Cochise Regional Hospital
Acute Care
Policies & Procedures
# ACUTE CARE POLICIES AND PROCEDURES

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Philosophy of the Nursing Department  
Effective: 06/2014

PHILOSOPHY

• We believe in the value of the Professional Nurse;
• We believe in “Patients First”;
• We believe quality nursing practice includes the art of “Nursing as Caring” and the science of critical thinking and clinical outcomes;
• We believe continued advancements in technology enhance nursing practice;
• We believe evidence-based practice and continuous quality improvement lead to positive patient outcomes;
• We believe in collaboration, teamwork, and innovation;
• We believe in professional growth advances and practice of nursing;
• We believe in the nurse’s role in promoting community wellness makes a difference.

PRINCIPLES

• Every patient’s care is guided by an RN;
• Patient safety is at the core of every nursing decision and action;
• Person centered care is coming to know one patient at a time, thus creating harmony and healing;
• Individual accountability improves quality of care;
• Nurses must act with integrity and within the established scope of practice;
• Communication among caregivers must embrace caring and be timely, continuous, and complete;
• Community is viewed from the patient’s perspective.

MISSION STATEMENT

Through teamwork, excellent patient care is obtained.
Admission Policy
Effective: 06/2014

Admission to the hospital will be without regard to race, color, creed, national origin, or ability to pay.
Each admission to the hospital will be on written or verbal order of a member of the Active or Courtesy medical staff.
The Nursing Admission Assessment shall be completed within eight (8) hours of admission. Patients admitted as outpatients from surgery shall have the admission forms completed pre-operatively.
At the time of the admission, each adult patient/resident will receive an admission packet consisting of:
1) Patients rights and responsibilities
2) Written summary of the state law on the patient’s right to accept and reject medical treatment
3) Information about the right to formulate Advance Directives. The patient will be consulted during the admission process regarding any Advance Directives he/she may wish to present. The patient can be referred to the Physician in charge for more information on Advance Directives.
4) Notice of Privacy Practices
5) A written summary of the telemedicine platform
The Admitting Nurse will assure that the patient has received the packet, determine if the patient/resident has any immediate needs for action or information, and ensure the signed admission packet is in the Empower Electronic medical record. The nurse admitting the patient will initiate that patient’s Care Plan, appropriate documentation and referral to the Case Managing Dept for Discharge Planning if applicable.
The patient will be consulted during the admission process regarding his Primary Care Doctor and their office information, which should be documented in the Empower system.
Admission as an Inpatient versus Observation status will follow CMS guidelines. Patients admitted to Cochise Regional Hospital will have a hospital stay an average of 96 hours. However, observation status should not normally exceed 24 hours.
Placement of patients within the hospital will be the responsibility of nursing service. Patients will be assigned rooms appropriate to their diagnosis, sex, age and need for close observation. Patient admissions, which create difficult or problem unit assignment situations, will be addressed using a collaborative problem solving approach.
Patients facing a potential surgical intervention may have initial medical management of a surgical condition and pre-operatory risk stratification (when applicable) done at Cochise Regional Hospital prior to transfer to higher level of care in case the surgical procedure is not available at Cochise Regional Hospital on a certain point in time.
Patient Rights and Responsibilities*

Effective: 06/2014

In caring for the medical problems of patients, Cochise Regional Hospital strives at all times to respect the patient’s individuality, privacy and other rights.

PATIENT RIGHTS

1. Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment of care.

2. The patient has the right to considerate, respectful care of his or her personal values and beliefs, at all times and under all circumstances, with recognition of his personal dignity.

3. The patient has the right to be informed about and participate in decisions regarding his/her care.

4. The patient has the right, within the law, to personal and informational privacy, as manifested by the following rights:

   a. To refuse to talk with or see anyone not officially connected with the hospital including visitors, persons officially connected with the hospital but not directly involved in his/her care.

   b. To wear appropriate personal clothing and religious or other symbolic items as long as they do not interfere with diagnostic procedures or treatments.

   c. To be interviewed and examined in surroundings designed to assure reasonable visual or auditory privacy. This includes the right to have a person of one’s own sex present during certain parts of physical examination, treatment, or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.

   d. To expect that any discussion or consultation involving his/her care will be conducted discretely and that individuals not directly involved in his/her care will not be present without his/her permission.

   e. To expect all communications and other records pertaining to his/her care including the source of payment for treatment to be treated as confidential.

   f. To have his/her medical record read only by individuals directly involved in his/her treatment or in the monitoring of its quality. Other individuals can read his/her medical record on the patient’s written authorization or that of his/her legally authorized representative.
g. To request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing.

h. The patient, at his/her own request and expense, has the right to consult with a specialist.

5. The patient has the right to security.

6. The patient has the right to access protective services.

7. The patient has the right to participate in ethical questions that arise in the course of care.

8. The patient has the right to seek pastoral care and other spiritual services except when it violates hospital safety and security.

9. The patient may refuse treatment of any procedure that has been explained fully to the extent permitted by law. When refusal of treatment by the patient or his legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

10. A patient may not be transferred to another facility or organization unless he has received complete explanation of the need for the transfer and of the alternatives to such a transfer. The patient has the right to be informed by the doctor responsible for his/her care, or his delegate, of any continuing health care requirements following discharge from the hospital.

11. Regardless of the source of payment for his care, the patient has the right to request and receive an itemized and detailed explanation of his total bill for services rendered in the hospital. The patient has the right to timely notice prior to termination of his eligibility for reimbursement by any third party pay for the cost of his care.

12. The patient should be informed of the hospital rules and regulations applicable to his/her conduct as a patient. Patients are entitled to information about the hospital’s mechanism for the initiation, review and resolution of patient complaints.

13. It is the policy of CRH to provide patients with information and assistance in formulating advance directives as desired by the patient and mandated by Arizona statute.

14. The patient has the right to information and assistance with his/her wishes regarding organ donation.

15. The patient has the right to have his/her pain managed appropriately, including:
a. Information about pain and pain relief.

b. A concerned staff that is committed to pain prevention.

c. Health professionals who respond quickly to reports of pain.

16. Patients, and when appropriate, the family, are informed of the outcomes of care including unanticipated outcomes.

PATIENT RESPONSIBILITIES

1. A patient is responsible to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters relating to his/her health. He/she has the responsibility to report unexpected changes in his condition, or perceived risks of care, to the responsible practitioner. A patient is responsible for reporting whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

2. Patients’ responsibilities in regard to his/her pain:

   a. Ask your doctor or nurse what to expect regarding pain and pain management.
   b. Discuss pain relief options with your doctor or nurse.
   c. Work with your doctor and nurse to develop a pain management plan.
   d. Ask for pain relief when pain first begins.
   e. Help the doctor or nurse measure the pain.
   f. Tell the doctor or nurse if pain is not relieved.

3. A patient is responsible for following the treatment plan recommended by the doctor primarily responsible for his/her care. This may include following the instructions of nurse and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner’s orders, and enforce the applicable hospital rules and regulations. The patient is responsible for keeping appointments and when he/she is unable to do so for any reason for notifying the responsible practitioner or the hospital.

4. The patient is responsible for his/her actions, if he/she refuses treatment or does not follow the doctor’s instructions.

5. The patient is responsible for assuring that the financial obligations of his/her patient care are fulfilled as promptly as possible.
6. The patient is responsible for following hospital rules and regulations affecting patient care and conduct.

7. The patient is responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and the hospital.

TOWARD IMPROVING YOUR CARE

You will have better outcomes if you become an active member of your health care team. Your role in helping facilitate the safe delivery of care is:

1. The quality of your care and positive outcomes are based on your provision of accurate information, to not only your physician, but also the health care team assembled to provide for your treatment.

2. Asking Questions – You are responsible for asking questions when you do not understand what you have been told about your care or what you are expected to do. Speak up if you have questions or concerns. You can ask a family member or friend to be your advocate, help you get things done, and speak for you, if you cannot make your concerns known.

3. Follow Instructions – You should express any concerns you have about your ability to follow and comply with the proposed treatment plan or your course of treatment.

4. Accepting Consequences – The patient and family are responsible for all outcomes, if they do not follow the care, service, or treatment plan as proposed by the health care team.

5. Show Respect and Consideration – Patients and families are responsible for being considerate of the hospital’s personnel and property, as well as respecting the rights of other patients.

6. Meeting Financial Commitments – You are responsible for the financial arrangements of your hospital stay. This includes making sure the correct insurance information is provided and arrangements for your portion of the payment has been taken care of.

*Spanish version available upon patient request*
State Law: Patient’s right to accept and reject Medical treatment*

* Spanish version available upon patient request
Advance Directives*

Effective: 06/2014

These are written statements about how you want your health care decisions made. Under Arizona law, there are three common types of advanced directives: They are:

A medical power of attorney, which is a written statement in which you name an adult to make health care decisions for you. That person will make such decisions for you only when you cannot make or communicate such decisions.

A living will, which is a written statement about health care you do or do not want and is to be followed if you cannot make your own health care decisions (for example – if you fell into a comatose state).

A prehospital medical care directive, which is a directive refusing certain lifesaving emergency care given outside a hospital or in a hospital emergency room. To make one, you must complete a special orange form and have your doctor sign it.

If you have not made any provisions for your own health care, the court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find a surrogate to make health care decisions for you:

1. Your husband or wife, unless you are legally separated.
2. Your adult child, if more than one then a majority of those available.
3. Your mother or father.
4. Your domestic partner, unless someone else has financial responsibility.
5. Your brother or sister.
6. A close friend of yours who shows special concern for you.

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide on the advice of an ethics committee, or if this is not possible, with the approval of another doctor.

* Spanish version available upon patient request
Notice of Privacy Practices for Personal Health Information*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes the practices of Cochise Regional Hospital for safeguarding individually identifiable personal health information. The terms of this Notice apply to patients' and their families.

We are required by law to maintain the privacy of our patient's and family's personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make new Notice effective for all personal health information maintained by us. You have the right to request a paper copy of the Notice.

Uses and Disclosures of Your Personal Health Information

Authorization: Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken action in reliance on the authorization, you have the right to revoke an authorization if the request is in writing and sent to: Cochise Regional Hospital, 2174 W. Oak Avenue, Douglas, Arizona 85607. A form to revoke an authorization can be obtained from Cochise Regional Hospital.

Disclosures for Treatment: We may disclose your personal health information as necessary for your treatment. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist you in your care.

Uses and Disclosures for Payment: We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Other Health-Related Uses and Disclosures: We may contact you to provide reminders for appointments; information about treatment alternatives or other health-related programs, products or services that may be available to you.

Business Associate: Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Family, Friends and Personal Representatives: With your approval, we may disclose to family members, close personal friends, or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are
unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

**Other Uses and Disclosures:** We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

* For any purpose required by law;
* For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
* To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
* For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions):
* For judicial or administrative proceeding (for example, pursuant to a court order, subpoena or discovery request);
* For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
* To coroners and funeral directors;
* For procurement, banking or transplantation or organ, eye or tissue donations:
* For certain research purposes;
* To avert a serious threat to health or safety under certain circumstances;
* For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
* For compliance with workers’ compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulations.

**Your Rights**

**Restriction on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to:

Cochise Regional Hospital, 2174 W. Oak Avenue, Douglas, Arizona 85607. A form to request access to your personal health information can be obtained from the Compliance Officer. We are not required to grant the request in certain circumstances.

**Accounting of Disclosure of Your Personal Health Information:** You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, or your personal health information. To request an accounting, you must send a written request to: Cochise Regional Hospital, 2174 W. Oak Avenue, Douglas, Arizona 85607. A form to request an accounting of your personal health information can be obtained from the Compliance Officer.
The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during the same period.

**Complaints:** If you believe your privacy rights have been violated, you can send a written complaint to us to the Compliance Officer, at Cochise Regional Hospital, 2174 W. Oak Avenue, Douglas, Arizona 85607. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact our Administration at (520) 364-7931

Patient Signature ____________________________ Date ______________

Witness Signature ____________________________ Date ______________

* Spanish version available upon patient request*
elemedicine Platform Summary*

Effective: 06/2014

Overview: Telemedicine is a growing field made possible by the emergence and availability of technology – and will be an especially important patient care tool in combination with the Empower Systems EHR. Physician access to timely patient data combined with an actual patient assessment is key.

Purpose: Telemedicine will bring to our patients an innovative Tele-Hospitalist service along with a wide range of specialists physicians that will guide and participate in the care of patients while at CRH. The goal is to enhance the types and quality of care, and to bring accessibility to that care to the citizens of our surrounding communities and Cochise County, right here at CRH.

Your doctors:

A) You are currently under the care of the Cochise Regional Hospital House Doctor.
B) The Tele-Hospitalist will be overseeing your care and will be providing consultation when requested by the house doctor. Doctors from other subspecialties will be providing you with outstanding medical care during this admission through the telemedicine robot when requested by the house doctor as well. These different subspecialties may include: Tele-Cardiology, Tele-GI, Tele-ID, Tele-Psychiatry etc.
C) The Tele-Hospitalist will always be available to see you with the robot if we need them. We don't always use the robot for same day follow-up visits, we can call the Doctor anytime by phone. If patient/family needs to speak to Doctor we can always call them as well.

* Spanish version available upon patient request
 Orientation of Staff  
**Effective: 06/2014**

**POLICY**

Patient Care Service staff is required to complete orientation and demonstrate competency as defined by professional licensure, required core and job-specific competencies including age-specific competencies.

**PROCEDURE**

Acute Care nurses are to be oriented by working with another nurse who has more than six (6) months of nursing experience in our facility. Orientation may consist of a total of six (6) shifts for Acute Care depending on experience of RN. If RN is applying for a night position, these shifts should include working 4 shifts on day shift and 2 shifts on night shift. RNs applying for a day shift may work all six (6) orientation shifts during the day shifts. Orientation also includes review of Orientation packet and completion of Orientation modules.

Emergency Department nurses orientation will take place in the Emergency Department, but will follow above-mentioned guidelines.

Evaluation of the orientee’s skills is to be made between the preceptor and nurse manager or Director of Nursing (DON).

If the new orientee is deemed competent, he/she will be scheduled to work as a staff nurse.

The below items should be completed prior to new employee working as a staff nurse:
- Review of competencies* (to be completed during orientation process by preceptor)
- Orient to crash cart, medication room, med-dispense, Empower
- Review of policy and procedure manuals prior to and/or concurrently starting orientation to the unit

* including the set up of Bipap/CPAP and mechanical ventilator  
* including the use of the telemedicine platform
Cochise Regional Hospital Admission vs Transfer Workflow

Transition period policy – Effective: 06/2014

1) The **Tele-Hospitalist** on call should be paged for all patients older than 18 years of age (EXCEPT STEMI*, Psychiatric patients without active medical problems, and Pregnant patients) that are not being discharged from the ER, prior to the establishment of the appropriate disposition:
   A) **Admission** to CRH; versus
   B) **Transfer** to Outside Facility

2) To page the **Tele-Hospitalist**, please place an order in the Empower system “Hospitalist - Page” which will trigger an automatic message with patient identifiers, which will be sent to the Tele-Hospitalist on call. If there is no answer in 15 minutes, please resend the message. If no answer in additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

3) The Tele-hospitalist will follow CMS guidelines in order to establish Observation vs Inpatient status. Moreover, not only patient needs, but also Cochise Regional Hospital capabilities will be taken into consideration while evaluating the need for transferring a patient to a higher level of care.

4) **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. To consult the Tele-Hospitalist, please place an order in the Empower system “Hospitalist - Page”, which will trigger an automatic message with patient identifiers, which will be sent to the Tele-Hospitalist on call. If there is no answer in 15 minutes, please resend the message. If no answer in additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

5) If the patient’s final disposition is a **TRANSFER** to an outside facility, the **on-site doctor** will coordinate the transfer process. Preference should be to transfer the patient to the closest hospital capable of addressing patient’s condition. **Sierra Vista Regional Health Center** should be able to manage most of our outside transfers and should be the referral center of choice (unless Sierra Vista Regional Health Center is not able to offer a specific service at that point in time and/or patient requests to be transferred to an alternative facility).

* For **STEMI** patients, please call STAT the **Sierra Vista Regional**
6) **ALL** patients admitted to Cochise Regional Hospital (CRH) should be admitted to the **onsite doctor**. **Tele-Hospitalist team** will follow all patients admitted to the Acute Care Floor, and will be available for official consultation 24/7 upon request.

7) 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 **Acute Care RN** should notify the subspecialist physicians of any consultations requested. For a **Subspecialist consult**, send a secure text message with patient identifiers and clinical information to the subspecialty of choice (Tele-Cardiology HCCI, Tele-GI, Tele-Infectious Disease, etc– the on call schedule to be released monthly). For a Tele-Psychiatry consult, please place an order in the Empower “Psychiatry consult – Dr Berkowitz”. If no answer in 15 minutes, please re-send the message. If no answer after an additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

E) **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.** To consult the Tele-Hospitalist, please place an order in the Empower system “Hospitalist - Page”, which will trigger an automatic message with patient identifiers, which will be sent to the Tele-Hospitalist on call. If there is no answer in 15 minutes, please resend the message. If no answer in additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

F) **Discharge and Follow-up Plan**.

8) Both the **Acute Care RN on duty** and the **onsite MD on-site** should carry the CRH provided cell phones at all times.

a. **From 7 am to 7 pm**, if the Acute Care RN has any questions/concerns regarding patients already admitted to CRH, they can either send a secure message to the Tele-Hospitalist on call (schedule to be released monthly), or text the onsite Doctor on call. If no answer in 15 minutes, please re-send the message. If no answer in an additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

b. **From 7 pm to 7 am**, for any questions/concerns regarding patients already admitted to CRH, the Acute Care RN on duty should send a secure message to the **onsite MD**, which will be providing overnight coverage. If no answer in 15
minutes, please call the MD on-site CRH cell phone number. If no answer after an additional 15 minutes, please call the Chief Medical Officer, Dr. Fochesatto, at 773-666-3587.

9) Discharge Planning is an important part of medical care. Discharge Planning at Cochise Regional Hospital is performed by the Case Manager Department*. Patient discharge needs include but are not limited to:

   A) Home Health Care referral, if applicable.
   B) Nursing Home referral, if applicable.
   C) Schedule follow-up appointments with both Primary Care Doctor and Specialists prior to discharge when indicated.**
   D) Schedule all outpatient tests at CRH prior to patient’s discharge**
   E) Fax all prescriptions to patient’s pharmacy prior to patient’s discharge**
   F) Call patient within 7 days post discharge to ensure compliance with medications, outpatient testing and follow up appointments, and to assess satisfaction rate.

* all Case managing documentation should be completed in the Empower System.
** after business hours, these tasks should be performed by the day shift Acute Care floor RN.
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 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.
PURPOSE

The chart is a legal representation of the patient’s stay in the hospital. All information regarding care, treatment and education of the patient must be documented in some form in the record of stay. The documentation must create a factual picture of events.

POLICY

- Events must be recorded in real time through one of the “Computer on wheels” when allowed by patients acuity; Retroactive documentation is only accepted when acute care floor acuity is high.
- Events must be recorded in proper chronological order
- Time entries using military time
  - Be sure to document the time patient arrived, and
  - The time patient is discharged
- CRH requires documentation on the Acute Care chart a minimum of every four (4) hours. However, documentation on the Acute Care chart should be done based on the following guidelines as per Patient’s Acuity Level;
  - Level 1 – every 3-4 hours
  - Level 2 – every 2-3 hours
  - Level 3 – every 1-2 hours
  - Level 4 – every 30 min - 1 hour
- Writing should be brief and concise, but should reflect current patient’s condition.
- All required clinical documentation fields showed in the Empower should be completed.
- Statements that are authentic and explicit may avert unnecessary legal action.
- General documentation should include:
  - Appropriate Assessment
  - A Plan of Care
  - Nursing Interventions
  - Evaluation of Behaviors
  - Therapeutic and Diagnostic Events
  - Education provided to patient or family regarding illness and expectations
• Provide objective, accurate description of complaints, measures taken and follow up to these complaints.
• If a late entry or addendum is needed, write the date and time of the event.
• If a change in the patient’s condition is identified, the physician should be notified promptly. Document the date, time physician notified, method of communication.
PURPOSE

The purpose of this policy is to provide general guidelines for safe and effective administration of medications.

APPLICABILITY

Administration of medication shall be recorded within the electronic health record only. Medications will be administered by, or under the supervision of, appropriately licensed personnel in accordance with applicable law and regulation governing such acts in accordance with approved medical staff rules and regulations. This policy applies to all CRH nursing staff who administers medication.

DEFINITIONS

1. Adverse reaction: a detrimental response in association with a given FDA approved or investigational medication that is undesired, unintended, or unexpected.
2. Controlled medication: Legally controlled substances of class I to V as designated by the DEA/FDA.
3. Medication administration – the provision of prescribed medications by authorized nursing personnel in a manner that assures proper patient and medication identification, monitoring of the medication’s effect on the patient, knowledge of possible side effects, and appropriate documentation.
4. Medication dispensing – the issuance of prescribed medications by authorized pharmacy personnel.
5. Medication error: wrong patient, wrong medication, wrong dose, wrong route, wrong time, or late dose.
6. Medication Related Events – an error made in administering a medication in relation to a near miss, wrong dose, patient, drug, route, rate, time, adverse reaction, the omission of a medication and prescribing or dispensing errors.
7. Medication Order Review – a process that assures that the MAR/eMAR is a correct reflection of current medication orders and is appropriate for the patient and their condition.
8. eMAR – electronic medication administration record.
9. Written Orders – An order hand-written or entered electronically.

PROCEDURE

A. Who May Administer Medications

1. Licensed Professional personnel with prescribing privileges at CRH
2. Licensed nursing personnel (RN/LPN as defined by the Arizona Nurse Practice Act)
3. Registered Radiology Technologist certified to inject contrast media or other medications for the purpose of diagnostic examinations and procedures under the supervision of a physician or following a protocol approved by the Medical Staff
4. Self-administration of medications is permitted when:
Ordered by the physician.
b. Verified by the pharmacy or other licensed professional.
c. Monitored by nursing and pharmacy.

Process for Medication Administration

Any person administering medications is responsible for the performing these steps prior to administration of a medication.

1. Open the eMAR on a computer in the patient's presence.
2. Review the eMAR, Pharmacy RN Task, or order while in the patient’s presence.
3. Verify Patient identification using one of the following methods:
   a. Ask the patient to state their name and date of birth and compare it to matching information on the eMAR.
   b. Compare the ID band adhered to the patient with matching information on the eMAR.
4. Compare eMAR, or order, while in the patient’s presence, to the label of the medication.
5. Verify the medication is the right medication, dose, route, time, and patient, not expired, no contraindications, and labeled correctly.
6. Prior to medication administration all issues or concerns regarding any order (s) have been clarified by the ordering physician and appropriately documented in the medical record.
7. Provide patient education.
8. Administer the medication using the bar coding technology:
   a. Scan employee ID
   b. Scan patient wrist band
   c. Scan medication bar code. At completion of this step documentation will automatically populate in the patients medical record.
9. Monitor the patient as needed.
10. Medications that are removed from their original packaging not prepared in the patient’s presence and not immediately administered to a patient by the person preparing the product must have the syringe or container labeled.
11. The label must include:
   a. Name of the medication.
   b. Dose or amount.
   c. Expiration date (when not used within 24 hours).
   d. Expiration time (if expiration time is less than 24 hours).
12. Labeling is not required if a medication is prepared in the patient’s presence by the same person administering the medication.
13. The beginning of each shift, the nurse will check the IV fluids for right solution, and right rate of medications being administered for the right patient.
Medication Related Events

When a medication related event occurs:

1. Assess and support the patient; provide necessary care.
2. Notify the patient’s physician.
   a. Refer to Medication Errors Reporting and Processing Policy
5. Facts surrounding the incident shall be discussed with the patient as appropriate by designated treating staff.
Administration of Intravenous Medications

**Effective: 06/2014**

**POLICY**

Selected I.V. medications requiring infusion may be administered through additive bags or attached to mini bag plus bags with secondary I.V. sets according to established protocol.

**PRINCIPLES**

1. Effective and safe administration of IV medications requires a knowledge of CRH policy and IV medication administration technique.

2. The amount of dilution of IV admixtures will be under the direction of the Pharmacy based on approval of the medical staff.

3. When the pharmacy is closed, IV medications to be administered via additive bags or attached to mini bag plus bags must be diluted via pharmacy protocols.

4. Flushing between drugs is recommended for highly incompatible medications.

5. Flushing before and after drugs administered in an IV lock (male adapter plug) is recommended to maintain patency of catheter.

6. When medication can be diluted in less fluid, IV push or a min-infuser system may be used.

**PROCEDURES**

An infusion pump shall be used whenever possible.

Admixture bags with secondary infusion sets shall be used.

Intravenous admixture medications shall be dispensed from the pharmacy upon receipt of written order from a physician or telephone order received from authorized nursing personnel on behalf of the physician.

All drugs requiring refrigeration shall be stored in the refrigerator and shall be available for the next scheduled dose. The medication shall be removed from the refrigerator and allowed to reach room temperature before administration.

**Primary tubing** shall be changed every 72 hours (hospital policy). New secondary tubing shall be hung with each different medication. **Secondary tubing shall be changed every 48 hours.**

If continuous IV fluids are running, check for compatibility of medications with IV fluids. It may be necessary to stop continuous infusion to administer medications. Continuous IV tubing shall be flushed with normal saline before and after medication administration in such cases.

In all medication administration procedures, it is imperative for the nurse to follow the five rights.
All IV medications shall be documented in the patient’s medical record per CRH policy.

**PREVENTIVE MAINTENANCE**

IV infusion pumps shall be checked annually and recertified by UHS. If any problems should occur with IV pump use, the maintenance department should be contacted and a work order form describing the problem attached to the pump and the pump removed from service.
Administration of Intravenous Push Medications

Effective: 06/2014

POLICY

Selected IV medications requiring no dilution or fairly rapid administration may be pushed directly into the IV tubing or IV lock according to established protocol.

ADVANTAGES

In emergency situations, some IV medications need to be given undiluted and rapidly to effectively control the problem. Other medications such as narcotics may work better if left undiluted.

PRINCIPLES

1. Effective and safe administration of IV medications requires a knowledge of CRH policy and IV medication administration technique.

2. The timing of IV push medications shall be under the direction of Pharmacy based on the approval of the medical staff.

3. When the Pharmacy is closed, IV medications to be administered must follow Pharmacy protocols.

4. Flushing between drugs is recommended for highly incompatible medications.

5. Flushing before and after drugs administered in an IV lock (male adapter plug) is recommended to maintain patency of catheter.

6. When medication can be diluted in small amounts of fluid, IV mini-infuser system may be used.

PROCEDURES

1. Intravenous medications shall be dispensed from the Pharmacy upon a medical order from a physician or telephone order received from authorized personnel on behalf of the physician.

2. All drugs requiring refrigeration shall be stored in the refrigerator and shall be available for the next scheduled dose. The medication shall be removed from the refrigerator and allowed to reach room temperature before administration.

3. If continuous IV fluids are running, check for compatibility of medications with IV fluids. It may be necessary to stop continuous infusion to administer medications.

Continuous IV tubing should be flushed with normal saline before and after medication administration in such cases.
4. In all medication administration procedures, it is imperative for the nurse to follow the five rights.

5. IV push medications should be given over a minimum of two (2) minutes period of time or as described by manufacturer or as dictated by pharmacy. It may be necessary to use a distal port in the IV tubing for this purpose.

6. Certain IV meds such as Dilantin, Digoxin and insulin require a longer infusion time. If the nurse is not familiar with the IV infusion of these medications, she/he should refer to the IV Drug Handbook located in the medication room or check with Pharmacy on medication infusion.

7. If medications are given through an IV lock (male adapter plug) the lock should be flushed with normal saline before and after medication administration to maintain patency. In some cases, 10 units of Heparin may be used to flush the IV lock.

8. All IV medications shall be documented and charged on the patient's MAR per CRH policy.
Dispatching/Obtaining Drugs when Pharmacy Closed  
*Effective: 06/2014*

**POLICY**

The Pharmacy shall maintain a limited supply of commonly used drugs in specially designated location(s) for use when drugs are not in the patient's supply and cannot be obtained from the Pharmacy in a timely manner.

Items shall be chosen with safety in mind, limiting wherever possible, quantities, dosage forms, and container sizes that might endanger patients.

When drugs are not available from the patient’s supply or other stocks, they shall be obtained from the Pharmacy by authorized personnel and the Nursing Supervisor shall be contacted. A pharmacist shall be contacted if needed.

A list of authorized nursing personnel shall be posted on the Pharmacy door.
**PURPOSE**

To support safe intravenous therapy and to establish the rate to infuse an intravenous fluid when ordered “TKO” or “KVO”.

**POLICY**

CRH is committed to providing quality care. In a majority of treatment plans, intravenous therapy is clinically indicated to regulate and maintain essential fluids and provide an avenue for administration of intravenous medications. This policy provides the framework necessary for ensuring effective management of intravenous therapy. Intravenous TKO rate shall be 30mL/hr.

**DEFINITIONS**

TKO: To Keep Open or KVO: Keep Vein Open – The amount of intravenous fluid required to keep the catheter or needle from clotting off, rendering the IV non-functional.

**SPECIAL CONSIDERATIONS:**

- If the physician orders TKO or KVO and a rate is not specified, the rate shall be 30ml per hour.
- For Pediatric patients, a physician order must define the TKO rate.
- If the rate is ordered TKO or KVO and the physician has designated a rate, that designate rate will be the infusion rate.
- An infusion pump may be used to maintain the TKO rate as appropriate.
- Other controller devices may be used or drop counting methods can be used by following the IV tubing manufacturer’s instructions.
Telemedicine RN policy
Effective: 06/2014

Overview: Telemedicine is a growing field made possible by the emergence and availability of technology – and will be an especially important patient care tool in combination with the Empower Systems EHR. Physician access to timely patient data combined with an actual patient assessment is key.

Purpose: Telemedicine will bring to our patients an innovative Tele-Hospitalist service along with a wide range of specialists physicians that will guide and participate in the care of patients while at CRH. The goal is to enhance the types and quality of care, and to bring accessibility to that care to the citizens of our surrounding communities and Cochise County, right here at CRH.

Role: The role of the support nurse will be a vital part of the initiation, performance and evolution of the telemedicine program at CRH. The Acute Care RN on duty will execute this role. Your assistance in the introduction of the program to our patients will be one of the keys to the overall success. This is closely followed by your on site assistance with the operation of the telemedicine robot.

Procedure: The TSN will do the following during a Telemedicine consultation:

1. Present the following points on a positive and supportive way:
   a) You are currently under the care of the Cochise Regional Hospital House Doctor.
   b) The Tele-Hospitalist will be overseeing your care and will be providing consultation when requested by the house doctor. Doctors from other subspecialties will be providing you with outstanding medical care during this admission through the telemedicine robot when requested by the house doctor as well. These different subspecialties may include: Tele-Cardiology, Tele-GI, Tele-ID, Tele-Psychiatry etc.
   c) The Tele-Hospitalist will always be available to see you with the robot if we need them. We don’t always use the robot for same day follow-up visits, we can call the Doctor anytime by phone. If patient/family needs to speak to Doctor we can always call them as well.

2. Get the Telemedicine Robot ready and establish connection with telemedicine Physician prior to bringing the robot in the patient’s room.

3. Support and assist the Telemedicine Physician by conducting the interview and physical examination under physician guidance and/or templates if applicable.
Pain Control Policy

Effective: 06/2014

PURPOSE

To create an assessment tool useful in evaluating, documenting and reassessment of pain in all patients at the Cochise Regional Hospital.

POLICY

1. All patients should be assessed for pain factors and history, initially upon presentation to the facility, then subsequently thereafter according to type of pain, level of effectiveness regarding medications or treatment utilized. All patients who receive treatment for pain relief, as warranted by their specific presentation and circumstances surrounding their admission to the facility, and monitored for effectiveness.

2. An interdisciplinary group, including physicians, nurses, pharmacist and others working to meet the individual needs of the patient and family will assure that pain management options are available and applied efficiently and appropriately.

3. Applicable clinical staff will be educated in the proper assessment and documentation of pain and management techniques.

4. All patients and/or family will be informed of potential for pain experienced during or as a result of diagnostic testing, medical procedures and/or surgical procedures.

PROCEDURE

1. Pain is an extremely subjective experience and as such, the patient is the best judge of the intensity and relief of pain. All patients will be assessed for pain and if pain is reported, an objective rating scale that fits that particular patients’ situation age, and/or needs will be used. Scales available include: Numeric Intensity Scale (0 – 10), Wong Baker Faces Scale, FLAAC Behavioral Pain Scale modified adult version, Neonatal/Infant Pain Scale (NIPS), and FLACC Behavioral Pain Scale for children <3 years.

2. Pain is assessed on initial admission to CRH, no matter what setting. The entire pain assessment includes initial assessment, treatment, reassessment and complete documentation on the patient’s medical record.

3. Assessment of Pain

The following factors regarding patient’s complaint of pain should be assessed and documented in the patient’s medical record.

   A. Characteristics of pain
      a) Region/Location
         ▪ Ask patient to point to painful area with one finger to help localize the pain.
         ▪ Get the patient to be as specific as possible
         ▪ Describe internal/external
         ▪ Does the pain radiate to any other regions?
b) Time/Duration
   - When it began?
   - Acute/Chronic?
   - How long the episode lasts?
   - How often the pain occurs?

c) Provoked
   - What makes the pain occur or increase in intensity?
   - What makes the pain go away or lessen?

d) Scale/Quality/Intensity
   Documentation will be made of the quantity of pain based on a 0 – 10 scale, with notation of the scale used.

See below for various scales available for assessment of pain.

A. Numeric Pain Intensity Scale  (0 to 10)
   This tool is usually appropriate for use with adults and children ages 8 and older. If there is any doubt that the child clearly understands the concept of assigning a number to describe the degree of their pain, utilize the Wong-Baker Faces Scale or the FLACC Behavioral Tool.

   ![0 - 10 Numeric Pain Intensity Scale]*

   0  1  2  3  4  5  6  7  8  9  10
   No Pain  Moderate Pain  Worst Pain Possible

B. Wong-Baker Face Scale
   Alternative description of pain quality, such as visual graphics may be used for the cognitive impaired or hearing/language impaired patients or children age 3 years and older.

   ![Wong-Baker Face Scale]

   Brief Word Instructions: Point to each face using the words to describe the pain intensity. Ask the patient to choose the face that best describes how he/she is feeling.

   Original Instructions: Explain to the patient that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Ask the person to choose the face that best describes how he/she is feeling.
C. FLAAC Behavioral Pain Scale Modified for Adults
Can be used for adults who are cognitively impaired and/or cannot report the 0 to 10 scale or the Wong-Baker FACES Pain Scale.

<table>
<thead>
<tr>
<th>Categories</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant grimacing, clenching jaw, biting lip.</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Thrashing, kicking or legs drawn up. May also be completely still.</td>
</tr>
<tr>
<td>Affect</td>
<td>Content, Relaxed.</td>
<td>Sullen, calmed somewhat with talk or touch, distractable</td>
<td>Flat, may also be distraught, difficult to console, agitated.</td>
</tr>
<tr>
<td>Complaint/Cry (If intubated, score ‘2’ for this category)</td>
<td>No complaints or cry</td>
<td>Moans or whimpers; occasional complaint</td>
<td>Frequent complaints, sobbing, calling or crying out.</td>
</tr>
</tbody>
</table>
D. Neonatal/Infant Pain Scale (NIPS)
Recommended for children less than 1 year old - A score greater than 3 indicates pain.

<table>
<thead>
<tr>
<th>Pain Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial Expression</strong></td>
<td></td>
</tr>
<tr>
<td>0 – Relaxed muscles</td>
<td>Restful face, neutral expression</td>
</tr>
<tr>
<td>1 – Grimace</td>
<td>Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression – nose, mouth and brow)</td>
</tr>
<tr>
<td><strong>Cry</strong></td>
<td></td>
</tr>
<tr>
<td>0 – No Cry</td>
<td>Quiet, not crying</td>
</tr>
<tr>
<td>1 – Whimper</td>
<td>Mild moaning, intermittent</td>
</tr>
<tr>
<td>2 – Vigorous Cry</td>
<td>Loud scream; rising, shrill, continuous (Note: Silent cry may be scored if baby is intubated as evidenced by obvious mouth and facial movement.)</td>
</tr>
<tr>
<td><strong>Breathing Patterns</strong></td>
<td></td>
</tr>
<tr>
<td>0 – Relaxed</td>
<td>Usual pattern for this infant</td>
</tr>
<tr>
<td>1 – Change in Breathing</td>
<td>Indrawing, irregular, faster than usual; gagging; breath holding</td>
</tr>
<tr>
<td><strong>Arms</strong></td>
<td></td>
</tr>
<tr>
<td>0 – Relaxed/Restrained</td>
<td>No muscular rigidity; occasional random movements of arms</td>
</tr>
<tr>
<td>1 – Flexed/Extended</td>
<td>Tense, straight legs; rigid and/or rapid extension, flexion</td>
</tr>
<tr>
<td><strong>Legs</strong></td>
<td></td>
</tr>
<tr>
<td>0 – Relaxed/Restrained</td>
<td>No muscular rigidity; occasional random leg movement</td>
</tr>
<tr>
<td>1 – Flexed/Extended</td>
<td>Tense, straight legs; rigid and/or rapid extension, flexion</td>
</tr>
<tr>
<td><strong>State of Arousal</strong></td>
<td></td>
</tr>
<tr>
<td>0 – Sleeping/Awake</td>
<td>Quiet, peaceful sleeping or alert random leg movement</td>
</tr>
<tr>
<td>1 – Fussy</td>
<td>Alert, restless, and thrashing</td>
</tr>
</tbody>
</table>
E. FLACC Behavioral Pain Assessment Tool

This tool is appropriate for use with children less than 3 years of age or those with cognitive impairments or any child who is unable to use any other scale. The patient is assessed in each of the 5 categories with a score applied to behaviors evaluated. The five scores are totaled and the severity of pain is determined based on the 0 – 10 scale.

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<td>Uneasy, restless, tense</td>
<td>Thrashing, kicking or legs drawn up.</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Lying quietly, normal position, moves easily.</td>
<td>Squirming, tense, shifting back and forth, hesitant to move, guarding.</td>
<td>Arched, rigid or jerking, fixed position, rocking, rubbing part of body part.</td>
</tr>
<tr>
<td><strong>Cry</strong></td>
<td>No cry/moan (awake or asleep)</td>
<td>Moans or whimpers, occasional cries, sighs or complaint</td>
<td>Cries steadily, screams, sobs, moans, groans, frequent complaints</td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>Calm, content, relaxed, needs no consoling</td>
<td>Reassured by hugging, talking to; distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

4. Treatment

A. After a thorough pain assessment, treatment for the pain should be considered.

B. Analgesic Pain Administration

- Consult the physician for order for analgesic in a timely manner if not already ordered.
- Give analgesics as ordered in a timely manner
- Instruct patient to request analgesic before the pain becomes severe.
- Consider administration of analgesics prior to anticipated activities and/or painful procedures (dressing changes, etc).
- Monitor for possible side effects of opiates when used as analgesic therapy (respiratory depression, hypotension, nausea, skin rash, anaphylaxis, etc.)
- Assess and document on the patient’s medical record efficacy of analgesic therapy, according to onset and peak performance of drug per up to date drug administration handbook.

C. Noninvasive Relief Measures

- Use of distraction, particularly in the pediatric patient.
- Imagery (have the patient think of “happy things”) may be helpful, particularly in the pediatric patient.
- Relaxation techniques, such as slow, deep easy breathing.
- Cutaneous stimulation, such as massage, application of heat or cold, vibration or pressure may also be useful.
- Elimination of unnecessary noise or bright lights

**D. Manipulating Factors Affecting the Pain Experience**
- Removing or loosening tight dressings or binders
- Emptying of distended bladder
- Steps to relieve constipation
- Changing body positions and ensuring correct body alignment

**5. Reassessments and Documentation**

All patients will be reassessed for pain every 2-4 hours and as needed per patient’s condition and/or medications being used

a. Cardiac pain should be reassessed every 5 minutes when treatment prescribed warrants use of nitrates and for IV medication ordered in 5 minute intervals to manage pain.
b. Acute/Chronic pain should be reassessed within 15 to 30 minutes after IV medications, for the evaluation of pain, anaphylaxis, bradypnea, etc.
c. All pediatric patients will be reassessed within 30 minutes of any orally administered analgesic and every 5 to 10 minutes after IV analgesics for the evaluation of pain, anaphylaxis, bradypnea, hypotension, etc.
d. The physician should be notified when any type of prescribed management regimen is not effective in relieving the patient’s pain.
e. Documentation of the initial pain assessment and reassessments should include, but is not limited to: pain as perceived by the patient, vital signs, any type of treatments administered, responses to treatments, and any other significant items as deemed necessary by the healthcare professional caring for the patient.

**6. Patient Education**

a. Patient and/or family teaching should begin after the initial pain assessment with identified knowledge deficit areas.
b. The physician should be notified for multiple, different interventions that are not effective in managing the patient’s pain experience.

c. Patients and/or family should be notified of any treatments, to include medications, prior to administration by the healthcare professional.
d. Patients and/or family should be given appropriate discharge instructions regarding the treatment of pain and follow-up recommendations.

**7. Staff Education**

All clinical staff will receive inservice education upon orientation regarding assessment of pain and management. After receiving education, the employee should be able to:
a. Perform appropriate pain assessment and reassessments
b. Render appropriate pain management regimens through multidisciplinary efforts.
c. Teach patient/family appropriate pain management on individualized basis.
Telemetry Monitoring

Effective: 06/2014

POLICY

Telemetry Monitoring shall be used only for definite therapeutic or diagnostic indications.

INDICATIONS

- Known or suspected arrhythmia
- Symptomatic chest pain (e.g., diaphoresis, irregular rhythm) not related to MI
- Patients receiving cardiogenic medications, including digitalis
- Suspicion of malfunctioning pacemaker
- Adjusting oral anti-arrhythmic drugs
- Hyperkalemia (k>4.5 mEq/L)
- Hypokalemia (k<3.5 mEq/L)
- Drug overdose (Acetaminophens) and other OTC drugs
- Suspected myocardial infarction without significant change in initial Troponin level.
- Patients whose blood pressure is being maintained by use of intravenous vasopressors
- Post-operative patients requiring monitoring
- Patients receiving insulin drips
- Patient in CHF that may require serial EKG’s/enzymes
- Generally, terminally ill, whose death is imminent and expectant (Hospice/Palliative Care patients) will not be monitored. However, DNR/DNI patients will be monitored accordingly in order to identify and prevent a pre-cardiorespiratory arrest condition.

PROCEDURE

1. Patients requiring cardiac monitoring will be placed on the telemetry system by the Primary Nurse once admitted to the AC unit. Monitoring will be continued until order from provider to discontinue monitoring.
2. The central monitoring will occur at the ED central station. The ED nurse will be responsible for responding to the monitor alarms at all times. However, CRH developed a redundant system where the primary nurse on the AC unit will also have the ability to observe the monitor (mirror monitor placed in the AC), monitor alarms and respond to any changes that are noted.
3. No staff member will disable or mute the alarms at any time.
4. Upon the conclusion of the admission assessment, the Primary Nurse will contact the assigned monitor staff in ED to identify patient and to confirm the receipt of remote monitoring. Primary RN will document this communication in clinical note in EHR.
5. Primary Nurse documents rhythm interpretation in the EHR. Rhythm strips are collected and scanned into the patient record in the EHR every shift or at any change in rhythm and/or patient’s condition.
6. The following information shall be documented on the telemetry strip: medical record number, patient’s name, date of birth, date and time, and vital signs.
7. In the event of any change in rhythm from baseline, the ED central station monitoring staff will immediately notify primary RN by phone of this event. If unable to contact the
primary nurse immediately by phone, the monitor nurse will use the PA system to notify the primary RN to contact ED STAT.

8. The RN shall notify the attending physician of any changes in rhythm or patient’s condition.

9. Patients must have IV access (hep lock).
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

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Quantity</th>
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</thead>
<tbody>
<tr>
<td>Precision Xceed Pro Glucose Testing System</td>
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<tr>
<td>Precision Xceed Pro Glucose Test Strips</td>
<td></td>
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<tr>
<td>Precision Xceed Pro, low and high control solutions</td>
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<tr>
<td>Precision Xceed Pro Operator’s Manual</td>
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<tr>
<td>Med dispense lancing device or equivalent solutions</td>
<td></td>
</tr>
<tr>
<td>Capillary tubes and bulb</td>
<td></td>
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<tr>
<td>Soap and water (or alcohol wipe)</td>
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</tbody>
</table>
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.
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.
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
- Rales

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

Incident Reporting of Accidents/Injuries
Effective: 06/2014

POLICY

The safety of patients, visitors, employees and volunteers is a primary concern of all individuals affiliated with Cochise Regional Hospital. All employees are expected to promote and maintain safe working practices and equipment. Any incident that may have injured a patient, visitor, employee, or volunteer, or loss of or damage to property, must be reported through prompt, accurate, and complete filing of an Incident Report.

PROCEDURE

Special Terms

Employee: Any person on the payroll of Cochise Regional Hospital.

Visitor: A non-employee for the purposes of this policy; includes physicians, patient visitors, and the general public.

Volunteer: An individual who provides services to Cochise Regional Hospital but is not on the payroll and does not receive re-numeration for services.

External Agency Personnel: Professionals employed through outside agencies to provide services by contract to Cochise Regional Hospital.

Incident: A real or alleged injury, illness, or loss or damage to property, which could result in a claim against Cochise Regional Hospital.

Property: Refers to all property on and within the hospital premises. Property can be hospital, patient, employee, volunteer, visitor, or external agency personnel property.

EMPLOYEE/VOLUNTEER INCIDENTS

Employees and Volunteers sustaining an injury while on duty will:

Report the incident to a supervisor immediately and then obtain an examination and treatment in the ER. The employee will complete an Incident Report form.

The supervisor will assist the employee or volunteer in the completion of the Incident Report form. The form must be forwarded to the Risk Manager immediately.

In an emergency, the employee or volunteer should always go directly to the Emergency Room. In cases of serious injury, the Administrator on-call will be notified by telephone immediately.

A Worker’s Compensation form shall also be completed and all information forwarded to the Human Resources by the following business day.
EXTERNAL AGENCY PERSONNEL

External Agency Personnel sustaining an injury while on duty will:

Report the incident to a supervisor immediately and then complete an Incident Report form.

Examination and treatment shall be done in the Emergency Room, and the Incident Report form should be forwarded to the Risk Manager.

In an emergency, the external agency personnel should go directly to the Emergency Room. In cases of serious injury, the Administrator on-call will be notified by telephone immediately.

LOSS OF OR DAMAGE TO PROPERTY

All losses of or damage to property are to be reported on the Incident Report.

The form is to be completed by the individual best qualified to describe the loss/damage. In all cases, the Incident Report form must be reviewed by the supervisor/manager of the unit where the loss/damage occurred.

All Incident Report forms will be forwarded to the Risk Manager within 24 hours of the loss/damage. In cases of serious loss/damage, the Administrator on-call must be called immediately.

MAINTENANCE OF INCIDENT REPORTS

All Incident Reports shall be kept for six (6) months while being processed through Risk Management and Performance Improvement activities. All Incident Reports shall be destroyed after six (6) months.
CONSENT IN EMERGENCY SITUATIONS

POLICY

Doubtful situations shall be resolved in favor of giving good health care.

Definition: For consent purposes, an emergency is a situation where the patient requires immediate care, and there is danger to life or health if the care is delayed.

Express consent is unnecessary in the context of such an emergency. An emergency exists if three (3) things are present:

The patient needs immediate medical attention. No restriction is placed on the form of assistance that can be rendered, if the patient has immediate need for that assistance. Treatment can range from first aid to surgery, but without express consent, is limited to what is necessary to resolve the emergency.

An attempt to secure express consent would delay treatment. The patient himself must be unable to give express consent (by reason of legal incompetence or a prohibiting mental or physical condition) and there must be no one else immediately available who is entitled by law to consent for the patient.

Delay of treatment would increase the risk to the patient’s life or health. An emergency may exist even though the patient’s life is not in danger. If the health of the patient may be substantially worsened by delay, the patient’s condition is sufficiently serious.

IMPLIED CONSENT IN EMERGENCIES: If there is no express refusal by a competent patient, treatment can be rendered in an emergency without express consent. If a patient is unconscious or otherwise unable to give consent, the emergency itself will be sufficient to justify emergency care.

Minors needing emergency care may be treated without parental consent only if delay involved in obtaining parental consent will harm the patient. If parents are available, either in person or by telephone, and delay involved in obtaining consent will not harm the patient, parental consent shall be obtained.

EXCEPTION - FOR COMPETENT REFUSALS: The law will not imply consent over the express opposition of a competent patient or a legally authorized representative. Emergency treatment shall not be undertaken when consent is expressly refused by a competent adult or a competent mature minor. With minors whose parents refuse consent, possible consideration for application for court authorization may be necessary.

EXPRESS CONSENT IN EMERGENCIES: When it is feasible to do so and no harmful delay is involved, written consents shall be obtained. If there is no opportunity to get a written consent, an oral consent often can be obtained, witnessed, and documented. Oral consent shall be followed with a confirmatory written consent, after treatment has begun. Emergency care shall not be interfered with, interrupted, or delayed to the detriment of patient, merely for the purpose of obtaining a written or oral consent.
Procedure in Emergencies When Consents have Not Been Obtained

Effective: 06/2014

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.

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. This determination must be documented in the Empower EHR.
CONSENT TO PHOTOGRAPH
Effective. 03/2014
Rev. 06/2014

I, ___________________________________________________________, a current resident/patient at/of (Resident/Patient)

Cochise Regional Hospital hereby authorize the attending physician or other designated person(s) to take:

1. Photographs of me for identification purposes. Yes No

2. Photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical record.) Yes No

3. Photographs of me for the purpose of (specify):

________________________________________________________
________________________________________________________
________________________________________________________

Resident/Patient Signature _________________________________ Date ____________
Responsible Party Signature ________________________________ Date ____________
Relationship to Patient _______________________________________

Witness Signature __________________________________________ Title __________ Date __________
List of Procedure Reference  
**Effective: 06/2014**

**POLICY**

Nursing will use the Lippincott Manual of Nursing Practices, most current edition for information and guidelines on procedures.
Restraint Policy (Physical/Chemical) for Behavioral Management
Effective: 06/2014

POLICY

Restraints will be used only when patient safety is at risk and when all other less restrictive measures have been found to be ineffective. Early release from restraints is encouraged. Restraints may be used for medical and surgical care if they address the underlying medical problem and/or are for the safety of the patient. Example: Body restraints during surgery, arm boards for IV’s, orthopedic appliances and braces, wheel-chairs, side rails used for patients who are in shock, unconscious, confused or restless, or who have been given sedatives, analgesics, or anesthetics, table-top chairs, pediatric cribs, protective helmets, and at times halter devices.

PROCEDURE

A specific physician’s order must be received. The restraint order must contain the following specific information:

- Whether it is a physical or chemical restraint
- Reason for restraint
- Type of restraint, ie., ankle, wrist, chest, etc.

The physician’s order must be signed within 24 hours and restraint order rewritten if needed. Restraints may be initiated only when less restrictive measures have been determined to be ineffective. This must be documented in the Empower EHR. The initial and continuing restraint use order are time limited. Every eight (8) hours for adults. Every two (2) hours for for ages 9 - 17, and every one (1) hour for ages under nine (9). The physician must make a face to face (or through telemedicine) assessment with patient and evaluate need for restraint within four (4) hours of initiation of order. May only be renewed in accordance with these time limits for up to a total of twenty-four (24) hours.

Less Restrictive Measures Include:

- **Modify** the environment (alter lighting, lower bed, clear clutter in room, keep personal items close, etc.)
- **Optimize** body position, balance and alignment.
- **Wrap** IV arm in Kerlex, thread IV tubing up through sleeve of gown, etc.
- **Review** patient’s medication with physician
- **Anticipate** toileting and hydration needs
- **Relieve** discomfort
- **Improve** communication with/for the patient
Provide regular ambulation opportunities
Reduce sensory stimulation, and
Encourage/provide family presence and support.

Validate that the patient is a candidate for restraint use if:

- Confused, disoriented or extremely restless to the degree that he/she is not responsible for safe decision-making and may accidentally or purposely harm himself/herself.
- Ambulating without assistance when assistance is required
- In danger of falling out of bed or chair.
- Interfering with, or pulling at, life support devices (IV, GI, GU tubes, etc.)

The restraint must be ordered by a physician or other independent practitioner permitted by the State and hospital to order restraints. The restraint order must never be written as a standing or on an “as needed” basis (prn) except for chemical restraints. If the restraint order is not ordered by the patient’s attending physician, there must be a consultation with the patient’s attending physician as soon as possible.

Monitor, assess and reevaluate the restrained patient continuously. Observe restrained extremity every two 30 minutes for evidence of circulatory restriction, loss of sensation, decreased pulse, change of color, edema and skin breakdown; if restrained by vest observe every two (2) hours for respiratory restriction.

Allow for motion and exercise for a period of not less than ten (10) minutes during each two (2) hours the restraints are employed. Turn and reposition patient every two (2) hours and provide for skin care. Question the patient about hydration, nutrition, toileting and discomfort needs. An account of this will be kept in the Empower EHR.

If the behavior requiring restraints application improves prior to expiration of the physician’s order, consider a trial period of early release of restraints. Record attempt, behavior and response in the Empower EHR.

Notify the patient’s family of restraint use.

Safety
Use slip knots when tying restraints
Do not tie straps to side rails or cross behind patient
Keep side rails up at all times
Evaluate patient’s ability to use call light and place within patient’s reach
Keep sharp objects away from patient’s reach

Do not use a draw sheet tied around a patient’s waist for safety

If the patient is combative, have a minimum of two (2) people present whenever a restraint is released.

Report promptly to the doctor the following conditions:

Ineffectiveness of restraints in controlling behavior and/or increase in agitation
  Extremity or respiratory complications resulting from being restrained
  Patient/family refusal of restraints.

If the behavior requiring restraint application improves prior to the expiration of physician’s order, **CONSIDER** a trial period of early release of restraints. **RECORD** attempt, behaviors and response.

**Reapply** restraints if the trial period fails.

**CHEMICAL RESTRAINTS**

A chemical restraint is a drug used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition. Instruct patient and family on the following upon initiation of chemical restraints:

  - Potential side effects from these types of medications
  - The increased potential for falling; and
  - Need to call for assistance when getting out of bed and ambulating.

Monitor sensorium/alertness/orientation/gait/balance, control associated with ambulation and self-care activities every four (4) hours for adults, every two (2) hours for ages 9 – 17, and every one (1) hour for ages under 9.

If findings place patient at risk for self-injury or falling, **PERFORM** the following:
  - Assist patient with ambulation, self care and toileting at least every four (4) hours while awake
  - Discuss changing medication with physician
  - Use side rails and call light
  - Keep personal items within easy reach.

Incorporate the need for physical or chemical restraint use in the patient’s plan of care.
Fall Prevention & Risk Assessment Policy  
*Effective: 06/2014*

**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-arrythmics
- 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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Had a fall within the last 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- q Yes (25 pts) q No (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>2. More than one (1) diagnosis including chronic conditions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- q Yes (25 pts) q No (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>3. The use of ambulatory aids (walker, cane, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- q Total Care (30 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Nurse Assist (15 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Independent (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>4. Currently on IV Fluids/Heparin Lock?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- q Yes (25 pts) q No (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>5. Gait &amp; Transferring</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Immobile (20 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Weak (10 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Normal (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>6. Mental Status</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Limitations (15 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Oriented x 3 (0 pts)</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>7. Review MAR &amp; Compare to list below. Does the patient currently take any of the listed medications?</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>Anesthesia within past 48 hours, Anticoagulants, Antidepressants, Benzodiazepines, Laxatives/Diretics, Opioids (narcotics), Sedatives/Hypnotics, Vasodilators</td>
<td></td>
<td>______</td>
</tr>
<tr>
<td>- q Yes (25 pts) q No (0 pts)</td>
<td></td>
<td>______</td>
</tr>
</tbody>
</table>

**Total Points**

<p>| |</p>
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**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
1. **Background**: A seizure is an abnormal, unregulated electrical discharge that occurs within the brain’s cortical gray matter and transiently interrupts normal brain function. A seizure typically causes altered awareness, abnormal sensations, focal involuntary movements, or convulsion (widespread violent involuntary contraction of voluntary muscles):
   a. Epilepsy (also called epileptic seizures): chronic brain disorder characterized by recurrent (>2), unprovoked seizures (ie, not related to reversible stressors). Epilepsy is often idiopathic, but various brain disorders, such as malformations, strokes, and tumors, can cause symptomatic epilepsy.
   b. Non-epileptic seizures: provoked by a temporary disorder or stressor (eg, metabolic disorders, CNS infections, cardiovascular disorders, drug toxicity or withdrawal). In children, fever can provoke a seizure.
   c. Symptomatic seizures: due to known cause (eg, brain tumor, stroke); most common among neonates and the elderly.
   d. Psychogenic seizures (pseudoseizures): symptoms that simulate seizure in patient with psychiatric disorders but that do not involve an abnormal electrical discharge in the brain.

2. **Signs and symptoms**:

   Seizures may be preceded by an aura. Auras may consist of sensory, autonomic, or psychic sensations (eg, paresthesias, a rising epigastric sensation, abnormal smells, a sensation of fear, a déjà vu sensation).

   Most seizures end spontaneously in 1 to 2 minutes. Generalize seizures are often followed by a post-ictal state, characterized by deep sleep, headache, confusion, and muscle soreness; this state last from minutes to hours. Sometimes the post-ictal state includes Todd’s paralysis (a transient neurologic deficit, usually weakness, of the limb contra-lateral to the seizure focus).

   Most patients appear neurologically normal between seizures, although high doses of the medications used to treat seizure disorders, particularly anticonvulsants, can reduce alertness. Any progressive mental deterioration is usually related to the neurologic disorder that cause the seizures rather than to the seizures themselves. Rarely, seizures are unremitting.

**POLICY**

   a. Place patient on seizure precautions if the patient has:
      i. Been admitted with seizures or suspected seizures or
      ii. Experienced a seizure within the last 3 days.

   b. Seizure precautions include:
      i. Padding side rails with seizure pads and keeping rails in upright position as needed
      ii. Implementing fall precautions and assisting with ambulation, if indicated

   c. Placing bed in lowest position
d. Keeping airway and suction equipment immediately available, including oxygen delivery systems, nasal and oral airways, Ambu-bag, mask and suction equipment

e. Communicating risk during hand-over (shift report)

4. Desired patient outcomes:

   a. The patient will remain free of injury
   
b. The patient and/or significant other will demonstrate understanding of the need for seizure precautions.

5. Clinical Assessment and Care

   a. Admission / Pre-Ictal
      i. Obtain seizure history, including aura, triggers, usual presentation or sequence of events, home medications, and impact on ADLs.
      ii. Maintain a quiet environment; avoid overactivity, agitation and exposure to triggers that may increase seizure risk.
      iii. Monitor lab work as ordered, especially electrolytes, anticonvulsant medication blood levels and blood glucose.

   b. During seizure / Ictal Phase
      i. Remain with patient. Do not restrain patient
      ii. Promote patient safety by loosening restrictive clothing, protecting head from injury and removing any furniture near the patient
      iii. Decrease risk of aspiration by turning patient onto side; once in position, do not move patient again during seizure
      iv. Use suction, as needed; do not force anything between the teeth
      v. Administer oxygen by face mask
      vi. Accurately observe, report, and document seizure characteristics to physician, noting duration and type of seizure,
      vii. Maintain patient dignity and privacy
      viii. Administer medications, per orders

   c. After Seizure / Post-Ictal Phase
      i. Place patient in recovery position (side-lying) to prevent aspiration and promote drainage. Collaborate with physician regarding insertion of oral airway if patient remains unconscious.
      ii. Perform full neurological assessment and compare against baseline.
      iii. Suction as needed, as gently and infrequently as possible to minimize increase in intracranial pressure
      iv. Assess for any evidence of injury
      v. If possible, avoid administration of sedatives or narcotics that may impair assessment of further neurologic changes.
      vi. Draw lab work, as ordered
vii. Perform Fall Risk Assessment and update Fall Treatment Plan.

6. **Reportable Conditions**
   a. Any changes in neurological status as compared to baseline, including seizures or loss of gag reflex.
   b. Any injuries resulting from seizure activity
   c. Abnormal lab values, as appropriate

7. **Patient Teaching**
   a. Explain the need for seizure precautions during admission
   b. Ask patient to report any auras or seizure activity
   c. Review anticonvulsant medication regime and side effects. Review need for compliance with medication treatment plan and serum drug level follow up after discharge
Crash Cart Policy
Effective: 06/2014

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.
Respiratory Clinical Care and Workflow

Rationale: CRH does not have an ICU and therefore the Respiratory Clinical and Workflow can be shared by several clinical care givers in the hospital.

Nurse Staff are responsible for the following:

1. Albuterol Nebulizer Treatments
2. All other Nebulizer Treatments
3. Peak Flow Test and Results Documentation

Physician and Qualified Nurses are responsible for the following:

1. Drawing from the patient the Arterial Blood Gas that will be transported to the laboratory.

Laboratory Staff are responsible for the following:

1. Analyzing and Resulting in the Laboratory Information System the blood with the ABG Machine

Physician, Qualified Nurses and Transport Team (Flight or Ground Ambulance) are responsible for:

1. Patients in Respiratory Failure
2. Oxygenation and Ventilation of the Patient by
   a. Ambu Bag
   b. Non-invasive Ventilation
   or
   c. Ventilator Set up and Management
3. Immediate Transfer the patient to a Tertiary Facility
Rapid Sequence Intubation

**Effective: 06/2014**

**Purpose:**

To establish guidelines and protocols for rapid, safe, and effective management of patients at CRH requiring an emergency airway.

**Definitions:**

**Rapid sequence Intubation (RSI)** is an important technique for airway management of patients in the emergency department and other hospital settings. RSI is defined as the technique where a potent sedative or induction agent is administered simultaneously with a paralyzing dose of a neuromuscular blocking agent to facilitate rapid tracheal intubation. This technique includes specific protection against aspiration of gastric contents, provides excellent access to the airway for intubation, and permits pharmacologic control of adverse responses to illness, injury and the intubation itself.

**Indications**

1. To facilitate intubation of a critically ill or injured patient, when the ability of the patient to protect his or her airway is in question and trismus or a gag reflex is present.
2. To protect the airway of patients in whom airway closure is a possibility. Examples include: inhalation burns, refractory anaphylaxis, laryngeal trauma.
3. Any patient who is unable to maintain adequate oxygen saturating (<90%) while breathing independently, and is showing signs of respiratory distress.
4. Patients with head injuries and lateralizing signs, or combative.
5. Glasgow Coma Scale of 8 or less.
6. To minimize the risk of aspiration in non-fasting patients with complex airway emergencies.
7. To minimize the risk of post-ictal patients who are combative and having recurrent seizures.

**Contraindications and Cautions:**

1. RSI (Rapid Sequence Intubation/Induction) may be contraindicated in patients with penetrating eye injuries due to increased intraocular pressure resulting from some of the medications.
2. Malignant hyperthermia has been related to the administration of succinylcholine.
3. Use cautiously and in reduced dosage in hypotensive or elderly patients.
4. Succinylcholine is contraindicated in patients who have hyperkalemia, unstable long-bone fractures, duchenne muscular dystrophy and significant burns or major crush injuries that are greater than 12 hours old.
Personnel:

Staff physicians (Emergency department physician or attending physician) will coordinate activities of staff nurses and respiratory therapists when applicable. All physicians utilizing the procedure must be intimately familiar with all medications that are used and will hold a current ACLS certification and PALS certification, if the procedure is to be done on a child. The physician will be proficient in advanced airway management skills. A minimum of one nurse and one respiratory therapist shall be present in the room for RSI.

Preparation:

1. Assure patient is in need of RSI
2. Establish 2 IV lines and assure patency
3. Place patient on cardiac monitor, pulse oximeter and BP cuff. Monitor vital signs every 5 minutes.
4. Usual equipment necessary for intubations must be present in the room prior to the start of RSI. All equipment is to be functioning properly and readily available. These include, but are not limited to:
   a. Crash cart with defibrillator
   b. Laryngoscope handles and blades
   c. Endotracheal (ET) tubes
   d. Stylet
   e. Suction, and functioning suction devices with Yankauer-type suction tips
   f. Bag-valve-mask (BVM)
   g. High-flow oxygen mask
   h. Medications to be utilized for RSI
   i. End tidal CO2 detector
   j. Lubricant
   k. Medications to be utilized for RSI
   l. Difficult airway equipment
      i. Laryngeal Mask Airways (LMA)
      ii. Cricothyrotomy Supplies
   m. Syringes and needles
   n. Ventilator

Procedure:

1. Premedication:
   a. Lidocaine: 1.5 mg/kg for potential or confirmed increased ICP
   b. Atropine: .01 - .02 mg/kg as a drying agent and prophylactically for bradycardia in children and infants under 10 years of age (minimum dose of 0.1 mg)

2. Induction and Paralysis:
   a. Etomidate (amidate): 0.3 mg/kg IV slowly
   b. Versed (midazolam): 0.1 to 0.3 mg/kg

3. Neuromuscular blocking/paralytic agent:
   a. Succinylcholine – 1 to 1.5 mg/kg IVP
i. Contraindications – hyperkalemia, unstable long-bone fractures, duchenne muscular dystrophy and significant burns or major crush injuries that are greater than 12 hours old.

b. Rocuronium (zemuron) – 0.6 – 1.2 mg/kg IVP

4. Intubation Procedure
   a. Patient Preparation:
      i. Explain procedure to patient if they are conscious and alert
      ii. Position patient in supine position and maintain C-spine immobilization if trauma or suspected trauma
      iii. Preoxygenate the patient with 100% oxygen. Avoid gastric distension from excessive pressure
      iv. Place 2 IV lines and assure patency
      v. Attach cardiac monitor, oxygen saturation monitor and blood pressure cuff
      vi. Draw up all pharmacologic agents in individual syringes
      vii. Have flowsheet available for documentation
   b. Procedural Steps:
      i. Administer the premedications as prescribed:
         1. Lidocaine to attenuate the increase in intracranial pressure associated with intubation. Lidocaine is usually used in patients with head injuries.
         2. Give atropine to minimize the bradycardic impact of succinylcholine for children younger than 10 years of age.
      ii. Administer the induction agent of choice.
      iii. Administer the neuromuscular blocking agent of choice
      iv. Apply cricoid pressure. This is done by placing your thumb and index finger on the cricoid cartilage and pressing backward firmly to occlude the esophagus. This helps prevent regurgitation and may improve visualization of the vocal cords. You may maintain cricoid pressure throughout the procedure until the endotracheal tube placement is verified and the cuff is inflated.
      v. Orally intubate the patient
      vi. Verify the ET tube placement by way of a positive color change on an end tidal CO2 detector, mist in ET tube, bilateral chest expansion and auscultation of lung sounds. CXR is only definitive way to verify correct ET tube placement.
      vii. Inflate the cuff – according to manufacturer’s recommendations and remove cricoid pressure.
      viii. Ventilate the patient with 100% oxygen while manually maintaining the tube placement.
      ix. Secure the tube with ETT holder or tape
      x. Document size of tube, depth of tube in cm specified at location of teeth or gums. Do not use lips as landmarks, as swelling can change your depth number location.
c. Post-intubation
   i. Administer long-acting paralytic agents to maintain sedation of patient. Pharmacologically paralyzed patients also require sedation, analgesia or both.
      1. Vecuronium (norcuron): 0.1 mg/kg
         a. Generally should be given every 30 – 45 minutes
      2. Versed (midazolam): 0.1 mg/kg

   3. Consider pain medication administration also.
      *Above medications may be titrated to desired affect. Must monitor blood pressure closely.

Additional Notes:

A. If intubation attempts fail, continue BVM. If airway cannot be maintained or if inadequate ventilation exist, consider placement of an LMA followed by cricothyrotomy if necessary.
B. Variations in the above sequence may be indicated and will be made at the discretion of the attending or emergency room physician.
C. Physicians performing RSI must be knowledgeable of all medications used or considered to prevent undesirable responses (i.e., meds that can cause hypotension, hyperkalemia or increase ICP).
D. Nasogastric / orogastric tube should be considered on all intubated patients.
Code Blue Policy and Procedure

Effective: 06/2014

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.
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.
Do Not Resuscitate Request Form

COCHISE REGIONAL HOSPITAL

WHAT A “DO NOT RESUSCITATE ORDER” MEANS

When a patient wishes no heroic measures to be instituted in the event of their death, a “Do Not Resuscitate” order is implemented by their doctor. Some people choose this option so that the decision is already made if the need arises.

This means that no CPR will be done and that life will not be prolonged by artificial means. Comfort measures are given if needed, such as oxygen or pain medication.

Once a “Do Not Resuscitate Order” has been implemented, it can be changed at any time.

For a “Do Not Resuscitate Order” to be carried out, the following must occur:

f. It must be the patient’s wishes.
   - or –
   If the patient is unable to make informed decisions, it must be the legal representative’s wishes.

g. The “Do Not Resuscitate” request form must be signed by the patient or legal representative.

h. The doctor must write a “Do Not Resuscitate” order in the medical record.

***************************************************************************

“DO NOT RESUSCITATE” REQUEST FORM

I request that a “Do Not Resuscitate” order be instituted on ________________________________________(Name of Patient).

I understand that this means no heroic measures will be taken in the event of the death of the above named person. I understand that to implement this order, the facility must have an order in the medical record written by the attending physician.

________________________________________
Patient/legal representative Date

________________________________________
Witness Date
Do Not Resuscitate Request Form

COCHISE REGIONAL HOSPITAL
LO QUE SIGNIFICA “UNA ORDEN DE NO RESUCITAR”

Cuando un paciente desea que no se realicen medidas extremas con respecto a su muerte, su médico indicará una orden de “No Resucitar”. Algunas personas escogen esta opción para que, en caso de necesitarse, la decisión ya esté hecha.

Esto significa que no se empleara CPR (resucitación cardiopulmonar) y que no se tratará por medios artificiales de evitar la muerte. Se proporcionarán medidas de alivio, tales como oxígeno y medicamentos para el dolor, si se requieren.

Para que se cumpla una orden de “No Resucitar” tendrán que seguirse los siguientes pasos:

a. Deberá ser con consentimiento del paciente.
   - o –
   Si el paciente está incapacitado para tomar esta decisión con conocimiento de causa, deberá ser con el consentimiento de su Representante legal.

b. La solicitud de “No Resucitar” deberá ser firmada por el paciente o su representante legal.

c. El médico deberá anotar la orden de “No Resucitar” en el registro médico.

******************************************************************************

SOLICITUD PARA ORDEN DE “NO RESUCITAR”

Solicito que se anote una orden de “No Resucitar” (NO CODE) en mi
________________________________________________________________________(Nombre del Paciente).

Comprendo que esto significa que no se realizaran medidas heroicas respecto a la muerte de la precitada persona. Estoy enterado que para que se cumpla esta orden, la institución deberá tener una orden en el registro médico, firmada por el médico que atiende.

_____________________________________________________________________
Nombre de Paciente o Representante Legal Fecha

_____________________________________________________________________
Testigo Fecha
Wound Care Cart Policy
Rev. 06/2014

PURPOSE

To ensure that the wound cart is constantly ready for use of the presence of acute and chronic wounds.

POLICY

1. All RN’s will be familiar with the contents and locations of all supplies and equipment in the wound care 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 wound supply cart, and documenting compliance on crash cart checklist.

PROCEDURE

1. All carts will be opened and checked for contents once a week (Monday) and following each use.
Nursing Department Responsibilities at Mealtime

*Effective: 06/2014*

**POLICY**

The Nursing Department is responsible for distributing food trays to all patients in the facility that is served in their rooms. Distribution of trays in the dining room depends on facility policy. The Nursing Department is responsible for documenting patient intake and appetite by percentages.

**PROCEDURE**

It is the responsibility of the Nursing Department to decide the order the room trays will be served. The Nursing Department is responsible for preparing patients for meals and for assisting patients who are unable to feed themselves. Positioning is a responsibility of Nursing. The Nursing Department is responsible for distributing food trays to patients in patient rooms.

Nursing cuts up meat, butters the bread and assists where needed. Nursing pours the beverages where needed. The Nursing Department is responsible for picking up food trays from patient rooms.
Recording Percentage of Meals Consumed  
**Effective: 06/2014**

POLICY

Nursing personnel are to observe and record the food consumption of each patient.

PROCEDURE

Nursing personnel shall be aware of the nutritional needs of each patient and should daily record food intake in the Empower EHR as % eaten each meal. The chart “Guidelines for Percentage of Meal Intake” on the following page may be posted at each nurse’s station and in the dining room for reference by the nursing attendants.

50-70% intake is minimally adequate. Report to attending physician after 2 meals and request order for Nutritional Assessment.

50% or below is poor and below necessary requirements. Report to attending physician after 2 meals and request order for Nutritional Assessment. Refusal to eat, report immediately.

Be sure to offer a substitute if <70% is eaten. Offer the alternate and if that is refused, offer a house supplement.

**Guidelines for Percentage of Meal Intake**

**BREAKFAST, LUNCH AND DINNER**

90% to 100% - Excellent  
80% to 90%  - Good  
70% to 80%  - Fair  
50% to 70%  - Minimally adequate: Report to attending physician after 2 meals and request order for Nutritional Assessment if applicable.  
50% or below - Poor: Below necessary requirements. Report to attending physician after 2 meals and request order for Nutritional Assessment if applicable.
Guest Meals
Effective: 06/2014

POLICY

Patients have the option of inviting one or more guests for a meal in order to encourage visits and participation with patients, create a family home-like setting, and promote good public relations.

PROCEDURE

Meals for guests will be provided upon request during regular meal service hours.

Meal times are: Lunch  12:00     Dinner  5:00

Meal is provided at no cost for a maximum of two visitors a day.
Noise Level
Effective: 06/2014

POLICY

After 8:00 P.M. all Departments of the Hospital will make an extra effort to maintain a low noise level. That is, there should be no:

- Loud talking or laughing
- Use of equipment that creates sound or noise
- Use of radio or television except as stated.
- Avoid unnecessary overhead paging.
Visiting Hours
Effective: 06/2014

POLICY

The hours established for visiting are from 11:00 A.M. to 8:00 P.M. in the Acute Care area.

Visitors will be monitored in order to:
- Minimize the risk of infection
- Protect the privacy of all patients
- To expedite necessary nursing responsibility

Critically ill patients may have visitors at the discretion of the Charge Nurse. Arrangements may be made for someone to remain with the critically ill patients at any time. Children under fourteen (12) years of age are not allowed to visit in the hospital. Children are not to be left unsupervised and must be accompanied by an adult at all times, in all areas of the hospital.

Members of the Clergy may visit patients any time. Every possible effort is to be made by Nursing Service Personnel to avoid entering the room when a clergyman is present.

It is the responsibility of Nursing Personnel to implement the visiting policies and should seek the assistance of the Nursing Supervisor, Security Staff, or Administration if questions arise.

Visitors are not permitted in the Operating Room and Recovery Room.

Restrictions

Exception to regular visiting hours, 11:00 A.M. to 8:00 P.M. will be made at the discretion of the Charge Nurse of the Department.

- Visitation is limited to two (2) visitors at a time.
- Visitors may not sit on unoccupied beds.

Patients in Protective Care

To minimize the spread of infection, visitors are required to follow Infection Control guidelines. All visitors should be instructed by Nursing Personnel in the procedures to be used while in the patient’s room.
Discharge Instructions

Effective: 06/2014

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 applicable patients discharged from CRH will receive condition-appropriate instructions for home care and appropriate referrals.
C. Care plans must be completed/resolved.

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 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.
INFLUENZA AND PNEUMOCOCCAL VACCINE

Effective: 06/2014

PURPOSE

The CRH recognize the major impact of both influenza and pneumococcal disease in the community and the effectiveness of vaccines for reducing health care costs and in preventing illness, hospitalization, and death. Improving the delivery of the vaccines is vital to further reduce and eliminate vaccine-preventable causes of morbidity and mortality. To meet this goal, the Medical Staff and Administration of this facility have adopted the following policy:

POLICY

It is the policy of CRH that a registered or licensed nurse may administer Influenza and Pneumococcal vaccine at this facility after standard risk assessment per the facility’s protocol without the need for an individual physician order. If a physician does not desire a specific patient to receive the vaccine, he/she must write an order to that effect in the patient’s chart.
NEUROLOGICAL ASSESSMENT POLICY

Policy
The purpose of this policy is to identify an abnormality in the nervous system and to document neurological assessment findings in a standardized way which will provide grounds to identify early deterioration of the neurologic status of patients at risk and to document response to treatment in such patients.

Procedure
Neurologic assessment will be documented in the Empower system in a standardized form under the nursing clinical notes. The nurse will perform neurologic assessment every 4 hours unless specified otherwise by the MD. Neurologic assessments will be performed to patients with the following conditions and as ordered by MD:

1) After Seizure episode
2) After a Fall episode
3) In patients admitted with the diagnosis of Strokes/TIA
4) In patients admitted with the diagnosis of Trauma
5) Any other patients upon physician discretion

Any changes noted by the nurse will be reported to MD. Neurological assessment will be discontinued only upon MD cancellation order is obtained.
SITTER POLICY

POLICY
It is the policy of the Cochise Regional Hospital to provide sitters, after completion of an orientation program, to provide constant observation/care per physician order. Sitters requested by the patient or family will be the responsibility of the patient/family.

ROLE OF SITTERS
The provision and documentation of nursing care will be based upon the competency of the sitter and is expected to include personal care (bathing, linen changes, oral care, brushing hair, position changes), assisting with meals, obtaining and documenting vital signs, weight, and intake and output. Final responsibility for the patient’s care and documentation rests with the patient’s assigned nurse. Sitters observe and report to the registered nurse information related to patient safety. Sitter services are obtained by calling the Director of Nursing Monday-Friday, during the hours of 0800 – 1630 or by contacting the Nursing Supervisor after hours and on weekends/holidays.

GUIDELINES FOR USE OF SITTERS
Requires a physician order to indicate the reason for the use of a sitter.
Patients require 1:1 care for reasons including, but not limited to, the following:
- Safety: To prevent a confused patient from falling, leaving the unit, or pulling out IV’s or other tubes, etc.
- Suicide Precautions: To prevent the suicidal patient from intentionally committing self harm.
- Danger to Others.
- Any other indication specified by the Physician.

The facility will attempt to respect patient’s preferences related to age, gender, and culture given staff availability.

SITTER RESPONSIBILITIES:

- Keep patient within line of sight at all times.
- If the patient is in the bathroom, the door to the bathroom must remain open with the patient accessible.
- Sitter may not leave the patient at any time unless directed by the patient’s nurse.
- When the patient is transferred to another unit, the sitter must go with the patient during the transfer and stay with the patient until the accepting RN arrives to the room.
- If the patient goes to a procedure, the sitter will go with the patient unless otherwise directed by the patient’s nurse.
- Rounding will occur hourly on the sitter, thus providing the sitter a break if necessary.
- Appropriate alternate sitter to be designated by primary RN when current sitter requires break.
- No cell phone use, calls, or texting.
- No personal use of computers.
- Follow standard infection control precautions.
- Wear appropriate PPE.
PATIENT ACCUITY SYSTEM POLICY

The purpose of this policy is to establish a patient acuity system for the Acute Care Unit. The patient classification scale (PCS) was developed because of the need for a more effective acuity scale. This tool was designed to improve communication and productivity while improving nurse and patient satisfaction.

The PCS will allow the Acute Care Manager, DON or charge nurse to predict staffing needs and more accurately control nurse to patient ratios. The concept of the PCS is to define a patient’s acuity status by balancing patient hospital needs along with nursing tasks.

Each concept addressed in the PCS has a uniquely definitive measure of nursing care provided at the bedside. The concepts along with variable determine the acuity level for each patient.

Conceptual definitions
1. Medications: The number of medications a patient receives during a 12-hour nursing shift that must be verified against a medical doctor’s orders and based on standards of medication delivery.
2. Complicated Procedures: Task and time oriented procedures carried out to perform competent patient care
3. Education: Requirements for complex patient care encompassing teaching about disease processes, procedures end-of-life care, preventive measures and standard facility protocol
4. Psychosocial: Nursing tasks related to monitoring and intervention correlating with mental disabilities, end of life care, palliative care, and including personal or family dynamics.
5. Complication Intravenous: Task and time oriented distribution and monitoring of IV med, bloo or blood products, or hemodynamic monitoring of vascular access.
### Patient Classification System

#### Acuity Rating Scale

| Room:________ | Date:____________ |
| Initials:_______ | Time:___________ |

<table>
<thead>
<tr>
<th>Acuity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications per shift</td>
<td>1-5</td>
<td>6-10</td>
<td>11-15</td>
<td>&gt;16</td>
<td></td>
</tr>
<tr>
<td>Complicated Procedures</td>
<td>Neuros Q4 Foley Suction</td>
<td>PICC NGT Central Line Incontinent Respiratory Monitoring PCA</td>
<td>Neuros Q2 Trach Freq._____ Wound/Skin Care Telemetry Assist with ADLs CBI</td>
<td>Total Care Isolation Restraints Feeder Confused Sundowners Falls Risk</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Standard CHF DM Smoking</td>
<td>Planned DC Family Education Pre/Post Procedure</td>
<td>New diagnosis Inability to comprehend Multiple chronicities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Depression Bipolar Palliative Care</td>
<td>Personal/Family Dynamics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicated IV’s /Meds</td>
<td>IDDM 2-5 IV meds K Rider Heparin &gt;5 IV meds TPN Lipids</td>
<td>Blood Tube feeding Cardiac Drip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divided by 5</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Acuity Ranking

The nurse begins ranking the patient with the highest level, column 4. If the patient met the criteria set by the variable for the fourth category, the objective is fulfill. A 4 is placed in the score column of that particular concept and this process continues until each concept row has been scored. Once a total sum of all concepts is achieved, it is divided by 5, the number that reflects the 5 major concepts. The final number becomes the patient’s acuity rating. Since often the final number is not a whole number, nurses must round the nearest whole number.

The PCS will be completed by the charge nurse on every shift for each patient and kept in the Acute Care Unit prior to the end of the shift. The PCS will be used as a tool for staffing adjustments. Nurse to patient ratio 1:5. The PCS will serve as a report tool, education reminder, holistic perspective of patient needs, and productivity.

The nurse will document in electronic chart according to Patient’s Acuity Level based on the following guidelines:

- **Level 1** – every 3-4 hours
- **Level 2** – every 2-3 hours
- **Level 3** – every 1-2 hours
- **Level 4** – every 30 min - 1 hour
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