a list of the current medications being taken by the patient. In order to get a current listing, the patient or their family will be asked to bring in all medications, herbal products, vitamins, and over-the-counter preparations being used at home. In the case of patients without the ability to retrieve their medications, and no family members who can obtain the medications, the admitting nurse can call the pharmacy the patient utilizes in order to obtain this information. The list of home medications will be entered by either the ED RN or by the Primary AC RN in the Empower system (under the home medications field). The admitting physician will then review the home medication list and perform the Medication Reconciliation electronically in the Empower system. For the patients’ safety and continuity of care, when discharging the patient to home, to skilled nursing facility, and/or transferring to another facility, a list of the only medications that patient should be taking after the discharge will be printed in the discharge summary.
Latex Sensitive Patients  
*Effective. 07/2014*

**POLICY**

Purpose of this policy is to identify patients who have latex allergies and protect patient from unintended exposure to latex items while hospitalized and provide nursing care guidelines for management of latex sensitive or allergic patients.

**PROCEDURE**

1. All patients presenting to the hospital for emergency services, medical services, and/or surgical services will be asked about allergies to latex. Patients will also be asked if they have multiple allergies, unexplained anaphylaxis during medical procedures, multiple surgeries during childhood because these persons are at high risk for latex sensitivities or allergies.

2. An allergy band will be placed on the patient.

3. When admitting a patient from the clinic or from emergency room who has latex allergies, the housekeeping staff will be notified and will terminally clean private room after all latex materials are removed. The housekeeping staff will use non-latex gloves while performing this required cleaning.

4. The patient will be placed in a private room when available and the door shut to prevent airborne antigens.

5. Signs will be posted over the patient’s bed and outside the door to the room.

6. Latex allergy will be placed on the Doctors orders, on the patient’s chart, and on the Kardex. It will also be included in the nursing diagnoses.

7. Notices will be sent to Dietary department, Pharmacy and Laboratory.  
a. Dietary have to be made aware that latex sensitive patients often have food allergies: banana, avocado, kiwi, nuts, melons, nectarines, plums, passion fruits, cherries, tomatoes, potatoes, celery, papayas, chestnuts and figs.

8. Determine of the physician wants anaphylaxis medications at the bedside.

9. All staff should wash hands and face prior to entering the latex sensitive patient’s room.

10. Latex free gloves should be readily available at the patient’s bedside. Non-latex blood pressure cuffs should be used on the patient.

11. Non-latex gloves or blood pressure cuffs can be used for laboratory tests and for intravenous insertions. Also clear tape or silk tape will be used for IV sites, not Opsite.
12. IV bags will not have additional admixtures, due to puncturing the rubber port on the bag being a source potential exposure, the port is backed with a plastic back and prevents latex exposure. Using the Advantage piggyback bags will also reduce the risk of exposure to latex for antibiotic infusions.

13. Should patients develop an allergic reaction such as:
   a. Contact dermatitis or urticaria – it is felt immediately by the patient but may not show up for 12-24 hours.
      i. Symptoms: immediate localized cutaneous redness and inflammation often with itching or blisters
   b. Anaphylactic reaction
      i. Starts with stuffy nose; cough; hives, rash, itching and watery eyes; progress to breathing problems; hypotension with tachycardia and arrhythmias; bronchospasms; wheezing; and laryngeal edema.
         i. Treatment
            A. Immediately stop treatment or procedure being performed on the patient.
            B. Call physician caring for the patient and the emergency room physician.
            C. Place patient on 100% oxygen.
            D. Ensure patient has large bore IV access – 14 gauge 10 18 gauge needle.
            E. Assess the patient’s airway, breathing, cardiovascular status with vital signs. Contact Respiratory Therapy to assist with airway management.
            F. Epinephrine is the treatment of choice for allergic reactions to latex.
            G. Anticipate need for Corticosteroids such as Solu-Medrol or Solu-Cortef; Antihistamines such as Benedryl, Pepcid, or Zantac; IV fluids; and Aminophylline.

Should incident of adverse reaction occur to latex, an adverse drug reaction form should be filled out for Pharmacy and Risk Management.

When the patient with latex sensitivity needs to go to surgery:

1. The latex sensitive patient will be scheduled for the first case of the morning.

2. The surgical suite should have all latex materials removed from the room at the end of the surgical day.

3. A terminal cleaning will be performed with the housekeeping staff using non-latex gloves and the room sealed for the night.

4. A latex free cart should be available for the case.

5. Restrict flow into the suite while surgery performed.

6. Medications should be drawn from multiple dose vials with the stopper removed.
7. Reactions can occur from 30 minutes to 6 hours after exposure to latex. The patient should be monitored closely for that period after any procedure.
Intravenous Therapy
Effective. 07/2014

POLICY

Intravenous therapy shall be used only for definite therapeutic or diagnostic indications. Peripheral venipuncture shall be performed only by Registered Nurses, Physicians, or Medical Technologists who have received training and are certified to perform this function. Central catheters, Medline catheters and PICC lines shall only be inserted by a physician or in the case of Medline and PICC lines by Registered Nurses who have received additional training and have demonstrated competency in this area. All intravenous system access shall be needle-free as much as is possible. All personnel initiating intravenous fluids shall practice good hand washing, wear gloves, and observe Universal Precautions.

PURPOSE

To provide guidelines for the therapeutic initiation and maintenance of intravenous fluids and medications, and reduce the overall incidence of infection with the use of intra-vascular devices.

PROCEDURE

- The device of choice for extended intravenous therapy will be the cannula over needle placement device.
- In short term infusion and small children, the “Butterfly” infusion set may be used.
- Central line catheters shall be devices designed specifically for use as a central line.
- All intravenous systems shall be accessed using a needle-free device.

CHOICE OF SITE

- In adults, the upper extremity shall be used in preference to the lower extremity.
- Those veins overlying a joint shall be avoided if possible.
- Excessive amounts of body hair may be removed prior to insertion of the IV cannula by shaving the area intended for placement of the cannula.
- If possible, the most distal site shall be used allowing for restarting the infusion in a more proximal location if needed.

SITE PREPARATION

- 70% Alcohol or Betadyne may be used to clean and degrease the skin.
- The antiseptic of choice shall be applied liberally and allowed to remain in contact with the skin for at least 30 seconds prior to venipuncture.
SITE DRESSING

• An occlusive dressing shall be placed over the insertion site of the cannula. This can be a transparent dressing or sterile gauze as long as the dressing does not interfere with the ability to access the site.
• The dressing shall be identified with the date the site was initiated, initials of the individual initiating the infusion, and the gauge of the cannula used.

MAINTENANCE OF THE IV SITE

• Patients with intravenous devices shall be evaluated at least every shift for evidence of cannula related complications. This evaluation should include gentle palpation of the site through the intact dressing.
• If the patient has an unexplained fever, pain or swelling at the site, tenderness, redness or increasing warmth, the dressing should be removed and the site accessed.
• The standard dwell time for short term peripherally inserted intravenous sites is three (3) days, however, exceptions may be made due to patient suitable access sites, access device type and type of solution and infusion.
• If the site is not changed, based on the nurse’s best judgment, this will be documented in the patient record.
• Needle-free devices shall be changed every 72 hours at the time of tubing change.

TUBING MAINTENANCE

• Tubing will be labeled as to the date and time it was hung.
• Intravenous tubing will be changed every 72 hours, and after the administration of blood, blood products, and lipid emulsions.
• Drugs will not be admixed in tubing.
• Tubing used to provide hyperalimination will be changed every 24 hours.
• The system should be maintained as a closed system as much as possible. All entries into the system should be through the needle-free valves that are disinfected with alcohol for at least 3 seconds just prior to use.
• Flushing or irrigation of the system to improve the flow should be avoided.

SOLUTION MAINTENANCE

• Every bottle of IV solution shall be labeled with:
  o Patient’s name and room number
  o Any added medications
  o Initials of person preparing the solution
  o Date and time of admixture

• Time solution was hung, rate of flow and time solution is discontinued will be tracked in the IV Flow Sheet which will be placed in the clipboard at the foot of the patient’s bed.
• Any solution that has been discontinued for more than two (2) hours is considered contaminated, and discarded. An entire new set-up is needed to restart the infusion.
• Any solution into which additives have been placed which does not bear the date and time of mixing shall be considered contaminated and will be discarded.
• As much as possible, all IV fluids containing additives shall be obtained from the pharmacist, where the addition of medications can be performed under the laminar flow hood.

INTERMITTENT INFUSION MAINTENANCE

• The site will be maintained and dressed as for an IV site.
• The IV catheter and extension tubing will be flushed with 2-3 cc of normal saline prior to and after each infusion containing medications.
• Tubing used for intermittent infusion will be labeled as for an IV and changed every 72 hours or PRN.
• The tubing will be discarded if it has not been maintained as a closed system, i.e., left hanging with an exposed connection site open to the air.

CHANGING PARTS OF THE IV SYSTEM FOR INJECTION OR PHLEBITIS

• The entire system should be discontinued if signs of bacteremia, erythema, or fever are noted and the IV site is suspect. The physician should be notified for appropriate orders.
• For phlebitis without signs of infection, the IV site should be changed.
• If an IV system is to be discontinued for suspected IV-related infection such as purulent thrombophlebitis, or bacteremia, the skin at the site should be cleaned with alcohol and the alcohol allowed to dry before the catheter is removed, and the catheter should be cultured.
• If the system is discontinued because of suspected fluid contamination, the fluid should be saved and the implicated bottle saved. If contamination of the fluid is confirmed, the implicated bottle and remaining units in that lot numbers should be saved and the lot numbers of the fluid and any additives should be recorded. If intrinsic contamination is suspected or confirmed with the local health authorities, the manufacturer and the CDC should be notified.

QUALITY CONTROL DURING AND AFTER ADMIXTURE

• Parenteral fluids should be admixed in the pharmacy unless clinical urgency requires admixture in the patient care areas. **Potassium for IV admixture will not be mixed in the patient care areas. Unmixed potassium will not be stored in the patient care area.**
• All personnel will wash their hands before admixing parenteral fluids.
• All containers should be checked for turbidity, leaks, cracks, particulate matter, and manufacturer’s expiration date prior to use. If any of these problems exist, the drug/solution should not be used, and the nursing supervisor notified to secure additional supplies if needed. All unsuitable drugs/solutions will be returned to the pharmacy noting why they were found to be unacceptable.
• Single use/dose vials should be used for admixture whenever possible. When a container for multiple use is opened, it will be marked with the date and time the container was entered. Package insert or other reliable reference should be checked for correct storage of opened vial.
Proper storage is product specific, and bacterial survival in some containers can be enhanced by refrigeration. The container will be discarded after it has been opened for 30 days.

- A distinctive admixture label will be attached to each admixed container stating the date, time, medication, amount, and the initials of the individual compounding the mixture.
- All admixed fluids should be stored in the refrigerator within 6 hours of mixing.
- If necessary, admixed parenterals may be sorted in the refrigerator up to one week after mixing, if refrigeration has been continuous, and begins as soon as the solution was admixed. Other factors such as stability of ingredients may dictate a shorter storage time. Package insert or other reliable reference should be consulted to determine storage time.
- Once started all parenterals should be completely used within 24 ours or discarded.

IN-LINE IV FILTERS

The use of in-line IV filters is not routinely recommended as an infection control practice. Consult the package insert for those medications for which this may be required.

IV TRAY

The IV tray should be completely cleaned at least weekly. The IV tray should not be taken into an isolation situation.

REFERENCES

Discharge Instructions  
*Effective. 07/2014*

**PURPOSE**

To provide procedures for effective patient discharge and follow up.

**POLICY**

A. All patients will be assessed for medical stability, orientation, readiness to learn and barriers to learning.

B. All patients discharged from the Emergency Department will receive condition-appropriate instructions for home care and appropriate referrals.

**RESPONSIBILITIES**

A. The physician or nurse will verbally instruct patient on specific discharge instructions, including medications, transportation concerns, concerns regarding dialysis treatments, and instructions reviewed with patient and/or family.

B. Patient will verbally state understanding or return demonstration of discharge instructions.

C. Condition-appropriate instructions generated by Empower EHR will be provided for all applicable patients.

D. Patient will receive upon discharge a copy of his/her discharge summary which includes: Diagnosis, Diet and Activities recommendations, outpatient follow up appointments/outpatient testing, condition-appropriate instructions and education materials, and all applicable prescriptions.

E. Assure that all medications and procedures ordered by the physician have been accomplished. Patient will be observed for at least twenty (20) minutes after receiving any antibiotic, narcotic or any other medications that the Emergency physician states appropriate to observe to insure there are no signs or symptoms of an untoward reaction. Take home medications must be dispensed by the physician.

F. Assure that all patients have appropriate transportation arranged upon discharge. This may include arranging transportation through family, friends, ambulance services, taxi vouchers or bus token. The case manager or social worker may be involved in the process as appropriate.
Transfer of Patient to Another Facility

Effective. 07/2014

POLICY

Guidelines are based on COBRA standards to insure that adequate care is given to each patient; if unable to continue with care, offer specialty care or higher level of care, patient is to be transferred to an appropriate facility.

PROCEDURE

All patients will be evaluated by the Emergency Department physician regardless of condition, race, religious preference or ability to pay.

If the physician determines, through the Hospital policy, that the patient should be transferred to another facility for further care, COBRA standards must be followed.

The patient must:

- Have no life threatening condition
- Not be in imminent labor
- Not require immediate surgery
- Be medically stable
- Agree to the transfer

Acceptance to the receiving facility must be made physician to physician with documentation of the receiving facility’s physician’s name.

Patient shall be informed of the reason for transfer:

- HMO request
- Continued care not offered at this Hospital
- Higher level of care
- Specialty care.

Transfer electronic form will be completed:

- Physician Authorization for Transfer form
- Patient Transfer Acceptance or Refusal form
- Physician Certification Medically for Transfer form
- Transfer Summary form

Copy of medical records, lab and x-rays will accompany the patient.

Documentation shall include, but is not limited to:

- Report given to transport team
- Condition of patient prior to transport
- Two (2) sets of Vital signs prior to transfer.
Emergency Medical Treatment and Patient Transfer  
*Effective. 07/2014*

**POLICY**

COCHISE REGIONAL HOSPITAL has approved this emergency medical treatment and patient transfer policy based on the state and federal laws relating to the emergency medical treatment and medically appropriate transfer of individuals between hospitals. The treatment and transfer of an individual shall not be predicated upon arbitrary, capricious, or unreasonable discrimination based upon race, religion, national origin, sex, physical condition or economic status.

**DEFINITIONS**

For purposes of this transfer policy the following terms shall have the meaning defined in 42 C.F.R. 489.24(b):

1. **“Capacity”** means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital’s past practices of accommodating additional patients in excess of its occupancy limits.

2. **“Emergency Medical Condition”** means (i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in —
   
   A. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   
   B. Serious impairment to bodily functions; or
   
   C. Serious dysfunction of any bodily organ or part; or
   
   (ii) With respect to a pregnant woman who is having contractions —
   
   A. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
   
   B. That transfer may pose a threat to the health or safety of the woman or unborn child.

3. **“Labor”** means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.

4. **“To Stabilize”** means, with respect to an emergency medical condition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman in labor, that the woman has delivered the child and the placenta.
5. “Transfer” means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead, or leaves the facility without permission of any such person.

I. MEDICAL SCREENING EXAMINATION

A. General

1. Medical Screening. When an individual comes to the emergency department of the hospital, or to any location on Hospital property, and a request is made on the individual’s behalf for a medical examination or treatment, an appropriate medical screening examination, within the capabilities of the emergency department (including ancillary service routinely available to the emergency department), shall be provided to determine whether an emergency medical condition exists, or with respect to a pregnant woman having contractions, whether the woman is in labor.

Medical screening examinations may be performed by non-physician personnel who, pursuant to hospital policy approved by the Board of Trustees, have been determined to be qualified to conduct such examinations. However, an Emergency Department physician shall examine all patients whose conditions or symptoms require physical examination, as outlined in the hospital’s separate triage or emergency screening policy.

An Emergency Department physician on duty shall be responsible for the general care of all patients presenting themselves to the Emergency Department. This responsibility remains with the Emergency Department physician until the patient’s private physician or on-call specialist assumes that responsibility, or the patient is discharged. (The transfer of responsibility from the Emergency Department to the on-call specialists or private physician shall be documented in the patient’s medical record.)

2. No Delay for Inquiry. A medical screening examination, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual’s method of payment or insurance status. However, if an initial triage assessment indicated that the patient need not be seen immediately, and if collection of demographic data, including financial/insurance resources, will not delay the medical screening examination, appropriate emergency personnel may collect such information.

3. Protection Against Retaliation. A physician or qualified medical person will not be penalized or have adverse actions taken against him based on a refusal to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

4. Nondiscrimination. The Hospital shall not refuse to accept an appropriate transfer of an individual with an emergency medical condition if the individual requires a specialized service (e.g., burn units, shock-trauma units, neonatal intensive care units) available at the Hospital, if the Hospital has the space and personnel available necessary to treat the individual, and the transferring facility does not have the specialized services needed.
5. Signage. The Hospital shall post a sign in the emergency department pursuant to 42 U.S.C. 1395cc(a)(91)(N)(iii), stating the rights of patients under 42 U.S.C. 1395dd (the Emergency Medical Treatment Act), and stating whether the Hospital participates in the Medicaid program. Signs must be clearly readable from a distance of 20 feet. The sign shall be printed in English and other major languages that are common to the area served. The signs shall be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

6. Emergency Room Log. The Hospital shall maintain a central log on each individual who comes to the Emergency Department seeking assistance, as described in Section I (A) (1) above, and whether the individual refused treatment, or was transferred, admitted and treated, stabilized and transferred, or discharged.

B. Stabilizing Treatment for Emergency Medical Conditions & Women in Labor

If it is determined through a medical screening examination that an emergency medical condition exists or that a woman is in labor, emergency department personnel shall: (1) provide such further medical examination and treatment as may be required to stabilize the medical condition, or provide treatment to the woman in labor, within the capabilities of the staff and facilities available at the Hospital, or (2) transfer the individual to another facility provided the conditions in sections II and III herein are fulfilled.

II. TRANSFER OF INDIVIDUALS

A. Transfer Prior to Stabilizing an Individual with an Emergency Medical Condition or a Woman in Labor

An individual with an emergency medical condition, or a woman in labor, must be stabilized prior to transfer, unless:

1. The individual, or a legally responsible person acting on his behalf, requests the transfer after being informed of the Hospital’s obligations under this policy and of the risks of transfer (a written request to transfer shall be obtained); or

2. A licensed physician evaluates the individual and signs a certification, which includes a summary of the risks and benefits, that, based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of the appropriate medical treatment at another medical facility outweigh the risks to the individual’s medical condition from effecting the transfer; and in the case of labor, to the unborn child from effecting the transfer; or

3. If a licensed physician is not physically present in the emergency department at the time a patient is transferred, a qualified medical person has signed a certification (as described in subsection 2) after a licensed physician, in consultation with the person, has made the determination described in subsection 2 and subsequently countersigns the certification.
B. Transfer of Individuals After Stabilization

Transfer to another medical facility by appropriate means may occur after stabilization, under the following circumstances:

1. Specialized Treatment. The individual requires specialized treatment not available at this Hospital and a hospital with specialized facilities has space and personnel available in the specialized facility.

2. Individual’s Choice. The individual requests to be transferred to a physician and a hospital of his or her choice.

3. Transfer of Non-Emergent Individuals. Transfer of patients who do not have an emergency medical condition or who are not in labor may occur routinely or as part of transfer agreements entered into by the Board.

C. Transfer Procedures

After determining that an individual will be transferred from the emergency department or any other department of the Hospital, the individual will be transferred in accordance with the following procedures:

1. Acceptance by Receiving Hospital and Receiving Physician. Prior to transfer, the receiving hospital and receiving physician must consent to the transfer of the individual and agree to provide appropriate medical treatment and hospital care.

2. Medical Treatment. The Hospital shall provide medical treatment within its capacity to minimize the risks of transfer to the individual’s health, or in the case of a woman in labor, to the health of an unborn child.

3. Appropriate Transport. The transferring physician will determine and order life support measures, personnel and equipment that are medically appropriate to sustain the individual during transfer.

4. Personnel Procedures. The Hospital will provide that licensed nurses and other qualified personnel are available and on duty to assist with patient transfers, provide accurate information regarding eligibility and payment practices, and ensure that written protocols or standing delegation orders, as approved by the medical staff, are in place to guide Hospital personnel when a patient is to be transferred to another Hospital.

5. Medical Records. If the Hospital transfers a patient, the Hospital will provide to the receiving physician and receiving hospital a copy of those portions of a patient’s medical record that are available and relevant to the transfer and to the continuing care of the individual. These records will accompany the patient to the receiving hospital; provided, however, that if all necessary medical records for the continued care of the patient are not available at the time the patient is transferred, then the records will be forwarded to the receiving physician and hospital as soon as possible. The
medical records shall contain information relating to the individual’s emergency medical condition, including a brief description of the individual’s medical history (if known) and physical examination, working diagnosis and recorded observations of physical assessment of the patient’s condition at the time of the transfer, treatment provided, results of any tests performed (if available), reasons for the transfer, and the physician certification form attesting to the need to transfer prior to stabilizing the individual (if applicable).

6. Medical Record Retention. The Hospital shall maintain medical and other records related to individuals transferred to or from the Hospital for a period of five years from the date of the transfer.

7. Required Reporting for Transfer. Hospital personnel shall include in the information being transferred with the individual the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

8. Transfer Agreements. All transfers shall comply with Hospital transfer agreements that have been entered into and accepted by the Hospital’s Board.

9. Report of Improper Transfer. The Hospital shall report to the Health Care Financing Administration of the U.S. Department of Health and Human Services, or to the state department of health, any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of 42 U.S.C. 1395dd.

III. ADMINISTRATIVE PROCEDURES

A. Quality Review

1. All transfers from the Emergency Room will be subject to automatic review by the medical staff committee charged with monitoring the quality of care in the Hospital.

2. The medical staff committee charged with monitoring the quality of care delivered in the Hospital will review appropriate records of individuals transferred from the Hospital to determine if the appropriate standard of care has been fulfilled.

B. On-Call List

The Hospital shall maintain a list of physicians who are on call for consultation by telephone and/or telemedicine with the ER physician after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition or women in labor.

C. Refusal to Consent to Treatment or Transfer

1. Refusal to Consent to Treatment. If an individual refuses to consent to examination or treatment, after being informed of the risks and benefits and the Hospital’s obligations under these rules, reasonable attempts shall be made to obtain a written refusal to consent to treatment or
examination on the form provided for that purpose. The individual’s medical record shall contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

2. Refusal to Consent to Transfer. If the Hospital offers to transfer the individual to another medical facility by appropriate means and the individual or a person acting on individual’s behalf refuses to consent to transfer after being informed of the risks and benefits of the transfer, reasonable attempts shall be made to secure the individual’s written refusal to consent to transfer. The individual’s medical record shall contain a description of the proposed transfer that was refused by or on behalf of the individual.

D. Qualified Medical Professional

For purposes of an MSE to evaluate whether an individual who presents to the hospital has an EMC as defined in 42 U.S.C. 1395dd includes a physician, physician’s assistant, nurse practitioner.

IV. ENFORCEMENT

CRH will enforce this Emergency Medical Treatment and Patient Transfer Policy in the same manner as it enforces the other policies and procedures that the Board has adopted for the governance of the Hospital
COBRA Guidelines
Effective. 07/2014

POLICY

All patients presenting to COCHISE REGIONAL HOSPITAL for a non-scheduled visit and seeking care must be accepted and evaluated regardless of the patient’s ability to pay.

PROCEDURE

All patients shall receive a medical screening exam that includes providing all necessary testing and on-call services within the capability of the Hospital to reach a diagnosis. Federal law requires that all necessary definitive treatment will be given to the patient and only maintenance care can be referred to a physician office or clinic.

The triage of a patient for managed care contracts without a medical screening exam is not acceptable under COBRA law. The Health Care Financing Administration (HCFA) states that third-party payors do not have the authority to authorize treatment.

COCHISE REGIONAL HOSPITAL may not transfer or discharge a patient who may be reasonably at risk to deteriorate from, during or after said transfer or discharge. If the patient is at reasonable risk to deteriorate due to the natural process of their medical condition, they are legally unstable according to COBRA standard. This standard also states that a pregnant woman is not legally stable until the baby and placenta have been delivered.

COCHISE REGIONAL HOSPITAL may not transfer patients who are potentially unstable as long as the hospital has the capabilities to provide treatment and care to the patient. A transfer of a patient to another facility may only be for reason of medical necessity.

COCHISE REGIONAL HOSPITAL will provide an on-call physician specialty list which includes all specialties privileged at this facility. (Special rules apply if there are not enough physicians to provide coverage on-call). The on-call list will be openly posted in the Emergency Department and a record of all on-call lists shall be maintained for 5 years. The specialist must respond to the Hospital to render an evaluation and care. Patients may not be sent to the on-call physician’s office for definitive care.

If a patient is to be transferred for medical necessity, the following guidelines must be followed:

A physician certification that the risks of transferring the patient are outweighed by the potential benefits. The individual risks and benefits must be documented and the patient’s medical record must support these, or the patient requests a transfer in writing.
In addition to the following:

The receiving hospital must give acceptance in advance. The acceptance must be documented in the medical record.

Patient gives written consent for transfer.

The patient must be transferred by an appropriate medical transfer vehicle. A patient may not be transferred in a private passenger vehicle unless the patient refuses to be transported by ambulance. The patient’s refusal must be in writing.

The physician will order appropriate medical personnel to attend the patient, maintain and/or initiate treatment or medications and manage known potential adverse affects.

Appropriate life support equipment will be ordered.

Copies of the medical record, x-rays, and laboratory tests will accompany the patient when transferred. In the event copying the records could jeopardize the patient, the records may be sent on a STAT basis to the receiving facility as soon as completed.

MEDICAL SCREENING EXAMS:

Medical Screening Exams should include at a minimum the following:

Emergency Department Log entry including disposition of patient;

Patient’s triage record;

Vital signs;

History;

Physical exam of affected systems and potentially affected systems;

Exam of known chronic conditions;

Necessary testing to rule out emergency medical conditions;

Notification and use of on-call personnel to complete previously mentioned guidelines;

Notification and use of on-call physicians to diagnose and/or stabilize the patient as necessary;

Vital signs upon discharge or transfer;
Complete documentation of the medical screening exam.

EMERGENCY MEDICAL CONDITIONS:

Emergency medical conditions under COBRA law constitute any condition that is a danger to the patient or unborn fetus or could result in a risk of dysfunction or impairment to the smallest bodily part or organ if the patient is not treated in the near future.

Emergency medical conditions include:

Undiagnosed, acute pain which is sufficient to impair the normal functioning

Pregnancy with contractions (defined as unstable)

Substance abuse symptoms (i.e., alcohol ingestion)

Psychiatric disturbances including severe depression, insomnia, suicide ideation or attempt, disassociative state, inability to comprehend danger or care for self.
SUMMARY

A bioterrorism attack is defined as a terrorist attack utilizing biological weapons. Two types of attacks are possible.

Covert, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms.

Because of the rapid progression to illness, it may not be practical to await diagnostic laboratory confirmation. It will most likely be necessary to initiate a response based on the recognition of high-risk syndromes.

Announced, in which persons are warned that an exposure has occurred.

The CDC and FBI have identified the most likely organisms that may be used in such an attack and have recommended appropriate plans for control and treatment.

POTENTIAL AGENTS:

There are four types of organisms that have been identified as the most likely to be utilized in a biological attack:

Anthrax, Smallpox, Botulism, and Plague.

The mode of transmission for these agents in a bioterrorist attack is expected to be aerosol with the potential for large numbers of casualties presenting to healthcare facilities.

INFECTION CONTROL PRACTICES:

Agents of bioterrorism are generally not transmitted by person to person contact.

Standard Precautions are to be utilized for all patient contact.

For certain disease, i.e. smallpox or pneumonic plague, additional precautions are also required. (See Emergency Management Plan)

For airborne agents, negative pressure rooms must be utilized. If there are more patients than rooms available, cohorting patient is advised.
PROTOCOL

Departmental Disaster Plans are to be followed.

The Command Center or nursing office shall notify the local FBI field office, local police department, CDC and state and local health departments of the suspected bioterrorist attack.

Decontamination of exposed individuals may be necessary prior to facility entry. (Refer to Emergency Management Plan).

Department Specific Protocol:

The Emergency Department is most likely to be the initial healthcare contact for patients exposed to chemical weapons.

Emergency Department staff must be aware of unusual cluster (see above) of symptoms and be prepared to initiate a response to bioterrorism-related outbreak.

Decontamination of patients will be conducted outside of the Emergency Department utilizing established policies and procedures.

Treatment of patients will follow infection control policies and the Emergency Management Plan.
**-policy**

The proper response to fire or smoke is R.A.C.E.

R = Rescue patients immediately from fire or smoke area.

A = Pull fire alarm station and call emergency number, giving exact location of fire.

C = Contain the smoke or fire by closing all doors to room and corridors.

E = Extinguish the fire (when safe to do so).

**procedure**

Rescue individuals from the immediate fire or smoke area. Always rescue people before pulling the fire alarm.

Pull the fire alarm and call emergency number to report the fire. Be sure to take this step immediately after rescuing, so that the appropriate emergency response personnel are notified and can start to the scene of the fire.

Contain the fire and smoke by closing all doors in the area.

After all doors are closed in the fire area, attempt to extinguish the fire if it is safe to do so. All employees shall be familiar with the location and operation of fire extinguishers through the fire and safety education program.

If fire or water threatens your area, initiate the following procedures:

- Remove all patients from the fire area;
- Turn off all equipment; however, leave the lights on;
- Calm and reassure any patients who are in your area, but not immediately threatened by the fire;
- Close oxygen shutoff valves as necessary located behind OR doors on the left side;
- Keep telephone lines clear;
- Close all doors and windows;
- Use the fire extinguisher to suppress the fire, only if you have been trained and it is safe to do so;
Notify the Control Center when you are in readiness for evacuation;

Stand by for orders;

Post someone at exit door to maintain order;

Supply a blanket to each patient and a wet towel to cover their face if necessary;

Evacuate bed patients using gurneys or carry them.

If the fire is not in your area, be alert, be guided by the instructions of your Area Fire Marshall, or Emergency Department Clinical Team Leader.

Area Fire Marshalls will:

Direct activities of staff members within their units;

Assign personnel to take fire extinguishers, and report to scene of fire;

Calm and reassure any patients who may be in the department;

Assign personnel to coordinate traffic flow at all fire doors and corridors;

Turn off all equipment;

Close all doors and windows;

Stand by for further orders.
CODE RED
Effective. 07/2014

POLICY

PURPOSE

Establish criteria on the response of the Emergency Department to a Code Red page.

POLICY

Code Red means a fire in the Hospital. The Hospital Operator will announce “Code Red” and its location three (3) times.

PROCEDURE

In the event a fire is discovered within the Emergency Department, pull fire alarm, notify the Hospital Operator, and follow R.A.C.E.

R = Rescue

A = Activate

C = Contain

E = Extinguish or Evacuate
Universal Precautions  
*Effective. 07/2014*

**POLICY**

All patients with blood borne pathogens cannot be reliably identified. Therefore, in order to minimize the risk of exposure to blood and body fluids, precautions will be consistently used for ALL patients.

Universal precautions are intended to prevent parenteral, mucous membrane, and non-intact skin exposure of health care workers to blood borne pathogens. These precautions apply to blood and other body fluids containing visible blood. Universal precautions also apply to semen, vaginal fluids, cerebrospinal fluids (CSF), synovial fluids, pleural fluid, pericardial fluids, and amniotic fluids.

Universal precautions do not apply to feces, nasal secretions, sputum, saliva, sweat, tears, urine, or vomitus unless they contain visible blood.

These precautions do not apply to human breast milk. However, gloves may be worn by health care workers in situations where exposure to breast milk might be frequent, as in breast milk banking.

**PROCEDURE**

Universal precautions are summarized as follows:

**Gloves:** Personnel are to wear gloves for touching blood and body fluids, mucous membranes, non-intact skin of all patients, for handling items or surfaces soiled with blood or other blood/body fluids containing blood and for performing venipuncture and other vascular access procedures. Gloves are to be changed after contact with each patient.

**Hand Washing:** Hands and other skin surfaces shall be washed immediately and thoroughly if contaminated with blood/body fluids. Hands shall be washed immediately after gloves are removed.

**Masks and Protective Eyewear or Facemask:** Personnel are to wear masks and protective eyewear during procedures that are likely to generate blood/body fluid droplets in order to prevent exposure of mucous membranes of the mouth, nose and eyes.

**Gowns/Aprons:** Personnel are to wear gowns or plastic aprons during procedures that are likely to generate splashes of blood or other body fluids.

**Needles/Sharps:** All personnel are to take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments during procedures, cleaning, and disposal. Needles are not to be recapped, bent or cut or manipulated by hand. All used needles/sharps are to be place in the puncture-resistant containers provided. These containers are located in all departments where
needles/sharps are used. In patient care areas, the containers are located in all medication rooms, on the medication carts and in the patient rooms. Small needle holders are provided and are to be used to transport used needles to the puncture resistant container.

Emergency Resuscitation: In order to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags or other ventilation devices are available for use on areas where the need for resuscitation is predictable.

Lesions/Dermatitis: Personnel who have draining lesions or weeping dermatitis should refrain from all direct patient care and from handling patient equipment until the condition resolves. Personnel with open cuts that cannot be covered by gloves or other forms of barrier protection shall refrain from patient care.

Pregnant Personnel: Pregnant personnel are not known to be at greater risk of contracting blood borne diseases than non-pregnant workers. However, if an infection develops during pregnancy, the infant may be at risk. If at all possible, the pregnant health care worker should not work with patients with known blood borne diseases. The pregnant health care worker should be especially familiar with and adhere to precautions to minimize blood/body fluid risks.

Blood/Body Fluid Spills: For cleaning up blood/body fluid spills: wear gloves, wipe up spills carefully with paper towels, spray area with a 1 to 10 gallon dilution of sodium hypochlorite (household bleach), allow to stand for 2 to 3 minutes, wipe area thoroughly with clean paper towels. Discard towels and gloves in the plastic lined trash containers. Wash hands carefully.

Blood/Body Fluid Specimens: All specimens of blood/body fluids are placed in leak-proof containers and placed in a plastic bag for transportation to the laboratory. Care should be taken when collecting the specimen to prevent contamination of the outside of the container.

References:
2. MMWR – CDC August 21, 1987, Vol. 36, No. 23
3. MMWR – CDC June 24, 1988, Vol. 37, No. 24
4. MMWR – CDC April 22, 1988, Vol. 37, No. 15
Fall Prevention & Risk Assessment Policy

PURPOSE

Cochise Regional Hospital’s fall prevention program named “Big Bird” identifies those patients that are a fall risk upon admission. All patients are considered a fall risk. Patients must score out not to be a fall risk. There are 7 basic questions that will be answered and points totaled for a final score that indicate the fall risk.

POLICY

It is the policy of Cochise Regional Hospital that all patients will be assessed by a Registered Nurse at the time of admission to determine fall risk and initiate nursing interventions.

DEFINITION

A fall is defined as an event in which there is uncontrolled, non-purposeful downward displacement of a patient’s body from a standing, sitting, or lying position. Events which require further investigation but are not considered falls include: Patients who sit on the floor voluntarily, and Patients who are assisted to the floor by the staff.

Risk Factors

There are many medications which impact the patient’s physiological balance including:

• Anti-arrhythmics
• Anti-depressants
• Anti-hypertensives
• Diuretics
• Hypoglycemics
• Laxatives
• Neuroleptics
• Non-steroidal and anti-inflammatory agents
• Psychotrophics
• Sedatives/hypnotics
• Vasodilators
• Opioids

PROCEDURE

Patients that are identified as a fall risk will be provided with a bright yellow blanket, yellow slippers and a yellow Fall Risk bracelet for easy identification. As the patient’s condition changes during the course of the hospital stay, the patient will be reassessed for fall risk by nurses caring for the patient. When the patient is considered a high fall risk, this will be documented in the Empower EHR, and the nursing care plan will reflect the appropriate safety measures that have been initiated to prevent falls.
All patients admitted to the Acute Care Department will be assessed during the interview process for completion of the admission database. The following 7 questions must be completed to determine the points a patient must acquire not to be a high fall risk. The following form is based on the Morse Fall Scale which is utilized in the EMR system that is in place.

Fall Risk Assessment Form
Acute Care

1. Had a fall within the last 3 months? Points
   q Yes (25 pts) q No (0 pts) ______

2. More than one (1) diagnosis including chronic conditions?
   q Yes (25 pts) q No (0 pts) ______

3. The use of ambulatory aids (walker, cane, etc.)
   q Total Care (30 pts)
   q Nurse Assist (15 pts)
   q Independent (0 pts) ______

4. Currently on IV Fluids/Heparin Lock?
   q Yes (25 pts) q No (0 pts) ______

5. Gait & Transferring
   q Immobile (20 pts)
   q Weak (10 pts)
   q Normal (0 pts) ______

6. Mental Status
   q Limitations (15 pts)
   q Oriented x 3 (0 pts) ______

7. Review MAR & Compare to list below. Does the patient
   Currently take any of the listed medications?
   Anesthesia within past 48 hours, Anticoagulants, Antidepressants,
   Benzodiazepines, Laxatives/Direutics, Opioids (narcotics),
   Sedatives/Hypnotics, Vasodilators
   q Yes (25 pts) q No (0 pts) ______

Total Points ______
Points

1-34 Normal  (Standard Nursing Prevention Interventions)
>34 High Fall Risk  (High Fall Risk Prevention Interventions)

If the total points are between 1 and 34, the patient will be considered a no fall risk and the following standard nursing interventions will be initiated:

**Standard Fall Prevention Interventions**

- Orient patient to surroundings
- Lighting adequate to provide safe ambulation
- Non-slip footwear
- Instruct to call for help before getting out of bed
- Demonstrate nurses’ call system
- Call bell within reach, visible and patient informed of the location and use
- Light cord within reach, visible and patient informed of the location and use
- Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unnecessary equipment)
- Personal care items within arm length
- Bed in lowest position with wheels locked
- Ambulate as early and frequently as appropriate for the patient’s condition
- Every 2 hour to assess for pain, position, potty, possessions & precautions
- Instruct patient in all activities prior to initiating

If the score is greater than 34, the patient is at high risk for falling and the following interventions will be initiated:

**High Risk Fall Prevention Interventions**

- Actively engage patient and family in all aspects of the fall prevention program (Big Bird)
- Yellow Fall Risk Bracelet, yellow non-slip footwear, and yellow blanket
- Orient patient to surroundings
- Lighting adequate to provide safe ambulation
- Instruct to call for help before getting out of bed
- Demonstrate nurses’ call system
- Call bell within reach, visible and patient informed of the location and use
- Light cord within reach, visible and patient informed of the location and use
- Provide physically safe environment (i.e., eliminate spills, clutter, electrical cords, and unnecessary equipment)
- Personal care items within arm length
- Telephone within reach
- Use of bed alarm and chair alarm
- Bed in lowest position with wheels locked
- Ambulate as early and frequently as appropriate for the patient’s condition
• Assign bed that enables patient to exit towards stronger side whenever possible
• Transfer to stronger side

• Instruct patient in all activities prior to initiating
• Check tips of canes, walkers, and crutches for non-skid covers
• Instruct patient in the use of grab bars
• Every 1 hour to assess for pain, position, potty, possessions, & precautions
• Room placement closer to nurse's station
• Consider use of sitters
• Bedside mat

Patient and family members will be instructed to ask or call for assistance with the use of the call light before getting out of bed. A member of the family or friend of impaired patients (i.e., inability to follow directions) will be allowed to stay at the bedside during the patient's hospital stay and at night. Patients will be re-oriented frequently to time and place as needed. Use of restraints will be used as a last choice for patient safety utilizing Cochise Regional Hospital Restraint Policy protocol.

References:
   Studer Group 2010: Best Practices Patient Falls
   U.S. Department of Veterans Affairs: http://www.va.gov
POLICY

PURPOSE

Establish guidelines to fulfill County Health Department requirements on animal bites treated in the Emergency Department.

POLICY

All animal bites are to be reported at the appropriate law enforcement agency.

PROCEDURE

Obtain appropriate information and document:

- Patient’s name, age
- What type of animal bite
- Location and owner of animal
- Treatment received

Document to which law enforcement agency the report was made.
STAT ER Order
Effective. 07/2014

PURPOSE

To establish standing order protocols for RN’s to follow at COCHISE REGIONAL HOSPITAL Emergency Department (ER).

POLICY

The Nursing Staff in the ER may implement the following standing order protocols:

1. ER Bed Protocol – Place patient on gurney and obtain BP/ pulse/ temp/ pulse ox/ ECG pm/ O2 2lpm via nasal cannula if dyspneic/ start saline lock on all Triage Levels I,II, and III (if pediatric patient ask MD prior to starting on Level III)

2. Chest pain - ER Bed Protocol +
   - Give ASA 81mg x4 chewed (if ASA allergy notify MD STAT)
   - NTG .4mg/ml SL x3 Q5 minutes apart with active chest pain and notify MD with results.
   - Obtain EKG
   - Portable CXR and notify MD when films are up
   - CBC, CMP, Cardiac Enzymes

3. SOB - ER Bed Protocol +
   - O2 via n/c or mask – titrate to keep SaO2 > 92%
   - Xopenex/ Atrovent Unit dose via HHN if wheezing
   - CXR PA/LAT if stable – CXR Portable if unstable
   - Obtain EKG
   - Page RT
   - CBC, CMP, Cardiac Enzymes
   - If Hx of CHF or signs of fluid overload—BNP
   - If febrile—Blood Cultures x 2

4. GI Bleed- ER Bed Protocol +
   - Start 2 Large bore IV’s with NS @ TKO
   - CBC/ CMP/ PT/ PTT/ Type& Screen

5. Vaginal Bleed (known IUP< 20 wks) – ER Bed Protocol +
   - Start a Large bore IV with NS@ TKO
   - Obtain UA (clean catch or cath )
   - Obtain Fetal Heart Tones (if possible)
   - Set up for a Pelvic Exam
• CBC/ BMP/ Serum Beta HCG(Quan)

6. Abdominal Pain – ER Bed Protocol +

• Obtain UA (clean catch or cath)
• Urine HCG for all menstruating females
• CBC, CMP, Amylase, Lipase

7. Trauma – ER BED Protocol +

• Alert MD STAT
• O2 via N/C or NRB Mask to keep SaO2 < 92%
• Use of OP airway if indicated (page RT)
• Remove all clothing and keep patient warm
• Apply C-Collar and initiate C-Spine precautions if indicated
• Splint any extremity injuries in-place
• Apply pressure to any wounds and dress appropriately
• Start 2 Large bore IV’s with NS @TKO
• CBC/CMP

8. Altered Mental Status- ER Bed Protocol +

• Portable CXR
• EKG
• Obtain UA (clean catch or cath)
• CBC/ CMP/ DOA/ ETOH
• Accu-check

9. Seizures- ER Bed Protocol +

• O2 via N/C or NRB to keep SaO2< 92%
• Alert MD STAT if seizing
• Use of OP airway if indicated (page RT)
• Accu-check
• CBC/ CMP/ ETOH/ DOA
• Seizure precautions
• 1 large bore IV


• If OD- call Poison Control for Tx Options
• Start IV with NS@TKO
• EKG
• Urine HCG for menstruating females
• Obtain UA  
• CBC/ CMP/ DOA/ ETOH/ Tylenol & ASA Levels  
• SEABHS Consult

11. Snakebite- ER Bed Protocol +

• Alert MD STAT  
• Start 2 Large bore IV’s with NS@TKO  
• Consult with Poison Control  
• Contact Pharmacy  
• CBC/ CMP/ PT/ PTT/ CPK/ ETOH  
• Mark and Document Bite and circle with a Sharpie marker

12. Pain Management-

• For any patients claiming any pain 8/10 or greater notify MD

13. Extremity Injuries

• Document peripheral pulses and cap refill on arrival  
• Splint extremity immobilizing joint above and below injury  
• Ice pack to affected area pm  
• Obtain appropriate X-Rays

14. Wounds/ Lacerations-

• Inspect all wounds and notify MD of any arterial involvement  
• Cleanse with Hibiclens and NS  
• Cover with a sterile dressing  
• Suture Kit to the bedside if indicated  
• Tetanus prophylaxis if indicated

15. Fever in Children (under age 12)-

• For Temp >100F give Tylenol 15mg/kg po/pr  
• For Temp >103F give Tylenol 15mg/kg po/pr along with Motrin 10mg/kg po and notify MD STAT
Adopted by the Medical Staff, 6/20/2014

Luciano Fochesatto, M.D.
Chief Medical Officer

Approved by the Board, 7/07/2014

Seth Guterman MD
Chairman of the Board

Approval Date: 7/15/14