TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
October 13, 2016 – 12:00 p.m. – Assembly Room 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Page Nos.	Time Allotted	Requestor/ Presenter
1.	Call To Order/Opening Remarks		2 min.	Chair
2.	Approval of Agenda	1-2	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the September 2016 Meeting	3-8	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	9-10		All
	Patient Care Services			
	1. Cardiac Cath Lab Standardized Procedure	11-13		
	2. Catheter Clearance with Alteplase (Cathflo Activase) Procedure	14-16		
	3. CERNER Downtime Policy	17-49		
	4. Chest Tube Management Procedure	50-53		
	5. Differentiating Intrauterine Fetal Demises from Miscarriages Procedure Tracked Changes	54-58		
	Differentiating Intrauterine Fetal Demises from Miscarriages Procedure Clean Copy	59-62		
	6. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure	63-64		
	7. Haloperidol IV Administration Procedure	65-66		
	8. Hazardous Drugs Procedure	67-70		
	9. Local Anesthetic Prior to Intravenous Insertion Standardized Procedure	71-72		
	10. Medical Equipment Brought into the Facility Policy Tracked Changes	73-77		
	Medical Equipment Brought into the Facility Policy Clean Copy	78-81		
	11. Ordering 12 Lead ECG for Administration of Droperidol and /or Discontinuing Drug Standardized Procedure	82-83		
	12. Pneumoccocal and Influenza Vaccine Screening and Administration and Procedure	84-86		
	13. Sponge, Sharps and Instrument Counts prevention of Retained Surgical Objects Tracked Changes	87-93		
	Sponge, Sharps and Instrument Counts prevention of Retained Surgical Objects Clean Copy	94-98		
	14. Utilization of Staff, Staffing Patterns Policy	99-101		
	Unit Specific **Infection Control**			
	1. Influx of Infectious Patients Epidemic Influenza OR Other Respiratory Transmitted Disease IC 15.0	102-107		
	Medical Staff			
	1. Disaster Privileges	108-115		

	1. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and Very Low Birth weight Infant (VLBW) 2. Non-Emergent Neonatal Endotracheal Intubation 3. Palliative Care of the Neonates at the End of Life Tracked Changes Palliative Care of the Neonates at the End of Life Clean Copy 4. Peripheral Arterial Line Insertion, Maintenance and Removal of 5. Staffing Ratios for Social services in the NICU 6. Standards of Care- NICU 2016 7. Standards of Care NICU 8. Visitation in the NICU Tracked Changes Visitation in the NICU Clean Copy **Women's and Newborn Services** 1. Newborn Sepsis Care Guidelines **Formulary Requests** 1. Corticosteroid- Epidural Administration by IR 2. Gadavist 3. Formulary Line Item Additions/Deletions • Capsaicin Topical Cream • Ticagrelor 60 mg tablets • Albuterol oral solution • Potassium chloride 40meq/30 ml cup • Vitamin K 5mg	116-121 122-124 125-128 129-131 132-134 135-136 137-146 147-154 155-157 158-159 160-162 163 164-165 166		
6.	Review and Discussion of CLINICAL Contracts- NO Contracts To Review (*Discussion/ Possible Action*)			
7.	Motion to go into Closed Session		2 min.	Committee
8.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))		30 min.	Chair
9.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair
10.	Comments from Members of the Committee		5 min.	Committee
11.	The next meeting of the Professional Affairs Committee of the Board is on November 10, 2016.		1 min	Chair
12.	Adjournment		1 min	Chair

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Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
September 8, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Dr. Marcus Contardo, Dr. Gene Ma, and Dr. Johnson.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP, Sharon Schultz, CNE/ Sr. VP, and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Rick Barton and Natalie Mueller, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Kathy Topp, Lisa Mattia, Rowena Okumura, Patricia Guerra and Karren Hertz.

Members Absent: Director Finnila and Dr. Scott Worman.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:05 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Contardo.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of August 2016.	Director Mitchell called for a motion to approve the minutes from August 11, 2016 meeting.	Minutes ratified. Director Finnila moved and Dr. Contardo seconded the motion to approve the minutes from August 2016.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Chemotherapy Exposure, Spills, and Handling of Linens 2. Chemotherapy Extravasation Procedure 3. Chemotherapy Pre-Administration Reqts. And Transportation 4. Documentation in the Medical Record Policy	There was a clarification made on the chemotherapy waste and red waste materials. Kevin McQueen noted that both type of waste are being handled by a single company for cost-effective purposes. A recommendation was made to move section i to section d as it states that the antidote should be administered prior to attempting to aspirate the residual drug from the IV device. It was noted that the FIN is being generated by the Registration Department. There was also a mention of some CERNER interface glitches that affects Pyxis procedure. Some changes in the list of people who are authorized to document in the medical record:	**ACTION:** The Patient Care Services policies and procedures were approved. Dr. Contardo moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

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Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	• Medical doctor should be termed Doctor of Medicine. • The term "licensed" should be removed in Licensed physical/occupational/ speech/ recreational therapists should be removed. • Resident should be specified as Resident Physician.		
5. Influenza Nasopahryngeal Swab Testing Procedure	The swab is being used for this procedure since it is necessary to obtain accurate results for influenza testing.		
Administrative Policies and Procedures			
1. Student Clinical Rotattion Education 249	This policy will ensure consistency for establishing student clinical affliations. Other related information can be also found in the Clinical Affiliation Agreement.	**ACTION:** The Administrative policies and procedures were approved. Director Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Unit Specific Infection Control			
1. Waste Management IC 101	Director Finnila commended that the chart on page 35 clearly indicates what type of waste and where it is supposed to go—whether it be red bag, regular bag or sharps container. It was noted that for additional information, staff should refer to the Infection Control manual.	**ACTION:** The Infection Control policies and procedures were approved. Director Schallock moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Neonatal Intensive Care 1. Peripheral Arterial Line Insertion, Maintenance and Removal of	This policy was pulled for further review because we needed to clarify the process for calibrating the transducer.	**ACTION:** Director Schallock moved, Director Finnila seconded and the NICU policies were approved to moved forward for Board approval.	Patricia Guerra
2. Peripheral Intravenous Infiltrations, Treatment For	There was no discussion on this policy.		
3. Skin to Skin Contact	There was a discussion if there is a need to change "patient" into "infant" for the whole policy since this policy specifically caters to infants. After some discussion, it was decided not to make the change.		
4. Umbilical Catheters, Insertion, Management, and Discontinuation of	There was no discussion on this policy.		
Oncology 1. Chemotherapy Administration Procedure	Chemoptherapy administration in the units is done in conjunction with the floor pharmacist. This policy clearly outlines the responsibility of a chemotherapy nurse when administering chemotherapy outside the oncology unit.	**ACTION:** The Oncology procedure was approved. Dr. Contardo moved and Director Schallock seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Outpatient Infusion Center 1. Ambulatory Infusion Pump (AIP) Policy	It was further clarified while the inpatient and outpatient uses different infusion pumps, the quality of care is the same; the patient's best interest is often the deciding factor on	**ACTION:** The Outpatient Infusion Center policies and procedures were approved. Director Schallock moved and Dr.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Chemotherapy Administration Procedure Infusion Center	which type of pump is going to be used.	Contardo seconded the motion to approve the policies moving forward for Board approval.	
3. Chemotherapy Exposure Spills and handling of Linens Contaminated with Chemotherapeutic Agents	This policy is a deletion.		
4. Chemotherpay Extrvasation	This policy is a deletion.		
5. Chemotherapy Writing and Preparation	This policy is a deletion.		
6. Disposal of Chemotherapy Waste	This policy is a deletion.		
Pharmacy			
1. Chemotherapy Prescribing, Processing and Preparation	This policy is being moved from the Pharmacy Manual to Patient Care Services.	**ACTION:** The Pharmacy policy was approved. Dr. Ma moved and Director Schallock seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Women's and Newborn Services			
1. Dinoprostone (Cervidil) 2. WNS Admission Registration Policy	There was no discussion on this policy. There was a brief discussion on the merge of pre-admit number and medical record number for the Women's and newborn Services Depratment.	**ACTION:** The Women's and Newbon Services policies and procedures were approved. Dr. Contardo moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Johnson moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:15 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
October 13th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Cardiac Cath Lab Standardized Procedure	2 year review, practice change	
2. Catheter Clearance with Alteplase (Cathflo Activase) Procedure	3 year review, practice change	
3. Cerner Downtime Policy	3 year review, practice change	
4. Chest Tube Management Procedure	3 year review, practice change	
5. Differentiating Intrauterine Fetal Demises from Miscarriages Procedure **Tracked** Differentiating Intrauterine Fetal Demises from Miscarriages Procedure **Clean**	3 year review, practice change	
6. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure	2 year review, practice change	
7. Haloperidol IV Administration Standardized Procedure	2 year review, practice change	
8. Hazardous Drugs Procedure	3 year review, practice change	
9. Local Anesthetic Prior to Intravenous Insertion Standardized Procedure	NEW	
10. Medical Equipment Brought into the Facility Policy **Tracked** Medical Equipment Brought into the Facility Policy **Clean**	3 year review, practice change	
11. Ordering 12 Lead ECG for Administration of Droperidol and-or Discontinuing Drug Standardized Procedure	2 year review, practice change	
12. Pneumoccocal and Influenza Vaccine Screening and Adminstration Standardized Procedure	2 year review, practice change	
13. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects **Tracked** Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects **Clean**	practice change	
14. Utilization of Staff, Staffing Patterns Policy	3 year review, practice change	
Unit Specific		
Infection Control		
1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15.0	3 year review, practice change	

PROFESSIONAL AFFAIRS COMMITTEE
October 13th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Medical Staff		
1. Disaster Privileges	**3 year review, practice change**	
NICU		
1. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and Very Low Birth Weight Infant (VLBW)	**DELETE**	
2. Non-Emergent Neonatal Endotracheal Intubation	**DELETE**	
3. Palliative Care Of the Neonates at the End of Life **Tracked** Palliative Care Of the Neonates at the End of Life **Clean**	**2 year review, practice change**	
4. Peripheral Arterial Line Insertion, Maintenance and Removal of	**2 year review, practice change**	
5. Staffing Ratios for Social Services in the NICU	**2 year review, practice change**	
6. Standards of Care - NICU 2016	**2 year review, practice change**	
7. Standards of Care NICU	**DELETE**	
8. Visitation in the NICU **Tracked** Visitation in the NICU **Clean**	**2 year review, practice change**	
Women and Newborn Services		
1. Newborn Sepsis Care Guidelines	**NEW**	
Formulary Requests		
1. Corticosteroid – Epidural Administration by IR	**practice change**	
2. Gadavist	**practice change**	
3. Formulary Line Item Additions/Deletions • Capsaicin topical cream • Ticagrelor 60 mg tablets • Albuterol oral solution • Potassium chloride 40meq/30mL cup • Vitamin K 5 mg	**practice change**	

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURES MANUAL~~

STANDARDIZED PROCEDURE: CARDIAC CATH LAB PROCEDURES

I. **POLICY:**

A. Function: Provide care for patients who will be receiving services through the Cardiac Cath Lab.

B. Circumstances:

1. Setting: Tri-City Medical Center (TCMC) Cath Lab
2. Supervision: None required.
3. Patient contraindications: None.

C. Expected Outcomes:

1. To outline personnel and duties involved in procedures in the Cath Lab.
2. To delineate steps in elective or emergent procedure in the Cath Lab.
3. To assure that any patient undergoing a cardiac procedure at TCMC will be assessed for pre procedure risk and will be directed to the appropriate level of care.

II. **PROCEDURE:**

A. **CARDIAC CATHERIZATION**

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   a. Obtain previous lab and history and physical if available.
   b. Cardiology:
      i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. CBC
      ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
      iii. **PT/PTT**/INR
      iv. Cardiac Troponin (Troponin I)
      v. CKMB
      vi. Labs may be drawn prior to procedure
   d. Nurses Order
      i. Start 22, 20 or 18 gauge IV
      ii. Intravenous (IV) Normal Saline (NS) at 20 mL/hr
      iii. Point of care (POC) blood glucose if patient diabetic
   e. Diet:
      i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

B. **PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY:**

   a. The RN shall order the following if previous results from greater than 90 days or no results available:
      i. Obtain previous lab and history and physical if available.
   b. Cardiology:
      i. **Perform** EKG, retrieve and print previous EKG if available
   c. Labs:
      i. CBC
      ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
      iii. **PT/PTT**/INR
      iv. Cardiac Troponin (Troponin I)

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Cardiology	Pharmacy and Therapeutics	Interdisciplinary Practice Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW 3/13; **4/14**	3/13; **4/14**	3/13; **05/14**	**02/16**	5/13, **03/16**	09/13, **07/16**	10/13, 09/16		10/13

v. CKMB
vi. Labs may be drawn prior to procedure

d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic

e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

C. **ELECTIVE CARDIOVERSION:**

1. The RN shall order the following if previous results from greater than 90 days or no results available:
a. Obtain previous lab & history and physical if available.
b. Cardiology:
i. **Perform** EKG. Retrieve and print any previous EKG, if available
c. Labs:
i. INR**, complete metabolic panel (Chem 12~~c7~~), CBC**
ii. Labs may be drawn prior to procedure
d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic
e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

D. **PERICARDIOCENTESIS:**

1. The RN shall order the following if previous results from greater than 90 days or no results available :
a. Obtain previous lab and history and physical if available.
b. Cardiology:
i. **Perform** EKG. Retrieve and print any previous EKG, if available
c. Labs:
i. CBC
ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
iii. **PT/PTT**/INR
iv. Labs may be drawn prior to procedure
d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic
e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

E. IMPLANTABLE CARDIOVERTER DEFIBRILLATOR IMPLANT/CHANGE:

1. The RN shall order the following if needed:
a. Obtain previous lab and history and physical if available.
b. Cardiology:
i. Perform EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete ~~M~~metabolic ~~P~~panel (Chem 12)
iii. INR/ PT/ PTT
iv. BNP
v. Labs may be drawn prior to procedure

d. Nurses Order
i. Start 22, 20 or 18 gauge IV
~~ii. IV D5W at 20 ml/hr~~
iii. NS at 20 ml/hr
e. Diet:
i. **NPO after midnight except for small amounts of water to take oral medications.**

~~E.~~F. PERMANENT PACEMAKER INSERTION/CHANGE:

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   a. Obtain previous lab and history and physical if available.
   b. Cardiology:
      i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. CBC
      ii. **Complete ~~M~~m**etabolic **~~P~~p**anel **~~7~~(cChem 12)**
      iii. **PT/PTT/**INR
      iv. Labs may be drawn prior to procedure
   d. Nurses Order
      i. Start 22, 20 or 18 gauge IV
      ii. IV NS at 20 mL/hr
      iii. POC blood glucose if patient diabetic
   e. Diet:
      i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

~~F.~~G. IMPLANTABLE LOOP DEVICE IMPLANT/EXPLANT:

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   a. Obtain previous lab and history and physical if available.
   b. Cardiology:
      i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   c. Labs:
      i. CBC
      ii. **Complete ~~M~~m**etabolic **~~P~~p**anel **~~7~~(cChem 12)**
      iii. INR
      iv. Labs may be drawn prior to procedure
   d. Nurses Order
      i. Start 22, 20 or 18 gauge IV
      ii. IV NS at 20 mL/hr
      iii. POC blood glucose if patient diabetic
   e. Diet:
      i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

III. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

IV. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed orientation are authorized to direct and perform the Cath Lab Standardized Procedure.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CATHETER CLEARANCE WITH ALTEPLASE (CATHFLO® ACTIVASE®)**
Purpose:	Provide **assistance to Registered Nurses with** ~~a standard for~~ **identifying central venous catheter occlusions and instructions for**~~safely~~ restoring patency of occluded central venous catheters with alteplase (Cathflo® Activase®)~~, in the adult population and outline the process for opening central venous catheters with fibrin related occlusions~~**in the adult population.**
Supportive Data:	Skill Level: Registered Nurse (RN)– requires physician order
Equipment:	2 mg vial of **alteplase** (Cathflo® Activase®) from pharmacy ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** Catheter specific flush 6 alcohol pads x 2 Non–vented port protector or sterile needleless cap Sterile gloves (2) 10 mL sterile water 10 mL syringe filled with normal saline (2) 10 mL syringes Anti-reflux valves (Microclave) for each clotted lumen **Port Protectors** ~~Swabcap~~ for each clotted lumen (2) packages of 4x4 gauze

A. DEFINTIONS:

1. **Patency – a catheter that flushes easily, without resistance, aspirates easily with brisk, free-flowing blood return**
2. **Partial Occlusion – flushing or instilling into a catheter can be done but flow is sluggish or difficult to infuse**
3. **Persistent Withdrawal Occlusion – flushing or instilling is done without resistance; however there is no blood return**
   a. **Often caused by a fibrin tail hanging off of the end of the catheter.**
   b. **When flushing the catheter, the tail moves away from the distal tip of the catheter, but when withdrawing blood from the catheter, the fibrin tail acts as a flap which occludes the distal tip.**
4. **Complete Occlusion - inability to flush or withdraw blood from the catheter**

~~A.~~**B. PROCEDURE:**

1. Obtain physician/**Allied Health Professional (AHP)** order for alteplase (Cathflo® Activase®) to restore patency to each occluded central venous lumen.
2. Obtain reconstituted alteplase (Cathflo® Activase®) from pharmacy
   a. If not reconstituted by pharmacy **perform hand hygiene and perform steps outlined below**:
      i. Reconstitute alteplase (Cathflo® Activase®) to final concentration of 1 mg/mL.
      ii. Aseptically withdraw 2.2 mL of sterile water using 10 mL syringe. (Do not use Bacteriostatic Water)
      iii. Inject the 2.2 mL of sterile water into the alteplase (Cathflo® Activase®) vial. Slight foaming is not unusual; let the vial stand undisturbed to allow large bubbles to dissipate
      iv. Mix by swirling until the contents are completely dissolved. Complete dissolution should occur within 3 minutes. DO NOT SHAKE. The reconstituted alteplase (Cathflo® Activase®) is a colorless to pale yellow solution.
3. Perform hand hygiene ~~-~~and withdraw 2 mg (2 mL) of alteplase (Cathflo® Activase®) using a 10 mL syringe.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmaceutical & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/03, 5/08, 2/11, 7/14	03/11, 7/14, **08/16**	03/11, 7/14, **09/16**	n/a	9/14, **09/16**	04/11, 10/14, **09/16**	05/11, 11/14	7/03, 3/04, 3/06, 8/08, 05/11,12/14

4. Clamp clotted lumen
5. Disconnect **intravenous** (IV) tubing (if applicable); place sterile luer cap on end of tubing.
6. Open one package of 4x4 gauze, keep gauze on top of opened package, and place both the opened package and gauze under the clotted lumen.
7. Open three (3) alcohol preps using aseptic technique and place on opened 4x4 package~~.~~
   a. Remove anti-reflux valve and use alcohol pad to vigorously cleanse the threads of the clotted lumen.
   b. Repeat two times using a new alcohol pad each time.
8. Attach 10 mL syringe containing alteplase (Cathflo® Activase®~~)~~ to clotted port~~.~~
9. Unclamp catheter and instill alteplase (Cathflo® Activase®) slowly
   a. Do not force
   b. If resistance met, gently pump syringe to facilitate instillation of alteplase (Cathflo® Activase®)
10. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and **port protector** ~~Swabcap.~~
11. **Document the date and time alteplase (Cathflo® Activase®) was instilled on a alteplase (Cathflo® Activase®) "Do Not Flush" label. Place the label directly over the microclave.**
~~11. Apply label **Cathflo label** marked "Do not touch" directly **over**to microclave~~
12. Allow **catheter lumen** to dwell undisturbed for 30 minutes
13. Instruct patient to alert nurse performing alteplase (Cathflo® Activase®) procedure if any requests to draw from line by other staff during dwell time occur.
14. After 30 minutes, perform hand hygiene, don clean gloves, remove **the alteplase (Cathflo® Activase®)** label and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood return
   a. If resistance is met, gently pump syringe to facilitate movement of lysed clot, being careful not to flush lumen contents into the patient.
   b. Maintain negative pressure with the syringe for at least 30 seconds, then attempt to aspirate for blood return.
   c. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL ~~blood~~**blood to remove alteplase (Cathflo® Activase®) and residual clot,**, clamp lumen, and discard blood.
      ii. Unclamp lumen and flush with **5-10 mL of normal saline** ~~(Alteplase) catheter specific flush~~, then reclamp lumen
      iii. Remove syringe and clean lumen treads with alcohol pads
      iv. Attach a new microclave and **port protector** ~~Swabcap~~ or return to IV infusion
      v. Document administration of alteplase (Cathflo® Activase®) and flush volume on electronic medication administration record (eMAR)~~.~~
      vi. Document ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** catheter clearance in medical record
      vii. Discard any unused solution
15. If unable to aspirate blood return after 30 minutes, allow the alteplase (Cathflo® Activase®) to dwell **undisturbed** an additional 90 minutes (total dwell time is 120 minutes).
   a. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and port protector
   b. Reapply alteplase (Cathflo® Activase®) sticker~~label~~ directly over microclave, document the time (the time represent the last the an attempt was to access the port)
   ~~15.~~**c.** ~~Replace microclave with Swabcap and label and repeat patient education instructions.~~
16. After 120 minutes, perform hand hygiene, don clean gloves, remove ~~label~~ **alteplase (Cathflo® Activase®) sticker** and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood.
   a. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL of blood **to remove alteplase (Cathflo® Activase®) and residual clot,**~~,~~ clamp lumen, and discard blood.

ii. Unclamp lumen and flush with **5-10 mL of normal saline** ~~(alteplase) catheter specific flush~~, then reclamp lumen.
iii. Remove syringe and clean lumen treads with alcohol pads
iv. Attach a new microclave and **port protector** ~~Swabcap~~ or return to IV infusion
v. Document administration of alteplase (Cathflo® Activase®) and flush volume on **e**MAR
vi. Document (alteplase) catheter clearance in medical record
vii. Discard any unused solution

17. If unable to aspirate for blood return after 120 minutes:
    a. Discard unused alteplase (Cathflo® Activase®).
    b. Obtain equipment as outlined in the equipment section of procedure.
    c. Notify pharmacy and request a second dose of 2 mg of alteplase (Cathflo® Activase®)
    d. Repeat procedure beginning with step 1
18. If blood easily aspirates after using a total of 4 mg of alteplase (Cathflo® Activase®):
    a. Aspirate 5 mL blood, clamp lumen and discard blood
    b. Unclamp lumen and flush with ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** catheter specific flush, then reclamp lumen
    c. Remove syringe and clean lumen treads with alcohol pads
    d. Attach a new microclave and ~~Swabcap~~ **port protector** or return to IV infusion
    e. Document administration of alteplase (Cathflo® Activase®) and flush volume on **e**MAR
    f. Document catheter clearance in medical record
    g. Discard any unused solution
19. If unable to aspirate for blood return after using a total of 4 mg of alteplase (Cathflo® Activase®):
    a. Clamp clotted lumen, remove syringe, and discard unused alteplase (Cathflo® Activase®)
    b. Clean lumen treads with a total of three alcohol wipes using aseptic technique
    c. Place microclave and ~~Swabcap~~ **port protector** on clamped clotted lumen
    d. Apply label to microclave marked "Do Not Touch and date, time, and your initials."
    e. Document administration of alteplase (Cathflo® Activase®) on **e**MAR
    f. Notify physician and document unable to obtain patency of lumen in the medical record
    g. Communicate events during hand-off

C. RELATED DOCUMENTS:

1. Patient Care Services Procedure: Central Venous Access Devices

D. REFEERNCES:

~~g.~~**1. Genentech USA, Inc. (2016). Cathflo activase (alteplase) reconstitution, dosing, and administration. Retrieved from http://www.cathflo.com/dosing/index.jsp**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 8/03	**SUBJECT:** Cerner Downtime
REVISION DATE: 2/04; 2/05; 5/05; 6/06; 9/08; 2/12	**POLICY NUMBER:** IX.H

Department Approval:	**07/16**
Clinical Policies & Procedures Committee Approval:	**~~02/12~~08/16**
Nurse Executive Committee Approval:	**~~02/12~~09/16**
Pharmacy & Therapeutics Committee Approval:	**09/16**
Medical Executive Committee Approval:	**~~03/12~~09/16**
Professional Affairs Committee Approval:	**05/12**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. To outline steps that must be completed to initiate physician orders and allow for uninterrupted patient care when computer downtime occurs.

B. **DEFINITIONS:**

1. **Affinity: Electronic financial record application.**
2. **Bedside Medical Device Integration (BMDI): An application that pulls data from clinical devices such as vital sign monitoring equipment into the electronic health record (EHR).**
3. **Computer Downtime Admissions, Discharges, Transfers ~~, Births and Deaths~~ (ADT) Log**: Used to communicate patient transfers and discharges to Registration, Laboratory, Nutrition Services, and Pharmacy.
4. **Downtime (DT)**: those periods that Cerner will be out of service and unavailable for use. There are two types of downtime:
   a. **Scheduled downtime** – to be used for backups, upgrades, and maintenance. All or part of the system is not available for use during this period of time.
   b. **Unscheduled downtime** – an unforeseen **system** failure**/downtime**. ~~When all or part of the computer system is noted to be down, but no announcement has been made, staff may call the Help desk at 940-7370. Staff will provide detailed description of the event.~~
5. **Lab Downtime Log**: Used to track all future lab orders not required during the downtime. These orders will be entered when the system is restored.
6. **Medication Administration Record (MAR)**: Blank MAR to be used for new patient admissions that occur during the downtime.
   ~~a. A backup file of the MAR is created at 0015 and every four (4) hours on a daily basis and is saved to PC RXMOPC05 to be used for extended scheduled downtime or unscheduled downtime.~~
7. **PACS: Picture Archiving and Communication System.**
8. **Universal Requisition**: Used to communicate physician orders for ancillary orders such as **L**aboratory, **R**adiology, **P**ulmonary, Nutrition Services, EEG, **C**ardiology, and **R**ehab.
~~9. An interface between medical devices and Cerner applications, associating patients to devices and to Cerner applications.~~

C. **POLICY:**

1. **Scheduled Downtime:**
   a. Planned downtime will be communicated to all patient care and associated support service areas in advance, by Cerner announcement screen, and email with a flyer for

posting. Immediately prior to beginning maintenance, an attempt will be made to notify all areas that the system will be going down and the expected duration of the downtime.

b. For Scheduled Maintenance, every attempt is made to perform the maintenance during off-peak processing times. In general, maintenance will be scheduled starting at 0001 on Thursday mornings and will be less than 4 hours in duration.

c. All nursing and ancillary areas will follow the policy and procedures listed below for order communication and completion, results notification, and clinical data documentation.

d. Once maintenance is complete, the system is brought back on-line and verified by Information Technology (IT).

e. All users will be notified when the system is back on-line and that they may resume normal operations by overhead paging and calling key departments.

2. **Unscheduled Downtime:**

a. During normal business hours staff members will contact the IT Help Desk at 760-940-7370 to check system status. After hours, staff members will check system status or report problems to the Administrative Supervisor **(AS)** ~~/Patient Flow Coordinator~~.

b. Management team will be notified by IT via email that the system is down. Management/AS will facilitate the communication of the need for above downtime procedures to be put into place, and end-users will be notified by overhead page.

c. Management/AS will stay in communication with IT for updates on progress of downtime repairs and communicate this to all affected departments.

d. All nursing and ancillary areas will follow the policy and procedures listed below for order communication and completion, results notification, and clinical data documentation.

e. Once the problem is fixed and the system is functional again, the system will be brought back on-line and verified.

f. Interfaces are brought back up (if applicable) by the IT Operations group and verified to be connected and passing data.

g. Users are notified when the system is back on-line by an overhead page and calls to the key departments to resume normal operations.

h. Each department will notify their offsite locations as appropriate. **IT to notify offsite locations and clinics as appropriate.**

D. **PROCEDURE:**

1. Powerchart/Orders/Tasks Lists/Documentation: Clinical Areas including Nursing and Ancillary Departments:

a. **Scheduled Downtime Preparation:**

i. Ensure the task list is updated to current time

ii. Print current census one hour before downtime

iii. Print additional patient labels for each inpatient

iv. Stop entering orders **60**~~30~~ minutes prior to Downtime

v. IT will "force" Operations Jobs as needed

vi. Universal downtime requisitions with unique tracking numbers and barcodes will be used for all orders

vii. Run **Active Order R**eports ~~as needed~~ for patient care **sixty (60) minutes prior to expected downtime** (e.g. ~~task lists, results~~**any**~~,~~ active orders)

viii. Obtain blank MARs for new patients

ix. IT to run MAR Report to print to the nursing units ~~thirty~~ **sixty** (~~3~~60) minutes prior to Downtime.

b. **Scheduled Downtime:**

i. Computer generated patient labels will be used, new patients will have handwritten labels for lab draws that are nurse collectables. The label will have patient name, medical record number (MRN), date of birth, and the logon **Identification** (ID) of the **Registered Nurse** (RN) collecting the specimen.

ii. Downtime Admit, Discharge, Transfer Log will be activated and all ADT transactions will be logged.

iii. Universal Downtime Requisition forms will be completed for all orders to be completed during Downtime and sent to the appropriate department. Phone notification will be used when appropriate. Routine orders not expected to be completed during the downtime should be entered when the system is back up by the ordering department/unit.

iv. All STAT orders will require a phone call to the servicing department

v. Lab: Any new routine orders to be done during the anticipated downtime should be forwarded to lab via the Universal Downtime requisition. Fax these requisitions to 4048.

1) All remaining future Lab orders, to be done post downtime, should have the order written on the manual tracking sheet on the nursing units for re-entry into Cerner. Any STAT labs will be called to the unit.

vi. Pharmacy: RNs will use the printed MAR for all inpatients. The RN will handwrite any new orders on this form as well as document all medications administered during downtime. All new patients will have medications handwritten on a blank MAR. Nurses must override for all new medication orders during downtime. New medication orders will not update on the Pyxis Medstation and new patients admitted during the downtime will have to be manually entered at the Pyxis MedStation. Caremobile and Careadmin devices will be unavailable during any system downtime.

vii. Radiology: Any order that needs to be performed during the downtime will be written on **a separate** ~~the~~ Universal Downtime requisition. **Each order needs a unique ID. No Universal Downtime Requisition copies will be allowed.** The original will be forwarded to the ancillary department, and the copy will be maintained in the requesting patient care area. Nursing staff will write the tracking number next to the order on the order sheet. Routine orders not expected to be done during the downtime should be entered when the system is back up by the ordering department/unit.

viii. Respiratory: All orders will be written on a manual downtime requisition and the Respiratory Care Practitioner (RCP) paged. The RCP will phone the unit and determine the priority of the order, then take appropriate action, (i.e. new start mini-neb- RCP will respond to the unit **as soon as possible (**ASAP**)**, verify the order, pick up the requisition and start the therapy.) All charting will be completed on handwritten Pulmonary charting forms. Retain copies of charting for billing purposes, and place in chart.

ix. Manual requisitions should be stopped **60**~~30~~ minutes before the scheduled Cerner recovery time.

x. Clinical documentation: If the downtime is more than 4 hours, clinical data will be tracked on manual forms for the duration of the current shift. If the downtime is less than 4 hours electronic documentation will be completed upon recovery of the system.

xi. Nutrition Services: All diet orders need to be communicated to the central diet office at 4890.

c. **Scheduled Recovery:**

i. When back on-line, ensure adequate staffing to enter clinical data back into the system.

ii. If manual downtime requisitions have been forwarded to the appropriate department, do not enter into Cerner.

iii. All receiving Departments except Nutrition Services (i.e. Lab, Respiratory Therapy, Radiology, Social Services, Rehabilitation Services, Respiratory) will enter orders from requisitions received during downtime referencing the tracking number in the comment field, (the owner of the original copy of the requisition will enter the orders).

iv. Nursing refers to the manual Lab Tracking list and places orders not sent via the downtime requisitions during downtime.

v. Departments who use task lists shall update tasks as soon as possible to keep lists current

vi. Respiratory charting is to be entered and processed in Cerner once the system is up. Retain master copies and keep records of all order changes and updates when system is back up.

vii. Nursing must update all discharges and transfers for information from their ADT logs and verify admissions.

viii. If the downtime is 4 hours or less, Nursing must enter all clinical documentation back into the system. Priority is given to allergies, height, weight, **Input & Outputs** (I&Os), vitals and meds given before clinical assessment data.

ix. If the downtime is more than 4 hours, nursing must reenter allergies, height, weight, I&Os, vitals and meds back into the system. All other documentation will remain on paper for the remainder of the shift.

~~ix.~~**x. If change of shift occurs, documentation must be completed by staff on paper or in the electronic health record (EHR) prior to leaving the shift.**

~~x.~~**xi.** During the Recovery Phase, Nursing will do a "chart check" to audit the orders and task list, the same as the midnight chart check. **Data can be entered by proxy if needed.**

d. **Unscheduled Downtime:**

i. When all or part of the computer system is noted to be down, but no announcement has been made, staff will call the Help desk at 940-7370. Staff will provide detailed description of the event.

ii. IT will investigate issue and determine if unscheduled system wide downtime has occurred and will notify departments if unscheduled downtime is confirmed.

iii. ~~Notify~~ IT Analyst ~~on call to~~will be notified immediately to start operation jobs for MAR printing.

~~i.~~**iv.** Printed labels will be used for inpatients, handwritten for any new admissions for lab draws that are nurse collectables. Handwritten labels will have p**atient** name, Medical Record Number, date of birth, and the logon ID of the RN collecting the specimen.

~~ii.~~**v.** Activate ADT Log to track all Admits, Transfers, Births, and Deaths.

~~iii.~~**vi.** Complete manual Universal Downtime Requisitions for all new orders and use phone notification when appropriate.

~~iv.~~**vii.** All STAT orders require a phone call to the servicing department.

~~v.~~**viii.** Lab: Any new routine orders, to be done through the anticipated DT, should be forwarded to the lab via Universal Downtime requisitions. Fax these requisitions to 4048. All remaining future Lab orders, to be done post DT, write order on manual tracking log for re-entry into Cerner. Any STAT labs will be called to the unit.

~~vi.~~**ix.** Pharmacy: Hardcopy MAR sheets will be printed from the MAR backup file RXMOPC05 and sent to the nursing floors. ~~Nursing shall review~~ **Any new** medication orders **will be** ~~and~~ update**d on** their copy of the printed MARs from the time the MAR backup file was created to the current time. All meds given during downtime shall be documented on the printed MAR. All new meds will be handwritten on the printed MAR. For new patients, a blank MAR will be used. Nurses must override for all new medication orders during downtime. New medication orders will not update on the Pyxis Medstation and new patients admitted during the downtime will have to be manually entered at the Pyxis MedStation.

~~vii.~~**x.** Radiology: A manual downtime requisition will be required for all new orders and a call will be made to the department. **Each order needs a unique ID. No Universal Downtime Requisition copies will be allowed .**The unit will keep the

carbon copy of all orders sent. Nursing staff will write the tracking number next to the order on the order sheet.

~~viii.~~**xi.** Respiratory: All orders will be written on a manual downtime requisition and the RCP paged. The RCP will phone the unit and determine the priority of the order, then take appropriate action, (i.e. new start mini-neb, RCP will respond to the unit ASAP, verify the order, pick up the requisition and start the therapy.) All charting will be completed on handwritten Pulmonary charting forms. Retain copies of charting for billing purposes and place in chart. For **arterial blood gases (**ABGs**)**, use the manual ABG requisition for recording results.

~~ix.~~**xii.** Nutrition Services: All diet orders need to be communicated to the central diet office at 4890.

~~x.~~**xiii.** Manual requisitions should be stopped ~~30~~ **60** minutes before the Cerner recovery time, if information provided.

~~xi.~~**xiv.** If the downtime exceeds 4hrs, Nursing and Rehabilitation Services will begin to document all clinical data on existing manual forms and will continue for the duration of the current shift.

e. **Unscheduled Downtime Recovery:**

i. If manual requisitions have already been forwarded to the appropriate department, do not enter into Cerner. The department that has received the requisition will enter the order into the system when it comes back up.

ii. Except for Nutrition Services, all receiving Departments (i.e. Lab, **Respiratory Therapy (**RT**)**, Social Services, Rehab Services, Radiology, and Respiratory) enter orders received from requisitions received during downtime. This includes the manual ABG requisitions. The tracking number should be referenced in the order comment field.

iii. Nursing refers to the manual Lab Downtime Log and enters any lab orders not sent down via a requisition during the downtime.

iv. Nursing enters all other orders not sent to a department via a downtime requisition.

v. Respiratory charting is to be entered and processed in Cerner once the system is up. Retain master copies and keep records of all order changes and updates when system is back up.

vi. Departments who use task lists shall update tasks as soon as possible to keep lists current

vii. During the Recovery Phase, Nursing should do a "Chart Check" to audit the orders and task list, the same as the midnight chart check.

viii. All paper documentation will be labeled "Downtime Documentation" and kept in the medical record.

ix. If the downtime is 4 hours or less, Nursing must enter all clinical documentation back into the system. Priority is given to allergies, height, weight, I&Os, vitals and meds given before clinical assessment data.

x. If the downtime is more than 4 hours, nursing must reenter the following:

1) Allergies
2) Height and weight,
3) I&Os,
4) Vitals
5) Medications given
6) Admission Medication Reconciliation
7) Admission Patient Histories

xi. All other documentation will remain on paper for the remainder of the shift.

2. **Enterprise Registration Management (ERM): Registration Department**

a. **Scheduled Downtime Preparation:**

i. Print census 15 minutes prior to the system scheduled down time for the current snapshot of room and bed assignments.

ii. Before downtime occurs, each Registration area will assemble their downtime tools (including Downtime Binder) in a central location to begin assigning account numbers as needed.
iii. A pool of financial numbers (FIN) are to be used for downtime, these numbers begin with a "9000" which differentiates them as a downtime encounter. Additional numbers if needed should be requested from the IT Department at least 24 Hours prior to the scheduled downtime.
iv. An Enterprise Master Patient Index (EMPI) search will be made on the alternative Medical Records database (Affinity) to check for possible medical record numbers for patients. A new MRN will not be issued until the system has been restored and the patient does not already have an MRN.
v. If a medical record number exists in the EMPI Search, it should be noted on the downtime registration facesheet in the medical record number field.
vi. All patient demographic, encounter specific and insurance information should be entered on the facesheet.
vii. Make multiple copies of the facesheet. One copy is for the nursing unit and/or servicing department, and the other is to keep in the Registration Department for entry when the system is active and for record keeping.
viii. Preprint labels with downtime numbers preprinted on them.

b. **Scheduled Downtime:**
i. If an armband is needed for a new admission during downtime, affix one manually written label to armband and apply to patient.
ii. Manual ADT using downtime numbers. (9000 numbers) All patient demographic, encounter specific and insurance information should be entered on the facesheet.
iii. Make copies of orders, insurance cards, and any other data that would be useful when the system is up.
iv. Enter all information into the downtime ADT Log.
v. Have patient sign all necessary consent forms.
vi. Keep all paperwork in one central location for re-entry when system is restored (if over 4 hours).
vii. Power Chart Maternity **(PCM)** – All **Obstetrics (**OB**)** Admissions **paperwork** will be routed through Main Registration during normal business hours and **Emergency Department (**ED**)** Registration during off hours regardless if downtime is scheduled or unscheduled downtime.
1) A communication notice will be sent to the Registration area with the patient information and admission details.
2) Registration will search the EMPI in the alternative system (Affinity) and assign the downtime financial number and communicate to OB.

c. **Scheduled Recovery:**
i. Complete all admit, discharge, transfer data from downtime ADT logs.
ii. ADT data to be re-entered in the following order: 1-Discharges, 2- Transfers, 3-Admits.
iii. All Admissions for OB must be entered through the Inpatient Downtime Conversation.
iv. Verify the WH TRACKING GROUP is entered during the admission to ensure these patients will show up on the PCM Tracking Shell.
v. All Mothers admissions should be done prior to any Newborn Admissions.
1) The newborn admit should be completed through the Admit Newborn Procedure which creates the link between mother and baby.
vi. The dirty Bed Queue will be updated AFTER the ADT reconciliation.
vii. The census will be balanced from downtime to current time and validated.
viii. IT and the departments are to be notified when all downtime ADT is complete.

d. **Unscheduled Downtime:**

i. If an armband is needed for a new admission during downtime, affix one manual label to armband and apply to patient.
ii. Manual ADT using downtime numbers. (9000 numbers)
iii. Make copies of orders, insurance cards, and any other data that would be useful when the system is up.
iv. Enter all information into the downtime ADT Log.
v. Have patient sign all necessary consent forms.
vi. Keep all paperwork in one central location for re-entry when system is restored (if over 4 hours).

e. **Unscheduled Downtime Recovery:**
i. Complete all admit, discharge, transfer data from downtime ADT logs.
ii. All Admissions for OB must be entered through the Downtime Conversation and linked to the WH TRACKING GROUP so these patients will show up on the PCM Tracking Shell.
iii. All Mother admissions should be done prior to any newborn admission.
1) The newborn admit should be completed through the Admit Newborn Procedure which creates the link between mother and baby
iv. ADT data to be re-entered in the following order: 1-Discharges, 2- Transfers, 3-Admits.
v. The dirty Bed Queue will be updated AFTER the ADT reconciliation.
vi. The census will be balanced from downtime to current time and validated.
vii. IT and the departments are to be notified when all downtime ADT is complete.

3. **Enterprise Scheduling Management (ESM): Scheduling - Ancillary Departments**
a. **Scheduled Downtime Preparation:**
i. Schedules will be printed out in advance of scheduled downtime, dependent on the needs of each department, (e.g.: Rehab Services: 1 week, Radiology 48 hours)

b. **Scheduled Downtime:**
i. Schedulers will not schedule appointments, or view/print schedules during downtime. When a patient calls to schedule an appointment, their information will be taken, including the patient's full name, birth date, phone number, name of test/procedure needed, reason for exam and ordering physician. It will be explained that they will be contacted as soon as possible when the system comes back up.

c. **Scheduled Recovery:**
i. Enter patient's information into system and either call with appointment times or schedule the appointment as soon as possible, dependent upon the department's needs.

d. **Unscheduled Downtime:**
i. Schedulers will not schedule appointments, or view/print schedules during downtime. When a patient calls to schedule an appointment, their information will be taken, including the patient's full name, birth date, phone number, name of test/procedure needed, reason for exam and ordering physician. It will be explained that they will be contacted as soon as possible when the system comes back up.

e. **Unscheduled Downtime Recovery:**
i. Enter patient information into system and either call them with appointment times or schedule the appointment as soon as possible, dependent upon the department's needs.

4. **FirstNet: Emergency Department (ED)**
a. **Scheduled Downtime Preparation:**
i. Organize pre-made downtime packets containing paper form and labels: Triage, Nursing Assessment (which contains documentation of med**ications** and **intravenous [**IVs**] fluids**), Progress Notes, Cardiac Monitor Strip, after

care/Discharge instructions, for example; Universal Downtime Requisition, ADT Log and Policy.

ii. Unit Secretary/**Emergency Medical Technician** (EMT) to prepare Universal Downtime Requisition forms which use unique tracking numbers.

iii. Secure prescription pads for the ED Physicians.

iv. Print a copy of the FirstNet Tracking Screen for an accurate patient list prior to downtime.

v. Unit Secretary to retrieve the manual tracking board to be used by ANM/Charge RN for use during downtime.

~~iv.~~**vi. Unit Secretary will transfer the FirstNet data to the manual tracking board.**

~~v.~~**vii.** ED Registration to run in-house census and prepare Downtime Log Book.

~~vi.~~**viii.** Unit Secretary/EMT will maintain and update the ADT log.

~~vii.~~**ix.** Print additional patient labels for patients already fully registered in FirstNet.

~~viii.~~**x.** ED shift supervisor, ANM or designee to communicate with **Administrative Supervisor** (AS) to facilitate timely disposition of pending admissions.

b. **Scheduled Downtime:**

i. ED staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department.

ii. ED Physicians, Residents, and Physician Assistants will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iii. Downtime events in the ED will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all Stat orders should be called to the departments.

iv. ED physicians, Residents and Physician Assistants **(PA's)** will dictate their notes into Dragon or use transcription service. Scribes will document assessments and notes in a word document on their tablets and will copy these documents into a PowerNote when the system is back online.

v. ED Quick Reg will have stopped and backup forms will be used by Registration. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

1) ED Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

vi. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications.

c. **Scheduled Recovery:**

i. When FirstNet is back on line, ED Registration will ensure adequate staffing to enter data back into the system.

ii. New patients who arrived during the downtime period that are currently in the ED will be entered by ED Registration - these patients will then appear on the FirstNet Tracking board in their correct locations. Nursing is not to register any patients into the system at this time, all registration to be done by ED Registration using the following conversations:

1) ED Downtime Conversation – If the patient has an existing MRN, use this conversation to quickly enter the patient into FirstNet. Enter the FIN (9000) downtime number that was assigned.

2) Downtime Outpatient – If the patient does NOT have an existing MRN, use this conversation and the system will automatically assign a MRN to the patient. Enter the FIN – (9000) downtime number that was assigned.

3) Confirm patient displays on tracking shell in the correct location

a) If the patient does not display on tracking after the registration, use the ED QUICK REG (Ambulance Icon) from the Registration Tab in FirstNet and search and select the current downtime encounter from the visit search window and verify the information and bed

assignment and select OK. This should force the patient to the tracking shell.

4) Once all patients who are currently in the ED are registered, enter the remaining patients who have been discharged and place them in the ED Wait Room so that the ED Clinicians can complete their documentation and discharge patient accordingly.

5) ED Reg**istration** will notify the ED shift supervisor, ANM or designee when all patients have been entered back into FirstNet.

iii. ED shift supervisor, ANM or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen and updates screen as indicated with transfers and discharges.

iv. All receiving Departments (i.e. Lab, RT, Radiology, Social Services, Rehab Services) will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

v. Nursing documentation will be entered back into FirstNet dependent upon the length of the downtime for all patients still in the ED.

vi. If downtime lasts less than one hour:

1) All clinical documentation shall be reentered in Cerner after the patient has been entered into FirstNet.

vii. If downtime lasts more than one hour:

1) Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

2) During the Recovery Phase, each RN will do a chart check on his/her designated patients to audit the orders and tasks assigned during downtime for completion.

3) All patients that were discharged during the downtime period will need to be discharged in the system by the Unit Secretary/EMT/RNs under the shift supervisor or designee's supervision.

4) Validate all downtime patients are in ADT (Affinity), appropriate documentation is transcribed into Cerner and all Ancillary orders placed during downtime are viewable in Cerner.

d. **Unscheduled Downtime:**

i. ED Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.

~~i.~~**ii. Unit Secretary to retrieve the manual tracking board to be used by ANM/Charge RN for use during downtime. The Unit Secretary will gather all patient information from Stations A, B, C and D and transfer it to the manual tracking board to be used by the ANM/Charge RN.**

~~ii.~~**iii. ANM Charge will update the board for admissions and discharges during the downtime processes.**

~~iii.~~**iv.** ED staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department.

~~iv.~~**v.** ED Physicians, Residents, and Physician Assistants will write orders for medications and IVs on their paper chart and notify nursing of those orders.

~~v.~~**vi.** Downtime events in the ED will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.

~~vi.~~**vii.** ED physicians, Residents and Physician Assistants will dictate their notes into Dragon or use transcription service. Scribes will document assessments and notes in a word document on their tablets and will copy these documents into a PowerNote when the system is back online.

~~vii.~~**viii.** ED Quick Reg will have stopped and backup forms will be used by Registration. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

1) ED Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

~~viii.~~**ix.** Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. **Unscheduled Downtime Recovery:**

i. When FirstNet is back on line, ED~~R~~ Registration will ensure adequate staffing to enter data back into the system.

ii. ED shift supervisor or designee or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen.

iii. New patients who arrived during the downtime period that are currently in the ED will be entered by ED Registration - these patients will then appear on the FirstNet Tracking board in their correct locations. Nursing is not to register any patients into the system at this time, all registration is to be done by ED Registration using the following conversations:

1) ED Downtime Conversation – If the patient has an existing MRN, use this conversation to quickly enter the patient into FirstNet. Enter the FIN (9000) downtime number that was assigned.

2) Downtime Outpatient – If the patient does NOT have an existing MRN, use this conversation and the system will automatically assign a MRN to the patient. Enter the FIN – (9000) downtime number that was assigned.

3) Confirm patient displays on tracking shell in the correct location

a) If the patient does not display on tracking after the registration, use the ED QUICK REG (Ambulance Icon) from the Registration Tab in FirstNet and search and select the current downtime encounter from the visit search window and verify the information and bed assignment and select OK. This should force the patient to the tracking shell.

4) Once all patients who are currently in the ED are registered, enter the remaining patients who have been discharged and place them in the ED Wait Room so that the ED Clinicians can complete their documentation and discharge patient accordingly.

iv. ED shift supervisor, ANM or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen and updates screen as indicated with transfers and discharges.

v. All receiving Departments (i.e. Lab, RT, Radiology, Social Services, Rehab Services) will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

vi. Nursing documentation will be entered back into FirstNet dependent upon the length of the downtime.

vii. If downtime lasts less than one hour:

1) Once the patient has been entered into FirstNet, all clinical documentation will be reentered in Cerner.

viii. If downtime lasts more than one hour:

1) Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

2) During the Recovery Phase, each RN will do a chart check on his/her designated patients to audit the orders and tasks assigned during downtime for completion.

3) All patients that were discharged during the downtime period will need to be discharged in the system by the unit secretary/EMT/RNs under the shift supervisor or designee's supervision.
4) Validate all downtime patients are in ADT (Affinity), appropriate documentation is transcribed into Cerner and all ancillary orders placed during downtime are viewable in Cerner.

5. **Laboratory - Microbiology, General Lab Blood Bank and Blood Gases**

a. **Scheduled Downtime Preparation:**
   i. Have an adequate number of Cerner downtime barcode labels printed.
   ii. Have an adequate number of reporting forms if manual forms are necessary.
   iii. Have phlebotomy review an "Unreceived List" for 8 hours in the past and future and mark any pending orders.
   iv. Lab to print the collection lists for the scheduled downtime after 2345 and include the 0600 Collection List for the AM run.

b. **Scheduled Downtime:**
   i. Nursing units will fax manual Downtime Requisitions to the fax in the Triage area (4048).
   ii. Specimens will come with a manual Universal Downtime Requisition on new orders only. Specimens from orders prior to DT will be ordered from the "Unreceived Specimen Log." All specimen-labeling needs to be checked against the written order information.
   iii. One set of Cerner DT barcode labels should be used for each Universal Downtime requisition. Place the label(s) on the appropriate manual requisition, specimen(s), or worksheet for the procedure and all setup media, slides, aliquots, attached to that procedure. Record specimen received date and time as well as set up date and time on the requisition.
   iv. For ongoing or manual procedures, use worksheets, work cards, Downtime Patient Results form, and other forms located in the downtime files to record bench workup. For online results use instrument printouts.
   v. For dispensing blood products, Nurse/Clinician will present the Transfusion Request Form handwritten with the Transfusion Service ID band number, patient's name, billing number and medical record number. Dispense information will be documented on the Downtime Patient Results form.
   vi. For reporting procedures, STAT results will be called to the units. Instrument printouts and manual Reporting forms will be used to distribute results to the ED. If there is an extended DT, this method of reporting will also be used for the nursing units. See specific Laboratory Downtime procedures for further details.
   vii. RCPs will continue to use the ABG Requisition Form to record results. A copy will be made for later recovery.

c. **Scheduled Recovery:**
   i. When Cerner is back on line, Lab orders will be entered using the Universal DT requisition and the appropriate Cerner DT barcode accession **numbers** ~~#~~.
   ii. Results will be entered into Cerner using the appropriate instrument printouts, manual report forms, or worksheets.
   iii. Blood product dispense information will be entered into Cerner.
   iv. ABG results will be entered from the ABG Requisition form.

d. **Unscheduled Downtime**
   i. Print the most current "Downtime Collection List" from LABPC06~~1~~ located at the **Chemistry Technical Specialist's** ~~Point of Care Coordinator's~~ desk **across from the blood gas analyzer** ~~adjacent to Triage~~ and give to the Phlebotomy team for draws already entered in Cerner.
   ii. Obtain the preprinted DT accession barcode labels.
   iii. Have an adequate number of reporting forms if manual forms are necessary.
   iv. Have phlebotomy review the last "Unreceived List" and mark any pending orders.

v. Nursing units will fax all Universal Downtime Requisitions for new orders to the Triage fax (4048).
vi. Specimens will come with a manual Universal Downtime Requisition on new orders only. Specimens from orders prior to DT will be ordered from the "Unreceived Specimen Log." All specimen-labeling needs to be checked against the written order information.
vii. One set of Cerner DT barcode labels should be used for each Universal Downtime Requisition. Place the label(s) on the appropriate manual requisition, specimen(s), or worksheet for the procedure and all setup media, slides, aliquots, attached to that procedure. Record specimen received date and time as well as set up date and time on the requisition.
viii. For ongoing or manual procedures, use worksheets, work cards, Downtime Patient Results form to record bench workup. For on line procedures use instrument printouts.
ix. For dispensing blood products, Nurse/Clinician will present the Transfusion Request Form handwritten with the Transfusion Service ID band number, patient's name, billing number and medical record number. Dispense information will be documented on the Downtime Patient Results form.
x. For reporting procedures, STAT results will be called to the units. Manual Reporting forms and instrument printouts will be used to distribute results to the ED to the units. If there is an extended DT, this method will also be used for reporting results to the nursing units. See specific Laboratory Department procedures for further details.
xi. RCPs will use the ABG Requisition form to record results. A copy will be made for later recovery.

e. **Unscheduled Downtime Recovery:**
i. When Cerner is back on line, Lab orders will be entered using the Universal DT requisition and the appropriate DT barcode accession number.
ii. Results will be entered into Cerner using the appropriate instrument printouts, manual report forms, worksheets,
iii. Blood product dispense information will be entered into Cerner.
iv. ABG results will be entered from the ABG Requisition form.

6. **PharmNet: Pharmacy**
a. **Scheduled Downtime Preparation:**
i. Call for one extra technician, one extra pharmacist depending on downtime duration.
ii. IT will force operation jobs to run extra MARs for all patients and pharmacists will attempt to enter all orders prior to run.
iii. Run IV batch early if due soon.
iv. Pre-printed IV labels will be available for most commonly dispensed products.
v. Confirm the most recent MAR backup file has been received by RXMOPC05

b. **Scheduled Downtime:**
i. Turn on "Critical Override" at Pyxis "Profile" MedStations just before the system goes down. Notify each profile nursing station, the Pharmacy Supervisor and/or the Director of Pharmacy that the system is on "Critical Override." Any new medication orders not in the Pyxis MedStation will be scanned down to the pharmacist by nursing.
ii. Down time pharmacy labels will be completed manually by Pharmacy.
iii. The responsible pharmacist will call down all new IVPB orders to the IV room. This information will then be recorded on the MAR along with date/time and the number of doses sent.
iv. The IV room will generate IV production off scanned orders

c. **Scheduled Recovery:**
i. When back on-line, ensure adequate pharmacist staff to enter orders.

ii. After new patients are admitted through the ADT system, pharmacists will begin to input orders into PharmNet.
iii. Nursing staff to enter allergies, height, and weight on all new admits so the pharmacist can complete medication order entry.
iv. Turn off "Critical Override" on all Pyxis "Profile" MedStations.

d. **Unscheduled Downtime:**
i. Turn on "Critical Override" at Pyxis "Profile" MedStations when the system goes down. Notify each profile nursing station, the Pharmacy Supervisor and/or the Director of Pharmacy that the system is on "Critical Override." Any new medication orders not in the Pyxis MedStation will be scanned down to the pharmacist by nursing.
ii. Call for one extra technician, one extra pharmacist and adjust staffing accordingly to workload and downtime duration.
iii. Orders for new admits will be recorded on a blank MAR located in the Pharmacy Computer Downtime Manual.
iv. Downtime Rx labels will be completed manually by Pharmacy. Pre-printed IV labels will be available for most commonly dispensed products.
v. The responsible pharmacist will call down all new IVPB orders to the IV room. This information will then be recorded on the MAR along with date/time and the number of doses sent.
vi. The IV room will generate IV production from the scanned orders
vii. Pharmacy will print a hard copy of the MAR from the MAR backup file on PC RXMOPC05 and send to the nursing unit. For extended downtime (over 24 hours), pharmacy will print a second hardcopy of the MAR from the MAR backup file for the pharmacy to use and manually update each patient's medication orders.

e. **Unscheduled Downtime Recovery:**
i. When back on-line, ensure adequate pharmacist staff to enter orders.
ii. After new patients are admitted through the ADT system, pharmacists will begin to input orders into Pharmnet.
iii. Nursing staff to enter allergies, height, and weight on all new admits so the pharmacist can complete medication order entry.
iv. Turn off "Critical Override" on all Pyxis "Profile" MedStations.

7. ~~Profile~~**HIM: Medical Records/Health Information**

a. **Scheduled Downtime Preparation:**
i. Medical Records will alert transcription team members of impending downtime. Medical Records will post the Downtime dictation instructions on each unit.

b. **Scheduled Downtime:**
~~i. Clinical units/departments will request old records from Medical Records/Health Information by phone.~~
~~1) Units will need to provide the medical record number for all charts being requested.~~
i. Physicians will continue dictating reports into the dictation system.
ii. Transcriptionists will continue transcribing reports into the transcription system, (ADT information will be based upon information sent to the system prior to downtime)
iii. Coding ~~staff will utilize the 3M encoder in stand-alone mode~~**will be suspended as documentation is not viewable**.
~~2) If the encoder is not available, coders will assign codes manually using the hard copy ICD-9 and CPT coding books.~~

c. **Scheduled Recovery:**
i. Cerner work queues will be tested and updated once all registration and discharge transactions have been entered.
ii. Reports transcribed without patient demographic information will be reviewed~~,~~ **and** edited **for viewing in PowerChart**~~, and routed for charting on the record~~.

iii. Each ~~Profile function~~**application** will be tested to ensure system integrity.
~~ii.~~**1)** ~~Coding staff will enter manually coded information~~.

d. **Unscheduled Downtime:**
i. Charts will be logged out of Medical Records on a manual log to identify location to which the chart has been taken.
ii. Physicians will continue to dictate reports into the dictation system.
1) If the dictation system is down, dictation is completed via back up dictation line ~~at 1-866-414-7522~~. Handheld dictation units are available if phone lines are down.
iii. Transcriptionists will continue transcribing reports (ADT information will be based upon information sent prior to downtime).
1) Transcribed reports will queue up in the transcription to Cerner interface until the system is on-line.
iv. Coding staff will be on standby.
v. Preparation of the record for scanning will continue.
vi. Analysis /Assignment of deficiencies to the physicians will be suspended until the system is available.

e. **Unscheduled Downtime Recovery:**
i. ADT interface to Transcription system will be tested.
ii. Interface to Cerner will be updated to pass transcribed reports to Powerchart.
iii. Each ~~Profile function~~**application** will be tested to ensure system integrity.
1) ~~Charts manually logged out of the department will be entered into the Profile Tracking application~~.
iv. **Master Patient Index (MPI) specialist to review MRN's assigned during downtime to confirm any combined MRN's needed.**

8. **RadNet: Radiology/Imaging Department**

a. **Scheduled Downtime Preparation:**
i. Print schedules for downtime plus 48 hours.

b. **Scheduled Downtime:**
i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed by registration for each patient.
ii. The ED Unit Secretaries and ED staff will call STAT radiology exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number. Outpatients will come from admitting with their hand written face sheet.
iii. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the PACS ID. The technologist will enter the downtime PACS ID into all digital modalities. Only one down time PACS ID may be used per exam.
iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name where indicated.
~~iv.~~**v. Completed exam downtime requisitions will be delivered to the film library for radiologist dictation. The radiologist will dictate the Universal Downtime number into the report.**
~~v.~~**vi. For existing Radiology requisitions d**~~D~~ictation will be completed as usual by entering the medical record into the dictation system.
~~vi.~~**vii.** Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

c. **Scheduled Recovery:**
i. Wait for ADT feed.
ii. Delete any duplicate orders.

iii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
v. The PACS supervisor will reconcile all downtime PACS ID numbers with the Cerner PACS ID in the PACS system.
vi. Reference Radiology Department specific policies for detailed downtime workflow.

d. **Unscheduled Downtime:**
i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed for each patient.
ii. The Unit Secretaries and ED will call STAT diagnostic imaging exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number.
iii. Outpatients will come from admitting with their hand written face sheet.
iv. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the PACS ID. The technologist will enter the downtime PACS ID into all digital modalities. Only one down time PACS ID may be used per exam.
v. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was use, the amount of contrast, and enter his/her full name where indicated.
~~iii.~~**vi. Completed exam downtime requisitions will be delivered to the film library for radiologist dictation. The radiologist will dictate the Universal Downtime number into the report.**
~~v.~~**vii.** Dictation will be completed as usual by entering the medical record into the ~~Lanier~~ dictation system.
~~vi.~~**viii.** Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

e. **Unscheduled Downtime Recovery:**
i. Wait for ADT feed.
ii. Delete any duplicate orders.
iii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
v. The PACS supervisor will reconcile all downtime PACS ID number with the Cerner PACS ID in the PACS system.
vi. Reference Radiology Department specific policies for detailed downtime workflow.

9. **Surginet: Surgery Scheduling, Pre-Op and Intraoperative Documentation**

a. **Scheduled Downtime Preparation:**
i. Have an adequate number of preoperative assessment, intra-operative worksheets, implant records, downtime schedule book and labels for each case / procedure made up for a minimum of one hundred-fifty (150) cases.
ii. Routine scheduling is not done during Surginet downtime. Surgery schedulers will call the surgeon's offices when the system is back up and running.
iii. Daily back-up of the next 3 months schedule is saved electronically to a USB drive.
iv. **Sterile Processing Department** (SPD) maintains a hard copy file of preference cards accessible to the OR staff.

b. **Scheduled Downtime:**

i. The circulating nurse will document the intra-operative phase of the cases or procedures on a hardcopy of intraoperative forms.
ii. Implants will be documented on a hardcopy of the implant record.
iii. Copies of the intra-operative forms and implant records will be placed on the patient record until the system is back up and running.
iv. TCMC will not be able to schedule appointments, view or print any Surginet Surgery schedules during the downtime.
v. Manual scheduling will go into effect.
vi. Add-on/urgent cases shall be manually scheduled during downtime. Schedule the cases in Surginet when the system is back up. Routine scheduling of elective cases is not done during Surginet downtime.
vii. Save copies of all downtime operative records for later entry (using late entry protocol) and charging.
viii. All peri-operative assessments and clinical case data (including implant information), will be manually documented during the Surginet downtime on a hard copy of the forms.
ix. Charges will be manually entered into Affinity during downtime on a daily basis.

c. **Scheduled Recovery:**
i. Enter future scheduled patients and data from the manual hard copy into the Surginet system.
ii. Print a new schedule if needed and validate the following: all manual schedules (Date of Procedure; OR Room Assigned, Start Time, Estimated OR Time, Patient's Name, Birth date, Social Security Number, Patient's home phone number, Pre-Operative Diagnosis, Procedure Scheduled, Surgeon, Name of Assistants, Special Equipment Needs, Name of Office Staff/Surgeon Scheduling, Insurance Information and the Initials of the Scheduling Secretary that documents the information etc) to the Surginet Schedule. Ensure there are no scheduling conflicts with rooms, equipment or supplies.
iii. Circulating nurses for the cases will back enter all clinical data for cases that occurred during the downtime following "Late Entry Protocol" into the Surginet System.
iv. Notify the physicians' office staffs that system is back online and verify that all patient information; procedures, dates and times are accurate.

d. **Unscheduled Downtime:**
i. The circulating nurse will document the intra-operative phase of the cases or procedures on a hardcopy of the intra-operative forms.
ii. Implants will be documented on a hardcopy of the implant record.
iii. Copies of the intra-operative forms and implant records will be placed on the patient record until the system is back up and running.
iv. TCMC will not be able to schedule appointments, view or print any Surginet Surgery schedules during the downtime.
v. Manual scheduling will go into effect.
vi. Add-on/urgent cases shall be manually scheduled during downtime. Schedule the cases in Surginet when the system is back up. Routine scheduling of elective cases is not done during Surginet downtime.
vii. Save copies of all downtime operative records for later entry (using late entry protocol) and charging.
viii. All peri-operative assessments and clinical case data (including implant information), will be manually documented during the Surginet downtime on a hard copy of the forms.
ix. Charges will be manually entered into Affinity during downtime on a daily basis.

e. **Unscheduled Downtime Recovery:**
i. Enter future scheduled patients and data from the manual hard copy into the Surginet system.

ii. Print a new schedule if needed and validate the following: all manual schedules (Date of Procedure; OR Room Assigned, Start Time, Estimated OR Time, Patient's Name, Birth Date, Social Security Number, Patient's home phone number, Pre-Operative Diagnosis, Procedure Scheduled, Surgeon, Name of Assistants, Special Equipment Needs, Name of Office Staff/Surgeon Scheduling, Insurance Information and the Initials of the Scheduling Secretary that documents the information etc) to the Surginet Schedule. Ensure there are no scheduling conflicts with rooms, equipment, or supplies.

iii. Circulating nurses for the cases will back enter all clinical data for cases that occurred during the downtime following "Late Entry Protocol" into the Surginet System.

iv. Notify the physicians' office staffs that system is back online and verify all patient information; procedures, dates, and times are accurate.

10. **Electrocardiogram (ECG~~EKG~~) Powerchart: ECG~~EKG~~s**

a. **Scheduled Downtime Preparation**

i. 30 minutes prior to downtime, download the modality worklist on all the **ECG~~EKG~~** carts.

b. **Scheduled Downtime**

i. Continue acquiring and transmitting ECGs during Millennium downtime.

ii. If the order **staff~~you~~** need to acquire is already on the cart's worklist, acquire the ECG with the appropriate order and transmit.

iii. If **staff~~you~~** cannot download orders to the ECG cart, enter the patient data manually on the cart and transmit.

1) Print 3 copies of every ECG acquired during downtime

a) 1st copy goes to ordering physician for preliminary interpretation/viewing. Critical result notification process remains unchanged (**ECG technician~~RT~~** will still add a comment on the ECG documenting the clinician they communicated critical results to).

b) 2nd copy goes to reading cardiologist bin

c) 3rd copy is kept by the **ECG technician~~Respiratory Therapist~~**. Retain these printed ECGs until downtime is over. They will be used to ensure all ECGs acquired during downtime have orders placed and match the order.

d) Be sure to attach an ADT (patient packet) sticker to each printed copy of the ECG.

c. **Scheduled Recovery -** when Millennium comes back up:

i. All ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order.

ii. When ~~you~~**staff** are notified that downtime is over, log into PowerChart.

iii. Review each printed ECG copy ~~you~~**staff** acquired during downtime.

1) If an order existed prior to downtime, verify that **the~~your~~** transmitted ECG auto-matched and completed the order.

2) If no order exists for one of **the~~your~~** printed ECGs, place an order for it using the ADT patient information that is on the patient's sticker. Then, verify that the ECG ~~you~~**staff** transmitted during downtime is available on the ECG match list, and match it to the order and finish **the~~your~~** ECG process (right-click and stamp **staff~~your~~** name on it as normal).

iv. **ECG technician~~Respiratory Admin~~** will go to Cardiologist reading bin and collect all paper ECGs that were submitted to the Cardiologist during downtime.

1) **ECG technician~~Respiratory Admin~~** will reconcile all signed paper ECGs with their corresponding order and matched ECG images to be sure that all

signed paper ECGs have orders placed and have been matched to their digital ECG images.

2) **ECG technician**~~Respiratory Admin~~ will then return the signed paper ECGs to the reading Cardiologist(s) and direct them to re-sign the digital copy for each printed ECG from their PowerChart ECG worklist.

3) Any unsigned paper ECGs will be discarded by the **ECG technician**~~Respiratory Admin~~ and the reading Cardiologist will read them from their PowerChart ECG worklist as normal.

d. **Unscheduled Downtime**

i. Continue acquiring and transmitting ECGs during Millennium downtime.

ii. If the order ~~you~~**staff** need to acquire is already on the cart's worklist, acquire the ECG with the appropriate order and transmit.

iii. If ~~you~~**staff** cannot download orders to the ECG cart, enter the patient data manually on the cart and transmit.

1) Print 3 copies of every ECG acquired during downtime

a) 1st copy goes to ordering physician for preliminary interpretation/viewing. Critical result notification process remains unchanged (**ECG technician**~~RT~~ will still add a comment on the ECG documenting the clinician they communicated critical results to).

b) 2nd copy goes to reading cardiologist bin

c) 3rd copy is kept by the **ECG technician**~~Respiratory Therapist~~. Retain to these printed ECGs until downtime is over. They will be used to ensure all ECGs acquired during downtime have orders placed and match the order.

d) Be sure to attach an ADT (patient packet) sticker to each printed copy of the ECG.

e. **Unscheduled Downtime Recovery -** when Millennium comes back up:

i. All ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order.

ii. When ~~you~~**staff** are notified that downtime is over, log into PowerChart.

iii. Review each printed ECG copy ~~you~~**staff** acquired during downtime.

1) If an order existed prior to downtime, verify that **the**~~your~~ transmitted ECG auto-matched and completed the order.

2) If no order exists for one of **the**~~your~~ printed ECGs, place an order for it using the ADT patient information that is on the patient's sticker. Then, verify that the ECG ~~you~~**staff** transmitted during downtime is available on the ECG match list, and match it to the order and finish **the**~~your~~ ECG process (right-click and stamp **staff**~~your~~ name on it as normal).

iv. **ECG technician**~~Respiratory Admin~~ will go to Cardiologist reading bin and collect all paper ECGs that were submitted to the Cardiologist during downtime.

1) **ECG technician**~~Respiratory Admin~~ will reconcile all signed paper ECGs with their corresponding order and matched ECG images to be sure that all signed paper ECGs have orders placed and have been matched to their digital ECG images.

2) **ECG technician**~~Respiratory Admin~~ will then return the signed paper ECGs to the reading Cardiologist(s) and direct them to re-sign the digital copy for each printed ECG from their PowerChart ECG worklist.

3) Any unsigned paper ECGs will be discarded by the **ECG technician**~~Respiratory Admin~~ and the reading Cardiologist will read them from their PowerChart ECG worklist as normal.

f. **ECG**~~EKG~~ **Downtime Scenarios**

i. All of Millennium is down

1) Impact:
   a) ~~Can't~~**Cannot** place ECG orders
   b) ~~Can't~~**Cannot** download orders to cart
   c) ~~Can't~~**Cannot** match ECGs
   d) ~~Can't~~**Cannot** unmatch ECGs
   e) ~~Can't~~**Cannot** view or sign ECGs
2) Downtime procedure:
   a) Enter patient information manually at the cart.
   b) Continue acquiring and transmitting ECGs as normal.
   c) Print any stat/critical ECGs and deliver to attending physician, since these will not be viewable in the chart until Millennium comes back up and they can be matched to their orders.
   d) Critical result notification process remains unchanged (**ECG technician**~~RT~~ will still add a comment on the ECG documenting the clinician they communicated critical results to).
   e) When Millennium comes back up, all ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order. At this point, they will be viewable in PowerChart/FirstNet.
   f) Print extra copies of all ECGs acquired during downtime, and place the ADT sticker/label on the ECG. These ECGs will be used to verify that all ECGs were transmitted and matched after we come out of downtime.
   g) Upon downtime completion (or cessation), **ECG technician**~~Respiratory Department~~ will place orders for all ECGs acquired during downtime, so that the transmitted ECGs can be matched to the orders.
   h) Any paper ECGs that are interpreted by Cardiologists during downtime will be collected by **ECG technician**~~Respiratory Administrator~~ at end of downtime. **ECG technician**~~Respiratory Admin~~ will reconcile all signed paper ECGs with their corresponding order and matched ECG images. **ECG technician**~~Respiratory Admin~~ will then return the paper ECGs to the reading Cardiologist(s) and direct them to sign the digital copy that is now available in their PowerChart ECG worklist.
3) Not impacted:
   a) Acquiring and transmitting ECGs.

ii. MGate server is down~~\~~
1) Impact:
   a) ~~Can't~~**Cannot** download new orders to cart.
   b) ~~Can't~~**Cannot** transmit ECGs to Cerner.
2) Downtime procedure:
   a) Continue to ask physicians to place orders for ECGs, even though ~~you~~**staff** ~~can't~~**cannot** download the orders to the cart or transmit the ECGs to Cerner for matching. This way orders will be present and ready to match to ECGs when they can be transmitted.
   b) Enter patient information manually at the cart.
   c) Print any stat/critical ECGs and deliver to attending physician, since these will not be viewable in the chart until the MGate comes back up and the ECGs can be transmitted and matched to their orders.
   d) Older ECGs that are already stored and matched can still be viewed and signed as normal.

e) When MGate comes back up, transmit all ECGs that were acquired during the downtime from the cart directory. Manually match the ECGs to their orders.

3) Not impacted:
   a) Placing ECG orders.
   b) Viewing and Signing ECGs already transmitted to Cerner.
   c) Matching ECGs.
   d) Unmatching ECGs.

11. **Fetalink: Fetal Monitoring System**

a. **Scheduled Downtime Preparation**

i. Planned Downtime will be communicated to Labor & Delivery in Advance.
ii. Labor & Delivery to finalize and disassociate all Fetalink episodes 15 minutes prior to scheduled downtime.
iii. For scheduled maintenance every attempt is made to perform the maintenance during off-peak times.
iv. Labor & Delivery will staff the unit for 1:1 monitoring during Fetalink Downtime.
v. Labor & Delivery Staff will ensure all fetal monitors in use have paper strips printing.

b. **Scheduled Downtime**

i. For Cerner scheduled downtime, finalize and disassociate all Fetalink episodes for patients not currently being monitored.
ii. Notification of downtime mode for users already signed into Fetalink is given by displaying the words "Downtime Mode" in the status bar of Fetalink.
iii. A warning message is given upon launching the application that "Fetalink is currently in downtime mode. Contact **the**~~your~~ system administrator for more information." Some features are unavailable at this time.
iv. During downtime user will have the ability to:
   1) Central/Bedside Monitor Patients.
   2) Make Annotations (including reason for monitoring).
      a) Annotations made during downtime post when Cerner goes back up as long as the patient is associated to the fetal monitoring episode.
      b) If Cerner goes back up and the patient was not already associated to the monitoring episode, the system will send the data to Cerner once the patient is associated to the fetal monitoring episode.
v. The following features are unavailable during Cerner downtime:
   1) Finalize Episode, Patient Archive, and printing Options are disabled.
   2) Extended view displays up to 24 hours of patient history data.
   3) Archive perspective is unavailable.
   4) An unassociated patient can be monitored, but not associated to a device.
   5) Strip annotation is available, but the annotations do not post to Cerner until the system is back up.

c. **Scheduled Downtime Recovery**

i. Once maintenance is complete the system is brought back online and verified by IT.
ii. Labor and Delivery staff will be notified once Fetalink is back up.
iii. Utilize P2DA to retroactively associate and finalize and/or disassociate patients to and from fetal monitors.~~ according to the times documented on the PowerChart/Fetalink Downtime Log~~.
iv. Accurate documentation on the paper log during downtime is critical when retroactively associating patients.
v. Users should associate and disassociate patients from fetal monitors in order of earliest time to latest time.
vi. When multiple patients are associated to one monitor during Cerner downtime user may be asked a "question" to confirm that the user wants to override an

episode that is associated to a different patient. Ensure the time ~~you~~**staff** are entering is correct and say "Yes" to continue.

vii. Launch a new episode of Fetalink.

viii. Ensure patients are associated to correct fetal monitor.

ix. Utilize P2DA/Scanner to associate new patients to fetal monitor.

d. **Unscheduled Downtime**

i. Notify Manager, Assistant Nurse Manager or designee or in off hours the Administrative Supervisor ~~or Patient Flow Coordinator~~ to communicate event to IT.

ii. Labor & Delivery Assistant Nurse Manager designee will make every attempt to staff unit to 1:1 ratio and will cancel all elective procedures until Fetalink is back up.

iii. Labor & Delivery Assistant Nurse Manager or designee will stay in contact with IT for updates on progress of downtime repairs.

iv. Notification of downtime mode for users already signed into Fetalink is given by displaying the words "Downtime Mode" in the status bar of Fetalink.

v. A warning message is given upon launching the application that "Fetalink is currently in downtime mode. Contact **the**~~your~~ system administrator for more information." Some features are unavailable at this time.

vi. During downtime user will have the ability to:

1) Central/Bedside Monitor Patients.

2) Make annotations (including reason for monitoring).

a) Annotations made during downtime post when Cerner goes back up as long as the patient is associated to the fetal monitoring episode.

3) If Cerner goes back up and the patient was not already associated to the monitoring episode, the system will send the data to Cerner once the patient is associated to the fetal monitoring episode.

vii. The following features are unavailable during Cerner downtime:

1) Finalize Episode, Patient Archive, and printing Options are disabled.

2) Extended view displays up to 24 hours of patient history data.

3) Archive perspective is unavailable.

4) An unassociated patient can be monitored, but not associated to a device.

5) Strip annotation is available, but the annotations do not post to Cerner until the system is back up.

e. **Unscheduled Downtime Recovery**

i. System is brought back online and verified by IT.

ii. Labor and Delivery staff will be notified once Fetalink is back up.

iii. Utilize P2DA to retro actively associate and finalize and/or disassociate patients to and from fetal monitors.~~ according to the times documented on the PowerChart/Fetalink Downtime Log~~.

iv. Accurate documentation on the paper log during downtime is critical when retroactively associating patients.

v. Users should associate and disassociate patients from fetal monitors in order of earliest time to latest time.

vi. When multiple patients are associated to one monitor during Cerner downtime user may be asked a "Question" to confirm that they user does want to override an episode that is associated to a different patient. Ensure the time ~~you~~**staff** are entering is correct and say "Yes" to continue.

vii. Launch a new episode of Fetalink.

viii. Ensure patients are associated to correct fetal monitor.

ix. Utilize P2DA/Scanner to associate new patients to fetal monitor.

12. Interventional Radiology (IR)

a. Scheduled Downtime Preparation:

i. Organize pre-made downtime packets containing paper form and labels:

1) Nursing Assessment (which contains documentation of Meds and IVs), Progress Notes, Cardiac Monitor Strip, after care/discharge instructions, for example; Universal Downtime Requisition.

ii. Charge nurse will print current IR census one hour before downtime.

b. Scheduled Downtime:

i. IR staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department.

ii. IR physicians~~,~~ and Allied Health Professionals~~Physician Assistants~~ (AHP) will write orders for medications and IVs on their paper chart and notify nursing of those orders. Downtime events in IR will follow the established procedures in this document, i.e. utilization of the Universal Downtime Requisition.

1) Additionally, all Stat orders should be called to the departments.

iii. IR physicians and AHPs ~~Physician Assistants~~ will dictate their notes into Dragon or use the transcription service.

iv. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

v. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications.

vi. For patients that are transferred to designated locations e.g., SPRA, PACU or ICU, the IR RN will give the receiving department RN a hands-off report, and the downtime patient chart.

c. Scheduled Recovery:

i. New patients who arrived during the downtime period that are currently in IR will remain on downtown forms.

ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.

iii. Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

iv. Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

d. Unscheduled Downtime:

i. Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.

ii. IR staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department.

iii. IR physicians~~,~~ and AHPs~~Physician Assistants~~ will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iv. Downtime events in the IR will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.

v. IR physicians~~,~~ and AHPs ~~Physician Assistants~~ will dictate their notes into Dragon or use transcription service.

vi. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

vii. Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. Unscheduled Downtime Recovery:
   i. New patients who arrived during the downtime period that are currently in IR will remain downtown forms. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.
   ii. Radiology Techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).
   iii. Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

13. Cardiology Department
   a. Scheduled Downtime Preparation:
      i. Print schedules for downtime.
   b. Scheduled Downtime:
      i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed by registration for each patient.
      ii. The ED Unit Secretaries and ED staff will call STAT cardiology exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number. Outpatients will come from Admitting with their hand written face sheet.
      iii. The technologist will substitute the full unique tracking number located on the Universal Downtime Requisition as the downtime medical record number. The technologist will enter the downtime medical record number into all digital modalities. Only one downtime medical record may be used per exam.
      iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name where indicated.
      v. Dictation will be completed as usual by entering the medical record into the dictation system.
      vi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.
   c. Scheduled Recovery:
      i. Delete any duplicate orders.
      ii. Enter and complete orders in Cerner using the unique Universal Downtime.
      iii. Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
      iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
      v. Reference Cardiology Department specific policies for detailed downtime workflow.
   d. Unscheduled Downtime:
      i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed for each patient.
      ii. Outpatients will come from admitting with their hand written face sheet.
      iii. The technologist will substitute the full unique tracking number located on the Universal Downtime Requisition as the downtime medical record

number. The technologist will enter the downtime medical record number into all digital modalities. Only one downtime medical record number may be used per exam.

iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was use, the amount of contrast, and enter his/her full name where indicated.

v. Dictation will be completed as usual by entering the medical record into the Lanier dictation system.

vi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

e. Unscheduled Downtime Recovery:

i. Delete any duplicate orders.

ii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).

iii. Transcription will paste transcribed results from Word into Cerner and validate accuracy.

~~ix.~~iv. Reference Cardiology Department specific policies for detailed downtime workflow.

14. Cardiac Cath Lab (CCL)

a. Scheduled Downtime Preparation:

i. Organize pre-made downtime packets containing paper form and labels: Nursing Assessment (which contains documentation of Meds and IVs), Progress Notes, Cardiac Monitor Strip, after care/Discharge instructions, for example; and Universal Downtime Requisition.

ii. Charge nurse will print current CCL census one hour before downtime.

b. Scheduled Downtime:

i. CCL staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department. CCL will continue Hemodynamics charting in McKesson, will print a copy for the nursing units.

ii. CCL Physicians will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iii. Downtime events in CCL will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition.

1) Additionally, all Stat orders should be called to the departments.

iv. CCL physicians will dictate their notes into Dragon or use transcription service.

v. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

vi. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications

vii. Patients that are transferred to designated locations e.g., SPRA, PACU or Unit the CCL RN will give the receiving department RN a hands-off report, and the downtime patient chart.

viii. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the downtime medical record number. The technologist will enter the downtime medical record number into all digital modalities, only one downtime medical record number may be used per exam.

ix. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name.
x. Dictation will be completed as usual by entering the medical record into the dictation system.
xi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

c. Scheduled Recovery:
i. New patients who arrived during the downtime period that are currently in CCL will remain on downtown forms and in McKesson hemodynamic system.
ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.
iii. Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).
iv. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
v. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
vi. Nursing will document on downtime forms and in McKesson for the duration of the downtime and no data will be back entered into the system when the system comes back online.

d. Unscheduled Downtime:
i. Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.
ii. CCL staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department. Will continue to document hemodynamics in McKesson.
iii. CCL Physicians, will write orders for medications and IVs on their paper chart and notify nursing of those orders.
iv. Downtime events in the CCL will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.
v. CCL physicians, will dictate their notes into Dragon or use the transcription service.
vi. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart. All registrations will be done manually using Registration's Cerner predetermined bank of account numbers.
vii. Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. Unscheduled Downtime Recovery:
i. New patients who arrived during the downtime period that are currently in CCL will remain downtown forms.
ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.

iii. **Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).**
iv. **Enter and complete orders in Cerner using the unique Universal Downtime**
v. **Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).**
vi. **Transcription will paste transcribed results from Word into Cerner and validate accuracy**.
~~x.~~vii. **Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.**

~~12.~~15. **BMDI: Bedside Medical Device Integration**

~~b.~~a. **Scheduled Downtime Preparation**
i. Nursing Manager will ensure each patient has the appropriate unit specific barcoded flow sheet.
ii. Nursing will retrieve all current BMDI clinical data 15 minute prior to the system down time. Nursing is not required to disassociate the Devices during the downtime.

~~c.~~b. **Scheduled Downtime**
i. If downtime is more than 4 hours; clinical data will be tracked on the unit specific flow sheet for the duration for the current shift. If the downtime is less than 4 hours, electronic documentation will be completed upon recovery of the system.

~~d.~~c. **Scheduled Downtime Recovery**
i. When back on-line, nursing will associate the newly admitted patients to the appropriate devices in order to start data collection.
ii. When back on-line nursing will ensure patients are associated with the appropriate devices. In the event the patient is not associated, nursing will reassociate to the appropriate devices.
iii. ~~If the downtime is 4 hours or less, n~~**N**ursing must use Viewed Acquired Data to pull in values and clinical data from the devices for their shift. Nursing must enter all clinical documentation back into the system. Vital signs and all bedside monitoring device data should be pulled into the EMR at the ordered interval (**every**~~q~~15min, 1h**our**, etc).
iv. In the event the View Acquired Data is unavailable, nursing is to use unit specific monitor history to gather clinical data to complete clinical documentation.
~~v. If downtime is greater than 4 hours, documentation will remain on paper for the remainder of the shift and will be part of the permanent record.~~
~~vi.~~v. During the Recovery Phase, nursing will instruct physicians and all ancillary departments where to locate the unit specific clinical documentation.

~~e.~~d. **Unscheduled Downtime**
i. Nursing will utilize the unit specific flow sheets until the system is back on-line or, the duration of their shift.

~~f.~~e. **Unscheduled Downtime Recovery**
i. When back on-line, nursing will associate the newly admitted patients to the appropriate devices in order to start data collection.
ii. When back on-line; nursing will ensure patients are associated with the appropriate devices. In the event the patient is not associated, nursing will reassociate to the appropriate devices.
iii. ~~If the downtime is 4 hours or less, n~~**N**ursing must use Viewed Acquired Data to pull in values and clinical data from the devices for the shift. Nursing must enter all clinical documentation back into the system. Vital signs and all bedside monitoring device data should be pulled into the EMR at the ordered interval (q15min, 1hr, etc).

iv. In the event the View Acquired Data is unavailable, nursing is to use unit specific monitor history to gather clinical data to complete clinical documentation.

v. If downtime is greater than 4 hours, documentation will remain on paper for the remainder of the shift and will be part of the permanent record.

vi. During the Recovery Phase, nursing will instruct physicians and all ancillary departments where to locate the unit specific clinical documentation.

~~g.~~**f. BMDI Application Downtime**

i. In the event ~~the~~ BMDI **(ibus servers)** ~~application is~~ **are** down and the ability to chart in Cerner occurs, ~~nursing is to utilize the department specific flow sheets to capture the patient's vital signs. If the downtime is less than 4 hours, nursing will associate the newly admitted patients as well as existing patients to the appropriate devices~~ **users will manually enter data from monitoring devices**. Once associated, nursing will reenter vital signs into IView based on the ordered intervals.

ii. If the downtime is greater than 4 hours nursing will continue documenting on the unit specific flow sheet for the remainder of the shift. The paper flow sheet is scanned down to HIM and placed in the patients chart as part of the permanent EMR.

iii. Once the BMDI application comes back up, nursing will associate all newly admitted patients and existing patients to the appropriate devices. Nursing will resume documentation of all BMDI clinical data into Cerner.

E. ~~Electronic~~ **FORMS** ~~available on the Intranet~~:

1. Downtime – Admission/Discharge/Transfer Log **Sample**
~~2. Downtime – Fetalink/PowerChart Maternity Log~~
~~3.~~**2.** Downtime – Laboratory Cerner Log **Sample**
~~4.~~**3.** Downtime – Medication Administration Record **Sample**
~~5.~~**4.** Downtime – Surgery Add-On Profile Sheet **Sample**
~~6.~~**5.** Downtime – Universal Requisition Form (Sample Only, must use NCR)

Downtime - Admission/ Discharge/Transfers Log Sample

Computer Downtime Log
Admissions – Discharges - Transfers

DATE	PATIENT NAME	ADM TIME	D/C TIME	DISCHARGE DESPOSITION	TRANSFER TIME	TRANSFER TO	ACCOMMODATION CODE/PT SERVICE

Downtime - Laboratory Cerner Log Sample

TCMC LABORATORY CERNER DOWNTIME LOG

During Cerner downtime, use this form to log any future Lab specimens. If Cerner is back on line before the scheduled test, use this log to enter the orders into Cerner. If Cerner is still down during any of these scheduled tests, make a manual Universal Downtime Requisition and send to Lab. DO NOT SEND THIS LOG TO LAB

PATIENT NAME	TESTS	ORDER DATE	ORDER TIME	ORDERED IN COMPASS	REQ. SENT TO LAB	USER ID

Downtime - Medication Administration Record Sample

Patient Name: _____ MRN: _____ Allergies: _____

Unit: _____ Room/Bed: _____ Admission Date: _____ Page _____ of _____

Age: _____ Sex: _____ Height (cm): _____ Weight (kg): _____ Physician: _____

Reason for Visit: _____ Administration Period: ____/____/____ from 0000 - 2359

Medication Dose Route Frequency	Start Time	Stop Time	Day Shift 0701 – 1900	Night Shift 1901 – 0700

Initials	Signature

Site Codes-site, route & initial must be on injectables

Ant. Thigh Left = 2	Ant. Thigh Right = 1
Gluteal Region Left = 4	Gluteal Region Right = 3
Deltoid Muscle Left = 6	Deltoid Muscle Right = 5
Abdominal Left = 8	Abdominal Right = 7

Omitted Dose Codes = Circle hours and reason

A-NPO Diagnostic	B-NPO Surgery	C-Patient Refusal	D-Nausea	E-Hold Dose	F-Pt off Floor	G-Other (see notes)

***Must chart doses in Powerchart when system returns**

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

8720-1012
(Rev. 8/12)

DOWNTIME MEDICATION ADMINISTRATION RECORD

Downtime – Surgery Add On Profile Sample

ADD-ON PROFILE SHEET

Date/Time Scheduled:	Patient and Procedure Information Read Back-by:
Date/Time of Surgery:	
Add On #:	

Patient: _____ DOB: _____ Age: _____

Location: _____ MR #: _____ NPO Status: _____

Procedure: _____

_____

If procedure is craniotomy/mass or brain biopsy Use Neurosurgery Screening Tool

Diagnosis: _____

Surgeon: _____ Assistant: _____

Equipment/Instruments Needed:	Positioning:
Loaner Inst/Trays:	Cardiac/Medical Hx:
Expected Arrival:	
Rep. Notified:	
SPD Notified:	

Surgeon Availability: Estimated OR Time:	ER/Floor/Pt Nurse notified:
Pre-Op Notified:	PACU Notified:
E-PRIV ☐ FLUORO ☐	X-Ray Tech Notified: C-Arm Fluoro:

Scheduled by: _____

In Computer: [ ] Yes: [ ] No:

Out/In Patient Information

Phone #: _____ SS#: _____

Insurance: _____

ADD-ON PROFILE SHEET

Time Surgeon called OR to schedule case _____

Requested time for case _____

Time OR room is available _____

Pt already seen by Surgeon: **Yes** **No**

Time Patient seen by Surgeon: _____

Time Anesthesiologist is contacted_____/arrival time_____

Time Pt's nurse contacted for handoff _____

Comments:

_____

_____

_____

_____

Time handoff report taken: _____

Time OR aide sent for Pt: _____

Time Pt arrived in OR suite: _____

Time Pt on OR table: _____

Time Surgeon contacted_____/Surgeon in OR room_____

Revised 9-02-15 lg

Downtime – Universal Requisition Form Sample

G 35079

Requested by: _____ Phone: _____

Date: _____ Time: _____

Ordering Physician: _____

Diagnosis / Reason for exam _____

Special Instructions (i.e. Allergy / Isolation / Impairment / Work Comp.): _____

PRIORITY
- ☐ STAT ☐ NOW ☐ TIMED _____
- ☐ ROUTINE ☐ PRE-OP
- ☐ SURGERY: DATE & TIME: _____

TRANSPORTATION MODE
- ☐ WHEELCHAIR ☐ GURNEY
- ☐ PORTABLE ☐ BED

☐ **LABORATORY:** MULTIPLE LAB TESTS CAN BE ORDERED PER REQUISITION EXCEPT FOR MICROBIOLOGY

☐ CHEM 12	☐ CHEM 7	☐ DIGOXIN
☐ TROPONIN	☐ CPK/CKMB	☐ BNP
☐ MAGNESIUM	☐ POTASSIUM	☐ GLUCOSE
☐ AMY	☐ LIP	☐ TOX SCREEN
☐ ACETA	☐ SAL	☐ ALC
☐ ABG		
☐ CBC	☐ CBCD	☐ SED RATE
☐ PT	☐ PTT	☐ FIBRINOGEN
☐ D-DIMER	☐ UA W/MICRO	☐ UCtF
☐ UHCG		

- ☐ NEOPANEL ☐ RPR
- ☐ HBSAG ☐ BLOOD CULTURE
- ☐ BILIRUBIN ☐ RUBELLA
- ☐ OTHER LABORATORY_____ ☐ GBS
- ☐ OTHER LABORATORY_____

- ☐ TRANSFUSION - FFP-PLATELETS-CRYO-PRBC ☐ TYPE + SCREEN ☐ BLOOD GROUP/RH
- ☐ TYPE + CROSS _____ UNITS ☐ C + S _____ SOURCE
- ☐ GRAM STAIN _____ SOURCE

ADDITIONAL PROCEDURE / TEST
- ☐ CARDIOLOGY ☐ EEG ☐ ECG
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY ☐ PULMONARY
- ☐ SPEECH THERAPY
- ☐ DIETARY
- ☐ OTHER _____
- ☐ OTHER _____
- ☐ COMMENT _____

☐ **RADIOLOGY:** Only 1 Radiology procedure per requisition

☐ CXR Single View	☐ CT Head & Contrast
☐ Ultrasound Abdomen	☐ CT
☐ CXR Two Views	☐ MRI
☐ Ultrasound Pelvic	☐ Nuclear Medicine
☐ ABD Single	☐ Interventional Radiology
☐ CT Head / no contrast	☐ CT ABD / Pelvis-Contrast
☐ ABD Acute	BUN _____
☐ OTHER RADIOLOGY	CR _____

EXAM: _____

Performed by: _____ Date / Time: _____

Ancillary Use Only

Procedure: Begin Time: _____ End Time: _____ Exam Done: _____

Tech Initials: _____ Contrast: _____ Amount: _____ Results to Floor: Called _____ Hardcopy: _____

Recovery Documentation: Entered by: _____ Date / Time: _____

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

1081-1001
(Rev. 12/08)

UNIVERSAL DOWNTIME REQUISITION FORM
(To be used for immediate orders during Downtime only)

Original = to Department (White) Copy = to Ordering Unit (Yellow)

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEST TUBE MANAGEMENT**
Purpose:	To define the nursing interventions for assisting with the insertion of chest tubes for the adult and adolescent patients. To define nursing management of adult and adolescent patients with chest tubes.
Supportive Data:	Closed chest drainage systems are used to facilitate the evacuation of fluid, blood, and air from the pleural space, ~~or~~ the mediastinum or both; **to** restore negative pressure to the pleural space; and promote reexpansion of a collapsed lung. Mosby's Chest Tube Insertion Procedure Mosby's Chest **Tube:** Closed Drainage System Procedure
Equipment:	1. One 250**mL**~~m-Ll~~ bottle of Normal Saline 2. Chest Tube Dressing Change Equipment a. Silvasorb Gel or Povidone-Iodine Ointment b. 2-inch silk tape **or micropore** d. Normal Saline e. 4x4 gauze sponges f. 4x4 gauze drainage sponges 3. Chest Tube Removal Kit a. Suture removal kit b. ChloraPrep (triple swabsticks) c. Silvasorb Gel, Bacitracin Zinc, and Povidone-Iodine ointment d. 2 Kelly clamps e. 4x4 gauze sponges (package of 10) f. Chux g. 2 zip holders e. 1 large red bag

A. **PROCEDURE:**

1. Assisting with the Insertion of a Chest Tube

a. Place Chest Tube Insertion Cart in patient's room.

~~2. Assisting With Chest Tube Insertion~~

i. Set up chest drainage device (Refer to Mosby's Chest- Tube: Closed Drainage System Procedure Extended Text). ~~See resource available on Intranet: Teleflex Pleur-Evac insert.~~

ii. Assisting physician (Refer to Mosby's Chest Tube Insertion Procedure)

iii. Ensure chest x-ray is completed per physician's order.

~~3.~~**2.** Chest Tube Monitoring, Nursing Assessment and Care

a. Refer to Mosby's Chest-Tube Insertion Extended Text.

b. **Ensure a** ~~Have~~ Chest Tube Removal Kit readily available **in patient's room.**~~.~~

i. Attach Chest Tube Removal Kit to Intravenous (IV) pole on Telemetry, Acute Care Services (ACS), and Forensics.

c. **Secure chest drainage system to the IV pole using two zip holders. Silk tape may be used to secure the drainage system.** ~~Ensure chest tube drainage system is secured.~~

~~i. Secure chest drainage device drainage system to an IV pole using two zip holders on Telemetry and Forensics.~~

d. Monitor the amount and type/color of drainage per the physicians' orders

e. Mark the collection chamber at the end of every shift and PRN with the ~~date and time~~**date, time, and initials**. Document the drainage amount in the medical record.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Staff Department or Division	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/09; 5/12; **11/15**	06/12, **12/15**	06/12, **01/16**	n/a	10/12, 09/16	11/12	12/12

~~d.~~**i. The amount of drainage within the first two hours after insertion may be approximately 100 to 300 mL, t~~T~~he amount of drainage should begin to decrease over the next few hours and days.**

f. Assess the patient as ordered after chest tube insertion. If no order for assessment, assess as outlined in Mosby's Chest Tube: Closed Drainage Systems procedure.

~~e.~~**g.** Discuss **with the physician** and obtain an order to perform range of motion exercises for shoulder on the side of the chest tube site to prevent frozen shoulder **secondary to immobility.** ~~f.~~

i. Discuss the need for physical therapist assistance with the physician.

h. Ambulate patient per physician's order.

i. If there is no order to ambulate ensure patients sits on the side of bed to enhance ventilation, maximize lung inflation and improve gas exchange.

ii. **Discuss the need for activity orders with physician.**

~~f.~~**i.** Patient positioning:

i. Elevate head of the bed (HOB) 30 to 45 degrees or per physician's order.

ii. Lobectomy and all other lung surgeries: position patient on the non-operative side or per physician's order.

iii. Pneumonectomy: position supine or on the operative side.

~~iii.~~**iv. Reposition patient at least every two hours**

j. Incentive Spirometry (IS)

i. Ensure patient uses the IS as ordered.

~~4.~~**3.** Dressing Change: Chest Tube Insertion Site

a. Change chest tube insertion site dressing every other day and PRN, unless ordered otherwise by physician.

b. Remove dressing and discard in appropriate receptacle.

c. Clean chest tube insertion site with normal saline applied to sterile 4x4 gauze sponge.

d. Pat insertion site dry with 4x4 gauze sponge.

e. Apply Silvasorb gel or follow physician's order.

f. Anchor chest tube to patient's skin.

g. Apply one to two 4x4 drain sponges underneath the chest tube and 1-2 on top of the chest tube. Ensure chest tube is not kinked.

h. Apply two to three 4x4 gauze sponges on top drain sponges.

i. ~~Secure dressings with 2-inch~~ **Apply** silk tape **or micropore over 4 x 4 dressing**. (Do not use paper, form or elastoplast tape to secure chest tube dressing.)

j. Ensure drainage tubing is visible, not kinked, and properly positioned. Do not position or secure drainage tubing behind patient's back.

k. Do not reinforce chest tube dressing. If dressing becomes saturated or soiled:

i. Remove dressing

ii. Assess connections

iii. Apply a new dressing

iv. Notify physician

~~5.~~**4.** Chest Tube Removal

a. Ensure a Chest Tube Removal Kit is readily available and assist physician as needed.

b. Monitor the patient for the following:

i. Obtain chest x-ray as ordered

ii. Ensure adequate respiratory status. Assess the following:

1) Breath sounds

2) Heart rate

~~1)~~**a) Monitor cardiac rhythm on Cardiac Monitoring Units**

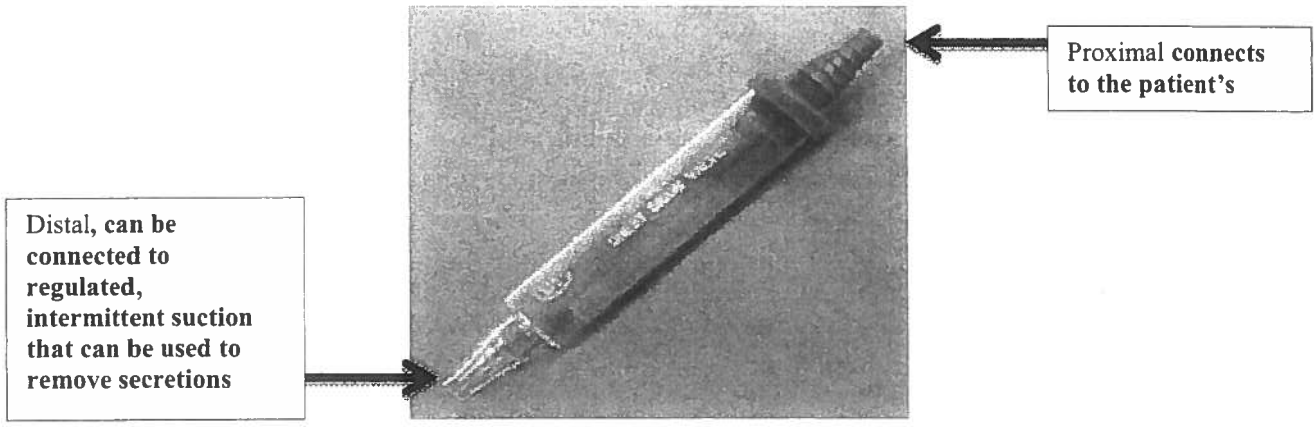
~~2)~~**3)** Respiratory rate and quality

~~3)~~**4)** Oxygen saturation

~~4)~~**5)** Notify physician for abnormal findings

iii. Monitor insertion site for bleeding. If bleeding is found, apply pressure and place a tight occlusive dressing over site. Notify the physician for persistent bleeding. (Persistent bleeding from the insertion site could mean the chest tube was against a vein of the chest wall before removal.)
iv. Monitor suture site and surrounding skin. Notify physician for abnormalities such as excessive redness, dark or inflamed skin with necrotic areas.
v. Monitor the site for signs of infection.
vi. Monitor insertion area for development of subcutaneous emphysema (Crepitus), which is an indication of an air leak into the surrounding tissues.
vii. Monitor for signs and symptoms of pericardial effusion or cardiac tamponade. i.e. distant heart tones, decreased blood pressure, tachycardia, pulsus paradoxus, narrowed pulse pressure
viii. Assess pain and medicate per physician orders

~~6.~~**5.** Heimlich Chest Drain Valve
a. The Heimlich Chest Drain Valve is used for uncomplicated pneumothorax with little or no drainage. The valve allows air and fluid to pass in one direction.
b. There is a flutter valve which replaces an under water drainage bottle system.
c. Observe the flutter every shift and ~~prn~~ **PRN** to ensure air is escaping from the pleural space.
d. Never clamp, close the ends of the valve, or use an airtight dressing or rubber glove over the valve.
i. If there is drainage from the valve, place gauze on the valve and secure with tape ensuring not to occlude or cover valve.
e. Assess the patient's vital signs including oxygen saturation and assess for signs of respiratory distress. Notify physician of abnormal findings.
f. Ensure the proximal end of the valve is attached to **the patient's chest tube catheter** ~~chest tubing~~.
g. Ensure the distal end of the valve, if ordered, is attached to a drainage bag or regulated suction.
h. Assess patient insertion site and surrounding skin. Notify the physician of abnormal findings.



Heimlich Chest Drain Valve

B. **REFERENCES:**

~~1. Wiegand, D. & Carlson, K. (2011). American association of critical care nurses: Procedure manual for critical care. (6th ed.). St. Louis, MO: Elsevier Saunders.~~

1. Becton, Dickinson & Company. (2015). Heimlich valve. Retrieved from http://www.bd.com/medical-surgical/products/heimlich.asp

2. Elsevier:Mosby's Nursing Skills. (2006-2011~~5~~). Chest **tube insertion.**~~closed drainage system. Retrieved May 10, 2012 fr~~**fr**om Tri-City Medical Center inter**a**nat.

3. Elsevier: Mosby's Nursing Skills. (2006-2011~~5~~). Chest tube**: Closed drainage device.**~~device~~: Retrieved from Tri-City Medical Center Intranet ~~Pleur-evac. Retrieved March 20 2009, from http://app32.webinservice.com/MosbySkills/skillsMain.asp~~

4. Teleflex Medical. (2009). Understanding chest drainage. Retrieved from http://www.teleflex.com/en/usa/ucd/index.php

~~Med Instrum, 1983 Jan-Feb:17(1):29-31. Retrieved May 17,2012 from http://www.ncbi.nlm.nih.gov/pubmed/6843411~~

4.**5. Urden, L.D., Stacy, K. M., & Lough, M. E. (2014). Critical care nursing. Diagnosis and Management. (7th ed.). St. Louis, MO: Elsevier**

~~C. RESOURCE AVAILABLE ON THE INTRANET:~~

~~1. Teleflex Pleur-Evac insert.~~

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MISCARRIAGE AND STILLBIRTH IDENTIFICATION AND DISPOSITION PROCESS ~~DIFFERENTIATING INTRAUTERINE FETAL DEMISE FROM MISCARRIAGE~~**
Purpose:	To outline the proper steps in differentiating between stillbirths (fetal **death in utero at equal to or greater than 20 weeks gestational age** ~~demises~~) and miscarriages~~.~~ **A s**~~S~~tillborn **delivery requires the family to make disposition arrangements with a mortuary/ funeral home and** s requires an "autopsy permit" before **it is evaluated by the pathology department**~~they are evaluated~~. **If no autopsy is requested, the stillbirth** ~~remain~~ **is taken to the hospital morgue.** A miscarriage ~~does not require a permit and~~ shall be handled as a routine surgical specimen **and be**~~;~~ **sent to the histology department with a tissue specimen requisition**~~.~~
Supportive Data:	A fetus which satisfies **any two of the following three criteria** will be classified as a stillbirth: 1. Foot length (heel to toe) greater than 3.1 **centimeters** ~~millimeters~~ 2. Crown-rump (CR) length: greater than 16.5 centimeters 3. Gestational age by dates: equal to or greater than 20 weeks
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. Chux 5. Disposable drape 6. Specimen bag 7. Tissue lab slip

A. DEFINITIONS:

1. **MISCARRIAGE: Pregnancy loss before 20 weeks gestation without signs of life. Refer to ~~See other measurement criteria, per Tri-City Medical Center (TCMC), Pathology department as referenced in~~ the Ssupportive Ddata section above,**
   a. **Hospital is responsible for the disposition of the remains which is usually by incineration.**
   b. **The Family may request to have remains taken to mortuary, but incur the associated costs**
2. **STILLBIRTH: Fetal death occurs before the baby is born and after 20 reported weeks of gestation. Refer to the Supportive Data section above.~~(The fetus shows no signs of life at birth). See other measurement criteria, per TCMC pathology department as referenced in "Supportive Data" section.~~**
   a. **The family is responsible for coordinating the disposition of the fetal remains with a funeral home.**
   b. **A "fetal death certificate" is prepared by the birth clerk.**
3. **NEONATAL DEATH: The death of a newborn within the first 28 days of life. (Fetus is born alive regardless of gestational age, but then dies within the first 28 days.)**
   a. **The family is responsible for coordinating the disposition of the remains with a funeral home.**
   b. **A birth certificate is issued AND a ~~"~~death certificate~~"~~ is completed by the provider verifying the death.**

~~A.~~B. PROCEDURE:

1. Perform hand hygiene and don gloves.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Department of OB/GYN	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
12/08, 06/11, **04/15**	04/11, **05/15**	04/11, **05/15**	03/16	**04/16**	05/11, **04/16**	06/11	06/11

2. Complete measurements to determine if fetus is stillbirth or miscarriage. Criteria for stillbirth require 2 or more of the following:
   a. Foot Length (heel to big toe) : > greater than 3.1 centimeters (cm)
   b. Crown- rump Length (head to buttocks): > greater than 16.5 cm
   c. Gestational Age by dates: Equal to or > greater than 20 weeks
3. If the fetal parameters/measurements are determined to be borderline, ~~and the clinician is not confident making the distinction between a miscarriage and stillborn,~~ the fetus must~~should~~ be sent to the Histology lab for final determination of whether or not it is a miscarriage or stillbirth.
   a. The tissue requisition accompanying the fetus/specimen needs to include the ~~clinician's~~ anatomic measurements, gestational age by dates and "Borderline Measurements" indicated.
   b. The staff member transporting the specimen to the laboratory will stay until the pathologist confirms the measurements and then returns to the department and reports the result findings so disposition option can ~~then~~ be discussed with the family. ~~will then make the determination and the findings will be communicated to the provider listed on the tissue requisition form.~~
   ~~Disposition options can then be discussed with the family.~~
      i. If after hours, the charge nurse will arrange to have a second staff member complete the measurements as a second validation.
4. Stillbirth
   a. A stillbirth's remains are transferred to the Morgue.
      i. If pathological examination is desired, an autopsy permit must be obtained and the Histology department notified of this request.
      ii. Staff in the ED and L&D unit ~~the Family~~ shall ensure~~complete~~ the Rrelease of the Ddeceased ~~f~~Form~~, if possible~~ is updated and has the required patient signature before discharge. ~~And t~~The form will be given to the charge nurse for final review, then ~~form~~ forwarded to the Administrative Supervisor~~patient office for follow-up coordination. (Form goes to the AdministrativeNursing Ssupervisor, if after normal work hours)~~.
      iii. The fetal remains will only be released to a designated mortuary.
5. Miscarriage:
   a. If the fetus fails to meet at least two of the stillbirth measurement criteria, it is considered a miscarriage and shall be taken to the lab for processing.
      i. The tissue requisition form that accompanies the specimen to the Histology department shall have the anatomic measurements, gestational age and suspected diagnosis indicated by the attending provider.
         1) The fetus will be processed by the H~~h~~istology department as a surgical pathology specimen
      ii. If the family desires to make arrangements for the miscarriage remains disposition with a mortuary or funeral home this MUST be indicated on the tissue requisition form: "DO NOT PROCESS,~~HOLD SPECIMEN,~~ FAMILY DESIRES DISPOSITION"
         1) Staff in Emergency Department/Labor & Deleivery/Post Anesthesia Care Unit ~~Family~~ shall complete the "Authority for Miscarriage Remains Release" ~~Ddisposition of miscarriage~~ form~~, if possible,~~ before discharge and the charge nurse will forward form to the Administrative Supervisor (AS)~~patient relations patient advocate office. (Nursing supervisor, if after normal work hours)~~.
         2) The AS~~patient relations patient advocate office~~ will communicate with the family no less than weekly to update~~determine~~ funeral home/mortuary arrangements.

3) **Once arrangements are made by the family, the AS~~patient relations representative~~ will notify the Histology Department~~,~~.**

4) **~~so~~ The Laboratory staff will transfer the remains ~~can be transferred from the lab~~ to the morgue ~~for eventual disposition~~.**

a) **The remains ~~fetus~~ will only be released to a designated mortuary.**

5) **If arrangements for disposition are not made by the family within 30 days, the AS will notify the Histology department to~~will~~ dispose of the remains by incineration based on Health and Safety Code 7054.3.**

a) **Reasonable efforts will be made by the AS~~patient relations office~~ to contact the family before the deadline is reached.**

~~2. Any newborn, regardless of gestational age who shows any sign of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles will be considered a live birth with an Apgar score given. Any infant meeting the criteria of a live birth requires a medical record number and a birth certificate.~~

~~a. In the event of a live birth, the representative for the specified donor organ and tissue procurement organization must be notified (refer to Authority for Release of Deceased form).~~

~~b. The infant will also require the completion of the newborn assessment.~~

~~3. Weigh and measure newborn (refer to Patient Care Services, *Deceased Patient Care and Disposition* procedure). Accuracy is important in differentiating the parameters.~~

~~a. Newborn/specimen guidelines:~~

~~i. Measure and record foot length.~~

~~ii. Measure and record crown-rump length.~~

~~iii. Compute and record gestational age by last menstrual date (LMP).~~

~~iv. Weigh and record in grams.~~

~~b. Criteria for stillbirth requires two or more of the following:~~

~~iii. Foot length (heel to toe): greater than 31 mm~~

~~i. Crown-rump length (C-R length): greater than 16.5 cm~~

~~ii. Gestation age by dates: equal to or greater than 20 utero-gestational weeks (23 weeks from LMP)~~

~~4. If the newborn fails to meet at least two of the three criteria, the delivery will be classified as a miscarriage.~~

~~a. The parents may choose to have the remains buried, cremated, or interred even if the newborn fails to meet stillbirth criteria.~~

~~i. This newborn will be handled as a stillbirth, rather than as a pathology specimen.~~

~~ii. The parents must make arrangements with a mortuary. The mortuary of choice must be communicated to the patient representative. The fetus will only be released to the designated mortuary.~~

~~5. Miscarriages will be placed in the specimen bag with a completed tissue requisition and be taken to Tri-City Medical Center's pathology/histology department. The tissue requisition must include the anatomic measurements, the gestational age by dates, and the conclusion that has been drawn from this information and what has been told to the patient. Please indicate if the measurements and or dates are "borderline measurements." The pathologist will make the determination and communicate the findings to the physician listed on the tissue requisition form. The physician will inform the mother and complete the appropriate records.~~

~~6. A stillborn infant will be handled according to the Patient Care Services *Deceased Newborn/Stillborn, Care of* procedure.~~

~~A labor and delivery summary must be completed for all obstetric patients experiencing a pregnancy loss.~~

~~7.~~**6.** Documentation:

a. Document **the date and time of the miscarriage/ delivery** ~~date, time~~ **as a clinical note entry in the patient's electronic health record and indicate where the remains were sent.** ~~, weight, length and disposition of newborn remains in the patient care record.~~

b. **A**~~The~~ stillborn ~~infant will~~ require**s** a **fetal** death certificate to be completed by the Birth Clerk ~~**and is sent to the morgue**~~.

c. A miscarriage ~~will~~ require**s** a tissue requisition **and is sent to the histology department in the lab**.

~~B.~~C. TECHNICAL NOTES:

1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.
2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."
3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."

D. FORM(S)/RELATED DOCUMENT(S):

1. **Authority for Miscarriage Remains Release Sample**

~~C.~~E. REFERENCES:

1. TCMC Pathology Department – Histology Policy and Procedure Manual.
2. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.).* Philadelphia: Saunders.
3. California Health and Safety Code Section 7050.0-7055
4. California Penal Code Section 643
5. California Perinatal Quality Care Collaborative (CPQCC) Network Database, version 1.10. (11/09/2010). Manual of definitions for infants born in 2010. Retrieved on 12/28/2010: http://www.cpqcc.org/data/cpqcc_downloads
6. ~~Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs), Conditions for Coverage (CfCs): Identification of Potential Organ, Tissue, and Eye Donors Questions and Answers (2004). Retrieved on 12/28/2010: http://lifesharing.org/images/stories/resources/medicalProfession/rulesandreg/cmshospqa.pdf~~

Authority for Miscarriage Remains Release Sample

A miscarriage is validated when the Estimated Gestational Age (EGA) is less than 20 weeks and/or when the head to buttocks length is **less than 16.5 cm** and the **heel to toe length is less than 3.1 cm** per Patient Care Services Miscarriage and Stillbirth Identification and Disposition Process Procedure.

Do the pregnancy remains meet miscarriage criteria?

YES_____ Please transfer the miscarriage remains to the Laboratory and review disposition options below.

Nurse Name_____ Date_____ Provider Name _____Date_____

Please be advised that you have choices concerning the final disposition of miscarriage remains, if desired.

HOSPITAL DISPOSITION

According to regulations, the hospital will dispose of the miscarriage under the terms and conditions customarily used. The hospital cannot return the remains to you.

I wish for Tri-City Medical Center to arrange for the disposition of remains under the terms and conditions customarily used.
Patient Signature _____ Date_____

ARRANGED DISPOSITION

If you would like to make alternate arrangements, the remains must be released to an approved agency for proper burial or cremation by a licensed funeral director or mortuary. **PLEASE READ and INITIAL the items BELOW:**

1. I wish to make arrangements with a licensed funeral director or mortuary and understand that I am responsible for all expenses. YES____
2. I understand that if arrangements are not made with a funeral home/mortuary within 30 days, the Laboratory Department will dispose of the remains under the terms and conditions customarily used by the hospital. YES_____
3. Due to regulatory guidelines, there may be reasons the remains may not be able to be released. YES_____

I _____**hereby authorize Tri-City Medical Center to release the remains to:**
Patient

To: _____ (____)_____
Mortuary/Procurement Agency — Area Code/Phone Number

Date	Signature	Area Code/ Phone Number	Email address

Mortuary Notified: Date_____ **Time**_____ **Initials** _____

MORTICIAN'S RECEIPT OF REMAINS

Received from TRI-CITY MEDICAL CENTER, the pregnancy remains from, (Name) _____

_____ (Date) _____ (Time) _____ (Signature of Mortuary Transporter)

Released By: _____ Date: _____ Time: _____

Public Administrator Notified: _____ Date: _____ Time: _____ Initials _____

Affix Patient

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

AUTHORITY FOR MISCARRIAGE REMAINS RELEASE

8720-

White: Medical Record Make (4) copies (1) Patient, (2) Administrative Supervisor (3) Laboratory (4) Mortuary

Clean Copy

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MISCARRIAGE AND STILLBIRTH IDENTIFICATION AND DISPOSITION PROCESS**
Purpose:	To outline the proper steps in differentiating between stillbirth (fetal death in utero at equal to or greater than 20 weeks gestational age) and miscarriage. A stillborn delivery requires the family to make disposition arrangements with a mortuary/ funeral home and requires an "autopsy permit" before it is evaluated by the pathology department. If no autopsy is requested, the stillbirth is taken to the hospital morgue. A miscarriage shall be handled as a routine surgical specimen and be sent to the histology department with a tissue specimen requisition
Supportive Data:	A fetus which satisfies **any two of the following three criteria** will be classified as a stillbirth: 1. Foot length (heel to toe) greater than 3.1 centimeters 2. Crown-rump (CR) length: greater than 16.5 centimeters 3. Gestational age by dates: equal to or greater than 20 weeks
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. Chux 5. Disposable drape 6. Specimen bag 7. Tissue lab slip

A. DEFINITIONS:

1. MISCARRIAGE: Pregnancy loss before 20 weeks gestation without signs of life. Refer to the Supportive Data section above,
   a. Hospital is responsible for the disposition of the remains which is usually by incineration.
   b. The Family may request to have remains taken to mortuary, but incur the associated costs
2. STILLBIRTH: Fetal death occurs before the baby is born and after 20 reported weeks of gestation. Refer to the Supportive Data section above.
   a. The family is responsible for coordinating the disposition of the fetal remains with a funeral home.
   b. A "fetal death certificate" is prepared by the birth clerk.
3. NEONATAL DEATH: The death of a newborn within the first 28 days of life. (Fetus is born alive regardless of gestational age, but then dies within the first 28 days.)
   a. The family is responsible for coordinating the disposition of the remains with a funeral home.
   b. A birth certificate is issued AND a death certificate is completed by the provider verifying the death.

B. **PROCEDURE:**

1. Perform hand hygiene and don gloves.
2. Complete measurements to determine if fetus is stillbirth or miscarriage. Criteria for stillbirth require **2 or more of the following**:
   a. Foot Length (heel to big toe) : > greater than 3.1 centimeters (cm)
   b. Crown- rump Length (head to buttocks): > greater than 16.5 cm
   c. Gestational Age by dates: Equal to or > greater than 20 weeks
3. If the fetal parameters/measurements are determined to be borderline, the fetus must be sent to the Histology lab for final determination of whether or not it is a miscarriage or stillbirth.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Department of OB/GYN	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
12/08, 06/11, 04/15	04/11, 05/15	04/11, 05/15	03/16	04/16	05/11, 04/16	06/11	06/11

a. The tissue requisition accompanying the fetus/specimen needs to include the anatomic measurements, gestational age by dates and Borderline Measurements indicated.
b. The staff member transporting the specimen to the laboratory will stay until the pathologist confirms the measurements and then returns to the department and reports the result findings so disposition option can be discussed with the family.
    i. If after hours, the charge nurse will arrange to have a second staff member complete the measurements as a second validation.

4. Stillbirth
    a. A stillbirth's remains are transferred to the Morgue.
        i. If pathological examination is desired, an autopsy permit must be obtained and the Histology department notified of this request.
        ii. **Staff in the ED and L&D unit** shall ensure the Release of the Deceased Form is updated and has the required patient signature before discharge. The form will be given to the charge nurse for final review, then forwarded to the Administrative Supervisor.
        iii. The fetal remains will only be released to a designated mortuary.
5. Miscarriage:
    a. If the fetus fails to meet at least two of the stillbirth measurement criteria, it is considered a miscarriage and shall be taken to the lab for processing.
        i. The tissue requisition form that accompanies the specimen to the Histology department shall have the anatomic measurements, gestational age and suspected diagnosis indicated by the attending provider.
            1) The fetus will be processed by the Histology department as a surgical pathology specimen
        ii. If the family desires to make arrangements for the miscarriage remains disposition with a mortuary or funeral home this MUST be indicated on the tissue requisition form: DO NOT PROCESS, FAMILY DESIRES DISPOSITION
            1) Staff in Emergency Department/Labor & Deleivery/Post Anesthesia Care Unit shall complete the Authority for Miscarriage Remains Release form before discharge and the charge nurse will forward form to the Administrative Supervisor (AS).
            2) The AS will communicate with the family no less than weekly to update funeral home/mortuary arrangements.
            3) Once arrangements are made by the family, the AS will notify the Histology Department.
            4) The Laboratory staff will transfer the remains to the morgue.
                a) The remains will only be released to a designated mortuary.
            5) If arrangements for disposition are not made by the family within 30 days, the AS will notify the Histology department to dispose of the remains by incineration based on Health and Safety Code 7054.3.
                a) Reasonable efforts will be made by the AS to contact the family before the deadline is reached.
        iii.
6. Documentation:
    a. Document the date and time of the miscarriage/ delivery as a clinical note entry in the patient's electronic health record and indicate where the remains were sent.
    b. A stillborn requires a fetal death certificate to be completed by the Birth Clerk.
    c. A miscarriage requires a tissue requisition and is sent to the histology department in the lab.

C. **TECHNICAL NOTES:**

1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.
2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."
3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."

D. **FORM(S)/RELATED DOCUMENT(S):**

1. Authority for Miscarriage Remains Release Sample

E. **REFERENCES:**

1. TCMC Pathology Department – Histology Policy and Procedure Manual.
2. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.).* Philadelphia: Saunders.
3. California Health and Safety Code Section 7050.0-7055
4. California Penal Code Section 643
5. California Perinatal Quality Care Collaborative (CPQCC) Network Database, version 1.10. (11/09/2010). Manual of definitions for infants born in 2010. Retrieved on 12/28/2010: http://www.cpqcc.org/data/cpqcc_downloads

Authority for Miscarriage Remains Release Sample

A miscarriage is validated when the Estimated Gestational Age (EGA) is less than 20 weeks and/or when the head to buttocks length is **less than 16.5 cm** and the **heel to toe length is less than 3.1 cm** per Patient Care Services Miscarriage and Stillbirth Identification and Disposition Process Procedure.

Do the pregnancy remains meet miscarriage criteria?

YES_____ Please transfer the miscarriage remains to the Laboratory and review disposition options below.

Nurse Name_____ Date_____ Provider Name _____Date_____

Please be advised that you have choices concerning the final disposition of miscarriage remains, if desired.

HOSPITAL DISPOSITION

According to regulations, the hospital will dispose of the miscarriage under the terms and conditions customarily used. The hospital cannot return the remains to you.

I wish for Tri-City Medical Center to arrange for the disposition of remains under the terms and conditions customarily used.
Patient Signature _____ Date_____

ARRANGED DISPOSITION

If you would like to make alternate arrangements, the remains must be released to an approved agency for proper burial or cremation by a licensed funeral director or mortuary. **PLEASE READ and INITIAL the items BELOW:**

1. I wish to make arrangements with a licensed funeral director or mortuary and understand that I am responsible for all expenses. YES____
2. I understand that if arrangements are not made with a funeral home/mortuary within 30 days, the Laboratory Department will dispose of the remains under the terms and conditions customarily used by the hospital. YES_____
3. Due to regulatory guidelines, there may be reasons the remains may not be able to be released. YES_____

I _____hereby authorize Tri-City Medical Center to release the remains to:
Patient

To: _____ (____)_____
Mortuary/Procurement Agency — Area Code/Phone Number

Date	Signature	Area Code/ Phone Number	Email address

Mortuary Notified: Date_____ Time_____ Initials _____

MORTICIAN'S RECEIPT OF REMAINS

Received from TRI-CITY MEDICAL CENTER, the pregnancy remains from, (Name) _____

_____ (Date) _____ (Time) _____ (Signature of Mortuary Transporter)

Released By: _____ Date:_____ Time:_____

Public Administrator Notified: _____ Date:_____ Time:_____ Initials _____

Affix Patient

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

AUTHORITY FOR MISCARRIAGE REMAINS RELEASE

8720-

White: Medical Record Make (4) copies (1) Patient, (2) Administrative Supervisor (3) Laboratory (4) Mortuary

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
~~STANDARIZED PROCEDURES MANUAL~~

STANDARDIZED PROCEDURE: DISCHARGE FROM OUTPATIENT POST–ANESTHESIA SERVICE

I. **POLICY:**

A. Function: To provide a timely and appropriate discharge of the stable patient from Post Anesthesia Care Unit (PACU).

B. Circumstances:

1. Setting: PACU
2. Supervision: None required
3. Physicians Orders: The physician orders must clearly reflect an **R**~~r~~egistered **N**~~n~~urse **(RN)** may discharge a patient when discharge criteria have been met.
4. Patient Contraindications: The anesthesiologist is to be notified of any patient who does not meet discharge criteria within four hours of admission post procedure, or any patient who has hemodynamic instability, surgical complications or fails to respond to treatment/interventions.

II. **PROCEDURE:**

A. A patient will be ready for discharge -as determined by the following criteria:

1. Airway:
   a. Intact airway protective reflexes
   b. Patent airway (no sign of airway obstruction and no need for airway support)
2. Ventilation/Oxygenation:
   a. Respiratory rate **greater than or equal to** ≥10 per minute/adult, age appropriate for pediatric patient
3. Cardiovascular:
   a. Blood pressure, heart rate, cardiac rhythm within patient's acceptable baseline parameters, and temperature greater than 36°C (96.8°F)
   b. Stable, no significant changes for at least 30 minutes
4. General Condition:
   a. Awake and follows commands per baseline
   b. Adequate intake and output, able to take oral fluids
   c. Comfort level meets target pain level
5. Vomiting controlled and/or patient able to tolerate present state of nausea
6. Ambulation
   a. Motor function/mobility progressing toward optimal level
   b. Demonstrates understanding of assistive devices as appropriate
7. Post-procedural/operative bleeding controlled
8. Psychosocial issues identified and addressed
9. Provision made for safe transport home
10. Discharge from PACU with a Modified Aldrete score of 9 – 10 or per physician written orders.
11. Last set of vital signs documented immediately before discharge.

III. **PROCESS:**

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Pharmacy and Therapeutics	Department of Anesthesiology	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/99, 4/00; 02/09;02/11; **07/13; 4/15**	02/11;7/13, **08/15**	03/11;07/13 , **09/15**	**09/15**	**01/16**	04/11;09/13, **07/16**	6/11;10/13, **09/16**		6/11;10/13

A. Discharge
   1. When the patient meets the above criteria, initiate standardized procedure as appropriate.
   2. Prepare patient or responsible party by reviewing patient education.
      a. Patient care provider verbalizes understanding of all discharge instructions.
      b. Written discharge instructions will be signed by the accompanying responsible adult and a copy provided upon discharge.
      c. Questions by patient/responsible adult invited and answered.
   3. Follow-up
      a. Post-Op phone call made the following day by RN
   4. Document in the patient's medical record
      a. Goals/outcomes met
         i. Deviations from expected outcomes to be documented on nursing record
      b. Patient education
      c. Follow-up phone call including any unexpected effects along with RNs instructions to patient or support person. ~~QRR completed when applicable.~~
      d. RN signature completed on all **physician**~~MD~~ orders and nursing documentation.
      e. Completion of Patient Charge document
      ~~f. Surginet log/**Special Procedure Recovery Area** (SPRA) log~~
      ~~g.~~**f.** Discharge in Cerner
   ~~5.~~

IV. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
   A. A current California RN license.
   B. A current **Advanced Cardiac Life Support** (ACLS) certification
   C. Initial Evaluation: During orientation period to include a nursing competency check-off list on discharge criteria.
   D. Ongoing Evaluation: Annually through skills lab.

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
   A. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.
   B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
   A. All RN's who have successfully completed requirements as outlined above are authorized to direct and perform Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure.

Tri-City Medical Center
Oceanside, California

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: HALOPERIDOL (HALDOL), INTRAVENOUS (IV) ADMINISTRATION

I. **POLICY:**

A. Function: To provide direction for the use of intravenously administered Haloperidol at Tri-City Medical Center (TCMC).

B. Circumstances:
   1. Setting: Emergency Department (ED), Intensive Care Unit (ICU), or Telemetry at TCMC
   2. Supervision: None

C. Definitions:
   1. The safe IV administration of haloperidol requires that the QTc interval on the 12 Lead **electrocardiogram (ECG)** be less than 450 milliseconds.
   2. The safe IV administration of haloperidol requires that the patient be monitored continuously for cardiac dysrhythmias for two (2) hours after the drug is given.
   3. The maximum drug amount for each IV dose of haloperidol is 5mg.
   4. The maximum cumulative drug amount for IV haloperidol dosing is 30mg per 24 hours.
   5. QT interval represents the duration of ventricular depolarization and subsequent repolarization measured from the beginning of the QRS complex to the end of the T wave using manual or electronic calipers
   6. QTc interval is a heart rate adjustment measurement for the QT interval. It is measured using a calculation and is not the same measurement as the QT interval.
      i. Nursing shall use the QTc interval listed on a 12 Lead ECG.

D. Exceptions:
   1. Haloperidol IV may be given in emergent situations to patients without a 12-lead ECG if the ordering physician determines the benefit to outweigh the risk of treatment.

II. **PROCEDURE:**

A. The attending physician initiates the process by ordering IV haloperidol for the patient.

B. The **Registered Nurse (RN)** shall check the chart for the most recent 12 Lead ECG.
   1. RN shall order a base line 12 Lead ECG if:
      i. There is not an ECG that was done within the past 24 hours available on the chart.
      ii. Patient at risk for prolonged QT intervals:
         a) Atrioventricular (AV) blocks
         b) History of Torsades de Pointes (TdP)
         c) Long QT Syndrome
         d) History of Myocardial Infarction (MI)
      iii. When recommended by pharmacy based on drug interaction that prolongs the QT interval.
      iv. When the QT interval on an ECG strip measured with calipers, prolongs exceeding the patient's baseline and/or exceeds 450 milliseconds
   2. Patients receiving 30 mg or more of haloperidol IV per day, order a 12 lead every other day, if not ordered by the physician to monitor the QTc.

C. The RN or physician shall check the QTc interval that is electronically measured and printed on the 12 Lead ECG.
   1. Do not administer haloperidol if the QTc interval is greater than 450 milliseconds.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Division of Cardiology	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/12, **9/15**	8/12, **10/15**	10/12, **10/15**	**01/16**	11/12, **01/16**	02/13, **07/16**	2/13, **09/16**		2/13

Discontinue the haloperidol and notify the physician for an alternative route or medication.

2. If the physician specifically orders haloperidol despite QTc greater than 450 milliseconds, document QTc and physician awareness of QTc.

D. The RN shall document the QTc interval on the medication administration record (MAR).

E. The patient shall be monitored for the following for 2 hours after haloperidol has been administered:

1. Cardiac effects (new onset tachycardia, **orthostatic** hypotension, hypertension, **abnormal T waves, prolongation of the QT from baseline** and ventricular dysrhythmias)
2. Signs of neuroleptic malignant syndrome (new fever greater than 37.7 celsius, tachycardia, diaphoresis, labile blood pressure, cardiac dysrhythmias)
3. Extrapyramidal reactions, including:
   i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis)
   ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano.)

~~4. Notify the physician and document symptomatic dysrhythmias or changes from the patient's baseline rhythm in the medical record.~~

~~Notify the physician and document signs of neuroleptic malignant syndrome and extrapyramidal reactions in the medical record.~~

F. Physician Notification and Documentation

1. Notify the physician and document n the medical record the presence of the following:
   i. Cardiac effects
   ii. Signs of neuroleptic malignant syndrome
   iii. Extrapyramidal reactions

2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.
   i. **Not required if a screening process triggers the order.**

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Current A**dvanced Cardiac Life Support** card.
C. Primary RN staff on with continuous cardiac monitoring at T**CMC.**~~ri-City Medical Center.~~
D. **Initial Evaluation: During Department Orientation.**
E. **Ongoing Evaluation: Annually during Skills Lab.**

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All R**N**~~segistered Nurses~~ **who have** successfully completing ~~the~~ requirements **as** outlined above are authorized to direct and perform Haloperidol, Intravenous (IV) Administration Standardized Procedure.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**HAZARDOUS DRUGS**
Purpose:	To ensure the safety of our employees/patients during the administration and patient care of those receiving hazardous drugs within Tri-City Medical Center (TCMC)
Supportive Data:	National Institute of Occupational Safety and Health (NIOSH) and Center for Disease Control (CDC)
Equipment:	Cytotoxic bin, yellow chemo waste bags, N-95 mask, double gloves, gown, splash goggles or face shield, protective shoe covers

A. **DEFINITION:**

1. Hazardous drugs are drugs known to cause:
   a. Genotoxicity – the ability to cause a change or mutation in genetic material
   b. Carcinogenicity – the ability to cause cancer in animal models, humans or both
   c. Teratogenicity – the ability to cause defects on fetal development or fetal malformation
2. Hazardous drugs are known to have the potential to cause fertility impairment, which is a major concern for most clinicians.
3. These hazardous drugs can be classified as antineoplastic, cytotoxic agents, biologic agents, antiviral agents and immunosuppressive agents.
4. Safe handling of hazardous drugs is crucial for both the patient and the provider.

B. **POLICY:**

1. TCMC staff working with hazardous drugs and the body fluids of patients receiving these drugs shall adhere to this procedure and reference Patient Care Services **(PCS) Procedure:** Disposal of Chemotherapy Waste.
   a. Body fluids include sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.
2. Only a TCMC trained registered nurse (RN) may administer a hazardous drug. Training consists of:
   a. Completion of the initial Net-Learning "Administering a Hazardous Drug" module
3. ~~Hazardous Drug List – Located on the TCMC Intranet under clinical references.~~

C. **PROCEDURE:**

1. **Administering a Hazardous Drug**
   a. Hazardous drugs will be identified by pharmacy and a warning will be placed in both the medication Pyxis and the electronic medical record (eMAR) to alert the nurse. **See Hazardous Drug List.**
   b. Ensure a yellow puncture-proof cytotoxic waste container is available on the unit (i.e., medication room or designated area).
   c. Hazardous drugs may not be handled with bare hands.
      i. Always double glove prior to handling a hazardous drug and its packaging.
   d. Never score or crush hazardous drugs (prevents inhalation of the drug.)
   e. Notify pharmacy if a hazardous drug must be administered via gastric tube (i.e. nasogastric or oral gastric small bore feeding tube).
   f. Document all hazardous drug patient education in the Education All Topics Ad-hoc form under "Medication Topics."
2. **Hazardous Drug Disposal and Waste**
   a. Dispose the following in a yellow puncture proof cytotoxic waste container:
      i. Needles and syringes used when administering hazardous drugs
      ii. Non-sharp materials exposed to a hazardous drug (i.e. pill packaging, IV tubing/empty IV bags, and gloves)

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/10, 02/11;3/12, 6/16	3/12, 7/16	3/12, 07/16	n/a	09/16	4/12, 09/16	5/12	5/12

iii. Hazardous drugs in a pill form that have been contaminated or just need to be wasted

b. Notify environmental services (EVS) when any yellow puncture proof cytotoxic waste container is ~~¾~~**2/3** full.

3. **Preventing Exposure to Body Fluid and Contaminated Linen**
   a. Precautions must be taken during administration and until 48 hours after last dose.
   b. Wear appropriate personal protective equipment (PPE) which may include the following:
      i. N-95 mask
      ii. Double gloves
      iii. Gown
      iv. Splash goggles or face shield
      v. Protective shoe covers
   c. Disposing of body fluid
      i. Dispose of body fluids in the toilet
      ii. **DO NOT USE THE TOILET SPRAYER.** Rinse containers with a cup of water to prevent splashing.
      iii. Before flushing toilet, cover open toilet with **new** chux. ~~(New chux to be used with each flush.)~~
      iv. Flush toilet twice**, and discard chux. (New chux to be used with each flush).**
      v. Place PPE and chux in chemotherapy waste bag**.**
      vi. Non-Oncology units contact EVS to dispose of chemo waste bag when they become**2/3** ~~¾~~ of the way full**.**
      vii. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit**.**
   d. All linen exposed to a hazardous drug or body fluid of a patient that is currently receiving or has received agents in the past 48 hours, must be placed (using gown and double gloved) in a yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
   e. Skin care of incontinent adult receiving hazardous drugs**.**
      i. Clean patients skin after voiding or having a bowel movement.
      ii. Apply protective barrier ointment or cream before diapering**.**
   f. All disposable equipment (i.e. foley catheter, bedpan, graduated cylinder, and diapers) used in caring for these patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

4. **Exposures and Prevention Related to Hazardous Drugs and Contaminated Body Fluids**
   a. In the event of skin exposure to a hazardous drug, remove any contaminated garment and immediately wash contaminated skin with soap and water.
   b. In case of eye exposure, immediately flush the eye with saline solution or water for at least 5 minutes.
   c. All linen exposed to a hazardous drug or body fluid of a patient currently receiving (or received) agents in the past 48 hours, must be placed (using gown and double gloved) in a yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
      i. Contact EVS when chemo waste linen bag is ~~¾~~**2/3** full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
   d. Place any disposable contaminated materials into a sealed, leak proof chemo waste plastic bag. Use the yellow puncture proof cytotoxic containers for sharps or breakable items.
   e. All containers will be clearly labeled citing the hazardous nature of the contents.
   f. Report any exposures or spills to your Assistant Nurse Manager/Relief Charge Nurse/supervisor.

g. Report any employee exposure to employee health services and/or emergency department.
h. Complete an Illness/Injury Investigation Report.
i. Report patient exposures to the patient's healthcare provider and per institution policy.

5. **Handling of Hazardous Drugs – Pharmacy Department**
   a. All storage bins will be labeled with a "Hazardous Drug" sticker.
   b. Use chemo gloves when handling hazardous drugs for:
      i. Unit dosing
      ii. Admixing
      iii. Preparing for feeding tube
      iv. If the packaging is not intact
   c. Any hazardous drug sent from the pharmacy (not dispensed from Pyxis) will have a "Hazardous Drug" label attached.
   d. Admixing and crushing of hazardous drugs will be done in the chemo hood. The chemo closed system is not necessary.
   e. All hazardous drugs will have warnings on the eMAR and the Pyxis system.
   f. All vials, bottles, packaging, syringes, etc. will be disposed of in the trace chemotherapeutic waste container.

D. **RELATED DOCUMENTS:**
1. **PCS Procedure: Disposal of Chemotherapy Waste**
2. **Hazardous Drug List**

E. **REFERENCES:**
1. Health Waste Management (HCWM). (2006). The 10 categories of hcrw-#9 genotoxic/cytotoxic waste.
2. National Institute for Occupational Safety and Health. (2004). Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings. ~~Retrieved November 17, 2010 from the NIOSH website at~~ http://www.cdc.gov/niosh/docs/2004-165/#c
3. ~~Hazardous Drug List – located on the TCMC internet under clinical references.~~

TRI-CITY MEDICAL CENTER
HAZARDOUS MEDICATIONS

GENERIC LIST		TRADE LIST	
Generic Name	Trade Name	Trade Name	Generic Name
Abatacept	Orencia	Androgel, Androderm	Testosterone
Azathioprine	Imuran	Arava	Leflunomide
Chloramphenicol	Chloromycetin	Avodart	Dutasteride
Colchicine	Colchicine	Cellcept, Myfortic	Mycophenolate mofetil
Cyclosporin	Neoral, Sandimmune	Cervidil, Prostin	Dinoprostone
Dinoprostone	Cervidil, Prostin	Chloromycetin	Chloramphenicol
Dutasteride	Avodart	Colchicine	Colchicine
Efavirenz	Sustiva	Cytovene	Ganciclovir
Estradiol	Estrace, Climara, Depo-Estradiol	Estrace, Climara, Depo-Estradiol	Estradiol
Estrogen-progestin combinations	Estratest HS	Estratest HS	Estrogen-progestin combinations
Estropipate	Ogen	Evista	Raloxifene
Finasteride	Proscar	Imuran	Azathioprine
Ganciclovir	Cytovene	Methergine	Methylergonovine
Gonadotropin, chorionic	Pregnyl	Neoral, Sandimmune	Cyclosporin
Infliximab	Remicade	Neutrexin	Trimetrexate glucuronate
Leflunomide	Arava	Ogen	Estropipate
Medroxyprogesterone Acetate	Provera	Orencia	Abatacept
Methylergonovine	Methergine	Pentam, Nebupent	Pentamidine isethionate
Methyltestosterone	Testred	Pitocin	Oxytocin
Mycophenolate mofetil	Cellcept, Myfortic	Podocon-25	Podophyllum resin
Nevirapine	Viramune	Pregnyl	Gonadotropin, chorionic
Oxytocin	Pitocin	Prograf	Tacrolimus
Pentamidine isethionate	Pentam, Nebupent	Prometrium	Progesterone
Podophyllum resin	Podocon-25	Proscar	Finasteride
Progesterone	Prometrium	Provera	Medroxyprogesterone Acetate
Raloxifene	Evista	Rapamune	Sirolimus
Ribavirin	Rebetol, Virazole	Rebetol, Virazole	Ribavirin
Sirolimus	Rapamune	Remicade	Infliximab
Tacrolimus	Prograf	Retrovir	Zidovudine
Tenofovir	Viread	Sustiva	Efavirenz
Testosterone	Androgel, Androderm	Testred	Methyltestosterone
Thalidomide	Thalomid	Thalomid	Thalidomide
Trifluridine	Viroptic	Valcyte	Valganciclovir
Trimetrexate glucuronate	Neutrexin	Viramune	Nevirapine
Valganciclovir	Valcyte	Viread	Tenofovir
Zidovudine	Retrovir	Viroptic	Trifluridine

Hazardous Drug Administration:
1. Hazardous drugs shall be administered by a TCMC trained licensed nurse.
2. Hazardous drugs should not be handled with bare hands.
3. Always double glove when handling a hazardous drug and it's packaging.
4. Never score or crush hazardous drugs.
5. Notify pharmacy if a hazardous drug must be administered via a gastric tube.
6. If directed, dispose of packaging and gloves in a yellow cytotoxic waste container. See order comments for disposal directions.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: LOCAL ANESTHETIC PRIOR TO INTRAVENOUS INSERTIONS

I. **POLICY:**

A. Function:

1. Administration of a local anesthetic for pain management during insertion of intravenous (IV) lines.

B. Circumstances:

1. Setting: Patient Care areas
2. Population: Adult, Pediatrics and infant patients
3. Contraindications: Allergy to ~~Lidocaine~~**lidocaine or prilocaine**
4. Supervision: None required

II. **PROCEDURE:**

A. Pre procedure

1. Criteria for use:

a. Deeper insertion

b. Patient anxiety due to IV insertion

c. Difficult insertion

d. Patient request

~~1.~~**2.** Assess for appropriate IV insertion site

~~2.~~**3.** Explain rationale for use of topical anesthetic prior to IV insertion to patient/parent/caregiver/significant other

B. Procedure

1. Topical Anesthetic Cream (**lidocaine and/or prilocaine**~~EMLA/ELA-MAX~~) Administration
   a. Equipment: Tegaderm patch or tape
      i. Alcohol or chlorhexidine wipe
      ii. Topical Anesthetic Cream (EMLA/ELA-MAX)
   b. Administration:
      i. Swab insertion site with alcohol or chlorhexidine wipe
      ii. Apply generous 1 inch square of topical anesthetic cream over insertion site.
      iii. Cover with Tegaderm or tape per manufacturer's instructions.
      iv. Wait for minimum amount of time per manufacturer's instructions.
   c. Insert IV per policy
2. Intradermal Lidocaine Administration
   a. Equipment:
      i. TB syringe with appropriate 27 g needle attachment
      ii. Alcohol or chlorhexidine wipe
      iii. Lidocaine 1% without epinephrine
   b. Administration:
      i. Draw up 0.1 mL of Lidocaine in a syringe
      ii. Swab insertion site with alcohol or chlorhexidine wipe
      iii. Inject Lidocaine intradermally to form a wheal at insertion site
      iv. Wait at least 1 minute
      v. Insert IV per **Mosby's Procedure Intravenous Therapy: Initiation** ~~policy~~
3. Post procedure
   a. Assess and monitor the following:
      i. Erythema

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Interdisciplinary Practice Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/15	09/15	09/15	n/a	124/15	07/16	09/16		

ii. Swelling
iii. Potential allergic reaction

b. Educate patient/parent/caregiver/significant other on complications listed above

III. **DOCUMENTATION:**

A. Complete documentation in the Electronic Health Record (EHR)
B. Enter order for initiation of standardized procedure per policy.
C. Medications are documented in the Medication Administration Record (MAR).
D. Insertion procedure and patient response is documented in the IVIEW band.

IV. RELATED DOCUMENTS:

~~D.~~**A. Mosby's Procedure Intravenous Therapy: Initiation**

~~IV.~~**V. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:**

A. Current California RN license
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Ongoing

~~V.~~**VI. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine and Administration.
B. Review: Every 2 years or review procedure per Hospital policy.

~~VI.~~**VII. V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE**:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Local Anesthetic Prior to Intravenous Insertions

Tri-City Medical Center
Oceanside, California

Tracked Changes Copy

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 6/02	**SUBJECT:** ~~Patient Owned/Supplied~~ Medical Equipment Brought into the Facility
REVISION DATE: 7/05, 7/07, 3/10, 6/12	**POLICY NUMBER:** XI.E

Department Approval Date(s):	02/16
Clinical Policies & Procedures Committee Approval:	~~06/12~~08/16
Nurse Executive Committee Approval:	09/16
Pharmacy & Therapeutics Committee Approval:	09/16
Medical Executive Committee Approval:	09/16
~~**Patient Care Quality Committee Approval:**~~	~~07/12~~
Professional Affairs Committee Approval:	08/12
Board of Directors Approval:	08/12

A. **POLICY:**

1. To provide guidelines for patient owned/supplied equipment that is brought into the center.

B. **DEFINITION:**

1. Patient-Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay~~.~~ (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.)

~~C. STANDARD OF PRACTICE:~~

~~1. It shall be the standard practice at Tri-City Medical Center (TCMC) to not allow patients to bring in their own equipment for use during their hospital stay. Equipment that is not the property of the medical center or under a rental agreement may not be used in the care of patients unless there is no comparable equipment available. However, there may be instances in which the patient must bring in their own equipment. When these situations arise, this policy will describe how TCMC employees and physicians should respond. This policy will apply to limited types of patient supplied equipment.~~

~~D.~~C. **POLICY~~PROCEDURE~~:**

1. ~~Patient and/or family request's the use of PSE. The nurse caring for the patient should explain to the patient that~~ **Tri-City Healthcare District's (TCHD)** ~~TCMC's~~ standard of care is to use hospital-owned equipment whenever possible ~~and that exceptions are made only when TCMC is unable to provide similar equipment~~.
   a. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.
   b. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):
      i. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States;
      ~~ii. High-risk equipment e.g.,~~
      ~~1) Defibrillators~~

~~2) Automated External Defibrillator (AED)~~
~~3) Patient-controlled analgesia (PCA) pumps~~
~~4) Anesthesia machines~~
~~5) External Medication pumps~~
~~6) Home Dialysis equipment~~

~~1.~~**c.** Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals**.**

~~c.~~**d.** Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:

i. If the equipment requires audible alarms that cannot be provided~~;~~
ii. If the equipment has alarms that can be defeated without clinical staff intervention~~;~~
iii. If the patient should become incapacitated or is otherwise unable to maintain their, equipment the hospital may provide substitute equipment~~.~~
iv. Any reason that TCMC deems reasonable that may place the patient's safety at risk~~.~~

2. Upon the patient's request to use PSE, **the nurse caring for the patient should explain to the patient that TCHD's standard of care is to use hospital owned equipment whenever possible.**

a. If patient is agreeable to the use of hospital equipment, change the PSE to hospital equipment and send PSE home with family member (if family member available)

~~2.~~**b. If the patient refuses hospital equipment and requests use of PSE** the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.

~~3.~~**i.** If the equipment is deemed medically appropriate~~, and the clinical staff deems that the patient or family members can safely and adequately use the equipment on his/her own,~~ the physician will authorize use with an order.

~~Once the physician's order is obtained, the clinical staff in the department where the patient is being treated will complete a basic check of the device following the steps in Section 8 and a visual inspection of the device prior to use. Clean as needed.~~
~~Bio-Med must be contacted to perform an operation and safety check on the device.~~

~~4.~~**3.** Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will ~~verify/complete the following for patient supplied equipment (PSE).~~**:**

a. **Verify** ~~A~~**a** physician**'s** order has been **obtained and** entered in Cerner approving the use of the patient's equipment.

b. Ensure~~Prior to use of the PSE while in the facility,~~ the patient or legal representative ~~must~~ sign**s** a liability waiver (See Patient-Supplied Equipment Waiver) for use of PSE.

i. The signed waiver shall be placed in the patient's chart.
~~a.~~**ii.** If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital.

~~b.~~**c.** ~~Clinical nursing staff has completed a v~~**V**isual**ly** inspect**ion the PSE** (assessing for damage to the device, infestation with insects, excessively soiled.)

~~c.~~**d.** ~~The exterior shall be thoroughly w~~**W**iped down **the PSE** with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at ~~E~~**extension~~.~~ 7410 or 5696** ~~3007~~.

~~d.~~**e. Notify** Bio-Med ~~shall be notified~~ as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (**Monday-Friday**).

i. If the device is brought in during the weekend, ~~then~~ the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.

ii. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center, (Off hours and weekends contact the Administration Supervisor to notify Bio-Med).

~~e.~~**f.** Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.

~~f.~~**g.** If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well being (example: pulse oximeter).

~~g.~~**h.** ~~The patient or legal surrogate has signed a liability release for patient supplied medical equipment and this has been placed in the patient's chart.~~

~~i.~~**4.** ~~Note:~~**For** ~~A~~**a**ny concerns or questions, please contact:

~~h.~~**a.** The Director of Risk Management for risk issues

~~i.~~**b.** The Chief Nurse Executive for patient care issues

~~j.~~**c.** The Management of Clinical Engineering for medical equipment issues.

~~E.~~D. SPECIAL CONSIDERATIONS:

1. Insulin Pumps:

a. See Patient Care Services (PCS) Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient

2. Wearable Defibrillator:

a. See PCS Policy: Wearable Defibrillator (LifeVest)

3. Implantable Pain Pumps:

a. The admitting physician will be notified immediately ~~-~~the patient has an implantable pain pump.

~~2.~~b. The admitting physician will attempt to contact the original prescribing physician of the pain pump for information on continuing, stopping or disconnecting.

c. The admitting physician will enter orders regarding the status of the pain pump.

i. If the medication will continue during hospitalization, the medication that is being infused by the pain pump must be entered into the electronic health record.

1) This will include the drug, dose, total volume, rate and volume infused.

2) The order must specify that the drug is infusing through pain pump.

~~1)~~3) The nurses will document on the electronic medication record (eMAR) daily.

4. Ambulatory Infusion Pump (AIP):

a. The admitting physician will be notified immediately that the patient is wearing an AIP.

b. Admitting physician will attempt to contact the original prescribing physician of the AIP for information on continuing, stopping or disconnecting.

i. Admitting physician may also call the number located on the AIP for other information.

ii. If the medication is a chemotherapeutic agent, the medication must be administered/discontinued by TCHD Chemotherapy Competent Registered Nurse (see PCS Procedure: Chemotherapy Administration).

c. The admitting physician will enter orders regarding the status of the AIP

i. If the medication will continue during hospitalization, the medication that is being infused by the AIP must be entered into the electronic health record.

~~2.~~1) **This will include the drug, dose, total volume, rate and volume infused.**
2) **The order must specify that the drug is infusing through AIP.**
~~b.~~3) **If the AIP is continued, nurses will document on the eMAR daily.**

~~F.~~E. **FORMS ~~LOCATED ON INTRANET~~**:
1. Patient-Supplied Equipment Waiver **Sample**

F. **RELATED DOCUMENTS**
1. **Outpatient Infusion Center Procedure: Ambulatory Infusion Pumps**
2. **PCS Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient**
~~1.~~3. **PCS Policy: Wearable Defibrillator (LifeVest)**
4. **PCS Procedure: Chemotherapy Administration**

PATIENT SUPPLIED EQUIPMENT WAIVER SAMPLE

This Patient Supplied Equipment Waiver between Tri-City Healthcare District (Tri-City) and _____ (Patient) is entered into on _____, 20__. Patient or legal representative must initial each statement in order to use Patient Supplied Equipment in Tri-City Healthcare District facility.

Type of Device used: _____ (Do not use for Insulin Pump, refer to Insulin Pump Policy)

_____ I understand that I have voluntarily brought my equipment into a Tri-City facility for my use during my stay at a Tri-City facility.

_____ I certify that I have been trained on how to use and repair this equipment, and that I am fully capable of using and repairing the equipment.

_____ I understand that Tri-City performed an inspection of my equipment. This inspection is not a warranty that the device is safe or free from defects. I am not relying on Tri-City's inspection of the equipment to ensure its safety or my proper use.

_____ I understand that Tri-City may unilaterally determine without warning to me that I may no longer use my equipment. Tri-City may replace my equipment with its own equipment.

_____ I understand that by signing this document, I hereby waive any claim or right of action against Tri-City related to my use of my equipment. I release Tri-City and its employees, agents, and assigns from any and all liability resulting from the use, operation, damage to, and repair of my equipment by myself, Tri-City, and any of its employees.

By agreeing to the above terms and conditions, I expressly assume the risks that may result from bringing personal medical equipment into a Tri-City facility. I release Tri-City from any damages, and agree to indemnify, hold harmless, and defend Tri-City, its employees, affiliates, directors, officers, subsidiaries, and agents against any and all liability arising out of the negligent operation of use of the medical equipment by me or my family or visitors. I acknowledge and agree that in no event shall Tri-City be liable for any indirect, special, consequential, incidental, or punitive damages, loss, or expense associated with the use of personal medical equipment by me or my family and/or visitors. This agreement shall be legally binding on me and my designated family member(s) and/or visitors operating my personal medical equipment. My signature below indicates I have read this agreement, understand it, and agree to be bound by its terms.

_____ _____
Patient or Legal Surrogate Date

_____ _____
Witness Date

Tri-City Medical Center
Oceanside, California

Clean Copy

PATIENT CARE SERVICES

ISSUE DATE: 6/02

SUBJECT: Medical Equipment Brought into the Facility

REVISION DATE: 7/05, 7/07, 3/10, 6/12

POLICY NUMBER: XI.E

Department Approval Date(s):	**02/16**
Clinical Policies & Procedures Committee Approval:	**08/16**
Nurse Executive Committee Approval:	**09/16**
Pharmacy & Therapeutics Committee Approval:	**09/16**
Medical Executive Committee Approval:	**09/16**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **POLICY:**
1. To provide guidelines for patient owned/supplied equipment that is brought into the center.

B. **DEFINITION:**
1. Patient-Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.)

C. **POLICY:**
1. Tri-City Healthcare District's (TCHD) standard of care is to use hospital-owned equipment whenever possible.
    a. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.
    b. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):
        i. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States;
    c. Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals.
    d. Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:
        i. If the equipment requires audible alarms that cannot be provided
        ii. If the equipment has alarms that can be defeated without clinical staff intervention
        iii. If the patient should become incapacitated or is otherwise unable to maintain their, equipment the hospital may provide substitute equipment
        iv. Any reason that TCMC deems reasonable that may place the patient's safety at risk
2. Upon the patient's request to use PSE, the nurse caring for the patient should explain to the patient that TCHD's standard of care is to use hospital owned equipment whenever possible.

a. If patient is agreeable to the use of hospital equipment, change the PSE to hospital equipment and send PSE home with family member (if family member available)
b. If the patient refuses hospital equipment and requests use of PSE the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.
    i. If the equipment is deemed medically appropriate the physician will authorize use with an order.

3. Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will :
    a. Verify a physician's order has been obtained and entered in Cerner approving the use of the patient's equipment.
    b. Ensure the patient or legal representative signs a liability waiver (See Patient-Supplied Equipment Waiver) for use of PSE.
        i. The signed waiver shall be placed in the patient's chart.
        ii. If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital.
    c. Visually inspect the PSE (assessing for damage to the device, infestation with insects, excessively soiled.)
    d. Wipe down the PSE with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at extension 7410 or 5696.
    e. Notify Bio-Med as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (Monday-Friday).
        i. If the device is brought in during the weekend, the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.
        ii. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center, (Off hours and weekends contact the Administration Supervisor to notify Bio-Med).
    f. Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.
    g. If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well being (example: pulse oximeter).
    h.
4. For any concerns or questions, please contact:
    a. The Director of Risk Management for risk issues
    b. The Chief Nurse Executive for patient care issues
    c. The Management of Clinical Engineering for medical equipment issues.

D. **SPECIAL CONSIDERATIONS:**

1. Insulin Pumps:
    a. See Patient Care Services (PCS) Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient
2. Wearable Defibrillator:
    a. See PCS Policy: Wearable Defibrillator (LifeVest)
3. Implantable Pain Pumps:

a. The admitting physician will be notified immediately the patient has an implantable pain pump.
b. The admitting physician will attempt to contact the original prescribing physician of the pain pump for information on continuing, stopping or disconnecting.
c. The admitting physician will enter orders regarding the status of the pain pump.
    i. If the medication will continue during hospitalization, the medication that is being infused by the pain pump must be entered into the electronic health record.
        1) This will include the drug, dose, total volume, rate and volume infused.
        2) The order must specify that the drug is infusing through pain pump.
        3) The nurses will document on the electronic medication record (eMAR) daily.

4. Ambulatory Infusion Pump (AIP):
    a. The admitting physician will be notified immediately that the patient is wearing an AIP.
    b. Admitting physician will attempt to contact the original prescribing physician of the AIP for information on continuing, stopping or disconnecting.
        i. Admitting physician may also call the number located on the AIP for other information.
        ii. If the medication is a chemotherapeutic agent, the medication must be administered/discontinued by TCHD Chemotherapy Competent Registered Nurse (see PCS Procedure: Chemotherapy Administration).
    c. The admitting physician will enter orders regarding the status of the AIP
        i. If the medication will continue during hospitalization, the medication that is being infused by the AIP must be entered into the electronic health record.
            1) This will include the drug, dose, total volume, rate and volume infused.
            2) The order must specify that the drug is infusing through AIP.
            3) If the AIP is continued, nurses will document on the eMAR daily.

E. **FORMS**:
1. Patient-Supplied Equipment Waiver Sample

F. **RELATED DOCUMENTS**
1. Outpatient Infusion Center Procedure: Ambulatory Infusion Pumps
2. PCS Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient
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