TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
April 12, 2018, Thursday
12:00 Noon– 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	1-3	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 March 2018 Meeting	4-10	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	11-13		Committee
	Patient Care Services			
	1. Abbreviations, Use of	14-21		
	2. Automatic Stop Orders Policy	22-23		
	3. Continuous Ambulatory Peritoneal Dialysis Procedure – tracked changes	24-27		
	Continuous Ambulatory Peritoneal Dialysis Procedure – clean copy	28-29		
	4. Emergency Department Standardized Procedure	30-36		
	5. Fall Risk Procedure and Score Tool Procedure	37-48		
	6. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	49-51		
	7. Infusion Pumps, Intravenous Therapy Policy	52-54		
	8. Point of Care Testing Competency Assessment Procedure	55-56		
	9. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	57-58		
	Administrative			
	1. Non-Beneficial Treatment 399	59-61		
	Unit Specific			
	Behavioral Health Services			
	1. AMA Discharges	62-63		
	2. Managing the Medical Record for ED visits	64-65		
	3. Notification of MediCal Beneficiary of Denial of Benefits	66		
	4. Notification of Responsible Persons	67		
	5. One to One Observation of Patients	68-70		
	6. One to One Patient Supervision	71		
	7. Orientation of New Patients	72-73		

	8. Pastoral Care	74		
	9. Patient Belongings	75-79		
	10. Patient Discharge Types	80-81		
	11. Patient Responsibilities	82-83		
	12. Patient Satisfaction Surveys	84		
	13. Psychiatric Advanced Directive	85		
	14. Release of Information	86-90		
	15. Role of Medical Staff Leadership in Behavioral Health Services	91-92		
	16. Scabies Lice Fleas in the BHU	93-95		
	17. Scope of Service - Behavioral Health Unit	96-98		
	18. Smoking Guidelines for Behavioral Health Unit	99-100		
	19. Solicitation of Patients/Referrals to Self	101		
	20. Telephone Use	102-104		
	21. Treatment of Patients	105-107		
	22. Unit Staff Meetings	108-110		
	23. Utilization Management	111-114		
	24. Visiting in Behavioral Health Unit	115-117		
	25. Vital Signs	118		
	26. Washer Dryer Use	119-120		
	Infection Control			
	1. Department Specific Infection Control Behavioral Health Services - IC 7	121-122		
	Women & Newborn Services			
	1. Breast Milk, Pumping, Handling and Storage of	123-124		
	2. Formula Feeding Procedure	125-126		
	3. Infant Feedings – tracked changes	127-144		
	Infant Feedings – clean copy	145-157		
	Formulary Requests			
	• Albuterol/Ipratropium inhaler	158		
	• Bupropion	159		
	• Combivir	160		
	• Darunavir	161		
	• Droperidol	162		
	• Exparel	163		
	• Fluticasone inhaler	164		
	• Fluticasone/Salmeterol inhaler	165		
	• Genvoya	166		
	• Ipratropium inhaler	167		
	• Lansoprazole solu-tabs	168		
	• Medium chain triglycerides	169		
	• Mepivacaine	170		
	• Nitroglycerin 0.3 mg and 0.6 mg sublingual tablets	171		
	• Nitroglycerin 0.4 mg spray	172		
	• Raltegravir	173		
	• Salmeterol inhale	174		
	• Tivicay	175		
	• Verapamil SR	176		
6.	Motion to go into Closed Session		2 min.	Committee
7.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance		30 min.	Chair

	Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))			
8.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair
9.	Comments from Members of the Committee		5 min.	Committee
10.	The next meeting of the Professional Affairs Committee of the Board is on May 10, 2018 .		1 min.	Chair
11.	Adjournment		1 min.	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
March 8, 2018

Members Present: Director Leigh Anne Grass, Director Laura Mitchell, Director Larrty Schallock, Dr. Contardo, Dr. Souza, Dr. Johnson and Dr. Ma.

Non-Voting Members Present: Scott Livingstone, COO , Sharon Schultz, CNE/ Sr. VP , Carlos Cruz, Chief Compliance Officer and Marcia Cavanaugh, Sr. Director for Risk Management.

Others Present: Christine Carlton, Alisa Quirey, Lori Roach, Kim Posten, Courtnel Nelson, Debra Feller, Oska Lawrence, Candice Parras, Aimee Hardt, Joy Melhado, Patricia Guerra and Karren Hertz.

Members Absent: Steve Dietlin and Susan Bond.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Grass called the meeting to order at 12:03 PM in Assembly Room 1.		Director Grass
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Schallock and seconded by Director Mitchell.	Director Grass
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Grass read the paragraph regarding comments from members of the public.		Director Grass

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of February 2018.	Director Grass called for a motion to approve the minutes from February 8, 2018.	Director Schallock approved and Director Mitchell seconded the motion to approve the minutes from February 2018. Director Grass abstain from voting as she was not present in last month's meeting.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Release of Deceased to a Family Member Policy 2. Safe Medical Device Act Tracking and Reporting Policy 3. Safe Surrender 4. Sponge, Sharps and Instrument Counts-Prevention of Retained Surgical Items	It was clarified that the hospital rarely uses this procedure but we need to have this policy in place for compliance purposes. A question was raised on what category does the surgial mesh fall—Deb Feller stated that it is documented in the charts exactly the same way. There was no discussion on this policy. There was a minor grammatical error on Item 8 section a. This will be corrected and the policy will move forward for Board approval.	**ACTION:** The Patient Care policies and procedures were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific Administrative Policies 1. Success Service Recovery Program- SSRP (Formerly Star Service Plan)	Dr. Souza posed a question if we are tracking down which departments do this program and the amounts they used for this purpose. Marcia responded by saying that this program is being used frequently by the staff and had helped in numerous instances in making the situation better on incidents that patients/ family are upset due to a service delay or other unforeseen circumstances.	**ACTION:** The Administrative policy was approved. Director Mitchell moved and Dr. Souza seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Behavioral Health Services 1. Approved Abbreviations- Clean Copy Approved Abbreviations- Tracked Changes 2. Assisting MediCal Recipients with Grievances and Appeals 3. Behavioral Health Unit Visiting Policy 4. BHU Multidisciplinary Treatment Plan 5. Clinical Assessment 6. Community Meeting 7. Conducting Searches	*Most of BHU policies contained in this list are self-explanatory with the exception of some as specified below.	**ACTION:** The Behavioral Health policies were approved. Director Mitchell moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Patient Room Patient Belongings 8. Confidentiality			
9. Cleaning and Changing of BHU/ CSU Bathroom Curtains	The term PICU should be taken out (old term for CSU) and it was recommended that the BHU and CSU should be spelled out for better clarification in this policy. Also, this policy is not duplicated since from the last revision date, the doors from BHU were taken out as part of recommendation of the last JC survey.		
10. Daily Environmental Safety Rounds			
11. Daily Schedule			
12. Direct Admissions to BHU	There was a clarification made that the on-call physician can make a direct referral for a patient to be admitted to BHU.		
13. Discharge Planning			
14. Dress Code for Patients	Flip flops are discouraged in BHU since it is a tripping hazard in the units.		
15. Elopement Precautions	Joy fully explained the BHU staff rounding procedure. There is staff rounding in the unit every 15 minutes in BHU (60 minutes in CSU). In case there's an incident, a Mental Health Worker (MHW) designates another person to round on his/her behalf. This will ensure that one person is always rounding to check on the status of patients in this unit while the other one attends to an issue in		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	the unit.		
16. Environmental Safety Standards in BHU			
17. Exclusionary Criteria			
18. Family Involvement in Treatment			
19. Food for the Unit			
20. Freedom of Movement			
21. General Supervision of Patients: Patient Rounds			
22. Hose Use During Garden Activity			
23. Inpatient Unit Admission Criteria			
24. Involuntary Hold Patients			
25. Management of Aggressive and Assaultive Behavior			
Food and Nutrition			
1. Clinical Nutrition Dietitian Staffing	There was no discussion on this policy.	**ACTION:** The Food and Nutrition policies were approved. Director Mitchell moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Nutrition Assessment and Care for Adult Geriatric Patients Protocol	There was minor typo on the criteria for nutritional assessment, the word greater than should say less than as it corresponds		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	to the correct symbol (<).		
NICU 1. Admission and Discharge Criteria for the NICU-Clean Copy Admission and Discharge Criteria for the NICU-Tracked Changes 2. Ordering of Durable Medical Equipment 3. Patient Assignment in NICU 4. Patient Classification (Acuity) in the NICU	The spelling of inotropic was corrected and there was a clarification on the 44 weeks post conceptual which is essentially not one month gestation.	**ACTION:** The NICU policies were approved. Director Schallock moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Infusion Center 1. Infection Prevention and Control Activities	There was no discussion on this policy.	**ACTION:** The Outpatient Infusion Center policy was approved. Director Mitchell moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Pharmacy 1. Automated Dispensing Machine 2. Licensure and Professional Standards 3. Medication Preparation 4. Receiving and Tracking Narcotic Pump Refills Prepared by Outside	It was noted that the notification on ADMs (Automated Dispensing Machine) can be done remotely. It was clarified that if the pharmacy require assistance on overrides without orders, staff may contact the Pharmacy Director and/or Clinical Manager.	**ACTION:** The Pharmacy policies were approved. Director Schallock moved and Director Mitchell seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Vendors **Progressive Care Unit** 1. Custody Awareness Safety Guidelines 2. Hunger Strike, CDCR 3. Release of A Deceased-Justice Involved Patient	Lori Roach briefly stated that nursing students rotate in PCU. For visitors, TCMC still need to make sure visitors obtain a clearance before allowing anyone in the unit. Department of Corrections is in charge of of notifying the family in cases of death. The spelling of manager was corrected in this policy.	**ACTION:** The notice of privacy practice was approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Mitchell.	Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Schallock moved, Dr. Souza seconded and it was unanimously approved to go into closed session at 12:40 PM.	Director Grass
8. Return to Open Session	The Committee return to Open Session at 2:15 PM.		Director Grass
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Grass
10. Comments from Members of the Committee	No comments.		Director Grass
11. Adjournment	Meeting adjourned at 1:25PM.		Director Grass

PROFESSIONAL AFFAIRS COMMITTEE
April 12th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Abbreviations, Use of	3 Year Review	
2. Automatic Stop Orders Policy	3 Year Review, Practice Change	
3. Continuous Ambulatory Peritoneal Dialysis Procedure – **tracked changes** 4. Continuous Ambulatory Peritoneal Dialysis Procedure – **clean copy**	3 Year Review, Practice Change	
5. Emergency Department Standardized Procedure	Practice Change	
6. Fall Risk Procedure and Score Tool Procedure	Practice Change	
7. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	3 Year Review	
8. Infusion Pumps, Intravenous Therapy Policy	3 Year Review, Practice Change	
9. Point of Care Testing Competency Assessment Procedure	3 Year Review	
10. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	3 Year Review, Practice Change	
Administrative		
1. Non-Beneficial Treatment 399	NEW	
Unit Specific		
Behavioral Health Services		
1. AMA Discharges	DELETE	
2. Managing the Medical Record for ED visits	3 Year Review, Practice Change	
3. Notification of MediCal Beneficiary of Denial of Benefits	3 Year Review	
4. Notification of Responsible Persons	3 Year Review, Practice Change	
5. One to One Observation of Patients	3 Year Review, Practice Change	
6. One to One Patient Supervision	DELETE	
7. Orientation of New Patients	3 Year Review, Practice Change	
8. Pastoral Care	3 Year Review, Practice Change	
9. Patient Belongings	3 Year Review, Practice Change	
10. Patient Discharge Types	3 Year Review	
11. Patient Responsibilities	3 Year Review	
12. Patient Satisfaction Surveys	3 Year Review, Practice Change	
13. Psychiatric Advanced Directive	3 Year Review	
14. Release of Information	3 Year Review	

PROFESSIONAL AFFAIRS COMMITTEE
April 12th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
15. Role of Medical Staff Leadership in Behavioral Health Services	3 Year Review, Practice Change	
16. Scabies Lice Fleas in the BHU	DELETE	
17. Scope of Service - Behavioral Health Unit	3 Year Review, Practice Change	
18. Smoking Guidelines for Behavioral Health Unit	3 Year Review, Practice Change	
19. Solicitation of Patients_Referrals to self	3 Year Review	
20. Telephone Use	3 Year Review	
21. Treatment of Patients	3 Year Review, Practice Change	
22. Treatment Planning	3 Year Review, Practice Change	
23. Unit Staff Meetings	3 Year Review, Practice Change	
24. Utilization Management	3 Year Review, Practice Change	
25. Visiting in Behavioral Health Unit	3 Year Review, Practice Change	
26. Vital Signs	3 Year Review, Practice Change	
27. Washer Dryer Use	3 Year Review, Practice Change	
Infection Control		
1. Department Specific Infection Control Behavioral Health Services - IC 7	3 Year Review, Practice Change	
Women & Newborn Services		
1. Breast Milk, Pumping, Handling and Storage of	DELETE	
2. Formula Feeding Procedure	DELETE	
3. Infant Feedings – **tracked changes** Infant Feedings – **clean copy**	3 Year Review, Practice Change	
Formulary Requests		
Albuterol/Ipratropium inhaler	Modification to Formulary Status	
Bupropion	Remove from Formulary	
Combivir	Remove from Formulary	
Darunavir	Addition to Formulary	
Droperidol	Remove from Formulary	
Exparel	Modification to Formulary Status	
Fluticasone inhaler	Remove from Formulary	
Fluticasone/Salmeterol inhaler	Remove from Formulary	
Genvoya	Addition to Formulary	
Ipratropium inhaler	Modification to Formulary	

PROFESSIONAL AFFAIRS COMMITTEE
April 12th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
	Status	
Lansoprazole solu-tabs	Remove from Formulary	
Medium chain triglycerides	Remove from Formulary	
Mepivacaine	Remove from Formulary	
Nitroglycerin 0.3 mg and 0.6 mg sublingual tablets	Remove from Formulary	
Nitroglycerin 0.4 mg spray	Remove from Formulary	
Raltegravir	Remove from Formulary	
Salmeterol inhale	Modification to Formulary Status	
Tivicay	Addition to Formulary	
Verapamil SR	Remove from Formulary	

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/97 **SUBJECT:** ~~Use of~~ Abbreviations, Use of

REVISION DATE: 5/02, 12/02, 5/03, 12/03, 3/04, 4/06, 08/06, 07/09

Department Approval:	**02/18**
Clinical Policies & Procedures Committee Approval:	**~~04/15~~03/18**
Nurse Executive Committee Approval:	**~~04/15~~03/18**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/15~~03/18**
Professional Affairs Committee Approval:	**06/15**
Board of Directors Approval:	**06/15**

A. **PURPOSE:**

1. To provide optimal safety for patients and clear understanding of written medical communication by eliminating the use of potentially dangerous abbreviations and dose designations.

B. **POLICY:**

1. Tri-City Medical Center (TCMC) has adopted the Neil-Davis Med Abbreviations ~~(Neil-Davis Med Abbreviations for abbreviations~~.
   a. In addition, Pharmacy has adopted the Institute for Safe Medication Practices (ISMP)'s Error-Prone Abbreviations, Symbols, and Dose Designations for medication orders.
2. Abbreviations identified as "Do Not Use Abbreviations" by the Joint Commission are prohibited for use in all orders and medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed orders.
3. Medication orders
   a. If an unapproved abbreviation is used on a medication order or other written communication for patient care, the ordering physician shall be contacted by the nurse or pharmacist for clarification. The clarified order shall be documented in the medical record.
   b. Medication orders containing unapproved abbreviations shall not be dispensed by pharmacy or administered by the nurse until clarified and the medication order re-entered.
4. Changes to abbreviation references will be approved by the Pharmacy and Therapeutics Committee (P&T), the Medical Executive Committee and the Board of Directors.

C. **RELATED DOCUMENTS**:

1. ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (**2015~~2013~~**)
2. Joint Commission "Do Not Use" List (**2017~~2014~~**)

D. **EXTERNAL LINK(S):**

1. Neil-Davis Medical Abbreviation - ~~MedAbbrev.com~~ **http://www.medabbrev.com/**

E. **REFERENCES:**

1. The Joint Commission (June **2017~~2014~~**). *Facts about the Official "Do Not Use" List.* Retrieved from www.jointcommission.org on **March 7th, 2018**~~April 6, 2015~~. **https://www.jointcommission.org/facts_about_do_not_use_list/** ~~http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf~~

ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations (20152013)

Institute for Safe Medication Practices

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations*

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) as being frequently misinterpreted and involved in harmful medication errors. They should **NEVER** be used when communicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

Abbreviations	Intended Meaning	Misinterpretation	Correction
µg	Microgram	Mistaken as "mg"	Use "mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use "right ear," "left ear," or "each ear"
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right eye," "left eye," or "each eye"
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	Use "mL"
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
IJ	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
IN	Intranasal	Mistaken as "IM" or "IV"	Use "intranasal" or "NAS"
HS **hs**	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use "half-strength" or "bedtime"
IU**	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
o.d. or OD	Once daily	Mistaken as "right eye" (OD-oculus dexter), leading to oral liquid medications administered in the eye	Use "daily"
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use "orange juice"
Per os	By mouth, orally	The "os" can be mistaken as "left eye" (OS-oculus sinister)	Use "PO," "by mouth," or "orally"
q.d. or QD**	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "I"	Use "daily"
qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly"
qn	Nightly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly" or "at bedtime"
q.o.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	Use "every other day"
q1d	Daily	Mistaken as q.i.d. (four times daily)	Use "daily"
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "daily at 6 PM" or "6 PM daily"
SC, SQ, sub-q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or ½ (apothecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half" or "½"
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Spell out "sliding scale (insulin)"
1/d	One daily	Mistaken as "tid"	Use "1 daily"
TIW or tiw	3 times a week	Mistaken as "3 times a day" or "twice a week"	Use "3 times weekly"
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unit"
UD	As directed ("ut dictum")	Mistaken as unit dose (e.g., diltiazem 125 mg IV infusion "UD" misinterpreted as meaning to give the entire infusion as a unit [bolus] dose)	Use "as directed"
Dose Designations and Other Information	**Intended Meaning**	**Misinterpretation**	**Correction**
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Naked" decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit
Abbreviations such as mg. or mL with a period following the abbreviation	mg mL	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period

Institute for Safe Medication Practices

ISMP's List of *Error-Prone Abbreviations, Symbols, and Dose Designations* (continued)

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "l" such as inderal40 mg, tegretol300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100ml)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	**Intended Meaning**	**Misinterpretation**	**Correction**
To avoid confusion, do not abbreviate drug names when communicating medical information. Examples of drug name abbreviations involved in medication errors include:			
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug name
DTO	Diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCl	hydrochloric acid or hydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT	hydrocortisone	Mistaken as hydrochlorothiazide	Use complete drug name
HCTZ	hydrochlorothiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mitoxantrone	Use complete drug name
NoAC	novel/new oral anticoagulant	No anticoagulant	Use complete drug name
PCA	procainamide	Mistaken as patient controlled analgesia	Use complete drug name
PTU	propylthiouracil	Mistaken as mercaptopurine	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Use complete drug name
TAC	triamcinolone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	TNKase	Mistaken as "TPA"	Use complete drug name
TPA or tPA	tissue plasminogen activator, Activase (alteplase)	Mistaken as TNKase (tenecteplase), or less often as another tissue plasminogen activator, Retavase (retaplase)	Use complete drug names
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed Drug Names	**Intended Meaning**	**Misinterpretation**	**Correction**
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name
"Norflox"	norfloxacin	Mistaken as Norflex	Use complete drug name
"IV Vanc"	intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Symbols	**Intended Meaning**	**Misinterpretation**	**Correction**
ʒ ɱ	Dram Minim	Symbol for dram mistaken as "3" Symbol for minim mistaken as "ml."	Use the metric system
x3d	For three days	Mistaken as "3 doses"	Use "for three days"
> and <	More than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "more than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
°	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "hr," "h," or "hour"
Ø or ø	zero, null sign	Mistaken as numerals 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words

**These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, acronyms, and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. Visit www.jointcommission.org for more information about this Joint Commission requirement.

ISMP
www.ismp.org

Institute for Safe Medication Practices

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations*

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) as being frequently misinterpreted and involved in harmful medication errors. They should **NEVER** be used when communicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated labels, labels for drug storage bins, medication administration records, as well as pharmacy and prescriber computer order entry screens.

Abbreviations	Intended Meaning	Misinterpretation	Correction
µg	Microgram	Mistaken as "mg"	Use "mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use "right ear," "left ear," or "each ear"
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right eye," "left eye," or "each eye"
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	Use "mL"
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
IJ	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
IN	Intranasal	Mistaken as "IM" or "IV"	Use "intranasal" or "NAS"
HS **hs**	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use "half-strength" or "bedtime"
IU**	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
o.d. or OD	Once daily	Mistaken as "right eye" (OD=ocular dextra), leading to oral fluid	Use "daily"
OJ			...uice"
Per os			...y mouth," or "orally"
q.d. or QD**		The "q" is misconstrued as an "I"	
qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly"
qn	Nightly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly" or "at bedtime"
q.o.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	Use "every other day"
qid	Daily	Mistaken as q.i.d. (four times daily)	Use "daily"
qGPM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "daily at 6 PM" or "6 PM daily"
SC, SQ, sub q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or ½ (apothecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half" or "½"
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Spell out "sliding scale (insulin)"
i/d	One daily	Mistaken as "iid"	Use "1 daily"
TIW or tiw	3 times a week	Mistaken as "3 times a day" or "twice in a week"	Use "3 times weekly"
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unit"
UD	As directed ("ut dictum")	Mistaken as unit dose (e.g., diltiazem 125 mg IV infusion "UD" misinterpreted as meaning to give the entire infusion as a unit [bolus] dose)	Use "as directed"
Dose Designations and Other Information	**Intended Meaning**	**Misinterpretation**	**Correction**
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Naked" decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit
Abbreviations such as mg or mL with a period following the abbreviation	mg mL	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period

DELETE

Institute for Safe Medication Practices

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations* (continued)

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "I" such as Inderal 40 mg; Tegretol 300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100mL)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	**Intended Meaning**	**Misinterpretation**	**Correction**
To avoid confusion, do not abbreviate drug names when communicating medical information. Examples of drug name abbreviations involved in medication errors include:			
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug name
DTO	Diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCl	hydrochloric acid or hydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT	hyd		ame
HCTZ	hyd		ame
MgSO4**	ma		ame
MS, MSO4**	mor		ame
MTX	met		ame
PCA	procainamide	Mistaken as patient controlled analgesia	Use complete drug name
PTU	propylthiouracil	Mistaken as mercaptopurine	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Use complete drug name
TAC	triamcinolone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	TNKase	Mistaken as "TPA"	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed Drug Names	**Intended Meaning**	**Misinterpretation**	**Correction**
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name
"Norflox"	norfloxacin	Mistaken as Norflex	Use complete drug name
"IV Vanc"	intravenous vancomycin	Mistaken as Ivanz	Use complete drug name
Symbols	**Intended Meaning**	**Misinterpretation**	**Correction**
3	Dram	Symbol for dram mistaken as "3"	Use the metric system
ℿ	Minim	Symbol for minim mistaken as "mL"	
x3d	For three days	Mistaken as "3 doses"	Use "for three days"
> and <	Greater than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "greater than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
°	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "hr," "h," or "hour"
Ø o r ∅	zero, null sign	Mistaken as numerals 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words

DELETE

**These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, acronyms, and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. Visit www.jointcommission.org for more information about this Joint Commission requirement.

ISMP
www.ismp.org

Facts about the Official "Do Not Use" List of Abbreviations
June 9, 2017

The Joint Commission's "Do Not Use" List is part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod(every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Development of the "Do Not Use" List
In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01. For more information, contact the Standards Interpretation Group at 630-792-5900 or complete the Standards Online Question Submission Form.

https://www.jointcommission.org/facts_about_do_not_use_list/
Retrieved March 7, 2018

~~Joint Commission "Do Not Use" List (2014)~~

The Joint Commission

Facts about the Official "Do Not Use" List

In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "do not use" list of abbreviations (see below) as part of the requirements for meeting that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

Currently, this requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols, and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	*Potential Problem*	Use Instead
U, u (unit)	Mistaken for "0" (zero), the	Write "unit"
IU (International		
Q.D., QD, q.d., qd		
Q.O.D., QOD, q.o. (every other day)	"I" and the "O" mistaken for "I	
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

DELETE

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

The National Summit on Medical Abbreviations
Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list. This special one-day Summit brought together representatives of more than 70 professional societies and associations and special interest groups to discuss medical errors related to the misuse and misinterpretation of abbreviations, acronyms, and symbols. The objective of the Summit was to reach consensus on the scope and implications of this serious and complex problem and to find reasonable solutions using all of the evidence at hand and in the most dispassionate way possible.

The National Summit on Medical Abbreviations was hosted by The Joint Commission with its co-conveners American College of Physicians, American College of Surgeons, American Dental Association,

American Hospital Association, American Medical Association, American Society of Health-System Pharmacists, Institute for Safe Medication Practices, and United States Pharmacopeia. Approximately 50 professional societies and associations and selected interest groups participated in the Summit representing every perspective.

For more information
Contact the Standards Interpretation Group at (630) 792-5900, or complete the Standards Online Question Submission Form at http://www.jointcommission.org/Standards/OnlineQuestionForm/.

6/14

DELETE

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/03	**SUBJECT: Automatic Stop Orders**
REVISION DATE: 06/03, 07/09, 03/14	~~**POLICY NUMBER: IV.I.5**~~
Department ~~Review~~Approval:	**01/18**
Clinical Policies & Procedures Committee Approval:	**~~01/14~~02/18**
Nurse Executive Council Approval:	**~~01/14~~03/18**
Pharmacy and Therapeutic Committee	**~~01/14~~03/18**
Medical Executive Committee Approval:	**~~02/14~~03/18**
Professional Affairs Committee Approval:	**03/14**
Board of Directors Approval:	**03/14**

A. **PURPOSE:**

1. To provide guidelines for discontinuing narcotics, antibiotics, chemotherapeutic agents, and all other drugs.

B. **POLICY:**

1. In the absence of a specific physician/**Allied Healthcare Professional (AHP)**'s order indicating the desired duration of therapy, automatic medication expiration is as follows:
   a. ~~Narcotics~~ **Opioids and benzodiazepines – seven (7)** days
   b. Antibiotics – **seven (7)** days
   ~~c. Chemotherapeutic agents – 1 time order (unless oral route and written for non-chemotherapeutic indication i.e. methotrexate for rheumatoid arthritis)~~
   ~~d.~~**c. Intravenous** (IV) acetaminophen- 24 hours (not to exceed 72 hours)
   ~~e.~~**d.** Ketorolac- **five (5)** days
   ~~f. Meperidine- 4 days~~
   ~~g.~~**e.** Paralytic agents (i.e. cisatracurium, rocuronium, pancuronium, vecuronium)- 48 hours
   f. Albumin- 24 hours (exceptions: status post ~~Cardiac~~ **Coronary** Artery Bypass Graft, hypotension during dialysis, hepatorenal syndrome, spontaneous bacterial peritonitis; not to exceed 14 continuous days)
   g. Mannitol – seven (7) days
   h. Phytonadione (Vitamin K) – seven (7) days
   i. Iron sucrose – maximum cumulative dose 1,000 mg within 14 day period
   ~~h.~~**j.** All other medications – 30 days
   ~~i.~~**k.** All medication written to be given for "duration of stay" shall be interpreted as the physician requesting therapy for the entire inpatient stay unless otherwise stated.
2. The expiration date(s) of these medications shall be monitored via the Pharmnet Pharmacy System.
3. The ordering physician/**AHP** will receive a renewal notice in their inbox to renew the medication electronically via **computerized physician order entry** (CPOE).
~~4. If medication order is not renewed within two days before the medication is stopped, Medication Renewal Forms shall be printed to the nursing units for placement in patient's medical chart by nursing personnel. Nursing personnel shall place a "Please Sign and Date Renewal Flag" on the renewal form and the form shall be placed in patient's chart.~~
~~5. If the physician desires to renew the medication listed on the Medication Renewal Form a check mark shall be placed in the renewal box located next to the medication order on the renewal form. The Physician shall sign, date and time the renewal order form in an area located at the bottom of the form.~~

~~6. If no action is taken, the Medication Renewal Form shall print in pharmacy the day of medication expiration for pharmacist follow-up with physician to determine if the medication is to be renewed or discontinued.~~

~~7.~~4. Medications that are not renewed shall not be given after the renewal date noted on the renewal form for each medication.

~~8.~~5. Any medications put on "hold" by the physician/**AHP** shall automatically be discontinued by the nurse or pharmacist and must be reordered by the physician/**AHP** if and when the medication is resumed.

~~9. A pharmacist shall call the physician if an order form is received without a signature by the physician. The pharmacist shall clarify with the physician if the medications appearing on the form are to be continued.~~

Tri-City Medical Center	Patient Care Services	**Tracked Changes**
PROCEDURE:	**CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) EXCHANGE; CONTINUOUS CYCLER~~CYCLIC~~ PERITONEAL DIALYSIS (CCPD) EXCHANGE**	
Purpose:	To outline nursing responsibilities in, trouble shooting and disconnecting a patient that has a **Liberty** ~~Newton IQ~~® Cycler (CCPD), and responsibilities in CAPD exchanges, trouble shooting and disconnecting a patient that has a **Fresenius Stay Safe CAPD exChange exchange** ~~Safe-Lock ® Premier ™ Plus exchange (8 Prong CAPD Manifold Set) or a Premier ™ Double Bag with Del-Clamp™ and Snap (One-time CAPD exchange).~~	
Supportive Data:	To maintain aseptic technique when disconnecting patients from a CAPD or CCPD device in addition to maintaining the CAPD and CCPD treatment for the patient when San Diego Dialysis, Inc nurses are not available within the facility.	
Equipment:	Mask, Gloves, Del Clamps™, IV Pole (CAPD), Spring Scale (CAPD), Chux Pad, Blue plastic hemostats	

A. **POLICY:**

1. Tri-City ~~Medical Center~~**Healthcare District (TCHD)** has contracted San Diego Dialysis Services, Inc. to administer **peritoneal dialysis**~~hemodialysis on 4 Pavilion in room 476~~ including set up and support for **in**patients receiving peritoneal dialysis as needed~~in our main hospital~~.
2. The responsibility of the San Diego Dialysis Services, Inc., per their contract, will be to:
   a. Prep, connect, monitor and disconnect patients requiring ~~hemodialysis and~~ peritoneal dialysis.
   b. Administer medications as ordered by privileged TC~~M~~C**HD** physicians during **continuous ambulatory peritoneal dialysis** (CAPD) and **automated peritoneal dialysis** (APD) treatments.
3. The **CAPD and continuous cycler peritoneal dialysis (CCPD) trained** nurses~~who are trained in CAPD a CCPD~~and APD~~,~~ will be responsible for trouble shooting **alarms**~~and clamping and unclamping for night CAPD exchanges when Safe-Lock ® Premier ™ Plus exchange (8 Prong APD Manifold Set) is used and the San Diego Dialysis Services, Inc.'s dialysis nurses are not~~ on **the Liberty cycler**.~~site.~~
4. ~~Nurses who are trained in~~ CAPD or CCPD **trained nurses**~~,~~ may also be required to disconnect peritoneal dialysis patients from the **Liberty Cycler® Stay Safe ®**~~APD for the Liberty Cycler® Safe-Lock ® Premier ™ Plus exchange (8 Prong APD Manifold Set) and Premier ™ Double Bag with Del-Clamp™ and Snap (One-time APD exchange),~~ when the San Diego Dialysis Services, Inc.'s dialysis nurses are unable to disconnect patients due to **immediate procedures**~~staffing shortages~~ or time constraints related to in house hemodialysis patients. ~~Nurses working in 3 Pavilion may be utilized as resources.~~
5. Emergency equipment shall be readily available at patient's bedside ~~in case of~~**for** emergency disconnection for both **CAPD**~~APD~~ and CCPD patients **includes**:
   a. **2 Masks (nurse and patient)**
   b. Gloves
   c. Chux
   d. 1 Stay Safe® Cap
   e. 1 Stay Safe® Organizer
   ~~a. 2 blue Del-Clamps™ (if tubing does not have the Stay Safe® patient connectors)~~
   ~~d.~~**f.** Blue plastic hemostats (if patient's catheter does not have a clamp)

B. **PROCEDURE:**

1. **CCPD**~~APD~~ for the Liberty Cycler®:

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/06, 06/12, 12/17	07/12, 02/18	08/12, 03/18	n/a	08/12, 03/18	09/12	09/12

a. Trouble-Shooting:
   i. Refer to the Peritoneal Dialysis Manual ~~located in 3 Pavilion~~ to trouble shoot any alarms on **Liberty**~~the Newton IQ®~~ Cycler.
   ii. If unable to trouble shoot alarms on the APD for the Liberty Cycler®: by using the Peritoneal Dialysis Manual, contact the on call Dialysis nurse at **1-855-726-9720**~~858-627-3506.~~

~~b. Disconnect using tubing other than the Newton IQ 4 Lead Set with Stay Safe® patient connectors:~~
   ~~i. Have the following supplies:~~
      ~~1. Mask~~
      ~~2. Gloves~~
      ~~3. Chux~~
   ~~ii. When the Newton IQ® Cycler reads "Completed" on the display screen the CCPD has finished and the patient can be disconnected.~~
   ~~iii. Close all clamps including the clamp closest to the patient.~~
   ~~iv. Close window/doors and turn off fans to minimize environmental contaminants.~~
   ~~v. Apply mask to self, patient, and others in the room.~~
   ~~vi. Thoroughly wash hands and don gloves.~~
   ~~vii. Place a Chux under the disconnecting area of the Transfer Set.~~
   ~~viii. Follow the disconnecting policy by turning the blue pin trigger of the Stay safe connector of the Liberty Cycler tubing, pushing in the pin trigger to set the pin into the patient's transfer set, then placing the Stay Safe connection into the Organizer before placing the new Stay Safe cap.~~
   ~~ix. Document the APD output from the Records screen at the end of the treatment where it reads Total UF. Document in Cerner the color, clarity and volume at the end of treatment.~~
   ~~x. If patient is to be discharged after CCPD is completed, an assessment by the San Diego Dialysis Services, Inc.'s dialysis nurse must be done on the patient prior to discharge.~~

b. Disconnecting with the **Liberty Cycler**~~Newton IQ 4 Lead Set~~ with Stay Safe® Patient Connectors:
   i. Place a new Stay Safe® Cap in the notch on the Organizer.
   ii. Turn the blue end of the Patient Connector clockwise until it stops.
   iii. Push in the blue end of the Patient connector until it stops.
   iv. Close the clamp on the Extension Set.
   v. Insert the Patient Connector into the Organizer.
   vi. Remove the protective cover from the new Stay Safe® Cap.
   vii. Unscrew the Extension Set from the Patient Connector.
   viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
   ix. Connect the protective cover on the used Patient Connector~~.~~.
   ~~xi. Disconnect cycler set from the drain line. Drain line may be emptied, stored, and reused. If reusing drain line, place protective cap on end during storage.~~
   x. Document the CCPD output, ~~(located in the right hand corner of the Newton IQ® Cycler screen),~~ color, and clarity of fluid using the I&O form in Cerner. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
   xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

C. **PROCEDURE:**

~~2.~~1. **CAPD Stay Safe single exchange**

a. **The following supplies are needed to perform the Fresenius** Stay Safe **CAPD Exchange Procedure:**

i. Bag of Stay Safe Delflex solution with appropriate dextrose percent (%), as ordered by the physician
ii. Stay Safe® Organizer
iii. Stay Safe® Cap(s)
iv. Masks for everyone in the room
v. Personal protective equipment (PPE) for ~~(S~~staff~~)~~, ~~(P~~patient/~~C~~caregiver as instructed by dialysis~~HT N~~nurse~~)~~
vi. Liquid antimicrobial soap and/or alcohol based hand sanitizer~~gel~~
vii. Intravenous (IV) pole
viii. Spring scale (optional)
ix. Organizer holder (optional)

~~Apply masks to all persons in the room; staff applies remaining PPE except gloves.~~
~~Wash hands with liquid antimicrobial soap and water per Procedure: Hand Hygiene, FMS-CS-IC-II-155-090C.~~
~~Apply non-sterile gloves (staff).~~

b. Apply masks to all persons in the room; staff applies remaining PPE except gloves.
c. Wash hands with liquid antimicrobial soap and water per Infection Control Procedure: Hand Hygiene – IC 8~~, FMS-CS-IC-II-155-090C~~.
d. Apply non-sterile gloves (staff).
i. Place a new Stay Safe® Cap in the notch on the Organizer.

~~2. SAFE LOCK ® PREMIER ™ PLUS EXCHANGE (8 PRONG APD MANIFOLD SET) AND PREMIER ™ DOUBLE BAG WITH DEL-CLAMP™ ® AND SNAP (ONE TIME APD EXCHANGE).~~

~~a. Trouble-Shooting:~~
~~i. Contact the on call Dialysis nurse at 760-509-8341.~~
~~b. San Diego Dialysis Services, Inc.'s dialysis nurses will set up and connect all APD patients to the above APD sets.~~
~~c. Check the physician's peritoneal dialysis order with the dialysate that has been set up by the San Diego Dialysis Services, Inc. nurse.~~
~~d. Ensure the dialysate and its contents (medications) coincide with the physicians order before performing an APD exchange on a patient.~~
~~e. Verify dwell times for the dialysate solution.~~
~~f. Don mask, place mask on patient then wash hands and don gloves~~
~~g. Drain (When San Diego Dialysis Services, Inc.'s dialysis nurses are not available)~~
ii. ~~Unclamp patient's catheter and~~Turn the blue end of the Patient Connector clockwise until it stops.
iii. Push in the blue end of the Patient connector until it stops.
iv. Close the clamp on the Extension Set.
~~i.~~v. Insert the Patient Connector~~Premier tubing and any other clamps that drain directly~~ into the Organizer~~drainage bag~~.
~~i. When drain is complete, clamp the drain line.~~
~~h. Fill~~
~~i. Unclamp the fill line and allow the patient to fill.~~
~~ii. When fill is complete, clamp the fill line~~
~~i. Disconnecting:~~
~~i. Have the protective cover~~following supplies:
~~1. Mask (2)~~
~~2. Glove~~
~~3. Chux~~
~~4. Del-Clamps™ (blue)~~
~~ii. After the last fill is complete and all lines are clamped, close window/doors and turn off fans to minimize environmental contaminants.~~

~~iii. Thoroughly wash hands and don gloves.~~
~~iv. Apply mask to self, patient, and others in the room.~~
~~v. Place Chux under the disconnecting area of the Snap disconnects extension set.~~
~~ii.~~**vi.** ~~Attach one Del-Clamp ™ to each side of the Snap disconnect extension set (on the soft part of the tubing) that is the most distal~~**Remove the protective cover** from the **new Stay Safe® Cap.**~~patient (the Snap disconnect extension set has two Snap disconnects).~~
vii. Unscrew~~Ensure that~~ the **Extension Set from**~~tubing is correctly positioned in~~ the **Patient Connector.**
~~iii.~~**viii. Connect**~~Del-Clamp™ closure by pressing~~ the **Extension Set to**~~tubing firmly into~~ the **new Stay Safe® Cap and remove from Organizer**~~Del-Clamp™ tubing guides~~.
~~vi. Close and lock both Del-Clamps™.~~
~~vii. Carefully bend the protective cover on~~Snap disconnect ~~that is between the two Del-Clamps™ to break the patient line.~~
~~iv.~~**ix.** ~~Weigh drain bags using the spring scale. Subtract the drain bag volume from the amount of dialysate that was during the APD fill.~~**Connect the protective cover on** used **Patient Connector.**
~~Example:~~
~~6900 mL of total fluid from drain bag(s).~~
~~- 6000 mL of dialysate used during the fill process of the APD procedure.~~
~~= 900 is the APD output.~~
~~v.~~**x.** Document the **CCPD**~~APD~~ output, color, and clarity of fluid ~~using the I&O form~~ in ~~Cerner~~**the medical record**. All **CCPD**~~APD~~ patients **must**~~shall~~ have the **CCPD**~~APD~~ output recorded after every completed **CCPD**~~APD~~ exchange.
xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.
~~viii. Notify the San Diego Dialysis Services, Inc.'s dialysis nurse to dispose of drain bags.~~

D. RELATED DOCUMENT(S):

1. **Infection Control Procedure: Hand Hygiene - IC 8**

~~C.~~**E. REFERENCE(S):**

1. Fresenius **Liberty Cycler Termination of Treatment**~~Safe-Lock Premier Plus APD Exchange~~ Procedure FMS-CS-~~ii~~**HI-I-530-110C4 18-DEC-2013**~~215-015A June 1, 2007~~
2. Fresenius Stay Safe CAPD Exchange Procedure FMS-**IS-II**~~CS-HI-~~I-**530-082C 18 DEC-2013**~~215-010A June 1, 2007~~
3. Fresenius Peritoneal Dialysis Procedure Manual-Clinical Services 1-200-0001-SD
~~3. Fresenius Snap-Disconnect Exchange Procedure FMS-CS-HT-I_215_0001A June 1, 2007~~
~~4. Newton IQ 4 Lead Cycler Set with Stay Safe patient Connectors package insert~~

Tri-City Medical Center	Patient Care Services	Clean Copy
PROCEDURE:	**CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) EXCHANGE; CONTINUOUS CYCLER PERITONEAL DIALYSIS (CCPD) EXCHANGE**	
Purpose:	To outline nursing responsibilities in, trouble shooting and disconnecting a patient that has a Liberty ® Cycler (CCPD), and responsibilities in CAPD exchanges, trouble shooting and disconnecting a patient that has a Fresenius Stay Safe CAPD exChange exchange	
Supportive Data:	To maintain aseptic technique when disconnecting patients from a CAPD or CCPD device in addition to maintaining the CAPD and CCPD treatment for the patient when San Diego Dialysis, Inc nurses are not available within the facility.	
Equipment:	Mask, Gloves, Del Clamps™, IV Pole (CAPD), Spring Scale (CAPD), Chux Pad, Blue plastic hemostats	

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) has contracted San Diego Dialysis Services, Inc. to administer peritoneal dialysis including set up and support for inpatients receiving peritoneal dialysis as needed.
2. The responsibility of the San Diego Dialysis Services, Inc., per their contract, will be to:
   a. Prep, connect, monitor and disconnect patients requiring peritoneal dialysis.
   b. Administer medications as ordered by privileged TCHD physicians during continuous ambulatory peritoneal dialysis (CAPD) and automated peritoneal dialysis (APD) treatments.
3. The CAPD and continuous cycler peritoneal dialysis (CCPD) trained nurses will be responsible for trouble shooting alarms on the Liberty cycler.
4. CAPD or CCPD trained nurses may also be required to disconnect peritoneal dialysis patients from the Liberty Cycler® Stay Safe ® when the San Diego Dialysis Services, Inc.'s dialysis nurses are unable to disconnect patients due to immediate procedures or time constraints related to in house hemodialysis patients.
5. Emergency equipment shall be readily available at patient's bedside for emergency disconnection for both CAPD and CCPD patients includes:
   a. 2 Masks (nurse and patient)
   b. Gloves
   c. Chux
   d. 1 Stay Safe® Cap
   e. 1 Stay Safe® Organizer
   f. Blue plastic hemostats (if patient's catheter does not have a clamp)

B. **PROCEDURE:**

1. CCPD for the Liberty Cycler®:
   a. Trouble-Shooting:
      i. Refer to the Peritoneal Dialysis Manual to trouble shoot any alarms on Liberty® Cycler.
      ii. If unable to trouble shoot alarms on the APD for the Liberty Cycler®: by using the Peritoneal Dialysis Manual, contact the on call Dialysis nurse at 1-855-726-9720
   b. Disconnecting with the Liberty Cycler with Stay Safe® Patient Connectors:
      i. Place a new Stay Safe® Cap in the notch on the Organizer.
      ii. Turn the blue end of the Patient Connector clockwise until it stops.
      iii. Push in the blue end of the Patient connector until it stops.
      iv. Close the clamp on the Extension Set.
      v. Insert the Patient Connector into the Organizer.
      vi. Remove the protective cover from the new Stay Safe® Cap.
      vii. Unscrew the Extension Set from the Patient Connector.
      viii. Connect the Extension Set to the new Stay Safe® Cap and remove from

Organizer.
ix. Connect the protective cover on the used Patient Connector.
x. Document the CCPD output, color, and clarity of fluid using the I&O form in Cerner. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

C. **PROCEDURE:**

1. CAPD Stay Safe single exchange
   a. The following supplies are needed to perform the Fresenius Stay Safe CAPD Exchange Procedure:
      i. Bag of Stay Safe Delflex solution with appropriate dextrose percent (%), as ordered by the physician
      ii. Stay Safe® Organizer
      iii. Stay Safe® Cap(s)
      iv. Masks for everyone in the room
      v. Personal protective equipment (PPE) for staff, patient/caregiver as instructed by dialysis nurse
      vi. Liquid antimicrobial soap and/or alcohol based hand sanitizer
      vii. Intravenous (IV) pole
      viii. Spring scale (optional)
      ix. Organizer holder (optional)
   b. Apply masks to all persons in the room; staff applies remaining PPE except gloves.
   c. Wash hands with liquid antimicrobial soap and water per Infection Control Procedure: Hand Hygiene.
   d. Apply non-sterile gloves (staff).
      i. Place a new Stay Safe® Cap in the notch on the Organizer.
      ii. Turn the blue end of the Patient Connector clockwise until it stops.
      iii. Push in the blue end of the Patient connector until it stops.
      iv. Close the clamp on the Extension Set.
      v. Insert the Patient Connector into the Organizer.
      vi. Remove the protective cover from the new Stay Safe® Cap.
      vii. Unscrew the Extension Set from the Patient Connector.
      viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
      ix. Connect the protective cover on used Patient Connector.
      x. Document the CCPD output, color, and clarity of fluid in the medical record. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
      xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

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

1. Infection Control Procedure: Hand Hygiene - IC 8

E. **REFERENCE(S):**

1. Fresenius Liberty Cycler Termination of Treatment Procedure FMS-CS-ii-I-530-110C4 18-DEC-2013
2. Fresenius Stay Safe CAPD Exchange Procedure FMS-IS-II-I-530-082C 18 DEC-2013
3. Fresenius Peritoneal Dialysis Procedure Manual-Clinical Services 1-200-0001-SD

PATIENT CARE SERVICES~~STANDARDIZED PROCEDURES MANUAL~~
Emergency
STANDARDIZED PROCEDURE: EMERGENCY DEPARTMENT

I. **POLICY:**
- A. Function: To define appropriate utilization of specific orders and order sets, otherwise referred to as standardized procedures.
- B. Circumstances:
  1. Setting: Tri-City Medical Center, Emergency Department (ED)
  2. Supervision: An Emergency Services Physician will be available for consultation. Registered Nurses will immediately contact the physician for any patient who is critical in nature or unstable. Physician contact will not be delayed in order to initiate or complete Standardized Procedures.
  3. Patient contraindications: None
- C. Documentation:
  1. The Registered Nurse (RN) will document all interventions performed into the electronic health record (EHR).
  2. The RN will enter all orders performed per the standardized procedure in the EHR.

II. **PROCEDURE:**
- A. Abdominal Pain between the ages of 10 – 25 :
  1. In patients who present to the ED with abdominal pain, the RN shall order the following:
     - a. Labs:
       - i. CBCD
       - ii. Metabolic Panel, Comprehensive
       - iii. Jic Blue
       - iv. Serum HCG in females
     - b. Nurse Orders:
       - i. Routine urinalysis with reflex culture
     - c. Medications:
       - i. Ondansetron (Zofran) 8 mg oral disintegrating tablet (ODT) times one (1), prn for nausea in patients 16 years of age and older.
- B. Abdominal Pain, ages 26 and older :
  1. In patients who present to the ED with abdominal pain, the RN shall order the following:
     - a. Labs:
       - i. CBCD
       - ii. Metabolic Panel, Comprehensive
       - iii. Jic Blue
       - iv. Serum HCG in females aged 26 to 55
     - b. Nurse Orders:
       - i. Routine urinalysis with reflex culture
     - c. Medications:
       - i. Ondansetron (Zofran) 8mg ODT times one (1), PRN for nausea, in patients 16 years or older.
     - d. Additional orders if patient presents with upper abdominal pain (above umbilicus or abdominal pain of unknown location) to rule out cardiac conditions:
       - i. Cardiology:
         - 1) EKG STAT
           - a) Print old EKG if available

Revision Dates	Clinical Policies & Procedures	Nursing Executive Committee	Department of Emergency Medicine	Pharmacy and Therapeutics	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/04, 03/06, 08/08, 07/09, 06/11, 06/14	01/11, 11/13, 10/14, 01/15, 12/16	01/11, 11/13, 10/14, 02/15, 03/17	06/11, 12/14, 05/17	06/11, 11/13, 01/15, 07/17	06/11, 02/14, 06/15, 10/17	06/11, 02/14, 06/15, 03/18	06/15	06/11, 02/14, 07/15

b) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to ED physician to rule out ST-elevation Myocardial Infarction (STEMI)

ii. Labs:
1) Creatine Kinase (CPK)
2) CK, Mb Fraction (CKMB) if **CK elevated**
3) Cardiac Troponin (Troponin I)
4) Lipase level

C. Asthma with Wheezing:
1. In patients who present to ED with wheezing and a stated history of asthma, the RN shall order the following:
a. Nursing Orders:
i. Pulse oximetry monitoring
b. Medications:
i. Albuterol 5 mg nebulized times one (1) with Ipratropium 0.5 mg nebulized times one (1) per Respiratory Therapy, in patients who are greater than 11 years of age.

D. Chest Discomfort in Patients over 30 years of age:
1. In patients who present to the ED with chest pain, pressure, squeezing, shortness of breath, pain or discomfort in other parts of the body including one or both arms or shoulders, upper back, neck, jaw, abdomen, or female, elderly or diabetic patients with atypical symptom suspicious for acute coronary syndrome (ACS) such as diaphoresis, nausea, dizziness, altered level of consciousness the Registered Nurse (RN) shall order the following:
a. Cardiology:
i. EKG STAT
1) Print old EKG if available
2) STAT ED EKG's will be completed with the goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
b. Labs:
i. CBCD
ii. Metabolic Panel, Comprehensive
iii. Creatine Kinase (CPK)
iv. CK, Mb Fraction (CKMB) if ~~CPK~~ **elevated**~~above normal~~
v. Cardiac Troponin (Troponin I)
c. Nurse Orders:
i. Bring patient to first available bed
ii. Initiate at least one peripheral intravenous (IV) saline lock
iii. Initiate cardiac monitor
iv. Initiate oxygen 2 liters per minute (LPM) per nasal cannula (NC) to maintain oxygen saturation by pulse oximetry (SPO2) greater than 92%
d. Medications:
i. Aspirin 325 mg one (1) tablet by mouth (PO) chewed times one (1) if not already administered
ii. Nitroglycerin (NTG) 0.4 mg sublingually, every five (5) minutes times three (3) doses for ongoing chest pain
e. Radiology:
i. X-Ray Chest 2 View
1) If patient is female and under 55, shield pelvis

E. Dysuria:
1. In patients who present to the ED with dysuria, hematuria, urgency, or frequency, the RN shall order:

a. Nurse Orders:
   i. Routine urinalysis with reflex culture
   ii. Urine HCG for females age 10-55

F. Extremity Trauma:
1. Notify physician STAT for open fractures, dislocations, or neurological or vascular compromise.
2. Consult physician for x-ray orders for back, skull, facial bones, chest, pelvis, hips, and ribs.
3. In patients who present to ED with injuries that are suspicious for fracture, the RN shall order the following:
   a. Medications:
      i. Acetaminophen
         1) For ages 3 months-11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
            a) Maximum 2600mg/day
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
         2) For 12 years and older, acetaminophen 650mg PO or PR times one
            a) Maximum 3000mg/day
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
   b. Radiology:
      i. Acromioclavicular Joints
      ii. Ankle complete 4 views left
      iii. Ankle complete 4 views right
      iv. Heel left OS Calcis
      v. Heel right OS Calcis
      vi. Clavicle left
      vii. Clavicle right
      viii. Elbow left
      ix. Elbow right
      x. Femur left
      xi. Femur right
      xii. Finger left
      xiii. Finger right
      xiv. Foot 4 views left
      xv. Foot 4 views right
      xvi. Forearm left
      xvii. Forearm right
      xviii. Hand 4 views left
      xix. Hand 4 views right
      xx. Hip Left, with AP Pelvis
      xxi. Hip Right with AP Pelvis
      xxii. Humerus left
      xxiii. Humerus right
      xxiv. Knee left
      xxv. Knee right
      xxvi. Shoulder left
      xxvii. Shoulder right
      xxviii. Tibia/Fibula left
      xxix. Tibia/Fibula right
      xxx. Wrist 4 views left
      xxxi. Wrist 4 views right

xxxii. X-ray extremity wound site if suspect foreign body

G. Fever in children under 3 months of age:
1. In patients who are under 3 months of age and who present to ED with rectal temperature of 38°C (100.4°F) or greater, assign an emergency severity index (ESI) level 2 and arrange for immediate placement in the treatment area. The RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Basic
      iii. C-Reactive Protein (CRP)
      iv. Blood Culture **(only one required for less than 3 months of age)**
   b. Nurse Orders:
      i. Routine urinalysis, catheter specimen
      ii. Urine culture
      iii. Pulse oximetry monitoring
      iv. Initiate intravenous (IV) saline lock
   c. Medications:
      i. Acetaminophen 15 mg/kg PO or PR times one (1)
         1) Maximum 2600mg/day
         2) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
   d. Radiology:
      i. X-Ray: Chest 2 View PA and LAT

H. Fever in patients older than 3 months of age:
1. In patients who present to the ED with fever, the RN shall order:
   a. Medications:
      i. Acetaminophen
         1) For ages 3 months - 11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
            a) Maximum 2600mg/day
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
         2) For 12 years and older, acetaminophen 325mg PO or PR times one (1)
            a) Maximum 3000mg/day
            b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
      ii. Ibuprofen
         1) For ages 6 months to 11 years, ibuprofen 10mg/kg PO times one (1), round to nearest 5mg
            a) Maximum 40mg/kg/day
            b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.
         2) For 12 years and older, ibuprofen 400mg PO times one (1)
            a) Maximum 3200mg/day
            b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

I. Generalized Weakness, Syncope, Dizziness or Altered Mental Status
1. In patients who present to ED with generalized weakness, syncope, or dizziness, the RN shall order the following:
   a. Cardiology:
      i. STAT EKG
         1) Print old EKG if available

2) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.

b. Labs:
   i. CBCD
   ii. Metabolic Panel, Comprehensive
   iii. Creatine Kinase (CPK)
   iv. CK, Mb Fraction (CKMB) if **CK elevated**
   v. Cardiac Troponin (Troponin I)

c. Nurse Orders:
   i. Routine urinalysis, clean catch
   ii. Urine culture, clean catch
   iii. **Serum** ~~Urine~~ HCG if female and 10 – 55 years of age

d. Radiology:
   i. Chest X-ray 2 View PA and LAT
      1) If patient female and under 50 years of age, shield pelvis

J. Gastro Intestinal (GI) Bleed

1. In patients who present to ED with the complaint of blood in the stool, vomiting of blood or coffee ground emesis, and a systolic blood pressure (SBP) less than or equal to 90 mmHg, the RN shall order the following:
   a. Nurse Orders:
      i. Initiate two 16 gauge (if possible) peripheral IVs
   b. Medications:
      i. Administer 500 ml 0.9 NaCl IV fluid bolus times one (1), infuse over 30 minutes
   c. Labs:
      i. Type and Screen
      ii. Check **capillary blood**~~Bedside~~ glucose
      iii. CBCD
      iv. Metabolic Panel, Comprehensive

K. Psychiatric Evaluation

1. Patients who present to the ED with suicidal ideation, hallucinations, delusions, or who are an immediate safety risk to self or others will be assigned an Emergency Severity Index (ESI) Level 2 and moved to the treatment area as soon as possible. If immediate bed placement is not possible for psychiatric patients at risk, security should be notified for direct observation while bed placement is arranged.
2. In patients who present to the ED with the above complaints the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Ethanol, Serum (Blood Alcohol Level)
      iv. Urine toxicology screen
      v. Cannabinoid level
      vi. TSH level
      vii. Serum HCG if female age 10 to 55
   b. Nurse Orders:
      i. Urinalysis, routine with reflex culture

L. **Sepsis**

1. **If patient presents to triage with signs/symptoms of SEPSIS including:**
   a. **Temperature >38.3 or <36 (or history of recent fever/ infection)**
   b. **Plus heart rate above 90 and/or respiratory rate above 20 and or Systolic Blood Pressure Below 90**
2. **The Nurse shall order the following:**

a. **Laboratory:**
   i. **CBCD**
   ii. **Metabolic Panel, Comprehensive**
   iii. **Blood Cultures times 2**
   iv. **Lactate with repeat lactate**
   v. **JIC Blood Bank**
   vi. **Urinalysis with reflex to culture**
   vii. **Serum HCG if female and 10 to 55 years of age**
b. **Radiology: Chest Xray**
c. **Cardiology: Stat EKG**
d. **Nursing:**
   i. **Start 18 gauge IV**
   ~~A.~~ii. **Fluid Bolus 500 mL Normal Saline**

~~L.~~**M.** Vaginal Bleeding, Know Pregnancy:

1. In patients who present to the ED with vaginal bleeding, and who are pregnant the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. ABORh Type
      iii. Beta HCG, Quantitative
   b. Nurse Orders:
      i. If heart rate is greater than 120 BPM or the systolic blood pressure is less than 90 mmHg:
         1) Immediately notify physician of patient's condition
         2) Initiate two 16 gauge (if possible) peripheral IV's
         3) Set up for pelvic exam and notify physician
         4) Routine urinalysis with reflux culture, catheter specimen
   c. Medications:
      i. Administer 500 ml 0.9 NaCl IV fluid bolus times one, infuse over 30 minutes

~~M.~~**N.** Vomiting, Diarrhea, Dehydration:

1. In patients who present to the ED with vomiting, diarrhea and or dehydration the RN shall order the following:
   a. Nurse orders:
      i. Initiate peripheral IV for severe vomiting
   b. Medications:
      i. Adults (16 years of age and older):
         1) Ondansetron 8 mg ODT times one (1)
         2) Ondansetron 4 mg IVP times one (1) for severe vomiting.
      ii. Pediatrics (0 to 15 years of age):
         1) Ondansetron 2 mg ODT times one (1) in patients less than 15 kg
         2) Ondansetron 4 mg ODT times one (1) in patients greater than 15 kg

III. **REQUIREMENTS FOR RN :**

A. Excellent customer service communication
B. Education: Successful completion of Standardized Procedure training
C. Initial Evaluation: Demonstrated competency
D. Ongoing Evaluation: Annual skills lab.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration. New standardized procedures or additions to existing

standardized procedures will be approved by the Department of Emergency Medicine, Pharmacy and Therapeutics (if medications are involved) and the TCMC Board of Directors.

B. Review: Every two (2) years

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 the Emergency Department Standardized Procedure.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**FALL RISK PROCEDURE AND SCORE TOOL**
Purpose:	To provide a comprehensive fall risk assessment on all patients each shift and implement appropriate fall risk interventions based upon the patient's identified fall risk factors.
Supportive Data:	~~Inclusive of all inpatient areas.~~ Requires a Registered Nurse (RN) to evaluate and identify risk factors for falls, develop an appropriate plan of care for prevention, perform a comprehensive evaluation of falls that occur, and revise the plan of care as appropriate for fall prevention.
Equipment:	Fall Risk Score Tool

A. **PROCEDURE:**

1. The **registered nurse** (RN) completes the Morse Fall Risk Assessment on every patient, including visually assessing and interviewing the patient, to determine the patient's fall risk score and secondary risk factors:
   a. Upon admission to the hospital
   b. Upon admission or transfer to another level of care~~-area~~
   c. Once a shift
   d. After any fall occurs
   e. When there is a change in the patient's status (physiological, functional, or cognitive)
2. Review the patient's medications for any that may alter the patient's ambulatory stability (see Medication Fall Alert Reference Text).
3. All patients receive the following Universal Fall Precautions as appropriate:
   a. Adequate lighting
   b. Assistive devices within easy reach
   c. Bed in low position
   d. Bed wheels and wheelchair brakes locked
   e. Assure call light and possessions are within easy reach
   f. Clean and dry surfaces
   g. Hand rails and grab bars accessible
   h. Hourly rounding
   i. Non-skid slippers or footwear are worn during ambulation
   j. Orient patients to their bed area, unit facilities, and how to get assistance
   k. Patient/family fall prevention education (uses the Patient and Family Guide and review Fall Prevention section)~~.~~
   l. Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.
      i. Excluding patients in Behavioral Health Services, Progressive Care Unit and Women and Newborn Services
   ~~l.~~**m.** Rooms free of clutter
   ~~m.~~**n.** Side rails up times **two (2)**
4. The patient's primary RN shall implement an individual Interdisciplinary Plan of Care **(IPOC)** for fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the **IPOC**~~Interdisciplinary Plan of Care~~. These include but are not limited to:
   a. Low Risk Patients (**equals** = 0 - 35 total score):
      i. Reinforce use of grab bars near toilets.
      ii. Reinforce possible medication side effects that could increase risk of falling.
      iii. Limit administration of combinations of medications that may increase fall risk when possible.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 1/08, 6/09, 09/15, 04/16, **09/17**	11/11, 10/15, 06/16, **03/18**	11/11, 10/15, 7/16, **03/18**	n/a	11/15, 11/16, **03/18**	2/12, 01/16, 01/17	2/12, 1/16, 01/17

iv. Select suitable chairs with armrests that are an appropriate height for rising and sitting.
v. Encourage patient to move/change position slowly.
vi. Place patients with urgency near toilets or use commodes.
vii. Instruct male patients prone to dizziness to sit while voiding.

b. Moderate Risk Patients (**equals =**36 - 44 total score):
i. Implement Universal and Low Risk interventions.
ii. Ambulate patients with assistance.
iii. Re-orient confused patients.
iv. Move confused patients close to nurse's station.
v. Encourage family members to sit with confused patients.
vi. Use bed exit alarms.
vii. Use chair alarms.
viii. Teach activity limits to patient and family.
ix. Large fall risk sign shall be placed at the head of the bed for moderate risk patients.
x. A fall risk magnet shall be placed on the patient's doorframe with the designated bed indicated on the magnet.
~~xi. Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.~~

c. High Risk Patients (**equals=** 45 **or more~~+~~** total score) require:
i. Implement Universal, Low, and Moderate Risk interventions.
ii. Place fall risk wristband on patient.
a. High Risk Rounding: strongly encourage patient to use the bathroom or Bedside Commode at least every **four (4) to- six (6)** hours while awake if they have not gone when offered during hourly rounding (does not include patients with **indwelling urinary catheter such as** Foleys).
iii. Remain with patient while toileting or showering~~ if appropriate~~.
~~b.~~**a. Document if patient refuses.**
~~iii.~~**iv.** Ensure commode is available at bedside if patient is unable to ambulate to the bathroom with assistance.

d. Responsibilities:
i. Fall Risk Armbands:
a. The RN or ~~D~~designee is responsible for placing the armbands on the wrist of patients identified as high risk (45 **or more~~+~~**).
b. The RN or ~~D~~designee is responsible for removing the armband upon change in ~~F~~fall ~~R~~risk ~~S~~score or upon discharge.
ii. Large Fall Risk Laminates:
a. The RN or ~~D~~designee is responsible for placing, updating, and/or removing the large Fall Risk laminates over the head of the patient's bed.
iii. Fall risk magnets:
a. The RN or Designee is responsible for placing, updating, and/or removing the fall risk magnet on the patient's doorframe with the designated bed indicated on the magnet.
iv. The Assistant Nurse Manager (ANM)/charge nurse shall check for appropriateness of signage during rounds.

e. The primary RN shall reassess the patient every shift for needs and change in status.
i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.

f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change or the absence of family.

g. The patient's fall risk status and family presence shall be reported during ~~communication~~ hand-off~~s~~ **communication**.

h. If a patient falls, the ANM or designee shall conduct an immediate educational debriefing for all staff involved.

i. An **incident report** ~~Quality Review Report (QRR)~~ and Post Fall Huddle shall be completed by the ~~Assistant Nursing Manager~~**ANM** or designee.

ii. The ~~QRR~~ **incident report** and Post Fall Huddle shall be reviewed by the Director/Manager and Risk Management.

i. Each outpatient care area and Emergency Department will assess the risk for falls based on their own unit specific guidelines, and intervene as appropriate.

B. **SPECIAL CONSIDERATIONS:**

1. Intensive Care Unit (ICU) Specific Fall Precautions:
   a. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:
      i. Stoplight magnets and overhead laminates are not required.
      ii. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
   b. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team Technician assistance with getting out of bed (requires physician order).
2. Peri-Anesthesia **Nursing Services** (PANS) ~~Specific Fall Precautions~~ **and Labor and Delivery Unit specific fall precautions:**
   a. All patients in PANS area **and Labor and Delivery Unit** are considered high fall risk due to post anesthesia-/-sedation status.
   b. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
      i. **Place**~~Including~~ call light within reach of bedside.
      ii. ~~Patients shall be a~~**Assisted patients** to bathroom and ambulate~~d~~ wearing shoes or non-slip socks.
      iii. RN, **Advance Care Tech, Peri-Operative Aide or** family member **must be** in attendance behind curtain to assist out-patient while dressing prior to discharge.
   c. Fall Risk magnets and overhead laminates are not required.
3. Emergency Department (ED) ~~S~~specific ~~F~~fall ~~P~~precautions:
   a. Patients seen in the ED are scored for falls using KINDER1 Falls Scale, which is an evidenced based best practice tool developed specifically for ~~Emergency Departments~~**ED**.
   b. Fall risk assessment is performed by an RN upon initial assessment.
      i. The patient is deemed not at risk.
      ii. The patient is deemed at risk if there is a yes answer to any question.
   c. Reassessments are performed with any change of condition.
   d. If a patient falls in the ED the patient automatically becomes an at risk for falls patient.
   e. The following interventions are instituted based on the patient's risk value:
      i. Universal Falls precautions are initiated on all patients in the ~~Emergency Department~~**ED**.
      ii. At risk for falls precautions (include but not limited to):
         a. Encourage family to remain with patient
         b. Encourage patient to change position slowly
         c. Increase intervals of nursing observation
         d. Patients shall be assisted to bathroom and with ambulation
         e. Fall Risk armband placed on patient
4. Imaging Services:
   a. See Imaging **Services:** General Safety **Management 128** Policy for Unit Specific Interventions

C. **FORM(S):**

~~5.~~1. Morse Fall Scale - Sample
~~6.~~2. Partnering for Fall Prevention- My Safety Plan ~~Sample~~
~~7.~~3. Post Fall Huddle - Sample

~~C.~~D. RELATED DOCUMENT(S):

1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions
2. Fall Risk Algorithm
3. Medication Fall Alert Reference Text

Morse Fall Scale - Sample

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	 0 15 30	
4. Intravenous therapy/heparin lock	No 0 Yes 20	
5. Gait Normal/bedrest/wheelchair Weak* Impaired†	 0 10 20	
6. Mental status Oriented to own ability Overestimates/forgets limitations	 0 15	
Total Score‡: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

Partnering for Fall Prevention- My Safety Plan~~—Sample~~

Partnering for Fall Prevention – My Safety Plan

Directions: This is a tool to partner with the patient and family for education of the patient's fall risk factors and strategies to reduce risk of falls and keep the patient safe.

Partnering for Fall Prevention - Our~~My~~ Safety Plan for You
We care about you and your safety. We want to partner with you and your family to prevent falls. Your medical assessment shows you ~~to~~may be at risk for falls.

You are considered at risk for falls or injury for one or more of the following ~~items~~reasons because:

- ☐ You are unsteady when you walk.
- ☐ You may bleed easily if you fall.
- ☐ You are taking medications that may make you fall more easily.
- ☐ Your medical history shows an increased risk for broken bones, due to: _____
- ☐ Recent surgeries or procedures put you at risk for falling, such as: _____
- ☐ Medical equipment (sequential devices, foot pumps, etc.) _____
- ☐ Other: _____

You and your family can ~~do to~~ help us keep you safe by doing the following:

- ☐ **Show** I know how to use my call light
  - ☐ RN: **Patient** demonstrated correct use of call light to notify nursing staff
- ☐ I will always use the call light to contact the nurse. I promise to stay in bed and call my nurse for help.
  - Whenever I need to get up
  - Whenever I need help reaching something that is out of my reach
  - Whenever I am feeling dizzy or sleepy from medications
- ☐ I will always call the nurse and not ask family for help getting out of bed
- ☐ I will wear my skid-proof slipper socks and yellow wrist band
- ☐ I have a bed alarm that is active at all times. It will alert nursing staff when I am out of bed. I will not turn off the alarm.
- ☐ I will not use the over-bed table to help me stand; it is on rollers and may cause me to fall if I lean on it.
  - ☐ RN: Reviewed falls prevention plan with patient and family
  - ☐ **Patient unable to sign the form**
  - ☐ **Patient refuses to sign the form**

Patient Initials/Date/Time: _____
RN Signature/Date/Time: _____

Post Fall Huddle – Sample

Date:__/__/____ Time:_____

Setting:_____ FIN #:_____ Entered By:_____

Reason for Audit: To involve front line staff in identifying problems and solutions, and in creating change in their work environment. To promote trust and team building among team members. To promote a positive Culture of Safety without individual blame.

Instructions:

1. Hold the Huddle as soon as possible and after every fall.
2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse manager or manager.
3. Meeting is organized by primary RN and is brief.

** Indicates that an answer is required.*

2013 Post Fall Huddle/ After Action Review

2013 Post Fall Huddle	Answer	Comments
1.* What was the lastest Fall Risk Score for the patient?		
2.* How did you find out that this patient fell?		
I saw the patient fall	[ ]	
Alarm went off	[ ]	
Patient/witness called	[ ]	
Heard noise/found patient on floor	[ ]	
Other	[ ]	
3.* What was the patient doing at the time of the fall?		
I don't know	[ ]	
Rolled out of bed	[ ]	
Getting in/out of bed to go to BR/commode/urinal	[ ]	
Trying to reach/pick up something	[ ]	
Trying to get in/out of bed for another reason	[ ]	
Trying to get on/off toilet/bedside commode	[ ]	
Trying to use the sink/shower	[ ]	
Other	[ ]	
4.* Prior to the patient fall, what was the activity level?		
Up ad lib	[ ]	
Ambulate with assistance	[ ]	
Bedrest	[ ]	
Up in chair with assistance	[ ]	
Other	[ ]	
5.* Prior to the fall, was the patient assisted by staff to the mechanism that led to the fall? (Example-Did staff assist the patient to the toilet and then left the patient alone?)	Yes | No	

6.* Why do you think the patient fell?		
I do not know	[ ]	
Confusion	[ ]	
Catastrophic event (stroke, arrhythmia)	[ ]	
Arms or legs got weak	[ ]	
Became lightheadeded, dizzy, or blacked out	[ ]	
Tried to sit but missed	[ ]	
Secondary gain (seeking attention)	[ ]	
Got tangled in equipment	[ ]	
Low blood sugar	[ ]	
Slipped or tripped (not in equipment)	[ ]	
Lost balance	[ ]	
Medication	[ ]	
Other	[ ]	
7.* Prior to the fall, identify the ancillary walking aid the patient had available in the room.		
None	[ ]	
Cane	[ ]	
Walker	[ ]	
Wheelchair	[ ]	
Other	[ ]	
NA	[ ]	
8.* Did you do hourly rounding?	Yes | No	
9. The last time you did hourly rounding, did you ask any questions pertaining to:		
Pain	[ ]	
Potty	[ ]	
Position	[ ]	
Possessions	[ ]	
10.* What could you have done to prevent this fall?		
11.* What will you do differently in the future?		
12.* Post Fall Checklist		
RL Completed	[ ]	
IPOC Post Fall Initiated	[ ]	
Physician Notified	[ ]	
Documentation in the Medical Record (event, phys exam, intervention)	[ ]	
Morse Fall Risk Score Updated	[ ]	
13.* RN : Patient Ratio (1 : __) Please fill in the number of patients the RN was assigned to.		
14.* Did you feel as though your patient assignment was appropriate?	Yes | No	

POST FALL HUDDLE/AFTER ACTION REVIEW – Sample

Date: / / Time:

Setting: FIN #: Entered By:

Reason for Audit: To involve front line staff in identifying problems and solutions, and in creating change in their work environment. To promote trust and team building among team members. To promote a positive Culture of Safety without individual blame.

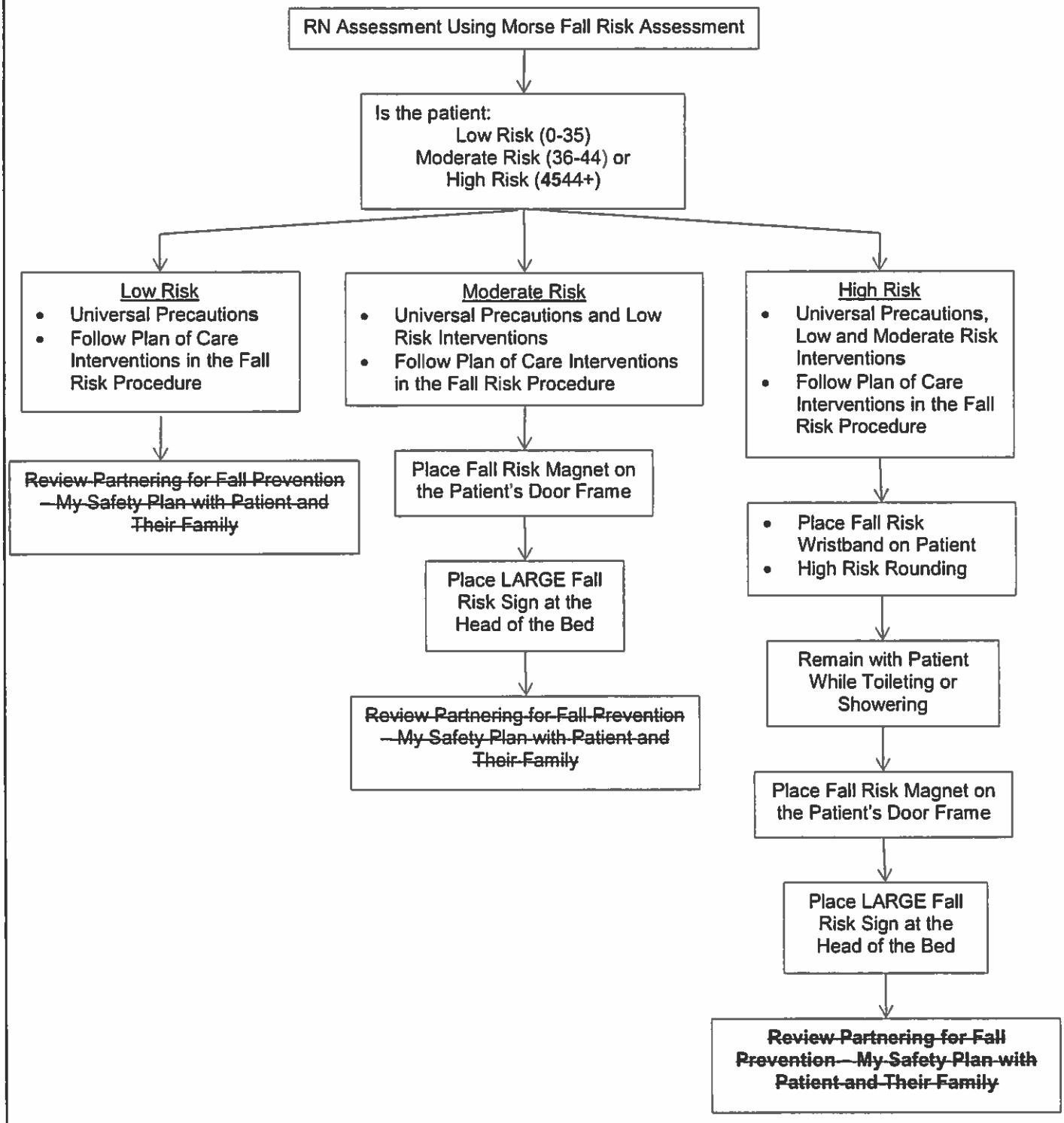
Instructions:
1. Hold the Huddle as soon as possible and after every fall.
2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse manager or manager. 3. Meeting is organized by primary RN and is brief.

** Indicates that an answer is required.*

2013 Post Fall Huddle/ After Action Review

2013 Post Fall Huddle	Answer	Comments
1.* Why did this patient fall? Ask the group "why" 3 times to find the root cause. Example: Why did this patient fall? The patient got out of bed alone because he had to go to the bathroom.		*Lessons Learned*
2.* Why did "answer to question 1" happen? Example: Why did the patient get out of bed alone? The patient got out of bed alone because he did not know where his call light was.		*Lessons Learned*
3.* Why did "answer to question 2" happen? Example: Why did he not know where his call light was? The call light was not within reach of the patient.		*Lessons Learned*
4.* What was the latest Fall Risk Score for the patient?		
5.* Were the appropriate interventions in place?	Yes | No	*What accounted for the difference?*
6.* How could the same outcome be avoided next time?		*Lessons Learned*
7.* What is the follow up plan?		*Follow up Plan*
8. Patient's account (if able to share)		*Patient's Account*
9. Agreement with patient for safety (Promise to use call bell; return demo how to use call bell)		*Safety Agreement*
10.* Type of Fall? Definitions for Type of Falls Accidental falls- Slipping, tripping, person making errors of judgement Anticipated physiological falls- Related to age and functional ability, Disease(s), Previous Fall(s), Weak or impaired gait, Lack of realistic assessment of their own ability, Person making errors of judgment. Unanticipated physiologic falls- Attributed to physiological causes but created by conditions that cannot be predicted Behavioral falls- Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.		
Accidental Fall	[ ]	
Anticipated Physiological Fall	[ ]	
Unanticipated Physiological Fall	[ ]	
Behavioral (Intentional) Fall	[ ]	
11.* Post Fall Checklist		
RL Completed	[ ]	
IPOC Post Fall Initiated	[ ]	
Physician Notified	[ ]	
Documentation in the Medical Record (event, phys exam, intervention)	[ ]	
Morse Fall Risk Score Updated	[ ]	

Fall Risk Procedure Algorithm



Medication Fall Alert Reference Text

Medication Fall Alert
Below are Medications That May Affect Patients' Fall Risk Level

***Denotes individual drugs associated with highest risk of dizziness or falls in each category**

Category One

1. Antihistamines
   a. Chlortrimeton (Chlorpheniramine Maleate)
   b. *Benadryl (Diphenhydramine Hydrochloride)
   c. Dramamine (Dimenhydrinate)
   d. Vistaril (Hydroxyzine)
   e. Antivert (Meclizine)
2. Cardiac Drugs
   a. Tenormin (Atenolol)
   b. Capoten (Captopril)
   c. Cardizem (Diltiazem)
   d. Vasotec (Enalapril)
   e. Zestril (Lisinopril)
   f. Lopressor (Metoprolol)
   g. *Procardia (Nifedipine)
   h. Inderal (Propranolol)
3. Hypotensive Agents
   a. Catapres (Clonidine)
   b. Apresoline (Hydralazine)
   c. Trandate (Labetalol)
   d. *Minipress (Prazosin) (Especially first dose syncope)
   e. *Hytrin (Terazosin)
   f. *Cardura (Doxazosin)

Category Two

1. Neurotoxic Chemotherapeutic Drugs
   a. Ifex (Ifosfamide)
   b. Vincasar (Vincristine)
   c. Platinol (Cisplatin)
   d. Methotrexate
   e. Cytosar-U (Cytarabine)
   f. Adrucil (5-fluorouracil)
   g. Taxol (Paclitaxel)
2. Vasodilating Agents
   a. Isordil (Isosorbide Dinitrate)
   b. *Nitrostat (Nitroglycerin)
3. Opiate Agonists
   a. Codeine (Includes cough syrups and Tylenol #3)
   b. Vicodin (Hydrocodone)
   c. *Morphine
   d. Percocet (Oxycodone)
4. Anticonvulsants
   a. Phenobarbital
   b. *Valium (Diazepam)
   c. Dilantin (Phenytoin)
   d. Tegretol (Carbamazepine)

Category Three

1. Psychotherapeutic Agents
   a. *Anafranil (Clomipramine)
   b. * Elavil (Amitriptyline)
   c. *Sinequan (Doxepin)
   d. Zoloft (Sertraline)
   e. Desyrel (Trazodone)
   f. *Tofranil (Imipramine)
   g. *Surmontil (Trimipramine)
2. Antipsychotic Agents
   a. *Serentil (Mesoridazine)
   b. *Thorazine (Chlorpromazine)
   c. *Clozaril (Clozapine)
   d. *Mellaril (Thioridazine)
3. Benzodiazepines
   a. Xanax (Alprazolam)
   b. *Librium (Chlordiazepoxide)
   c. *Dalmane (Flurazepam)
   d. Ativan (Lorazepam)
   e. Restoril (Temazepam)
   f. Halcion (Triazolam)
4. Diuretics
   a. **Lasix** ~~Furosemide (Lasix~~ **Furosemide**)
   b. **Bumex** ~~Bumetanide (Bumex~~ **Bumetanide**)
   c. **Demadex** ~~Torsemide (Demadex~~ **Torsemide**)
5. Miscellaneous Anxiolytics, Sedatives & Hypnotics
   a. Equanil (Meprobamate)

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INFUSION PUMP – SYRINGE OR PATIENT CONTROLLED ANALGESIC (PCA) MODULE INFUSION SYSTEM WITH GUARDRAILS**
Purpose:	To regulate intravenous (IV) infusion using an electronic control device.
Supportive Data:	The Alaris Intravenous Infusion Pump with Guardrails System provides medication error prevention software to protect patients at the point of infusion delivery.
Equipment:	1. Alaris administration set 2. Primary IV solution 3. Pump programmer point of care (POC) 4. Pump Syringe Module or Patient Controlled Analgesic (PCA) Module

A. **PROCEDURE:**

1. Syringe Module:
   a. Prior to the start of an infusion program, confirm syringe type and size. The system will provide a prompt for the programmer to select both the syringe type and size.
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
   b. Priming the Alaris Syringe Module:
      i. Prime tubing prior to attaching system to patient with normal saline.
      ii. Attach administration set to syringe and prime tubing with the medication that is ordered.
      iii. Once set is primed, close slide clamp.
   c. Loading the Alaris Syringe Module:
      i. Prior to loading syringe, close roller tubing clamp to prevent uncontrolled flow.
      ii. Open syringe barrel clamp until it clears syringe chamber.
      iii. Twist gripper control clockwise and raise device head to fully extended position.
      iv. Insert syringe barrel flange between barrel flange grippers.
      v. Lock syringe in place by closing barrel clamp.
      vi. Twist gripper control clockwise then lower drive head.
      vii. Lock plunger in place with plunger grippers.
   d. Programming Guardrails:
      ~~d.~~i. ~~s~~See **Patient Care Services Procedure:** Infusion Pump~~:~~ – Infusion System with Guardrails ~~Procedure~~
   e. Removing the Alaris Syringe Module:
      i. Silence alarm.
      ii. Close roller tubing clamp.
      iii. Open plunger grippers and syringe barrel clamp.
      iv. Remove syringe by applying downward pressure to remove disc.
   f. Near End of Infusion:
      i. The system will alternate between Near End and remaining volume to be infused (VTBI).
      ii. The audio prompt requires being silenced just once and will not reoccur following initial silencing.
2. PCA Syringe Module:
   a. Select syringe type and size.
   b. Prime tubing prior to attaching tubing to patient:
      i. Option One: Manually express air from the administration tubing set by:
         1) Prime tubing prior to attaching system to patient with normal saline.
         2) Attach administration set to syringe and prime tubing with the medication that is ordered.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/08, 04/09, 01/18	07/11, 03/15, 02/18	08/11,03/15	05/15, 03/18	10/11, 06/15, 03/18	11/11, 07/15	11/11, 07/15

3) Once set is primed, close slide clamp.
ii. Option Two: Prime tubing using Alaris PCA Module.
iii. The tubing may be primed from the Infusion Mode Screen prior to programming the PCA Module:
1) Select Options key.
2) Press Prime Set with Syringe.
3) Press and hold Prime key to prime tubing.
4) Press Exit when prime is complete.

c. After priming tubing, close slide clamp.

3. Initial Set-Up:
a. Label syringe per the **Patient Care Services Policy:** Patient Controlled Analgesia **(PCA)** ~~Policy~~.
b. Load syringe with administration set attached.
c. Press System On key.
d. Select Yes or No to New Patient.
e. Select appropriate profile.
f. Press Channel Select key.
g. Set key to Program position.
h. Press Confirm time setting.
i. Choose correct syringe type and size.
i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
j. Select correct medication and concentration.
k. Enter the dose and time limits.
l. Enter the total dosage patient may receive as ordered.
m. Responds to appropriate clinical advisory.
n. Close and lock door.
o. Attach administration set tubing set to patient.
p. Verify entered prescription with a second Registered Nurse **(RN)**.
q. Press Start to begin PCA Module.
r. Document in the medical record per the **Patient Care Services Policy:** Patient Controlled Analgesia **(PCA)** ~~Policy~~.

4. Changing Syringe:
a. Press Pause.
b. Close roller tubing clamp.
c. Unlock door and remove old syringe.
d. Press Silence.
e. Date and time new syringe and attach to tubing.
f. Load new syringe.
g. Set key to Program position, close door.
h. Press Channel Select.
i. Select correct syringe type and size.
j. Press Confirm.
k. Press Restore.
l. Verify entered drug, concentration, and settings.
m. Lock door and open roller tubing clamp.
n. Press Start.

5. Administering a Bolus:
a. Press Channel Select.
b. Set key to Program position and enter authorization code.
c. Enter bolus dose amount and lock door.
d. Press Confirm.
e. Confirm settings and press Start.
f. Document bolus in the medical record.

6. Reviewing History:
   a. Review patient history at the beginning of the shift and every four hours.
   b. Press Channel Select Key.
   c. Press Options.
   d. Press Patient History.
   e. Review drug totals.
   f. Press Zoom key to review time intervals.
   g. Press Detail to collect average dose per hour.
   h. Press Main History.
   i. To clear patient history, press Clear History and select Yes.
      i. Clear patient history every four hours and prior to transferring a patient to another nursing unit.
   j. To view 24 hours totals, select 24 h Totals.
   k. Press Exit after viewing history.
   l. Press Start to return to program.
   m. Document patient history every four **(4)** hours in the patient's electronic medical record **(EMR)**.
7. Documentation:
   a. Document the start and change of syringes in the ~~medical record~~**EMR**.
   b. A second RN must verify for accuracy the initiation, change in dosage or any boluses and document it in the **electronic medication administration record** (eMAR).

B. RELATED DOCUMENT(S):

1. **Patient Care Services Policy: Patient Controlled Analgesia (PCA)**
2. **Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails**

~~B.~~C. REFERENCE(S):

1. Cardinal Health. (2010-2014). Alaris syringe module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf
2. Cardinal Health. (2010-2014). Alaris pca module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/05	**SUBJECT:** Infusion Pumps, Intravenous (IV) Therapy
REVISION DATE: 04/07, 03/11	~~**POLICY NUMBER: IV.EE**~~

Department Approval:	**01/18**
Clinical Policies & Procedures Committee Approval:	~~**03/15**~~**02/18**
Nursing Executive Committee Approval:	~~**03/15**~~**03/18**
Pharmacy & Therapeutics Committee Approval:	~~**05/15**~~**03/18**
Medical Executive Committee Approval:	~~**06/15**~~**03/18**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**07/15**

A. **PURPOSE:**

1. To establish standards at Tri-City ~~Medical Center~~**Healthcare District (TCHD)** for the management of **intravenous** (IV) administration sets, solutions, and medications in order to decrease the incidence of infections, complications, and errors.

B. **DEFINITION(S):**

1. Back flushing – A means to prime a secondary administration set in order to flush the secondary set of residual medication and/or to flush secondary tubing between the deliveries of incompatible medications.
2. Channel – The module attached to the programming module for the delivery of IV fluids or medications.
3. Channel Labels – Provides a hospital- defined list of labels, which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., blood or chemotherapy), or the catheter location (i.e., pulmonary artery or intraperitoneal).
4. Drug Library – A drug dataset defines a list of up to 1500 drugs and concentrations appropriate for each Profile™. Programming via the drug dataset automates programming steps, including the drug name, drug amount and diluent volume, and represents established best practice Guardrails™ limit checking.
5. Epidural – Analgesia infusion delivered via the epidural space.
6. Flush solution – A solution used to provide a flush between or at the end of IV medications. The flush solution shall be compatible with the medications delivered.
7. Guardrails™ – The programming software within the Alaris Medley infusion system designed to help prevent programming errors by:
   a. Providing an advisory prompt if an out-of-limit entry is made at the time the device is programmed to infuse medications defined in the drug library
   b. Comparing user programming with the hospital-defined best practice guidelines
   c. Customizing device configurable settings to meet the need of the selected patient population
8. Intrathecal – Analgesia infusion delivered through the intrathecal space.
9. Point of Care (POC)/Programming Module – The module of the Alaris Medley medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module cannot deliver any medication without a pumping module. Each programming module has the ability to control four pumping modules.

10. Priming Volume – The amount of fluid used to clear the administration set of air. The amount of priming volume varies by administration set. The amount of priming volume can be found on the administration set package.
11. Profile™ – Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

C. **INTRAVENOUS (IV) INFUSIONS:**

1. All solutions and medications administered via an ~~i~~IV route shall be administered using an IV infusion device except in the following situations:
   a. IV push administration.
   b. Surgery, under the direct supervision of an anesthesiologist.
   c. Emergent situations, under the direct supervision of the Registered Nurse (RN).
   d. Identified research studies when the research RN is present to monitor the infusion.
   e. High census, if there is a shortage of infusion pumps; plain solutions (without additives) at rates less than or equal to 75 mL/hour may be infused without an infusion pump.
2. Staff must utilize both the appropriate Profile™ with Guardrails™ features and the channel labels when programming the Alaris infusion system to enhance the safe delivery of ~~intravenous~~ **IV** medications and solutions.
   a. **Intensive Care Unit** (ICU)**/Emergency Department** (~~ER~~D)**/Operating Room** (OR) shall be used by ICU, Post Anesthesia Care Unit (PACU), Cardiac Catheterization Lab, Interventional Radiology, and ~~Emergency Department (~~ED~~)~~, Surgery.
   b. IMC~~1~~/Tele**metry** shall be used by Telemetry and **Progressive Care Unit**~~Forensics~~.
   c. Acute Care shall be used by 1North, Acute Rehab, 2Pavilion, 3Pavilion, 4Pavilion, and the Forensic Unit.
   d. **Neonatal Intensive Care Unit** (NICU) shall be used by ~~Neonatal Intensive Care Unit (~~NICU~~)~~ and ED.
   e. Peds~~1~~ shall be used **for pediatric patients**~~by, ED, and PACU~~.
   f. ~~WNS (formerly~~ WCS~~)~~ shall be used by Labor ~~&~~**and** Delivery and Mother Baby.
   g. Oncology
3. Profiles and Channel Labels shall be checked by the licensed nurse at the beginning of each shift.
4. Profiles ™ shall be checked and changed as needed when a patient is transferred to another patient care unit. The receiving unit RN shall be responsible to check and change the patient profile.
5. Channel labels shall be utilized for medications and/or solutions that are not a part of the drug data set.

D. **PRIMING AND FLUSHING:**

1. The priming volume shall be subtracted from the volume to be infused in order to ensure the medication and/or solution is infused over the prescribed rate as appropriate in NICU and Pediatrics.
2. To clear residual medication volume from the IV administration set, the back flushing technique shall be utilized. Approximately 20 mL of medication shall be flushed back into the empty bag or bottle. The flush solution is then infused at the same rate as the original rate of the medication.

E. **SMART SITE PORTS:**

1. Smart Site injection sites on the IV tubing are accessed only with a luer lock syringe.
   ~~1.~~**a.** Note: Using a needle or blunt tip syringe will damage the valve and result in leaking. The valve may be secured by attaching a Smart Site valve cap.

F. **CARE AND CLEANING:**

1. One POC and channel shall be left in the patient's room at discharge and cleaned by Environmental Services (EVS). Extra POCs and channels shall be stored in a designated area on the unit or in the Sterile Processing Department (SPD).

a. The tubing and IV bag shall be removed and discarded by the unit's RN prior to EVS cleaning pump.
b. EVS shall not clean pump if tubing and/or IV bag have not been removed.
c. EVS shall attempt to locate the Assistant Nurse Manager (ANM) shift supervisor/designee and request the tubing and IV bag be removed. If the ANM, shift supervisor/designee cannot be located, or the tubing/IV bag is not removed in a timely manner, cleaning the pump shall be nursing's responsibility.

2. Cleaned infusion pumps shall be covered with a plastic bag.
3. Cleaning needs of the Infusion Pump during patient care shall be the responsibility of the RN caring for the patient.
   a. They shall be wiped down with a hospital- approved disinfectant weekly and when visibly soiled. (Refer to Infection Control Policy ~~Manual, IC 9r~~: Cleaning and Disinfection~~,~~ - **IC 9**)
   b. To avoid damage to the connectivity points never spray cleaning solutions directly onto the pump.
   c. Spray cleaning solution onto a cloth and wipe the pump with the moistened cloth.
4. Greater than 70% alcohol solutions are damaging to equipment surface, and shall not be used.
5. Infusion pumps shall be kept plugged into an electrical outlet at all times.
   a. Cleaned infusion pumps not in use shall be stored in the patient's room or designated storage area.
   b. ~~Sterile Processing (~~SPD~~)~~ shall make rounds (Monday-Friday) to maintain a minimum supply in SPD.
      ~~b.~~**i.** ~~(~~Exception: Forensic Unit~~)~~

G. **RELATED DOCUMENTS**

1. Infection Control Policy: ~~Manual IC 9r~~ Cleaning and Disinfection **IC 9**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**POINT OF CARE TESTING COMPETENCY ASSESSMENT**
Purpose:	To outline the mandatory Point of Care testing personnel competency requirements.
Supportive Data:	To meet regulatory requirements, to include but not limited to College of American Pathology and Joint Commission
~~Equipment:~~	~~POC Competency Forms (located on Intranet)~~

A. POLICY:

1. Point of Care Testing (POCT) includes analytical patient tests performed outside the clinical facilities of the main laboratory. All POCT is covered under the Laboratory's Clinical Lab Improvements Amendments license, and is subject to the same regulations. The College of American Pathologist (CAP) personnel competency requirements for POCT includes:
   a. Evidence testing personnel have adequate, specific training to ensure competence.
   b. A list delineating the specific tests each POCT personnel is authorized to perform.
   c. A documented program ensuring each person performing POCT maintains satisfactory levels of competence.
2. Joint Commission requires competency to be assessed using at least two **(2)** of the following methods per person per test:
   a. Performance of a test on a blind specimen.
   b. Periodic observation of routine work by the supervisor or qualified designee.
   c. Monitoring of each user's quality control performance.
   d. Use of written test specific to the test assessed.
3. Competency for waived testing shall be evaluated upon hire and annually thereafter. Competency for non-waived testing shall be evaluated upon hire, semi-annually during the first year, and annually thereafter. Competency shall be reassessed at any time when problems are identified with employee performance.
4. The records must make it possible for the Inspector to determine what skills were assessed and how those skills were measured. Some elements of competency include, but are not limited to:
   a. Direct observations of routine patient test performance, including, as applicable, patient identification and preparation; and specimen collection, handling, processing and testing.
   b. Monitoring the recording and reporting of test results, including, as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records.
   d. Direct observation of performance of instrument maintenance and function checks, as applicable.
   e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples.
   f. Evaluation of problem solving skills.
5. For non-waived (moderate-complexity) tests, all of the above six **(6)** elements must be assessed annually. For waived tests, it is not necessary to assess all elements at each assessment. Ongoing supervisory review is an acceptable method of assessing competency.
6. Personnel will not be allowed to perform POC testing without completion of the competency requirements.

B. PROCEDURE:

1. The Laboratory Medical Director authorizes personnel to perform testing. Authorization is determined by job description and is specific to nursing unit and job title. Refer to the Laboratory Point of Care Coordinator and Quality Management Manual for any clarification.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/10, 06/11, 06/14, 10/17	04/11, 06/14, 11/17	05/11, 06/14, 12/17	08/14	n/a	n/a	06/11, 10/14	06/11, 11/14

2. Evidence of training and competency shall be documented and records shall be maintained in the Employee file.
3. Management is responsible to ensure all testing personnel within their department have completed the required competencies.
4. If an individual fails to complete competency assessment by the due date, they will not be allowed to perform POC testing until the competency is completed.
5. Return all completed competencies to the Education department.
   a. Blank forms are found on the TCMC Intranet.

C. **FORM(S):**

~~b.~~1. **Point of Care Competency Form**

~~C.~~D. **REFERENCE(S):**

1. College of American Pathology. (2014) Point of Care Testing Checklist.
~~1.~~2. e-dition.jcrinc.com WT.03.01.01. Retrieved on May 11, 2011.
~~2.~~3. **The Joint Commission (2017). *Hospital Accreditation Standards.* Illinois: Joint Commission Resources.**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**POWER INJECTION PROCEDURE FOR PERIPHERALLY INSERTED CENTRAL CATHETER (PICC)**
Purpose:	To outline the **Registered Nurse's** (RN's) responsibility when attaching and disconnecting a Power Injectable Peripherally Inserted Central Catheter with the Contrast Power Injector. Maintain compliance with state and manufacturers guidelines.
Supportive Data:	The Power Injectable **computerized tomography** (CT) **peripherally inserted central catheter** (PICC) is indicated for short or long term peripheral access to the central venous system for intravenous therapy and power injection of contrast media. For blood sampling, infusion, or therapy use a 5 French or larger catheter. The maximum recommended infusion rate is 4 milliliter/sec for power injection of contrast media. The maximum pressure of power injectors used with the Power Injectable CT PICC may not exceed 250 psi.
Equipment:	Power Injectable CT PICC, Power Injector, Computerized Axial Tomography Scanner/ **magnetic resonance imaging** (MRI) Scanner. 1. Non-sterile gloves. 2. 3 alcohol swabs. 3. Sterile field (may use 4x4 sterile gauze). 4. 10mL or more Sterile Normal Saline filled syringe. 5. 1 Anti-reflux valve for each lumen.

A. **POLICY:**

1. Use only lumens marked "Power Injectable" for power injection of contrast media.
   a. Warning: Use of lumens not marked "Power Injectable" for power injection of contrast media may cause failure of the catheter.
2. Confirm injection flow rate does not exceed capacity of 5 French double lumen **peripherally inserted central catheter** (PICC) line with technologist.
   a. Warning: Exceeding the maximum flow rate of 4 mL/sec may result in catheter failure and/or catheter tip displacement.

B. **PROCEDURE PERFORMED BY A REGISTERED NURSE:**

1. Perform hand hygiene.
2. Don clean non-sterile gloves.
3. Clamp both PICC ports and suspend all Intravenous (IV) meds and Total Parenteral Nutrition (TPN).
4. Select port to be used and ensure patency.
   a. Warning: Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure.
   b. Cleanse catheter tip thoroughly with three (3) alcohol swabs and allow to air dry.
   c. Attach a 10 mL or larger syringe filled with sterile normal saline.
   d. Unclamp and aspirate for adequate blood return and flush the catheter with the full 10 mL or more of sterile normal saline.
5. Detach syringe.
6. Attach the IV tubing from the power injector syringe directly to the PICC with the anti-reflux valve attached.
7. Keep PICC to be used for power injection unclamped while keeping secondary catheter lumen not connected to power injection system clamped.
8. Notify technologist that the system is connected.
9. Monitor PICC and injection site while the injection is under way. Immediately notify technologist if of any abnormal infiltration, leaking or catheter failure.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/06, 06/08, 11/09, 01/18	11/09, 03/15, 02/18	12/09, 03/15, 03/18	05/15, 03/18	06/15, 03/18	02/10, 07/15	02/10, 07/15

10. Exit the room upon request of the technologist to avoid any exposure to radiation. Technologist will give a 10 second warning announcement.
11. After imaging is complete, disconnect the power injection tubing.
12. Flush the Power PICC with 10 mL of sterile normal saline, using a 10 mL or larger syringe.
13. Resume previous IV fluids or clamp unused port.

C. **RELATED DOCUMENT(S):**

1. Infection Control Policy IC8 Hand Hygiene
2. Patient Care Services Central Venous Access Procedure

D. **REFERENCE(S):**

1. Angiodynamics, Inc. Morpheus CT PICC Insertion Kit, http://www.angiodynamics.com/products/morpheus-smart-picc2014.
2. Bard Access Systems Power PICC. Polyurethane Radiology Catheters with Microintroducer Set, Instructions for Use. http://powerpicc.com/clinician-info.php 2014

Tri-City Medical Center
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: NEW **SUBJECT:** Non-Beneficial Treatment

REVISION DATE(S): **POLICY NUMBER:** 8610-399

Department Approval:	02/18
Administrative Policies and Procedures Committee Approval:	02/18
Medical Executive Committee Approval:	03/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. The purpose of this policy is to outline a process for physicians to follow when a patient or his/her designated decision maker has requested treatment that in the best judgment of the patient's physician is non-beneficial in compliance with the relevant California statutes regarding health care decisions.

B. **POLICY:**

1. Tri-City ~~Medical Center~~**Healthcare District** and physicians of the ~~Tri-City Medical Center~~**TCHD**'s Medical Staff are not obligated to provide a patient with medical treatment that, in the physician's best judgment, will not be beneficial. This policy applies to all patients regardless of race, color, national origin, religion, disability, age, sex, marital/familial status, socioeconomic status or sexual orientation. Disagreements concerning this issue between doctors, patients, family members, surrogates, conservators, nurses and other health care personnel will be addressed in the following manner:
   a. Preempt conflict. Attempt to promote understanding among the involved parties in advance.
   b. Negotiate solutions to disagreements using available hospital resources including the Ethics Committee, palliative care services, and chaplaincy services.
   c. An effort should be made to contact the patient's outpatient primary care physician if available.
   d. If disagreement persists, seek consultation from another physician.
   e. If the consulting physician disagrees with the attending physician, consider transfer of the patient's care to another physician.
   f. If both physicians agree, but there is still disagreement with the patient, family, conservator, or surrogate, consultation from the hospital Ethics Committee should be requested.
   g. If the Ethics Committee review disagrees with the recommendation of the two physicians, help with transfer of the patient to another physician or institution should be provided. Until such transfer can occur, the current physician remains ethically and legally responsible for the care of the patient.
   h. If the Ethics Committee review concludes that the proposed treatments are non-beneficial but there is still failure to reach consensus with the patient, family, conservator, or surrogate, the following steps should be taken:
      i. Risk Management and Administration of the hospital must be notified.
         1) Inform the patient or designated decision maker of the decision of the medical team. Document this discussion in the patient's health record.

2) The patient or the designated health care decision maker for the patient should be promptly notified in writing that the non-beneficial treatment will not be provided. A letter must be issued to the patient or designated health care decision maker on hospital stationery and signed by the patient's Attending Physician and the hospital's Chief Medical Executive, or their designees, documenting this decision. The letter will be hand delivered, if possible.~~2~~

ii. Discuss the option of transfer to an appropriate care setting. It is the responsibility of the patient, family, conservator, or surrogate to find an acceptable medical practitioner or institution and arrange the transfer of the patient. Reasonable efforts will be made to assist in the transfer of the patient.

iii. Recognize the opportunity of the patient or designated decision maker to seek a judicial mandate to continue the treatments in question. Continuing care will be provided to the patient until a transfer can be accomplished or it appears that transfer cannot be accomplished. No new treatment, which has been determined to be non-beneficial, will be initiated unless court ordered.

i. If the patient has not been transferred or a judicial mandate has not been issued within a reasonable period of time, not to exceed ten **(10)** days from the issuance of the letter, the treatment in question may be withheld or withdrawn.

C. RELATED DOCUMENT(S):

~~j.~~1. **Non-Beneficial Treatment Patient Letter**

~~C.~~D. REFERENCE(S):

1. California Probate Code sections 4735, 4736 and 4740

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

To:
[Name of patient/surrogate]
[Address]

[Date]

Re: Medical care of patient, [Name and MRN] at Tri-City Healthcare District

Dear [Name of patient/Surrogate],

We have been caring for your [relationship to patient], [Patient's Name], during his/her current hospitalization at Tri-City Healthcare District. We have been asked by you to provide treatments for [Patient's Name] which includes treatments like [Name each treatment deemed to be non-beneficial]. We understand why you are requesting this care and have carefully considered your reasons for requesting this care.
Our goal in caring for our patients is to provide them with medical treatments most appropriate for their condition. We have consulted with our colleagues and we have evaluated the potential outcomes of the treatment requested. We have also consulted our hospital ethics committee and they agree that the treatments mentioned above would not be beneficial to [Patient's Name] and would not be appropriate. After careful review and discussion, we do not believe that the requested treatments would be beneficial under the circumstances.

We are providing you with this written notice of our decision in compliance with the hospital's policy and the California Probate Code that addresses requests for medical treatments which physicians believe are non-beneficial. We have also asked our Chief Medical Executive to sign this letter. He has reviewed this matter and his signature indicates the hospital's support of our decision.

We recognize that making treatment decisions for gravely ill persons is challenging for everyone involved. If you disagree with our decision, you may seek out another physician and institution willing to accept [Patient's Name] for transfer and provide the care you are seeking. Although you are responsible for locating alternative providers, we will make reasonable efforts to assist you. You may also seek a court order that directs our hospital to continue the treatment in question. You must carry out these alternatives within 1 - 10 days of this notice. After that time, we will not continue to provide the non-beneficial treatments.

We do recognize how difficult this time is for the patient, clinicians, and family. We will continue to provide the current medical treatment to [Patient's Name], and continue to work with you to develop a mutually acceptable plan of care.

Sincerely,

[Name], MD [Name], MD Attending Physician Chief Medical Executive

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

DELETE – incorporated into Patient Care Services Policy: Discharge of Patients and Discharge Against Medical Advice (AMA)

SUBJECT: AMA Discharges
POLICY NUMBER: 100

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~03/18
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

~~A. **PURPOSE:**~~

~~To help provide a process whereby a patient is advised of the risks associated with leaving the Behavioral Health Unit **or Crisis Stabilization Unit** against medical advice (AMA) and guidelines for action when a patient elects to leave AMA.~~

~~B. **POLICY:**~~

~~1. A voluntary patient may leave the hospital at any time by giving notice to any member of the hospital staff on his/her desire to leave and by completing usual discharge processes.~~
~~2. A Conservatee may leave in a like manner if the patient's Conservator gives notice.~~
~~3. If a voluntary patient cannot be persuaded to continue his or her hospitalization, cannot be safely discharged, and meets criteria for involuntary hospitalization, an appropriately credentialed clinician will initiate a 72 hour hold and the patient will not be permitted to leave the unit.~~

~~C. **PROCEDURE:**~~

~~1. Definitions~~
~~a. Against Medical Advice (AMA): Terminating treatment without a discharge from the attending psychiatrist or his/her designee or terminating treatment against the attending psychiatrist's advice **or his/her designee.**~~
~~b. Discharge: Absolute unconditional release of a patient from the hospital by action of the hospital or court.~~
~~c. Elopement: The unauthorized leave of a patient who has been admitted and leave the hospital without permission.~~
~~d. Conservator: A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or developmentally disabled.~~
~~2. If a voluntary patient requests to terminate treatment, cannot be persuaded to stay, and does not meet 5150 criteria the staff will:~~
~~a. Notify the attending psychiatrist **or his/her designee** after making a clinical determination regarding the safety of allowing the patient to leave.~~
~~b. Provide the patient with discharge instructions, medication reconciliation paperwork and other discharge information~~
~~c. Ask the patient to complete a Termination of Treatment Against Medical Advice form~~
~~d. Document in the medical record the patient's response to discussion including:~~

i. Risks to health associated with leaving AMA
ii. How the patient left
iii. With whom and at what time the patient left
iv. Persons notified and actions taken by them
v. Any instructions given to the patient regarding follow-up treatment

3. If a voluntary patient requests to terminate treatment, cannot be persuaded to stay and meets 5150 criteria the staff will:
   a. Notify the attending psychiatrist **or his/her designee**
   b. Ask a credentialed clinician to independently evaluate the patient and, as appropriate, initiate a 72-hour hold.
   c. Document the details of the occurrence in the medical record.
   d. Explain to the patient the reasons he/she will not be permitted to leave the unit
   e. Complete 72-hour hold advisement, give patient original and place copy in medical record behind the original 72-hour hold form.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Managing the Medical Record ~~When a~~for BHU Patient ~~Goes to~~in the Emergency Department ~~for Treatment While Hospitalized~~**
POLICY NUMBER: **303**

ISSUE DATE: **03/08**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide continuity in the medical record.

B. **POLICY:**
1. Patients who require emergency medical interventions while hospitalized on the **Inpatient Behavioral Health Unit** (BHU) will not be discharged from the unit.

C. **PROCEDURE:**
1. When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room..." three **(3)** times overhead. Once notified, the **Rapid Response Team** (RRT) member will simultaneously respond to that room/location within **five** (5) minutes. ~~[Refer to Patient Care Services Manual Policy IV.L: Rapid Response Team and Condition Help (H)]~~
2. When an individual who is being treated on the ~~inpatient Behavioral Health Unit~~**BHU** develops a medical symptom or complaint the nurse will assess the need for immediacy in addressing that symptom or complaint and will report the results of that assessment to the attending psychiatrist and hospitalist.
   a. If possible, a consultation will be initiated for the physician/**Allied Health Professional (AHP)** specialty that addresses the presenting complaint or to the internist who performed the initial history and physical examination.
   b. When the condition is emergent or potentially emergent, the nurse will ensure that the patient is transported to the Emergency Department **(ED)** for immediate intervention.
      i. The attending psychiatrist and hospitalist will be notified.
      ii. The ~~Emergency department~~**ED** will be notified and given clinical information.
      iii. A staff member from the BHU will accompany the patient by either wheelchair or stretcher as the condition warrants.
      iv. A Security staff member may accompany the patient and staff member if it is clinically indicated.
      v. The BHU record will be sent with the patient.
3. The patient will not be discharged from the ~~Behavioral Health Unit~~**BHU**.
4. The patient will be issued a new encounter for the ~~emergency department~~**ED** visit to allow that patient to be entered into the Firstnet system.

5. When the patient returns to the BHU, the original encounter remains intact and the ~~Emergency Department~~**ED** encounter will be discharged. The patient's BHU medical record will be returned to the BHU with the patient.
6. The accounts will be combined at the time of patient discharge.
7. If the patient is sent~~,~~ from the ~~Emergency Department~~**ED**~~,~~ to a medical or surgical unit for treatment of the complaint, the patient will be discharged from the BHU.

D. RELATED DOCUMENT(S):

~~8.~~**1. Patient Care Services Policy: Rapid Response Team and Condition Help**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Notification of Medi-Cal Beneficiary of Denial of Benefits
POLICY NUMBER: 103

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that all Medi-Cal beneficiaries are notified in a manner consistent with CCR, Title 9, Chapter 11, Section 1850.210 when the Point of Authorization (United Behavioral Health: UBH) denies continued inpatient hospitalization services to the beneficiary by the Mental Health Provider (MHP), i.e. Tri-City ~~Medical Center~~**Health Care District (TCHD)** Behavioral Health Services **(BHS)**.

B. **POLICY:**

1. When it becomes known, through the continued stay utilization review process, that payment for continued stay on the Inpatient Behavioral **Health** Unit **(BHU)**, known herein as the ~~Mental Health Provider (~~MHP~~)~~ has been denied, the Utilization Review Manager will notify the Medi-Cal beneficiary of the action and of his/her right to appeal the payment decision and will discuss the beneficiary's rights to appeal.

C. **PROCEDURE:**

1. A fax will be sent from UBH to the MHP indicating that further treatment days will be denied.
2. The Utilization Review Manager will discuss the faxed information with the patient. The Notice of Action includes:
   a. The reason the mental necessity criteria was not met.
   b. The beneficiary's options for obtaining care outside of the MHP, if applicable.
   c. The beneficiary's right to request a second opinion on the determination.
   d. The beneficiary's right to file a complaint or grievance with the MHP.
   e. The beneficiary's right to a fair hearing including the method by which a hearing may be obtained and information that describes that the beneficiary may be either ~~self represented~~**self-represented** or be represented by an authorized third party such as legal counsel, relative, friend or another person, as well as the time limits for requesting a fair hearing.

D. **REFERENCE(S):**

~~f.~~**1. CCR, Title 9, Chapter 11, Section 1850.210**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Notification of Responsible Persons
POLICY NUMBER: 710

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that appropriate notification will occur if/when a patient experiences a significant change in physical or mental status while hospitalized ~~in~~**on** the Inpatient Behavioral Health Unit **(BHU),** ~~.~~ **or the Crisis Stabilization Unit (CSU).**

B. **POLICY:**

1. In the event that a patient experiences a significant change in either physical or mental status, appropriate notification will occur in accordance with patient consent and all HIPAA regulatory standards.

C. **PROCEDURE:**

1. When a patient experiences an acute or serious change in physical status the following individuals will be notified:
   a. The attending Psychiatrist
   b. Attending medical ~~doctor~~**physician/Allied Health Professional (AHP)** if one has been identified
   c. Immediate family or legal conservator
   d. Program Manager
2. When a patient experiences an acute or serious change in mental status the following individuals will be notified:
   a. The attending Psychiatrist
   b. Immediate family or legal conservator
   c. Program Manager
3. In the event that the patient is relocated to another unit within the hospital or to another facility, the patient's family and or legal conservator is notified.

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

1. **Behavioral Health Services Policy: Confidentiality**
~~4.~~2. **Behavioral Health Services Policy: Family Involvement in Treatment**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: One to One Observation of Patients
POLICY NUMBER: 711

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide guidelines for intensive patient monitoring to assure the safety of the patient and the environment.

B. **POLICY:**
1. When a patient displays behavior that places his safety, the safety of others, or the safety of the environment in immediate risk, the patient will be closely observed by a clinical staff member who will be assigned specifically to provide that monitoring.

C. **PROCEDURE:**
1. Criteria for assigning one-to-one supervision:
   a. The patient has expressed intent to inflict serious injury to him/herself in the immediate future, is unable to contract for safety, and is unable to adequately control impulses to carry out the intent such that **every 15 minutes** (Q-15)~~-minute~~ checks do not assure his or her safety.
   b. The patient has displayed behavior either immediately prior to admission or while on the unit that is indicative of his or her intent to inflict serious injury to self.
   c. The patient has expressed intent to inflict serious injury on another or others in the milieu and may not be able to control impulses to carry out the intent such that Q-15 ~~minute~~ checks to do assure his or her safety.
   d. The patient has displayed behavior, either immediately prior to admission or while on the unit, that is indicative of intent to harm others and/or the patient has displayed or is reported to have recently displayed poor control of impulses to act on this intent.
   e. The patient's reality testing or level of symptoms is such that he or she has been determined to be at risk for acting out in a manner that puts the environment at serious risk.
   f. The patient has a medical condition that puts him or her at immediate high risk for falls such that it is not safe to leave the patient unattended.
   g. The patient has a medical condition (such as dressings, open wounds, etc.) that would put that patient or others in the environment at risk if the patient was unable to comply with treatment, and it has been determined that Q-15 ~~minute~~-checks do not assure his or her safety or protection.
   h. The patient placed ~~is~~-ion four-limb restraints.

2. When it becomes necessary to assign the patient to one-to-one supervision the **registered nurse** (RN) and/or Psychiatrist will explain the nature and purpose of this level of observation to the patient/**family** and answer questions as indicated.
3. When a patient is placed on one-to-one supervision, the patient will be restricted to the Behavioral Health Unit **(BHU)** except to receive emergency medical care.
   ~~3.~~**a.** If the patient must leave the unit, a member of the BHU clinical staff and a Security Officer will escort the patient.
4. The patient will continue to exercise all patient rights (i.e. clothing, visitors, telephone) while on one-to-one supervision unless there are indications specific to each right to impose a limitation.
~~4.~~**5.** A ~~registered nurse~~**RN** may initiate one-to one observation when, in his or her judgment, it is clinically warranted to assure the safety of the patient or the environment. After doing so, the RN will obtain a written physician order for this level of observation as soon as is practicable.
~~5.~~**6.** The Psychiatrist will be responsible for writing an order to discontinue one-to-one observation when, in his or her clinical judgment, the reason for initiating this level of supervision no longer exists. A ~~registered nurse~~**RN** may not discontinue one-to-one supervision without a physician order.
~~6.~~**7.** The staff member who is assigned to provide one-to-one supervision will not have an additional clinical assignment and will be expected to provide observation and care to only one patient.
   a. ~~The staff member assigned will be provided with relief at regularly scheduled intervals at least every 2 hours, for fifteen minute breaks and for meals.~~**If a break is needed contact the Assisted Nurse Manager (ANM)/Charge RN on the unit so proper coverage can be obtained during your absence.**
   b. The staff member will not leave the assignment until a relief person presents him or herself to take over.
   c. All clinical staff who provide one-to-one observation will possess the necessary competencies to adequately provide this level of care including but not limited to:
      i. Knowledge of indicators for suicidal risk
      ii. Knowledge of indicators for elopement risk
      iii. Knowledge of indicators of escalation of aggression
      iv. Verbal de-escalation skills
      v. Restraint and seclusion
      vi. Therapeutic communication skills
~~7.~~**8.** The staff member who is assigned to provide one-to-one observation will remain at close proximity (arm's length) to the patient at all times. This includes:
   a. Bathing and toileting
   b. Meals
   c. Smoking breaks
   d. Sleep
~~d.~~**9.** The assigned staff member will ~~document~~ **give report of** significant observations about the patient ~~at least once every hour and more frequently as indicated on a form provided for this purpose~~**to assigned RN**.
~~a.~~**10.** Information may include approaches that have been helpful, triggers, patient preferences, patient concerns, and observations that will assist others to better understand and treat the patient.
   ~~b. This content of this documentation will be reviewed by the assigned RN and will be communicated between care-givers and at change of shift but will not become a part of the patient's permanent medical record.~~
~~9.~~**11.** The staff member who is assigned to provide one-to-one observation will interact with the patient in a therapeutic manner and will refrain from engaging in personal conversation, reading, **use of cellular phones,** watching television, or other activities that might provide a distraction from the intent of the assignment~~.~~.
~~10.~~**12.** The ~~Registered Nurse~~**RN** assigned to the patient's care will assess the patient's condition throughout the shift and provide professional nursing care as indicated.

~~11.~~13. The ~~Registered Nurse~~**RN** assigned to the patient's care will include documentation in the clinical record that addresses the patient's behavior as it relates to the need for one-to-one supervision, the patient's response to this level of supervision, and other available clinical data that supports the need for continued supervision at this level or indicates the patient's safety may be assured at a less restrictive level of supervision, i.e. Q-15-~~minute~~ checks.

~~12.~~14. One-to-one observation, because of its restrictive nature, will be discontinued as soon as the attending psychiatrist, with input from clinical staff, determines that the patient's safety can be assured with Q-15-~~minute~~ monitoring. Once discontinued, one-to-one supervision may be resumed if clinical justification exists. If it is resumed by the RN, he or she will obtain a new physician order for this level of observation as soon as is practicable.

Tri-City Medical Center
Oceanside, California

BEHAVIORAL HEALTH SERVICES

DELETE- Duplicate Policy of Inpatient Behavioral Health Services: One-to-One Observation of Patients

SUBJECT: One to One Patient Supervision
POLICY NUMBER: 6340-015

ISSUE DATE: 5/83
REVISION DATE(S): 7/85, 4/87, 5/91, 8/94, 5/97 6/99, 3/00, 4/03, 12/04, 4/05, 3/13

Department Approval:	09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

~~A. One-to-One Patient Supervision:~~

~~1. Staff must be at arm's length from the patient at all times. This includes trips to the bathroom, shower, meals, patio, and sleep hours.~~

~~2. Patient is restricted to the Behavioral Health Unit except for emergent Medical care.~~

~~3. Staff providing one-to-one supervision are to have no other patient assignments. Relief is provided every 2 hours for the staff member, for 15 minute breaks.~~

~~4. Patient on one-to-one supervision required a daily Progress Note every shift addressing the requirement for one-to-one and the patient's progress to be completed by assigned RN.~~

~~5. A nurse can order one-to-one supervision status if in nurse's clinical judgment, the patient would benefit from one-to-one supervision. Attending physician must be notified for a physician order, as soon as possible.~~

~~6. Removal from one-to-one supervision status requires a physician's order. This decision is made between a Physician and ANM/Charge Nurse.~~

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Orientation of New Patients
POLICY NUMBER: 712

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the process of patient orientation to the **I**inpatient ~~psychiatric~~ **Behavioral Health** ~~u~~**Unit (BHU)**.

B. **POLICY:**

1. Each patient will receive an orientation to the ~~Inpatient Behavioral Health Unit~~**BHU** by the admitting Registered Nurse **(RN)** or designee. Orientation information will be presented in a manner that maximizes the patient's understanding of the information.
2. Orientation information will be presented in both verbal and written formats.

C. **PROCEDURE:**

1. Each patient who is admitted to ~~the unit~~**BHU** will be given a copy of the Unit Rules with the instruction that they are expected to read them and ask for clarification if there are items they do not understand. Rules will be briefly reviewed with the patient.
2. Patients will be given a tour of the unit including ~~smoking areas,~~ their room, **day room,** dining **room** and other common areas. They will be oriented to the use of the laundry, telephone, and shown where information is located regarding patient rights, patient grievances, interpreters, daily therapy schedule, nurse assignment and community resource information.
3. Patients will be informed of visiting hours,~~ and~~ where visitors may and may not visit**, and what visitors may and may not bring.**
4. Patients will be shown where their belongings will be kept and how they are to request access to them. They will be told what items they may and may not keep with them.
5. Patients will be informed about how and where to procure clean linen and to dispose of used linens.
6. Patients will be informed of their rights and responsibilities and voluntary patients will be asked to sign consent forms at the time of admission.
7. Patients will be introduced to other staff and to other patients.
8. Each patient's orientation will be adapted to the patient's clinical presentation. When the patient's symptoms are of such severity that it is deemed either unsafe or impractical to orient the patient, the orientation will be given as soon as the patient's condition is such that it is deemed safe and practical.

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

1. **Behavioral Health Services Policy: Patient Belongings**

2. **Behavioral Health Services Policy Patient Responsibilities**
~~9.~~3. **Behavioral Health Services Policy: Patient Rights**
~~10.~~4. **Behavioral Health Services Policy: Consent Related to Mental Health Treatment**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Pastoral Care
POLICY NUMBER: 713

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To define availability of pastoral care, religious consultation and education to patients.

B. **POLICY:**
1. Recognizing that spiritual values and issues may affect patient response to treatment, patients will have access to clergy while they are hospitalized on the Inpatient Behavioral Health Unit **(BHU) or Crisis Stabilization Unit (CSU)**.

C. **PROCEDURE:**
1. Patients' spiritual needs are assessed as part of the Psychosocial Assessment.
2. Identified problems are discussed in the Interdisciplinary Treatment Planning meeting and a plan is developed to address identified problems.
3. When a patient requests pastoral assistance or consultation the program staff will contact the Chaplain's office to arrange for such consultation.
4. The patient may contact a clergy person of his or her choice to visit during the hospitalization.
5. If clergy visits the patient, private space will be provided to accommodate the consultation. The patient may visit with clergy outside of regularly scheduled visiting hours with prior approval by the attending psychiatrist.
6. Staff will maintain a supportive and unbiased relationship with patients regarding religious issues and patients' secular needs will be referred to clergy.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Patient Belongings**
POLICY NUMBER: **402**

ISSUE DATE: **03/08**
REVISION DATE(S): **06/11, 03/13**

Department Approval:	~~06/16~~**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. In order to provide and maintain a safe and secure environment for all patients and hospital personnel, a patient's personal belongings/room may be searched for dangerous objects and/or drugs. Patients are requested to be present during the search of their personal belongings/room.

B. **DEFINITION(S):**

1. Contraband: for the purpose of this policy, contraband is defined as materials or articles not authorized to remain in the possession of patients while admitted to **Tri-City Healthcare District** (TC~~MC~~**HD**). Contraband includes, but may not be limited to:
   a. Weapons (firearms, knives or other objects that are easily used or adapted to cause personal injury, including any item identified as a weapon in the ~~California~~ **Cal.** Penal Code **§ 12276** that might be used as weapons).
   b. Recording devices, cell phones, and cameras.
   ~~a.~~**c.** Alcohol, **cigarettes and other tobacco products,** illicit drugs or **Food and Drug Administration** (FDA)- approved drugs, and any other unauthorized substances meant to be inhaled, ingested or taken into the body and not prescribed or permitted by the patient's physician~~(s)~~**/Allied Health Professional (AHP)** for use while the patient is under the care of the facility
      i. ~~Note:~~ Medication permitted under policy **Patient Care Services** Policy: ~~IV.DD~~, ~~"~~Medications Brought in by the Patient~~"~~ are not contraband when handled in accordance with that policy.
         ~~i.~~**1)** Patients will be encouraged to send all medications home with a family member.
         ~~ii.~~**2)** Other medications will be sent to pharmacy for safe-keeping. A list will be kept in the patient's medical record and the medications will be returned to the patient at the time of discharge from the unit.
         ~~iii.~~**3)** Patients will be informed that illicit drugs will not be returned to them upon discharge if taken into possession by the hospital. Security will be notified for proper disposal

~~iv. Patients will be informed that prescription opioids, barbiturates, narcotics, and other controlled substances will not be returned to them upon discharge if taken into possession by the hospital pharmacy.~~

~~c.~~**d.** Drug paraphernalia as defined in ~~§Section~~ 863 of Title 21 of the United States Code, which includes equipments or materials of any kind meant for use in planting, growing, harvesting, manufacturing, compounding, producing, processing, preparing, packaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance.

2. Illegal Contraband: for the purposes of this policy, illegal contraband is defined as that subset of materials or articles that meet the definition of contraband, above, and addition, are normally illegal for individuals to possess or use in public places under the laws of the United States and/or California.

3. Restricted Items: restricted items or other items in addition to contraband which could be used for injury to self or others and are, therefore, not allowed to be in the possession of patients on a locked unit. Some examples include: scissors, glass items, drug paraphernalia, blades or safety razors, aerosol cans, mirrors, ropes, shoe laces, soda cans, model glue, plastic bags, unpackaged food and silverware. Other items may be considered restricted at the discretion of the staff.

~~3.~~**4.** Safety Assessment: a procedure, not involving a search of the person by which an attempt is made to find potentially harmful objects and restrict them from the unit milieu.

C. **POLICY**:

1. Patients are entitled to receive, possess, and use personal property while hospitalized, under the conditions and exceptions set forth in this policy. TC~~M~~**HD** Behavioral Health Unit (BHU) is committed to maintaining a safe and therapeutic environment for patients, visitors, and staff. Possession of contraband, as defined above, by patients, and visitors is not authorized while on TC~~M~~**HD** In-patient BHU premises.

2. On the BHU, patients and visitors will be informed through some combination of verbal instruction, written materials and posted signs of unit rules regarding articles which may not be held in their possession.

3. If contraband is noted anywhere on the BHU, employees are authorized to take appropriate action to secure the items. Security is available to assist as necessary with materials or articles suspected to be Illegal Contraband. Security will secure the items and will be responsible for seeing that items of Illegal Contraband are turned over to local law enforcement authorities. Articles of contraband that are not Illegal contraband will be retained by TC~~M~~**HD** security pursuant to **Security Policy: 232 Property Custody**~~TCMC policies applicable to patient valuables (Administrative Policy Manual: Policy 8610-217)~~.

D. **PROCEDURE**:

1. Clothing and Personal Items:

~~i.~~**a.** On admission, all patients will be informed of the reason and rationale for inspecting personal property, and the prohibition of specific items that are not allowed on the ~~PICU~~**BHU** ~~and main unit (both locked)~~.

~~ii.~~**b.** On admission each patient's belongings will be searched **and inventoried**~~,~~ in the presence of the patient or witnessed by another staff member if the patient is unable to be present.

~~iii.~~**c.** All patients will be transported from the Emergency Department **(ED)** to the BHU in a hospital gown and will have their clothing searched in the ED for contraband or restricted items, prior to entering the BHU.

~~iv.~~**d.** All patients who are admitted directly to ~~the unit~~**BHU** and who arrive in street clothing will be asked to change into a hospital gown in a private room, and will have their clothing searched for contraband or restricted items.

~~v.~~**e.** Staff will check patient luggage, bags, billfolds and/or purses for contraband or ~~restricted items~~**restricted items**.

~~vi.~~**f.** Each patient will have a closet/locker in his or her room for the storage of clothing and some personal belongings.

~~vii.~~**g.** Certain personal property will not be kept in patient rooms because of their potential for inducing injury. Secure storage will be provided for each patient with his/her name on it for the safe keeping of belongings that are not permitted in patient rooms. Contents will include items that will be collected after their use and those for which the patient may require one to one supervision during their use.

~~viii.~~**h.** Patients will have access to the times at 0800 hours each day

~~ix.~~**i.** Patients may use the articles from their storage with supervision or independently as is clinically indicated.

~~x.~~**j.** The patient will be permitted to inspect personal property at reasonable times.

~~xi.~~**k.** Examples of items kept in secured storage include the following:

~~1.~~**i.** All glass items **including, but not limited to**, mirrors, perfume, **and** make-up bottles.

ii. Any clothing with drawstrings: sweatpants, running shorts, hoodies, pajamas, etc.

iii. Tobacco items, lighters, or matches.

~~2.~~**iv.** Razor blades and non-electric razors. (Disposable razors are supplied by the unit and ~~their~~ use is supervised)

~~3.~~**v.** Battery operated or cordless electric razors.

~~4.~~**vi.** Belts, neckties, scarves, long jewelry, pins.

~~5.~~**vii.** Nail files, metal combs, metal hair picks, necklaces.

~~6.~~**viii.** Needlework equipment, long strands of yarn, needles, knitting needles, crochet hooks.

~~7.~~**ix.** Certain projects made in craft's groups.

~~8.~~**x.** Spray cans (hairspray).

~~9.~~**xi.** Toxic substances such as hair dye or permanent wave solutions.

~~10.~~**xii.** Pencil and make up sharpeners.

~~11.~~**xiii.** Plastic bags.

~~12.~~**xiv.** Recording devices, pagers, cell phones, cameras.

~~13.~~**xv.** Money in excess of **ten dollar** ($10), checkbooks, credit cards.

~~14.~~**xvi.** Walkman, earphones, headphones (with supervision)

~~15.~~**xvii.** Other items that, in the nurse's judgment, should not be kept in the patient's room.

2. When personal items are taken into possession by the hospital, the patient and a designated individual are provided a copy of the ~~"Receipt for Belongings taken into Possession"~~**Property Custody Record** form that lists these items. A copy of this form is to be placed on the medical record. ~~If the designated individual is not present, a copy of the form may be mailed to that individual upon the request of the patient.~~

~~i.~~**a.** The items will all be returned to the patient at the time of discharge.

~~ii.~~**b.** Whenever possible, items that will not be used during the hospital stay will be sent home with the patient's family.

3. Food:

~~i.~~**a.** Food items will not be allowed in patient rooms due to the possibility of insect infestation.

~~ii.~~**b.** Dietary trays will be permitted in the dining room and patio. Dietary trays are to contain plastic-ware only, excluding plastic knives. Plastic forks will be given out, upon request, and collected by staff after meals.

~~iii.~~**c.** ~~Visitors will be asked to check with staff before bringing in food and beverages to the patient.~~**Food and drinks from outside of the hospital will not be allowed.**

~~iv.~~**d.** No beverages with caffeine will be permitted ~~on the unit~~ except with a written order by the physician/**AHP**.

~~v.~~**e.** The kitchen will be kept locked when not in use.

~~vi.~~**f.** Snacks will be available between meals ~~and in the evening~~ at scheduled times.

~~vii.~~**g.** No cans will be permitted on the unit.

4. If the patient refuses to have contraband or restricted items placed in secure storage ~~per TCMC BHU policy~~, the **Registered Nurse** (RN) will implement a denial of rights per the **Behavioral health Services**~~patient rights~~ Policy: ~~(BHU 6340-614)~~ **Patient Rights**.

~~4.~~5. The ~~MD~~**physician/AHP** or RN will write an order in the patient's medical record documenting the item removed from the patient and the circumstance requiring removal of the item, i.e. patient may not have belt on the unit due to active suicidal ideation.

~~5.~~6. The denial of right order to remove patient's clothing or belongings must be reviewed on a daily basis by the RN and the treatment team and will be removed when the circumstances that justified the denial of right cease to exist.

~~6.~~7. In accordance with Cal.~~ifornia~~ Code Title 9 § 865.1 the notification of the removal of rights must address the following:

- **a.** Date and time the right was denied
- **b.** Specific right denied
- **c.** Good cause for the denial of right
- **d.** Date of review if denial was extended beyond 30 days
- **e.** Signature of the professional person in charge of the facility or his designee authorizing the denial of right

~~7.~~8. The notification can be done at admission by ~~MD~~**physician/AHP** or RN, as designated by the professional person in charge of the facility.

~~8.~~9. The RN will document the denial of right in the patient's electronic medical record (Cerner ad hoc form), and on the Patients' Rights Denial- Monthly Tally hard copy form placed in the back of the medical record.

~~9.~~10. The following items must be inventoried and checked in by staff, but may be retained by the patient **with complete responsibility for safeguarding his or her valuables**:

- ~~i.~~**a.** Toothbrushes, toothpaste tubes, and other non-medication tubes of similar kind.
- ~~ii.~~**b.** Combs, hairbrushes, rollers
- ~~iii.~~**c.** Emery boards, lipstick, mascara and eye shadow that are not in containers with glass mirrors
- ~~iv.~~**d.** Wallets, and personal papers
- ~~v.~~**e.** Jewelry except long or heavy necklaces or pins
- ~~vi.~~**f.** Eyeglasses and saline solution for contact lenses
- **g.** Other items that, in the nurse's judgment will not be injurious to the patient or to other patients on the unit.

E. FORM(S):

~~vii.~~1. **Property Custody Record**

F. RELATED DOCUMENT(S):

1. **Administrative Policy: 217 Disposal of Drugs and Drug Paraphernalia**
~~viii.~~2. **Behavioral health Services Policy: Patient Rights**
3. **Patient Care Services Policy: Medications Brought in by the Patient**
4. **Security Policy: 232 Property Custody**

~~E.~~G. REFERENCE ~~LIST~~(S):

~~2.~~1. **Cal. Code Reg. Title 9 § 865.1**
2. **Cal. Penal Code § 12276**
3. Consent Manual: The Industry Resource for Consent and Related Health Care Law, 38th Ed., 2011.
4. **Drug Paraphernalia Title 21 U.S. Code § 863**

Property Custody Record

Tri-City Medical Center
Security Department

Property Custody Record

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

q Owner: _____

q Other: _____

Location / Reason Property Obtained:

_____

_____

_____

q Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

q Property Returned to Owner
q Property Returned to Other Reason: _____
q Property Destroyed After Thirty(30) Days
q Property Destroyed Before Thirty(30) Days Reason: _____

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Patient Discharge Types
POLICY NUMBER: 704

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for the determination of discharge criteria and their application to the discharge process.

B. **POLICY:**

1. Each individual receiving treatment will be evaluated by applying established severity of illness criteria and in accordance with standards for clinical pertinence. Discharges from the inpatient unit may be of either a clinical or administrative nature. All administrative discharges must be approved by the attending psychiatrist and will be reviewed by the program director.

C. **PROCEDURE:**

1. A patient may be discharged from treatment when it is determined that those goals defined in the treatment plan have been successfully achieved and the patient no longer meets the severity of illness continued stay criteria for the inpatient level of service.
   a. The treatment team will meet daily to discuss the patient's progress toward goal achievement. Each specific patient's treatment plan will be reviewed at least once every week and more frequently as is clinically indicated.
   b. The discharge planners will actively work with patients and their support systems to formulate a viable discharge plan that will be enacted when treatment goals in the inpatient level of service have been met.
2. A patient may be discharged from treatment when, based upon clinical presentation, it is determined that another level of service would better meet the patient's needs.
3. A voluntary patient may be discharged if they are unable or unwilling to continue in treatment.
   a. When a patient requests a discharge against medical advice the clinical staff will attempt to ascertain the patient's reason for wanting to leave the program and will encourage the patient to complete his or her course of treatment.
   b. The attending psychiatrist will be notified when a patient requests to leave the program against medical advice.
   c. When a patient requests an **Against Medical Advice** (AMA) discharge, the clinical staff will continue to work with the patient to assure the best possible discharge plan that includes medications and an appointment for follow-up treatment.
   d. When a voluntary patient asks to leave the program and, in the opinion of the clinical staff, that patient is assessed to be either a danger to self or others, or unable to provide for basic needs, (gravely disabled); the patient may be placed on a 72-hour hold for

further assessment. When this occurs, all applicable forms and advisements will be completed in accordance to the **Patient Care Services** Policy: ~~"~~72~~-~~ Hour Hold~~s~~, **Evaluation and Treatment of the Involuntary Patient.**~~"~~

e. In the event a patient is placed on a 72-hour hold, the patient will be informed of the reason(s) he/she will not be permitted to leave the unit.

4. A patient may be discharged or transferred to another unit or facility if, during the course of treatment they meet exclusionary criteria and therefore present a great health risk to self, other patients, or staff by their continued presence.
   a. When a patient develops an acute medical or surgical condition while on the inpatient psychiatric unit, a medical consult will be completed and the patient may be discharged from the program and admitted to an appropriate medical/surgical unit within the hospital.
   b. When an emergent medical or surgical condition occurs, the patient may be transported to the Emergency Department **(ED)** for immediate evaluation, treatment, and/or disposition.
      i. In this event, the BHU medical record is kept active until such time as it is ascertained that the patient will not immediately return to the Inpatient ~~psychiatric unit~~**BHU**.
      ii. ~~(~~If a BHU patient is taken to the ~~Emergency Department~~**ED** for assessment, is treated, and returns to the BHU, the original BHU record is continued since it is not necessary that the patient is discharged and readmitted to the unit.~~)~~

D. <u>RELATED DOCUMENT(S):</u>

1. **Patient Care Services Policy: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Patient Responsibilities
POLICY NUMBER: 513

ISSUE DATE: 3/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**03/13**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. In order to provide safe delivery of care, treatment, and services, the Behavioral Health Unit (BHU) is entitled to reasonable behavior on the part of patients, within their capabilities, and their families.

B. **POLICY:**

1. It is the policy of BHU to assure each patient is a partner in the health care process as appropriate to his or her abilities.
2. Upon admission, each patient will be given a copy of the Unit Rules and Patient Responsibilities. The Patient Responsibilities are listed below:
   a. As a patient of the BHU, you have the responsibility to:
      i. Provide accurate information. To the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications must be provided. You also must report perceived risks in your care and unexpected changes in your condition.
      ii. Ask questions. When you do not understand your care, treatment, and service, or what you are expected to do, you must ask questions.
      iii. Follow instructions. You must follow the care, treatment, and service developed. Express any concerns about your ability to follow the proposed care plan.
      iv. Accept consequences. You are responsible for the outcomes if you do not follow the plan of care, treatment, or service.
      v. Follow the rules.
      vi. Participate to the best of your ability in the unit groups and activities. Becoming involved in the therapeutic milieu and mingling with your peers is part of recovery.
      vii. Report to a staff member immediately if you feel unsafe or if you feel you might harm yourself, another patient, or a staff member.
      viii. Show respect and consideration. You must be considerate of the BHU staff and property, as well as other patients and their property.
      ix. Meet your financial commitments. You should promptly meet any financial obligation agreed to with the hospital.

C. **PROCEDURE:**

1. The Clinical Staff will be responsible for interpreting patients' responsibilities to them and for assisting patients to meet their responsibilities to the best of their ability.
2. Additional information on patient rights and patient responsibilities will be made available to patients upon request.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Patient Satisfaction Surveys
POLICY NUMBER: 106

ISSUE DATE: 03/08, 03/13
REVISION DATE(S):

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To maintain high quality and consumer responsive care for patients through the application of feedback obtained through the use of patient satisfaction surveys.

B. **POLICY:**

1. Patient satisfaction surveys will be conducted at the time of the patient discharge using valid sampling standards.

C. **PROCEDURE:**

1. A written satisfaction survey will be made available to all patients ~~at the time of~~**prior to** their discharge from the ~~inpatient~~**Behavioral Health Unit (BHU) or Crisis Stabilization Unit (CSU).** ~~psychiatric unit.~~
2. Surveys will be deposited and kept in a secured locked box such that patient confidentiality is maintained.
3. Results of the survey process will be aggregated monthly **and shared at monthly staff meetings**.
4. **The Clinical Nurse Manager will review patient satisfaction survey results and identify areas for improvement** ~~that~~**and the** ~~The minimal overall acceptable standard is equal to or greater than 85% patient satisfaction. If patient satisfaction falls below 85% the~~ department will implement a performance improvement initiative that addresses the area(s) of concern.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Psychiatric Advance Directive
POLICY NUMBER: 719

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide opportunities for patients to have input into the treatment they will receive if they require emergency psychiatric interventions related to out-of-control or aggressive behaviors.
2. To ensure that patients' physical disability and history of abuse are considered when interventions are enacted in response to aggressive behaviors.

B. **POLICY:**

1. Upon admission, or as soon thereafter as possible, each patient will be asked to provide information about situations that may cause their behavior to escalate, their preferences for intervention should escalation occur and any factors that may help the clinical staff determine the safest and most humane manner in which to respond to problematic behaviors.

C. **PROCEDURE:**

1. All clinical staff will be required to attend an eight (8) hour course on N~~n~~on-v~~V~~iolent ~~physical~~ e~~C~~risis i~~I~~ntervention for t~~t~~he purpose of gaining an understanding of the cycle of aggression, verbal de-escalation interventions, and the team approach for managing out of control aggressive or destructive patient behaviors. The class must be completed upon hire, and every year for a four (4) hour renewal course, thereafter. In alternate years the clinical staff will complete a NetLearning module to independently review the course material.
2. Upon admission, as part of the Initial Nursing Assessment, the patient will be asked questions to ascertain the following information:
   a. History of physical or sexual abuse or trauma
   b. Physical or medical limitations or co-morbidities
   c. Events or situations that have caused him or her to become angry, agitated, or violent in the past (triggers)
   d. De-escalation techniques that have been successful in reestablishing control and calm in the past
   e. Preferences for interventions, e.g. quiet time in patient's room, space to pace outside, early use of prn (as needed) medication, use of the quiet room for brief periods, shower, phone call to family member, etc.
3. The information obtained in this assessment will become part of the patient's treatment plan and preferences will be taken into consideration in the event the patient experiences an escalation of aggression.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Release of Information
POLICY NUMBER: 500

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To identify those circumstances that necessitate a consent for release of information.
2. To identify how a patient consents to the release of information.

B. **POLICY:**
1. A separate and individual **Patient Consent Visitation and/or Phone Calls Form**~~Consent for Release of Information~~ will be used to obtain copies of clinical records from any of the patient's previous treatment providers. A **Patient Consent Visitation and/or Phone Calls Form**~~Consent for Release of Information~~ will also be used with each significant individual involved in continuity of care with whom staff members have verbal contact unless information is being shared between two caregivers engaged in the ongoing treatment of the patient. Although obtaining records is not the goal in this instance, consent for the purpose of open communication regarding different aspects of the patient's care is necessary. **Patient Consent Visitation and/or Phone Calls Form**~~Patient Consent for Release of Information~~ does not deny the patient his or her right to confidentiality.

C. **PROCEDURE:**
1. The patient will be told what information will be requested and to whom it will be released. The patient will be afforded an opportunity to discuss the release. The decision to consent must be voluntary.
2. The patient will be informed that they have the right to revoke the release with a written request.
3. If the patient is under conservatorship, the signature of the conservator will be obtained for the purpose of the Consent to ~~Treat and for the administration of~~**Receive** Psychotropic Medications.
4. The patient will be told that provision of treatment is not based on the consent to release information unless the physician/**Allied Health Professional (AHP)** indicates that it is necessary for treatment.
5. The patient will be asked to read the authorization form or will have the form read to him or her and asked if there are questions. The staff member will make a good-faith effort to answer all questions.
6. On each form the specific record(s) to be released will be indicated and the specific purpose of the disclosure will also be provided.
7. The patient will be asked to sign the form and date it indicating the release's expiration date.
8. A witness will sign name, date, and indicate title.

9. The signed form(s) will be placed in the Legal Section of the patient's medical record.

D. **FORM(S):**

~~10.~~1. **Patient Consent Visitation and/or Phone Calls**
~~11.~~2. **Consent to Receive Psychotropic Medication 6340-1001**

Patient Consent Visitation and/or Phone Calls

Your presence here is confidential and cannot be disclosed by staff without your permission. Please list the people you do not want to hear from or see while on the unit.

Do you wish to receive phone calls and/or have visitors? ☐ Yes ☐ No

Do we have permission to talk to your family, friends or significant other? ☐ Yes ☐ No

Please indicate whom we have permission to talk to regarding your care.

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

I DO NOT wish to have my presence here known or receive telephone calls and/or visitation from the following people:

Date	Patient Initial	Name		
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.
		1.	2.	3.

Name: Patient/Representative _____ Signature: Patient/Representative _____ Date ___/___/___ Time ___:___ AM/PM

If signed by a person other than the patient, indicate relationship to patient: _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

Witness – TCHD Representative (print name) _____ Signature _____ Date ___/___/___ Time ___:___ AM/PM

INTERPRETATION / INTERPRETER'S STATEMENT

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI

☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name _____ Interpreter Signature (if present) _____ Date ___/___/___ Time ___:___ AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

Note: Changes can be made to the above list adding or crossing out names. Please sign and date each change.

Affix Patient Label

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

6340-1009
(Rev. 3/17)

PATIENT CONSENT VISITATION AND/OR TELEPHONE CALLS

Consent to Receive Psychotropic Medication 6340-1001

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

INSTRUCTIONS TO PATIENT: The form describes information your physician will provide to you regarding your treatment with Antipsychotic, Psychotropic or Neuroleptic medications. Please read the form thoroughly before you sign it and if you have any questions, ask your physician. **This is a two-sided form.**

My physician has advised me that psychotropic medications are necessary for my treatment and has discussed the following information with me:

Category of Medication and Name of Medication:

☐ Anti-Depressant _____ ☐ Mood-Stabilizer _____
☐ Anti-Anxiety _____ ☐ Anti-Psychotic _____
☐ Hypnotic _____ ☐ Other _____

1. My physician discussed the nature of my medical condition with me.
2. My physician has given me the reason for taking such medications including the likelihood of improving or not improving without such medications and has informed me that my consent can be withdrawn at any time by telling either my physician or member of my treatment team.
3. My physician has told me of any reasonable alternative treatments available, if there are any.
4. My physician has informed me of the type of medications he/she will prescribed for me; how often, in what amount, for how long and by what route (by mouth or injection).
5. My physician has told me of common side effects that may occur when taking these medications, and especially those that I may have because of factors personal to me.
6. My physician has discussed with me any possible side effects, which may occur to patients taking certain categories of medications. Such side effects may include persistent involuntary movement of the face of mouth and might at times, include similar movements of the hands and feet, and that these symptoms are potentially irreversible and may appear after the medications have been discontinued. These medications may also cause restlessness, increased muscle tone, elevated blood sugar, lipids, and weight gain.
7. The general side effect profile(s) of the above medications have been reviewed with me and could include some specifically from the list below. This is not a complete list of all the possible side effects. I consent to the use of the prescribed medication (s). I understand that I can withdraw this consent at any time by informing my physician.

Cardiac conduction changes	Elevated cholesterol/triglycerides	Motor changes/EPS
Changes in blood count	Glaucoma	Nausea/vomiting
Confusion	Headaches	Renal impairment
Diabetes/elevated glucose	Hypothyroidism	Sedation/stimulation
Diarrhea/constipation	Insomnia	Seizures
Elevated blood pressure	Liver inflammation	Stroke
		Weight gain/loss

While I have a right as a patient to refuse to accept these medications, my physician may, in an emergency, order that I be given these medications without my consent. Such an emergency is defined when there is a sudden marked change in my condition leading to a need to protect my life or prevent serious bodily harm to me or to others.

Affix Patient Label

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

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

Page 1 of 2

6340-1001
(Rev 9/15)

I. Having been advised and informed of all of the above by my physician, I consent to receiving these medications as my physician prescribes them.

PATIENT'S SIGNATURE	DATE/TIME	PHYSICIAN'S SIGNATURE	DATE/TIME

II. Patient has been advised of, and understands, ALL the above information and consents to receiving these medications as I prescribe them. However, the patient chooses not to sign this consent form.

PHYSICIAN'S SIGNATURE	DATE/TIME	RN WITNESS	DATE/TIME

III. Patient willing to take medications, however, patients cognitive functioning limits the ability to understand and sign.

PHYSICIAN'S SIGNATURE	DATE/TIME	RN WITNESS	DATE/TIME

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Role of Medical Staff Leadership in Behavioral Health Services**
POLICY NUMBER: **003**

ISSUE DATE: **07/85**
REVISION DATE(S): **02/87, 05/91, 06/94, 06/97, 07/00, 04/02, 07/03, 04/05, 03/13**

Department Approval:	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **POLICY:**

1. In the Behavioral Health ~~Unit~~ Service **(BHS)** ~~Line~~, the Medical Director and Psychiatric Division Chief **will** provide medical leadership and care of psychiatric patients.

B. **PSYCHIATRIC DIVISION CHIEF:**

1. Availability
   a. The Division Chief is available to the Clinical Nurse Manager and nursing staff via direct communication or an as needed basis.
2. Responsibility
   a. The Division Chief shall have responsibility in assisting with standards development/approval, problem identification/solving in patient care issues and in conflict resolution with specific physicians.

C. **MEDICAL DIRECTOR:**

1. Existence/Availability
   a. The Behavioral Health Unit **(BHU)** Medical Director has an annually negotiated contract for services with Tri-City ~~Medical Center~~**Healthcare District (TCHD)**. The Medical Director's responsibilities include:
      i. Providing psychiatric medical leadership for attending/consulting physicians/**Allied Health Professionals (AHP)** and the multi-disciplinary staff.
      ii. Conflict resolution that is intradepartmental or interdepartmental.
      iii. Working collaboratively with the Clinical Nurse Manager to insure all necessary compliance with **Lanterman-Petris-Short Act** (LPS), **Joint Commission** (JC~~HAO~~), Title 22, and State of California/~~Tri-City Medical Center~~**TCHD** regulations.
      iv. Monitoring bed utilization.
      v. Staff development.
      vi. Participating in Quality Assurance/Performance Improvement activities, including standards of development/approval.
      vii. Policy implementation.

D. **HOSPITALIST:**

1. Availability
   a. The Medical Director is responsible for oversight of the hospitalist and is available to the nursing staff as needed. They provide medical care to the supervising physician's/**AHP's** patients under the direction of the physician/**AHP**.
2. Responsibility
   a. The responsibilities of the hospitalist include:
      i. Make daily rounds.
      ii. Record initial history and physical and pertinent progress of the patient on the chart.
      iii. Schedule diagnostic procedures, laboratory studies, x-rays, electrocardiograms, consultations, and transmit verbal orders of the supervising physician (to be countersigned by the physician/**AHP** within 24 hours).
   b. Questions on any orders are to be confirmed by the nurse directly with the physician/**AHP**.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

DELETE – incorporated into Infection Control Policy: Scabies and Lice

SUBJECT: Scabies, Lice, and Fleas in the BHU/CSU
POLICY NUMBER: 404

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/1609/1703/18~~
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

~~A. **PURPOSE:**~~

~~1. To ensure the provision of treatment and to prevent the transmission of infestation in the event of patient and/or staff exposure to scabies, lice and/or fleas in the Behavioral Health Unit (BHU) or Crisis Stabilization Unit (CSU).~~

~~B. **POLICY:**~~

~~1. Patients who are infested with scabies, lice and or fleas will be treated in accordance with established hospital Infection Control **Policy: Scabies and Lice** policy (AP&P 400).~~

~~2. Transmission:~~

~~a. Scabies is a parasitic disease (infestation) of the skin caused by the human itch mite, *Sarcoptes scabiei.* Scabies is generally transmitted to by direct skin-to- skin contact with an infested patient. Activities such as performing physical assessments or, bathing and changing a patient's soiled linen are conducive to transmission because physical contact is often prolonged. The mite can only survive for a few hours on inanimate objects such as dry surfaces, clothing or bedding.~~

~~b. Lice are ectoparasites, which infest head and body and may result severe itching. Lice are host specific and those of animals do not infest humans. Transmission requires direct contact with an infested person and objects used by them (for example, shared clothing and headgear).~~

~~c. Fleas are external parasites are generally found on or in the skin and are important pests because they bite or annoy both humans and their pets. Fleas are small (1/16"), dark, reddish brown, wingless, blood sucking insects. Their bodies are laterally compressed, (i.e., flattened side to side) permitting easy movement through the hairs on the host's body. Their legs are long and well adapted for jumping. They are known to jump 7-8 inches vertically and 14-15 inches horizontally. The flea body is hard, polished, and covered with many hairs and short spines directed backward. The mouthparts of an adult flea are adapted for sucking blood from a host.~~

~~3. Infestation:~~

~~a. Scabies: Following an incubation period of 2 days to 6 weeks, the infested person will complain of itching, which intensifies at bed time under the warmth of blankets. In previously infested persons, itching may be noticeable as soon as 48 hours following infestation. In typical scabies, the rash is generally characterized as red, raised bumps~~

(papules). Skin lesions are generally seen on the hands, wrists, elbows, and folds of armpits, female breasts or the male genitals.

b. Lice: Under optimal conditions, eggs hatch within 7–10 days. Body and head lice survive for a week without feeding off the host, crab lice only 2 days. Nymphs survive only 24 hours without food.

c. Fleas: Fleas vary in life cycles from 2 weeks to 2 years. Fleas lay eggs while on the host, then the eggs drop off into carpet, bedding, furniture, or onto the floor. After a few days, the eggs hatch into very small, legless larvae. Partly digested blood that flakes continuously from a flea infestation patients/pets is the main food source for larvae. The bites can cause intense itching often resulting in secondary infection. The usual flea bite has a small red spot where the flea has inserted its mouthparts. Around the spot there is a red halo with very little swelling.

C. **PROCEDURE:**

1. Standard Precautions should prevent the transmission of most cases of scabies, lice and fleas. If an exposure to a patient with scabies, lice and/or fleas occurs before Contact Precautions are applied and the patient is treated the employee should:
   a. Report and document exposure of staff as per **Infection Control Policy: Scabies and Lice**AP & P 400.
   b. Follow all treatment guidelines.
2. Contact the patient's physician/**Allied Health Professional (AHP)** to specific treatment orders for the patient.
3. Employees who are symptomatic will be referred to Work Partners for treatment. In this instance, all caregivers will be treated even if they are not symptomatic. Employees and their patients should be treated at the same time.
4. Follow up treatments are not necessary unless re-exposure or symptoms persist.
5. A clinical note will be made in the patient's chart documenting interventions, treatments and response.
6. Treatment of the BHU environment may follow the common guidelines. Place the patient in a single room as soon as possible. Isolate the patient as much as possible from other patients and staff to minimize transmission. Housekeeping should be contacted for a deep cleaning.
   a. Scabies: While scabies is readily transmissible with skin-to-skin contact, the mite can only survive in the environment for 48 hours without a human host. The bedding and clothing of the patient may contain viable mites, but exposure to a human host must occur within a short period of time for transmission to occur. Vacuuming and general cleanliness should provide adequate environmental control. Fumigation is not necessary; furniture should not be discarded. Clothing or bedding used by the patient during should be laundered and dried with the hot cycle. Items that cannot be laundered or dry-cleaned should be placed in a plastic bag and sealed for seven days to allow time for mites and eggs to die. Isolate patient until treatment has been completed.
   b. Lice: While the majority of head lice are transmitted directly from person to person, to control any head lice that are temporarily surviving off of a human host, you should: Wash bedding in hot water and dry in a hot dryer or iron with a hot iron. Wash and dry recently worn clothing (including coats, caps and scarves) in hot temperatures. Clothing or bedding that cannot be washed may be dry cleaned or sealed in a plastic bag for two weeks (the plastic bags contain the lice until they are dead, and prevent head lice from temporarily infesting these items again while the treatment process is taking place. Clean floors, carpeting and furniture by thorough vacuuming. Cleaning efforts should occur on the day of the first head lice treatment, and subsequently whenever live lice are found on the patient's head during the daily inspections.
   c. Fleas: These flakes will turn red when moisture is applied to them. Frequent, rigorous vacuuming and disrupting of flea breeding sites can help greatly in indoor flea control. Vacuum under furniture, cushions, chairs, beds, and along the edges of walls, this is a favorite flea breeding site. Be sure to discard your vacuum cleaner bag or dump the

container contents immediately after cleaning. Fleas can develop inside a vacuum cleaner bag and can re-infest the area.

RELATED DOCUMENT(S):

d. **Infection Control Policy: Scabies and Lice**

REFERENCE(S):

1. Control of Communicable Diseases Manual, D.L.Heymann, Ed. 18th edition, 2004
2. 1. APIC Text of Infection Control and Epidemiology, revised edition, 2005

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Scope of Service – Behavioral Health Unit**

ISSUE DATE: **10/11**
REVISION DATE(S): **11/13, 03/13**

Department Approval:	~~06/16~~**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **GOAL(S):**

1. To provide individualized quality patient care in a safe environment.
2. To reduce complications and unexpected outcomes.
3. To continuously evaluate and improve the service provided.
4. To participate in multi-disciplinary care by working closely with other disciplines.
5. To provide individualized treatment to promote mental health and substance use recovery.
6. Patients will be given the opportunity to increase their involvement in the therapeutic milieu and to discuss their issues and concerns in a daily meeting that includes other patients and members of the treatment team.

B. **BRIEF DESCRIPTION OF SERVICE:**

1. The inpatient service offers psychiatric treatment for a variety of acute states of mental illness with 24 hour care. A**n eighteen (18)** ~~29~~ bed intensive care unit accommodate patients with an immediate need for acute psychiatric services. Admission to the unit is typically via ~~the Medical Center~~**Tri-City Healthcare District's (TCHD)** Emergency Department **(ED)** or by physician/**Allied Health Professional (AHP)** referral. The **Behavioral Health Unit** (BHU) staff includes a multi-disciplinary team of psychiatrists, psychologists, licensed marriage and family therapists (MFT), licensed clinical social workers, registered nurses, recreational therapists, licensed psychiatric technicians, mental health workers, and supervised MFT interns and trainees who collaborate to help individuals achieve recovery goals.

C. **METHODS USED TO ASSESS PATIENTS' NEEDS:**

1. Treatment is planned, implemented and evaluated by an interdisciplinary team comprised of mental health clinicians, the patient, and the patient's family or legal representative. All patients will receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized. Patients receive treatment in the least restrictive environment based on assessment of the clinical needs. The program maintains mechanisms by which patients move between the available levels of service within the department and in the community.
   a. All patients who are admitted to the program will routinely have an admission psychiatric assessment, physical assessment, nursing assessment, psychosocial assessment, and activity therapy assessment.
   b. Patients are considered members of the treatment team and will be asked to provide information regarding their concerns, needs, limitations, physical health needs, pre-existing conditions and preferences as part of the assessment process.

c. Information from all assessments, including input from the patient, will be used in the formulation of the patient's individualized treatment plan that includes provision for ensuring the patient's safety when there are co-morbid medical conditions, physical limitations, or other safety issues.
d. The interdisciplinary treatment plan is formulated and altered based on the assessment data collected by each member of the treatment team.
e. The clinician will use all available clinical resources to gather assessment data including but not limited to the patient's subjective report, objective observations, written information from laboratory and diagnostic testing, past medical record information, and information from family and significant others.

D. **SCOPE AND COMPLEXITY OF SERVICES:**

1. Mental health practitioners who are licensed and registered in accordance with their discipline specific requirements will provide clinical treatment. The ~~Behavioral Health Department~~**BHU** will develop and implement competency standards to insure that clinicians have the requisite skill, knowledge, experience and education to provide services. The department will maintain a description of its scope of care, services provided, type of individuals served and the important aspects of care. Patients will be treated in the least restrictive environment; treatment intensity will be determined on the basis of the severity of the patient's symptoms and the assessment of the patient's treatment needs.
2. An interdisciplinary team led by the psychiatrist and comprised of members of other disciplines including but not limited to psychologists, registered nurses, licensed psychiatric technician, recreational therapists, licensed clinical social workers, ~~marriage and family therapists (~~MFT~~)~~, mental health workers, and supervised MFT interns and trainees will deliver services. The patient and his or her family, conservator, significant other and or primary care giver will be considered vital members of the team and will be included in the assessment, treatment planning and evaluation processes.
3. Treatment will occur within the context of a therapeutic milieu in which activities are purposefully planned and executed to meet the needs of patients. Biweekly clinical collaboration meetings reflect one form of information exchange between disciplines and interdisciplinary care. Team conferences are also scheduled on an individual basis as needed. Types of treatment available include but are not limited to:
   a. Individual Psychotherapy
   b. Group Psychotherapy
   c. Family Psychotherapy
   d. Psychopharmacology

E. **ADMISSION CRITERIA-TYPE AND AGES OF PATIENTS SERVICED:**

1. Adults who are referred for admission to the Inpatient ~~Behavioral Health unit~~**BHU** must meet DSM **V** ~~IV-R~~ Severity of Illness criteria, have a primary psychiatric diagnosis, and be able to derive benefit from the therapeutic milieu. Patients will be considered inappropriate for admission if they meet any of the following exclusionary criteria:
   a. Under age **eighteen (18)**.
   b. Primary Substance abuse diagnosis.
   c. Primary dementia diagnoses.
   d. Co-existing medical condition(s) requiring care by nursing staff with specific medical surgical nursing competencies including but not limited to:
      i. Intravenous **(IV)** Medication
      ii. Indwelling Catheter
      iii. Tracheostomy
   e. Individuals with developmental disabilities of such a degree that they are unable to participate in daily unit activities.
      i. Unstable medical condition, i.e. chest pain, acute infectious disease, uncontrolled hypertension or blood glucose levels.

F. **STAFFING AND THE AVAILABILITY OF STAFF:**

1. ~~The unit~~**BHU** is staffed with a clinical nurse manager, two assistant nurse managers **(ANM)**, registered nurses **(RN)**, a licensed psychiatric technician, licensed clinical social workers, ~~marriage family therapists~~**MFTs**, recreation therapists, and mental health workers. The clinical nurse manager has 24-hour responsibility for patient care and unit management Staff work 8-hour and 12-hour shifts.

G. **SCOPE OF SERVICE:**

1. The ~~Assistant Nurse Manager (~~ANM~~)~~ or Charge RN will make staff assignments according to patient acuity, staff availability, individual staff competencies, and the amount of supervision needed by staff members in accordance with Title 22 Regulations. Patient acuity and specific patient needs are determined for each patient by the nurse for each shift, and then used for staffing. The staffing matrix provides information about staff/staff mix requirements based on acuity and minimum staffing requirements. Minimum staffing requirements provide a nurse/patient ratio of 1 RN for every 6 patients .The Clinical Nurse Manager/ANM will confer if additional staff is needed based on acuity.
    a. BLS, Non Violent Crisis Intervention or equivalent **managing aggressive behavior** (MAB) training are required of all nursing personnel working on the unit. Initial and annual competency requirements for staff are defined and updated on a yearly basis at Skills Lab and unit based training. Competency requirements for 5150 designee or face-to-face one hour assessment for the specially trained RN is done annually at Skills Lab and unit based training.

H. **ASSESSING DEPARTMENT SERVICES:**

1. The unit is a 24-hour, 7-day-a-week service. If a patient needs a higher level of care, physicians/**AHPs** and nursing staff coordinate the transfer to an appropriate facility with assistance of case management as appropriate.

I. **THE EXTENT TO WHICH THE DEPARTMENT'S LEVEL OF CARE/SERVICE MEET PATIENT NEEDS:**

1. The level of care provided by the Acute Inpatient ~~Behavioral Health Unit~~**BHU** meets the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

J. **PERFORMANCE IMPROVEMENT:**

1. In order to improve patient care, the inpatient ~~behavioral health unit~~**BHU** has implemented a **performance improvement** (PI) committee that will address high risk indicators and research quality measures to improve overall safety and patient care outcomes.

K. **STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:**

1. The nursing service abides by regulations by California Title XXII Standards: Psychiatric Unit General Requirements, Comprehensive Accreditation Manual for Psychiatric Health Care, The Joint Commission, **Centers for Medicare and Medicaid Services (~~HCFA~~CMS)** Regulations, ~~CMS,~~ Welfare and Institutions Code § 5150, and **California Board of Registered Nurses** (BRN).

L. **MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:**

1. Medications, general and narcotics, are dispensed via the Pyxis system. Daily patient doses are stored and dispensed from the locked profile machine. Medications requiring refrigeration are stored at the appropriate temperatures. Nurses assess and document the administration/effectiveness/side effects of medication.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Non-Smoking Environment
POLICY NUMBER: 406

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~02/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To communicate the prohibition of smoking, offer Nicotine Replacement Therapy for patients to decrease or stop nicotine intake, and implement a smoke free environment at Tri-City **Healthcare District (TCHD)** Behavioral Health Unit (BHU) **and Crisis Stabilization Unit (CSU)**. All patients, work associates, families and visitors are expected to comply with the smoking regulations.

B. **DEFINITION(S):**

1. Smoking: any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, cigarette, chewing tobacco, snuff, electronic cigarettes, in any form.

C. **POLICY:**

1. As part of ~~Tri-City~~**TCHD**'s commitment to provide a healthy environment for patients and work associates, smoking is prohibited indoors and on the Behavioral Health Services **(BHS)** patios owned or operated by ~~Tri-City~~**TCHD** ~~Behavioral Health Services~~**BHS** for all persons, including patients, staff, and visitors.
2. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving care within **the BHU or CSU**~~Inpatient Behavior Health Unit~~. Compliance with this policy is mandatory and will be strictly enforced. Findings will be reported as needed to clinical managers, **Assistant Nurse Managers** (ANMs), charge nurse, or the hospital safety committee to develop strategies to eliminate the incidence of policy violations.
3. As part of each patient's individual assessment by the attending provider, the various options for helping that patient avoid the distraction and discomfort of smoking cessation will be addressed. This will allow the patient to better focus on the primary psychiatric reason for their hospitalization.
4. When each patient is admitted, the patient should be educated by the admitting nurse on the **Administrative Policy: 205** ~~no~~ Smok~~inge~~**-Free Environment**~~policy~~, the Nicotine Replacement Therapy, and health information about smoking.
5. All patients will be requested to turn in their smoking materials upon admission; these are considered contraband and will be returned at discharge. Any materials found on the unit will be confiscated by staff and returned to the patient at discharge.

6. Visitors are not to bring in cigarettes or other tobacco products. Patients, visitors, and any other guests who fail to comply with this policy may result in termination of visiting privileges and will be reminded that Inpatient BHU is a smoke-free department and will be advised of resources available to assist with compliance while they are on the unit.
7. Smoke breaks are being replaced with healthy breaks, outdoor scheduled activities per unit schedule under direct staff supervision.

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

1. **Administrative Policy: 205 Smoke-Free Environment**
2. **Administrative Policy: 234 Security Department Incident Notification**
3. **Administrative Policy: 424 Coaching and Counseling for Work Performance**

~~D.~~E. **REFERENCE ~~LIST~~(S):**

~~1. Administrative Policy 8610-205: Smoke-Free Environment~~
~~2. Administrative Policy 424: Coaching and Counseling for Work Performance Improvement~~
~~3. Administrative Policy 234: Security Department Incident Notification~~

~~4.~~1. Centers for Disease Control and Prevention. *Healthy Workforce Initiative:* Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.**cdc**.gov/nccdphp/dnpa/hwi/toolkits/**tobacco**/index.htm

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Solicitation of Patients/Referrals to Self
POLICY NUMBER: 518

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To specify parameters with respect to the solicitation of patients or referrals to self.

B. **POLICY:**

1. Tri-City ~~Medical Center~~**Healthcare District (TCHD)** employees and contracted employees will not refer patients, directly or indirectly to their private practices.
2. ~~Tri-City Medical Center~~**TCHD** employees and contracted employees will not, directly or indirectly, approach, solicit or suggest to any patient or patient's representative that the patient should or must see such employee on any basis outside the program for additional care or therapy, with the exception of those patients who were seen in a therapist's private practice prior to the patient's admission. In such cases, referrals back to the therapist's private practice are acceptable, if deemed clinically appropriate.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Telephone Use
POLICY NUMBER: 519

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide guidelines that describes patient access to the telephone during inpatient hospitalization **or admission to the Crisis Stabilization Unit (CSU).**

B. **POLICY:**

1. Patients are entitled to unimpeded private and uncensored communication with others by telephone. Telephone communication may be restricted if warranted by documented circumstances.

C. **PROCEDURE:**

1. Patients will be informed of all rights related to telephone use upon their admission to the unit.
2. Telephones will be available for patient use. Patient telephones are cordless, rechargeable phones. Posted times for telephone calls will be in all telephone areas and on bulletin boards. Patients may use the telephone outside of these times with the permission of the treatment team, depending upon the prevailing circumstances.
3. Patients will have unlimited access to the telephone within the posted hours.
4. Upon request from a patient in seclusion or restraint, staff may make at least **two (2)** telephone calls a day on behalf of the patient.
5. The clinical staff will insure that the use of the telephone does not interfere with a patient's treatment. Problems observed will be directed first to the patient's assigned nurse and then to the assistant nurse manager **(ANM)** for resolution.
6. The patient's right to communicate by telephone will not be limited except as authorized in the patient's treatment plan. The rationale for any limitation will be documented. A limitation on telephone use may be imposed as follows:
   a. To prevent violation of the law.
   b. To prevent substantial and/or serious physical or mental harm to the patient or others.
   c. To prevent reasonably expected future telephone harassment by a patient or an individual previously harassed and who has complained. A limitation to prevent harassment will require a written request from the victim of the harassment to limit the patient's telephone use. The written request will also describe the frequency or content of past calls that were considered harassment.
   d. When excessive use of the telephone prevents the patient from participating in therapeutic programming.

7. A patient will be promptly informed of any telephone use limitation and a limitation of rights form will be completed in the ~~Denial of Rights~~**Right of Behavioral Health Patients** Form ~~(~~**per Behavioral Health Services** Policy: ~~6340-614: Patient Rights)~~. On request, the patient will be informed of the purpose a limitation is intended to achieve, the persons or entities involved and additional information as deemed appropriate.
8. The treatment team will review limitations on a daily basis.
9. A limitation on telephone rights will not apply between a patient and an attorney or a court or between a patient and other individuals if the communication involves matters that are or may be the subject of legal inquiry.
10. The patient may appeal any limitation to the Patient Advocate's office.

D. FORM(S):

~~11.~~1. **Right of Behavioral Health Patients 8340-1007**

E. RELATED DOCUMENT(S):

~~12.~~1. **Behavioral Health Services Policy: Patient Rights**

Right of Behavioral Health Patients 8340-1007

Each patient, resident or client in this facility has the following rights:

(a) To wear his own clothes; to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.
(b) To have access to individual storage space for his private use.
(c) To see visitors each day.
(d) To have reasonable access to telephones, both to make and receive confidential calls.
(e) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
(f) To refuse convulsion treatment including, but not limited to, any electroconvulsive treatment, any treatment of the mental condition which depends on induction of a convulsion by any means, and insulin coma treatment.
(g) To refuse psychosurgery.
(h) To refuse antipsychotic medication.
(i) Other rights as specified by regulation. (Section 5325, W & I Code)

The professional person in charge of the facility or his designee may, for good cause, deny any of the rights under (a) to (e), inclusive. If you believe that one of your rights was denied without a good reason, you may call the Patients' Advocate who must respond to your complaint within two working days.

Patient Advocacy Program	(619) 282-1134 or 1 (800) 479-2233	24 hours
Name	Phone	Hours

You may call collect from North County.
It is his responsibility to investigate and resolve your complaint to your satisfaction. If he is unable to do so, the complaint must be referred by him to the local mental health director. After that, if the problem is still not resolved, it must be referred to the Patients' Rights Specialist, State Department of Health, Sacramento. If you are unable to locate a Patients' Advocate, you may contact:

California Office of Patients' Rights
1831 K Street • Sacramento, CA 95811
Telephone: 916-575-1610 • Fax: 916-575-1613
COPRinforequest@disabilityrightsca.org

(This notice must be posted, as well as distributed to each mental patient admitted in state hospitals, health facilities and community care facilities.)
No person may be presumed incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether voluntarily or involuntarily received. (5331 W. I Code). I understand the Patient's Rights as stated above.

Patient Signature	Printed Name	Date	Time
Witness Signature	Printed Name	Date	Time

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

8340-1007
(Rev 7/14)

RIGHT OF BEHAVIORAL HEALTH PATIENTS

White - Chart Yellow - Patient

Affix Patient Label

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Treatment of Patients
POLICY NUMBER: 721

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13, 06/16

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To ensure that the treatment of patients is conducted in compliance with all applicable guidelines and standards.

B. **POLICY:**
1. Treatment is planned, implemented, and evaluated by an interdisciplinary team comprised of mental health clinicians, the patient, and the patient's family or legal representative. All patients will receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized. Patients receive treatment in the least restrictive environment based on assessment of the clinical needs. The program maintains mechanisms by which patients move between the available levels of service within the department and in the community.

C. **PROCEDURE:**
1. Mental health practitioners who are licensed and registered in accordance with their discipline specific requirements will provide clinical treatment.
2. The Behavioral Health ~~Department~~**Unit (BHU)** will develop and implement competency standards to insure that clinicians have the requisite skill, knowledge, experience, and education to provide services.
3. ~~The department~~**BHU** will maintain a description of its scope of care, services provided, types of individuals served, and the important aspects of care.
4. Patients will be treated in the least restrictive environment; treatment intensity will be determined on the basis of the severity of the patient's symptoms and the assessment of the patient's treatment needs.
5. An interdisciplinary team led by the psychiatrist and comprised of members of other disciplines will deliver services. The patient and his or her family, conservator, significant other and or primary care giver will be considered vital members of the team and will be included in the assessment, treatment planning, and evaluation processes.
6. Treatment will occur within the context of a therapeutic milieu in which activities are purposefully planned and executed to meet the needs of patients.
7. Types of treatment available include but are not limited to:
   a. Individual Psychotherapy
   b. Group Psychotherapy
   c. Family Psychotherapy
   d. Psychopharmacology

e. Diagnostic Evaluation
f. Milieu Therapy
g. Psychoeducation
h. Activity Therapy
i. Life Skills Management

8. The clinical team includes but is not limited to:
   a. Psychiatrists
   b. Psychologists
   c. Nurse Practitioners
   ~~c.~~**d.** Social Workers
   ~~d.~~**e.** Marriage and Family Therapists **(MFT)**
   ~~e.~~**f.** MFT Interns and Trainees
   ~~f.~~**g.** Registered Nurses **(RN)**
   ~~g.~~**h.** Recreational Therapist
   ~~h.~~**i.** Psychiatric Liaisons
   ~~i.~~**j.** Mental Health Workers
9. Patients may make transitions from one level of care to another based on the severity of their symptoms and clinical needs. When an internal transfer occurs between the inpatient unit and the intensive outpatient program:
   a. The decision will be made collaboratively by the treatment team and will include the patient and significant other in the decision making process.
   b. Clinical information will be shared between the sending and receiving program by:
      i. Telephonic Report
      ii. Faxed Assessments and Most Recent Treatment Data
      iii. Completed Transfer Packet with Pertinent Information
      iv. Completed Problem List
      v. Medication Reconciliation Reports
   c. In some instances the patient will be more formally referred to another service. In these instances a designated staff member from the receiving program will meet with the patient and significant other and review clinical data before making a decision about acceptance. The decision will be made on the basis of program admission criteria (including exclusion criteria) and the patient's willingness/desire to participate in the program
   d. Documentation in the medical record will include the clinical justification for the transition.
10. Patients may be discharged to an outside agency based upon clinical need.
   a. At the time of discharge the patient and/or significant other will be given referral information including appointment times and contact persons.
   b. Patients will be discharged or transferred to other agencies in keeping with established policy addressing such items as transportation arrangements, completion of transfer summaries, and notifications to receiving agency, medication reconciliation, insurance information, and authorization information.
11. Staff members will maintain therapeutic boundaries in all relationships with patients.
   a. Relationships will be patient-centered and based upon the identified needs of the patient.
   b. Staff members will not engage in personal, social, or sexual relationships with patients who are on the unit.
   c. Staff members will be discouraged from establishing personal, social, or sexual relationships with patients after their discharge from the unit.
   d. Staff members will not share information with patients about their personal problems, seek advice from patients, or otherwise engage in interactions that are focused on the needs of the staff member rather than the needs of the patient.
   e. In the event that a patient with whom a staff member currently has or has had a personal, social or sexual relationship is admitted to the unit, the staff member will be

responsible for disclosing the existence of that relationship to his or her immediate supervisor as soon as it is discovered:

i. The staff member may be floated to another area of the hospital for the duration of the patient's hospitalization to preserve the patient's right to privacy and confidentiality and to avoid real or perceived conflicts of interest.
ii. This will include but is not limited to spouses/ significant others, children, siblings, other relatives, friends or acquaintances.
iii. This will not include patients with whom the staff member has had a therapeutic relationship with in another treatment setting.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Unit Staff Meetings**
POLICY NUMBER: **104**

ISSUE DATE: **03/08**
REVISION DATE(S): **08/09, 03/10, 03/13, 06/16**

Department Approval:~~n/a~~	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish guidelines for the program staff meetings

B. **POLICY:**
1. The Inpatient Behavioral Health Unit **(BHU), Crisis Stabilization Unit (CSU), and Psychiatric Liaison Team** will have staff meetings and clinical problem solving meetings at least **every two (2) months~~;~~ or semimonthly** ~~monthly~~, and more frequently as are indicated.

C. **GUIDELINES:**
1. The Clinical Nurse Manager of Behavioral Health Services **(BHS)** will conduct general staff meetings once per month. All staff members are expected to attend **or call in to the conference telephone.**
   a. The purposes of the general staff meetings are:
      i. To give staff the opportunity to discuss program administrative issues and day-to-day operations.
      ii. To encourage staff to participate in decision-making.
      iii. To provide information.
      iv. To provide educational updates and roll-outs.
      ~~iv.~~**v.** To keep communication lines open between clinical staff and administration.
      vi. To discuss ongoing program performance, improvements,~~and~~ safety issues**, and quality improvement measures.**
      ~~v.~~**vii. To invite guest speakers and in-service training related to new medications, community resources, or other related services.**
   b. Staff will be encouraged to submit agenda items prior to the meeting.
   c. BHU Safety representative will submit agenda items and share applicable info from hospital safety meetings.
   d. Minutes will be taken and circulated to those who were unable to attend within **ten (10)** days of staff meeting. Past minutes will be kept on file, in a binder in the administrative assistant office. Monthly minutes will be posted in the staff lounge.
2. The Clinical Nurse Manager will facilitate Assistant Nurse Manager **(ANM)** meetings biweekly.
   a. The purposes of the ~~Assistant Nurse Manager~~**ANM** meetings are:
      i. To provide encouragement and support to ~~Assistant Nurse Managers~~**ANM.**
      ii. To encourage team-building, information sharing and communication.

iii. To encourage consistency between shifts and within shifts.
iv. To develop leadership and management skills.
v. To review employee~~/patient rounding, and stop light report progress~~ **related issues.**
vi. To review patient related issues.
vii. To review RL Solutions.

b. All ~~Assistant Nurse Manager~~**ANM**s are encouraged to attend each meeting.

~~a. Minutes will be taken and circulated by the administrative assistant to Clinical Nurse Manager and Assistant Nurse Managers.~~

c. The ~~Assistant Nurse Manager~~**ANM** will meet prior to the monthly general staff meeting to preview the agenda and make suggestions. The administrative assistant will coordinate the agenda items between the Clinical Nurse Manager, **the Psychiatric Liaison Supervisor,** ~~Assistant Nurse Manager~~**ANM**s, and the Clinical Educator via email.

3. ~~Shared Governance Committee~~**Professional Nursing Governance Committee (PNGC):**

a. Professional **Practice and** Development **Council** (PPDC):
i. The purposes of this meeting are to maintain BHU educational standards that promote nursing professional development and ongoing clinical competency and quality.
ii. To establish and promote relationships and partnerships among all types of community organizations, such as NAMI Walk, Meeting of the Minds and Depression screenings.
iii. To encourage communication of best practices, improvement, and evidence-based nursing practice (EBP) by participating and attending educational activities and Journal Club.
iv. To act as a resource for other communities of practice.
v. To encourage and provide educational advancement to all staff including mental health workers (MHW), recreational therapists (RT), social workers (SW), and marriage family therapists (MFT).
vi. Promote continuous improvement in the quality of patient care
vii. Develop, implement, and evaluate BHU and service performance improvement efforts.
viii. To ensure evidence-based practice (EBP)
~~v.~~ix. To communicate performance improvement findings, recommendations, and collaborate with the other councils to ensure dissemination of comprehensive quality data to direct-care staff personnel.

b. Nursing Leadership/**Quality** Council (NL**QC**)::
i. The purposes of this meeting are to encourage the professional development of nurses at all levels to empower them to contribute to the decision-making process related to practice in strategic planning, advocacy and influence, visibility, and communication.
ii. To facilitate excellence and promote positive patient outcomes.
iii. To support and guide changes in work environment and patient care based on input and collaboration with nurses at every level.

c. ~~Nursing Practice (NP):Practice Committee~~**Nursing Informatics Council (NIC):**
i. The purposes of this meeting are to ensure consistency in standards of nursing practice.
ii. To assure nursing practice and standards are evidence-based and consistent with current research and national standards of nursing practice.
iii. To integrate care delivery systems within the professional practice models to promote and support delivery of nursing care.

~~d. Nursing Performance Improvement/Quality (NPIQ): Performance Improvement Quality Committee~~

~~i. The purposes of this meeting are to promote continuous improvement in the quality of patient care~~

~~ii. To develop, implement, and evaluate BHU and service performance improvement efforts.~~
~~iii. To ensure evidence based practice (EBP)~~
~~iv. To communicate performance improvement findings, recommendations, and collaborate with the other councils to ensure dissemination of comprehensive quality data to direct care staff personnel.~~

4. Clinical Program Meetings:
   a. The Clinical Nurse Manager will facilitate a bi-annual (twice a year) meeting of senior clinical staff including representatives from social work, recreational therapy, nursing, psychiatric liaisons, marriage family therapists/interns and nursing education
   b. The purposes of the meeting are:
      i. To assess clinical programming **and group schedule.**
      ii. To develop new program components.
      iii. To share ideas for improving patient care.
      iv. To encourage team-building among clinical staff.
   c. Information discussed at the Clinical Leadership Meetings will be included on the general staff meeting agenda.
5. Psychiatric Liaison/~~**Crisis Stabilization Unit**~~**CSU**~~, BHU Emergency Department~~ Meetings:
   a. The Psychiatric Liaison Supervisor will facilitate a monthly staff meeting. All **CSU staff and** psychiatric liaison **team members**~~s~~ are expected to attend or access conference telephone. The BHU Clinical Nurse Manager and ~~ED Manager/Director~~**ANMs** will also attend to provide leadership and support to the psychiatric liaison team.
   b. The purposes of the meeting are:
      i. To give the staff opportunity to discuss day-to-day operations.
      ii. To provide information.
      iii. To provide education updates and roll-outs.
      ~~iii.~~**iv.** To review clinical cases for the benefit of training and education.
      ~~iv.~~**v.** To encourage team building, information sharing and communication.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: **Utilization Management**
POLICY NUMBER: **107**

ISSUE DATE: **03/08**
REVISION DATE(S): **08/09, 03/10, 03/13**

Department Approval:	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide a system and processes that enable qualified professionals to systematically review medical records to ensure that quality of care standards are maintained and that the intensity of care services available at the Inpatient ~~and outpatient level~~**Behavioral Health Unit (BHU)** are **to** provide~~d~~ exclusively to those individuals who meet the accepted industry severity of illness criteria for those levels.

B. **POLICY:**

1. A systematic and routine review of medical record documentation will be conducted in the ~~Behavioral Health Service~~**BHU** on an ongoing basis to ensure that patients are receiving care at the appropriate level of intensity in relation to the acuity of their symptoms.

C. **PROCEDURE~~GUIDELINES~~**

1. Authorization to Perform Utilization Review~~: will be~~
   - ~~1.~~**a.** ~~I~~Limited to assigned ~~M.D.~~**physician/Allied Health Professional (AHP), nurse practitioner,** registered nurse **(RN), marriage and family therapist** (MFT), case manager, social worker or psychologist who have training in documentation review and knowledge of the relationship between severity of illness and intensity of service criteria.
   - ~~a.~~**b.** Behavioral Health Department Utilization Review:
     - i. If a denial is received, the reviewer staff will immediately notify the attending physician**/AHP** and will attempt to provide the attending physician**/AHP** with the payer's contact person's name (preferably their physician advisor) and phone number, should she/he choose to immediately appeal the denial.
     - ii. In all cases, the decision to discharge a patient is solely in the purview of the attending physician**/AHP**.
   - **c.** Retrospective Review:
     - ~~b.~~**i.** ~~m~~**M**ay be performed in the following circumstances:
       - ~~i.~~**1)** Problem cases not identified by concurrent review mechanism,
       - ~~ii.~~**2)** Random sampling of cases to pick up situations that are new,
       - ~~iii.~~**3)** To address cases of inappropriate utilization,
       - ~~iv.~~**4)** Review of cases for which third-party payers question or deny care, and/or
       - ~~v.~~**5)** When required by a third-party payer.
   - **d.** Focused Review:

i. A focus review is review of known or suspected specific problems.

~~c.~~ii. The Utilization Review Committee may initiate focused review of records and approve sampling the methods. The focused review will apply to all patients regardless of payment source and may be based on diagnosis, procedure, admission, duration of stay, physician/**AHP** or ancillary services furnished, Diagnostic Related Groups, delay of services, and all professional services performed on the hospital premises with respect to the medical necessity for these services. Cases denied for payment by third-party payers are also included. Activities as such will be reported to the Quality Assurance Committee.

~~d.~~e. The Utilization Review staff may identify cases that are associated with unusually high costs or excessive services, or identify classes of admission wherein patterns of care are found to be questionable. Patterns of resource utilization may be evaluated on a retrospective basis as a part of the overall evaluation of the utilization

~~1. Reporting to Hospital Utilization Review Committee: A member of the Department Utilization Review will be appointed to attend the Hospital Utilization Review Committee on a regular basis. The member will communicate relevant studies, ongoing concerns, and progress toward assuring appropriate utilization of services.~~

2. Conflict of Interest:
   a. A physician/**AHP** may not participate in the review of any case in which he/she has been or anticipates being professionally involved. Physicians/**AHPs** having either a direct or indirect financial interest in the case(s) being reviewed may not participate except to furnish additional information as may be requested by the Chairman.
3. Confidentiality:
   a. The proceedings of the Utilization Review Committee ~~and~~, its derivative documents, findings, and minutes are all confidential and are protected from discoverability under Section 1157 of the California Evidence Code. Members of the Committee have a duty to preserve this confidentiality.
   b. To ensure confidentiality, patient references will be only as medical record numbers, and the physician references will be only as an assigned code number.
   c. The Utilization Review Committee must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient's medical information.
   ~~a.~~**d.** Documentation of Utilization Review Committee activities shall not be incorporated into the patient's chart.
4. Review Activities:
   a. The medical director of the ~~Behavioral Health Unit~~**BHU** will be responsible for secondary review of all cases referred by staff reviewers and will make a determination regarding the appropriateness of the documentation of severity of illness criteria as they relate to the intensity of services being provided.
      ~~a.~~**i.** When the medical director determines that documentation does not substantiate continued care at the current level, he will contact the attending physician/**AHP** to discuss the case further. In those instances where there exists a significant divergence of opinion between the medical director and the attending physician/**AHP**, the Hospital Utilization Review Committee Chairman may be consulted so that resolution of the dispute may be mediated
   b. The Utilization Review professional(s) within the ~~Department of Behavioral Health~~**BHU** will perform the following activities:
      i. Concurrent Review
         ~~i.~~1) a**Review** at periodic intervals in accordance with provider requirements, utilizing continued stay SI/IS criteria. Concurrent review includes admission review and continued stay review, and focuses on the medical necessity for admission and continued hospital stay for all patients. The source of payment is not the sole determinant in identifying patients for concurrent review. All patients are screened and case priority determined by factors including the hospital's case load, identified problems, and

specific practitioners with known or suspected patterns of inappropriate utilization.

ii. Admission Review

~~ii.~~**1)** **P**~~is~~ performed at time of the patient's presentation for behavioral health services to assure admission to the appropriate level of service. The admission review must be completed and documented, in all cases, within 48 hours of admission following admission. Admission review is an assessment of the medical necessity for a patient's admission to the program.

~~1)~~**a)** If the admission meets criteria and is considered appropriate by the psychiatric liaison, the reviewer will monitor the admission and assign a continued stay review date based on the medical record information.

~~2)~~**b)** If the admission does not meet the screening criteria for medical necessity, the reviewer will contact the attending physician to discuss the case

iii. Continued Stay Review ~~is the~~

~~iii.~~**1)** Assessment of the medical necessity of a patient's need for continued stay at the designated level of care. The continued stay review date is assigned by the admission reviewer based on the patient's principal diagnosis, severity of illness, intensity of service, as established by ~~the Department~~**BHU**. Justification for continued stay is based on the professional staff and attending physician's documentation in the medical record. If a case meets criteria for continued stay, the reviewer will assign the next review date.

~~1)~~**a)** Cases which do not meet the criteria for continued stay will be referred to the physician advisor for review. The physician advisor uses clinical judgment as well as screening criteria as the basis for decision. If an adverse decision is considered, the attending physician**/AHP** will be given an opportunity to present his/her views before a determination is made.

~~2)~~**b)** In cases of a dispute between the attending physician and the physician advisor, a second physician advisor in the same or related specialty as the attending physician may be consulted whenever possible.

~~3)~~**c)** If a decision is made that further stay is not medically necessary, the attending physician**/AHP** is afforded an opportunity to appeal the decision as set forth under ~~Section XII,~~ Appeals Process in the Hospital Utilization Review Plan. Should the adverse determination be upheld, the Hospital Utilization Review/DRG Committee will provide written notification to the patient or his/her representative, the attending physician, Business Office, peer review organization (PRO) and Medical Records Department

iv. Periodic open chart review and notification of physician and other documenting professionals when current documentation does not support continued stay in relation to SI/IS criteria.

v. Collaboration with social work staff to integrate discharge planning into the treatment plan at time of admission to facilitate timely discharge.

5. Case Management ~~is a~~

a. Methodology for moving a patient from admission to discharge with outcomes that are determined by quality standards, within a designated time frame, with patient and family participation and the control and careful use and coordination of systems and resources. Case Management integrates the utilization review/management, discharge planning and quality improvement functions.

b. The scope of case management in the ~~behavioral health population~~**BHU** entails the initial review and determination, based on SI/IS criteria, of appropriate placement, ongoing review for continued stay, and discharge planning. The goals of case management activities are to reduce length of stay, prevent barrier days, and improve resource utilization with emphasis on cost-effective and cost-efficient strategies that maximize quality delivery systems. The case management function, in ~~Behavioral Health Services~~**BHU** is integrated into the professional duties of the psychiatric liaison and social work staff and is overseen by the clinical nurse manager of the ~~Inpatient and Outpatient Services within the Department~~**BHU**.

c. Discharge planning is an integral part of case management process and must be initiated as early as possible, including prior to admission, to facilitate timely discharge. Departmental discharge planning activity shall include placement in alternative care facilities, and arrangements for appropriate community resources to improve or maintain the patient's health status on an outpatient basis. The members of the health care team collaborate in an interdisciplinary approach to facilitate discharge planning. The patient and his/her family or caregiver network are included in team membership.

6. Approval of Department Utilization Review Plan:

~~5.~~a. The ~~Behavioral Health Department~~**BHU** Utilization Review Plan will be reviewed as revised, in accordance with Hospital Standard for Plan reviews. Revisions will be submitted to the Tri-City ~~Medical Center~~**Healthcare District** Utilization Review for approval.

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Visiting in Behavioral Health Services**
POLICY NUMBER: **520**

ISSUE DATE: **03/08**
REVISION DATE(S): **08/09, 03/13**

Department Approval:	**~~06/16~~09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **DEFINITION(S):**
1. To provide guidelines for patients to have access to visiting with family and significant others during their hospitalization.

B. **POLICY:**
1. The patient is entitled to visit with persons of his or her choice during the hospital stay.

C. **PROCEDURE:**
~~1. Visitors will be restricted from visiting patients in the Crisis Stabilization Unit due to the level of acuity and nature of treatment reserved for patients in crisis.~~
~~2.~~1. Visitors will be allowed to visit patients in the Inpatient Behavioral Health Unit **(BHU) and the Crisis Stabilization Unit (CSU)** with the following restrictions:
   a. Family and significant others may visit patients during the times that are posted in the ~~Behavioral Health Unit~~**BHU and the CSU**.
      i. Visiting hours are posted on entry to the unit and at other areas of the unit.
      ~~i.~~**ii. Visiting hours are reviewed and outlined in daily community meeting.**
      ~~ii.~~**iii.** Visiting outside of regularly posted hours may be arranged by the patient with the physician/**Allied Health Professional (AHP)** and/or nursing staff.
   b. The staff will ensure that visiting hours do not interfere with a patient's treatment.
   c. Visits will be limited to two **(2)** visitors per patient at any time **in the BHU and one (1) visitor per patient in the CSU**. If there are more than two **(2)** visitors, it will be explained to them that they may share the visiting time.
      i. Clergy members are not counted as one of the two visitors permitted to each patient.
      ii. Visiting by clergy will be permitted outside of regular visiting hours if the patient so wishes as long as it does not interfere with the patient's treatment program
   d. The units will have designated visiting areas. Visitors will not be permitted to visit in patient rooms.
   e. All packages and belongings intended for patients brought to the units by visitors will be checked and inventoried by nursing personnel in the presence of the patient and/or visitor prior to being given to the patient.
   f. Visitors may not bring food or drinks onto the units.

g. Visitors will be encouraged to refrain from bringing personal items such as purses and backpacks to the unit. When a visitor arrives with such items they will be instructed to leave them in the provided lockers in the visitor's waiting room. Tri-City **Healthcare District (TCHD)** is not responsible for lost or stolen valuables.
h. No cellular telephones, cameras, or video recording devices are permitted on the units.
i. In the event that a visitor exhibits inappropriate behavior (e.g. is under the influence of drugs or alcohol, becomes verbally or physically abusive) staff will insist that the visit is terminated. If the visitor refuses to leave the unit, security will be called to escort the visitor out of the building.
j. Visitors are asked to wear a "Visitor" identification badge upon entering the units.
    i. Unauthorized visitors will be asked to leave the building without seeing the patient.
    ii. At all times staff will interact with visitors employing service excellence skills.
    iii. Staff will identify all persons entering the building and will not permit any individual to have access to either unit until the nature of their presence has been clarified.

~~3.~~2. The patient will be informed of all rights and units' rules related to visiting upon admission and will be provided with a written copy of the rules that include the unit visiting hours and policy.
~~4.~~3. Problems observed during visiting will be directed to the Assistant Nurse Manager **(ANM)** for disposition and reported to the patient's attending psychiatrist.
~~5.~~4. Patients have the right to refuse visits from designated individuals.
a. Patients will be afforded an opportunity to indicate, in writing, those individuals they would welcome as visitors and those they do not wish to visit.
b. The written list will be included in the patient's medical record.
~~6.~~5. Staff must be aware of the whereabouts of visitors at all times.
~~7.~~6. The patient's right to visitation will not be limited except as authorized in the patient's treatment plan in accordance with the **Behavioral Health Services** Policy: "Patient Rights." A limitation may be imposed:
a. To prevent violation of the law.
b. To prevent substantial and or serious physical or mental harm to the patient or others.
    i. Mental harm may include a visit that, in the opinion of the clinical staff, would substantially upset the patient and interfere with ongoing treatment. A visit may be limited or prohibited to prevent mental harm only if the person and the limitation are specifically identified in the plan of treatment.
    ii. Physical harm may include a visit that, in the opinion of clinical staff, would pose a risk to the patient, another visitor, or staff and interfere with ongoing treatment. Examples include visitors with whom there is a recent history of domestic violence, visitors against whom there is a restraining order, etc. A visit may be limited or prohibited to prevent physical harm only if the person and the limitation are specifically identified in the plan of treatment.

~~8.~~7. A patient will be promptly informed of any visitation limitation and a limitation of rights form will be completed. In addition, the patient will be informed of the purpose that the limitation is intended to achieve, the persons involved, and additional information as is deemed appropriate.
~~9.~~8. Limitations will be reviewed daily by the treatment team and when a limitation is removed it will be noted in the patient record as the right having been restored.
~~10.~~9. Visits from a patient's private physician or a mental health professional, a court, a patient's attorney, or other person when communication involves matters which are or may be the subject of legal inquiry will not be limited except that non-emergency visits of a private physical or a mental health professional may be limited to reasonable times. A time is reasonable if a visit does not seriously tax the effective functioning of the unit. A limitation upon visitation rights will not apply between a patient and attorney or court;~~,~~ or between a patient and other individuals if the communication involves matters that are or may be the subject of legal inquiry. The attending physician/**AHP** will be notified of a patient's request to talk to an attorney or other individual regarding a legal matter.

~~11.~~**10.** The patient may appeal any limitation to the patient advocate through the established grievance procedure.

~~12.~~**11.** Children under **the** age **of** 16 will not be permitted to visit the ~~Behavioral Health Unit.~~**BHU**. Patients with young children may be permitted to visit in the unit lobby or front office if, in the opinion of the clinical staff, it is deemed safe for them to do so.

a. Off unit visits will not be permitted if the patient is on a 1:1 or is high risk for elopement.

b. Off unit visits will not be permitted if the patient, as assessed by the clinical staff, is too ill to manage the visit outside of the unit.

D. RELATED DOCUMENT(S):

~~c.~~**1. Behavioral Health Services Policy: Patient Rights**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit

SUBJECT: Vital Signs
POLICY NUMBER: 723

ISSUE DATE: 03/08
REVISION DATE(S): 08/09, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**

1. Holistic care of patients in a Behavioral Health Unit **(BHU)** requires attention to their physical well-being as well as their illnesses requiring inpatient treatment. Therefore, routine vital signs are done on all patients.

B. **POLICY:**

1. **Vital signs are to be taken on admission, in the morning and in the evening, when a patient has a change in health status (e.g. after a fall) or reports symptoms such as chest pain, feeling hot, or faints, and any other time a physician/Allied Health Professional (AHP) has ordered or the nurse believes is clinically appropriate.** ~~Vital signs will be measured and recorded on each patient on admission, twice once daily, and as needed.~~
2. Vital signs include temperature, respiration, heart rate, blood pressure, and pain rating.
3. **Any member of the nursing staff, licensed or unlicensed, may take vital signs.**

~~3. Patients participating in research trials will have vitals measured and recorded according to research protocols.~~

~~A. PROCEDURE:~~

~~1. Any member of the nursing staff, licensed or unlicensed, may take vital signs.~~

~~1. Vital signs are to be taken in the morning, after a fall, and any other time a physician has ordered or the nurse believes is clinically appropriate.~~ **~~Vital signs are to be taken on admission, in the morning and in the evening, when a patient has a change in health status (e.g. after a fall) or reports symptoms such as chest pain, feeling hot, or faints, and any other time a physician has ordered or the nurse believes is clinically appropriate.~~**

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: Washer/Dryer Use
POLICY NUMBER: 405

ISSUE DATE: 04/05
REVISION DATE(S): 04/10, 03/13

Department Approval:	~~06/16~~09/17
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish guidelines for safe usage of washer and dryer in the Behavioral Health Unit **(BHU) and Crisis Stabilization Unit (CSU).**

B. **POLICY:**
1. Any wet or soiled clothing or linen is considered to be potentially infectious. Therefore, Standard Precautions are always used in handling of these items.
   a. Contain patient's clothing at source of used in moisture proof bag.
   b. Carry bagged laundry to the laundry room for washing/drying.
   c. Launder one patient's clothing at a time. Do not mix clothing with other patient's clothing.
2. The laundry room will remain locked at all times for safety and protection of patient property. Staff will facilitate use of laundry room.

C. **PROCEDURE:**
1. Routine washing and drying of patient's clothing:
   a. Don gloves prior to handling patient's clothing.
   b. Place clothing into washer.
   c. Select load size, i.e., small, medium, large.
   d. Set water temperature. Hot water should be used for heavily soiled clothing.
   e. Sort clothing accordingly.
   f. Measure detergent (30 cc medium load, 60 cc large load).
   g. Turn control knob to desired wash cycle.
   h. Push appropriate button to start machine.
   i. Check inside washer for cleanliness, and if necessary, wipe with Super Sani-Cloth, Germicidal Disinfectant Wipes (purple top container)~~,~~ hospital approved disinfectant.
   j. After wash cycle has finished, place laundered clothing into dryer.
2. Operation of dryer:
   a. Clean lint filter before starting dryer for each use.
   b. Select desired temperature.
   c. Turn control knob clockwise to desired drying cycle.
   d. Turn control knob clockwise to desired time of automatic shutoff.
   e. Remove clothing promptly and return to patient promptly (use patient labels as appropriate).

3. Washing and Drying of heavily soiled or stained clothing:
   a. Disinfection of washing and drying machines in health-care facilities is not needed as long as gross soil (e.g., feces) is removed before washing and proper washing and drying procedures are used.
   b. The physical removal of bulk solids before the wash/dry cycle, proper temperature, and detergent shall be used for heavily soiled clothing items.

D. **REFERENCE(S):**

1. Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC), Atlanta, GA 30333, 2003.

Tri-City Health Care District
Oceanside, California

Infection Control ~~Policy Manual~~

ISSUE DATE: 09/01	**SUBJECT:** Department Specific: Behavioral Health ~~Unit~~Services (BHS)
REVISION DATE: 07/03, 07/07, 07/10, 06/14	~~POLICY NUMBER: IC.7.1~~
Department Approval:	09/17
Infection Control Committee Approval:	~~07/07, 07/10, 04/14~~10/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/10, 05/14~~01/18
Professional Affairs Committee Approval:	
Board of Directors Approval:	~~07/10,~~ 06/14

A. **POLICY:**

1. **Patients with mental illness may be at increased risk for infection because of impaired judgement, poor impulse control, reduced self-care, irregular or poor medication compliance, lack of personal hygiene or dental care. The unique practices of the various treatment settings in the Behavioral Health ~~Unit~~Services (BHS), as well as the behaviors of the clients themselves, can lead to a heightened risk for transmission to other clients and staff. Infection Prevention in ~~behavioral health~~BHS requires application of recommended prevention strategies to the extent possible. The unique behavioral traits of some clients may pose an obstacle to traditional methods. The goal is to identify infections and utilize strategies to prevent transmission in this at risk population.** ~~The Behavioral Health Unit is a unique setting staffed by a multidisciplinary group. The purpose of the service is to provide for the treatment and management of mental illness with a limited use of invasive procedures. Rather than treatment of physical illness, the focus is on decreased mental suffering. Treatment is designed to change behaviors and permit increased outpatient societal functioning. Patient movement might be broad and far ranging and the interaction with other patients and staff is close, continuing with a purposefully directed component of care and recovery. The patient may not be a reliable medical historian. The pathophysiology of the mental illness may present behavior that could result in infection to self or others. For example, during hospitalization, patients may be sexually active and expose themselves or others to sexually transmitted diseases. Inadequate hygiene, nutrition, and hydration as well as psychotropic medications, increase susceptibility to infection. Medications designed to moderate the mental illness may mimic early signs and symptoms of infection. Staff will consult with appropriate physicians for the treatment of infected patients and the need to transfer to a medical floor.~~

B. **PREVENTION STRATEGIES:**

~~2.~~1. Standard Precautions are implemented for every patient in ~~BHU~~**BHS** regardless of their diagnosis. Hand hygiene and cough etiquette is encouraged among staff and patients. Hand hygiene and personal hygiene reinforced daily during community meetings. Staff and patients perform hand hygiene prior to eating meals.

~~3.~~2. The ~~Behavioral Health Unit~~**BHS** does not have negative pressure rooms. Patients requiring Airborne Precautions for infectious tuberculosis, measles, or varicella (chickenpox or disseminated herpes zoster) shall be transferred to an appropriate medical bed **within the hospital.**

~~4.~~3. A patient requiring Contact Precautions for conditions other than multi-drug-resistant organisms (e.g. MRSA and VRE) or Droplet Precautions may remain on the unit if the psychiatrist deems this necessary. **Patients requiring Droplet precautions will be asked to wear a surgical**

mask as tolerated (if patient presents as a danger to self, consideration of one-on-one observation will be considered).

~~5.~~**4.** **If a patient is diagnosed** ~~In cases of patients~~ with a multi-drug-resistant organisms **(e.g. MRSA and VRE)** the ~~individual~~ patient's clinical situation, hygiene practices and facility resources will be considered in deciding whether to implement Contact Precautions **with that patient.**~~.~~

~~6.~~**5.** Clean linen is kept covered and stored inside a clean supply room. Dirty utility rooms are locked

~~7.~~**6.** The cleanliness of the kitchen is the responsibility of the staff. ~~Patients will be instructed, assisted and monitored with safe food preparation and handling.~~

~~8.~~**7.** Each patient will be assigned a closet for personal clothes and belongings.

~~9.~~**8.** Patients will be instructed on the use of laundry facilities. Patients are to wash only their own clothes ~~and~~**with direct** staff **supervision** ~~will assist as needed~~. Staff is responsible for the cleanliness of the laundry area. Family members can be asked to take heavily soiled clothing home for washing.

~~10.~~**9.** Housekeeping performs sanitizing, disinfecting, and general cleaning tasks such as but not limited to trash/recycling removal, dusting, vacuuming, polishing, and mopping.

~~11.~~**10.** ~~Bathtub~~**Shower area is to be cleaned by the environmental services staff assigned to the** ~~Behavioral Health area is to be cleaned by the environmental services staff assigned to the Behavioral Health Unit~~ **BHS** after each patient use.

11. Sharps boxes will not be kept in patient rooms for safety reasons.

12. **Staff to wipe off reusable equipment with hospital approved disinfectant wipes in between patient use.**

C. RELATED DOCUMENT(S):

~~1.~~ ~~Administrative Policy #401 Injury Prevention Program~~

~~2.~~ ~~BHU- MRSA – Contact precautions Modifications for Patients on behavioral health units~~

~~13.~~**1.** Employee Health **& Wellness** ~~Services~~ Policy: **Injury Illness Prevention Program**

~~14.~~**2.** **Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC.11**

3. **Infection Control:** Cleaning and Disinfection IC.9

~~15.~~**4.** **Infection Control:** Hand Hygiene IC.8

~~16.~~**5.** **Infection Control:** Philosophy - IC ~~1.2~~

~~17.~~**6.** **Infection Control:** Standard and Transmission Based Precautions IC.5

~~18.~~ ~~Participation of Staff in the Infection Control Program IC.7~~

~~B.~~D. REFERENCE(S):

1. **APIC Text of Infection Control and Epidemiology 4th edition 2014-Chapter 49 Behavioral Health; Larysa M. Fedoriw, MPH.**

~~1.~~ ~~Hatch, R, Mental Health in APIC Text of Infection Control and Epidemiology. Wash. DC, 2000.~~

2. **Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee** ~~Management of Multi-drug-Resistant Organisms in Healthcare Settings, 2006 HICPAC~~

Tri-City Medical Center	Distribution: Women's & Children's Services,
PROCEDURE:	**BREAST MILK, PUMPING, HANDLING, AND STORAGE OF**
~~Purpose:~~	~~To provide a standardized process for collection, storage and handling of maternal breast milk in the hospital setting.~~
~~Supportive Data:~~	~~Mothers giving their babies pumped milk~~ ~~program that hospitals support. If circum~~ ~~baby occur then the staff is to provide fo~~ ~~pumping, handling and storing of human milk.~~

DELETE: replace with Elsevier Online Skills: Breastmilk: Collection, Storage and Administration

A. ~~**CRITERIA FOR BREAST MILK STORAGE:**~~

1. ~~Gloves should be worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:~~
   a. ~~Milk in chronological order~~
   b. ~~Fresh expressed milk~~
   c. ~~Refrigerated milk~~
2. ~~At all times, all containers shall be labeled with patient identification label including mother or infant's name, medical record number, date and time.~~

B. ~~**BREAST MILK STORAGE GUIDELINES:**~~

1. ~~Breast milk shall be stored as follows in a designated refrigerator/freezer:~~

~~Breast Milk Storage Guidelines~~		
~~Method~~	~~Term Infant~~	~~Pre-Term or Sick Infant~~
~~Room temperature less than or equal to 25° C (77° F)~~	~~6-8 hours~~	~~4 hours~~
~~Refrigeration of Fresh Milk less than or equal to 4° C (39° F)~~	~~3-5 days~~	~~96 hours~~

C. ~~**PROCEDURE:**~~

1. ~~Collection~~
   a. ~~Provide instruction to MOB on "Pumping, Storing & Transporting Breast Milk for hospitalized infants. Parent information sheet given by lactation consultant.~~
   b. ~~Direct parent to a pump rental facility and use of in-house pump when parent is at hospital with baby.~~
   c. ~~Instruct mother of baby in hand expression and manual pumping as alternative ways of collecting milk.~~
   d. ~~Provide individualized labels with the mother's name and medical record number, containers and lids, and NICU will provide infant labels on initial NICU visit.~~
   e. ~~When giving or receiving milk from the refrigerator the identification band will be checked with the milk label.~~
   f. ~~Instruct mother to write the date and time of collection.~~
   g. ~~Instruct mother in hand washing before and after pumping.~~
   h. ~~Instruct mother in cleaning collection bottles and flange.~~
   i. ~~Educate mother in how to store breast milk in small volumes to minimize waste.~~
2. ~~Hospital Pump Care:~~
   a. ~~Breast pumps shall be wiped down with a hospital approved germicide as follows:~~
      i. ~~Prior to each use in the NICU.~~
      ii. ~~Prior to each new patient use in areas other than NICU.~~
      iii. ~~If a spill occurs.~~
   b. ~~If internal contamination is noted, take the pump out of service and send to Biomed for deep cleaning.~~

Review/Revision Date	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/03, 05/06, 06/07, 05/08, 04/09, 06/11, 12/14, 09/15, **01/18**	08/07, 06/15, **02/18**	n/a	08/07, 08/15, **03/18**	09/07, 06/09, 09/15	09/07, 06/09, 09/15

D. **DOCUMENTATION:**

1. Document parent education in patient record.

E. **CROSS-REFERENCE:**

1. See Breast Milk Misadministration procedure

F. **REFERENCES:**

1. Human Milk Banking Association of North America, Inc. Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes and Child Care Settings. 2005. Raleigh, NC: HMBANA.
2. *Infant Feedings: Guidelines for Preparation of Formula and Breast milk in Health Care Facilities*. American Dietetic Association. Copyright – 2004
3. Meirer, P.P. (1997). Professional Guide to Breastfeeding Premature Infants. Ross Products Division, Abbott Laboratories.
4. Pardou, A., et al. (1994) Human Milk Banking: Influence of storage process and of bacterial contamination on some milk constituents. Biol Neonate; 65; 302-309.
5. Pierce, K.Y. & Tully M.R. (1992). Mother's Won Milk: Guidelines for storage and handling. Journal of Human Lactation; 8 (3); 159-160.
6. The Academy of Breastfeeding Medicine Protocol Committee; Caroline J. Cantry, MD, FABM; Cynthia R. Howard, MD, MPH, FABM. Protocol #7: Model Breastfeeding Policy. Approved 2/20/2004.
7. Lawrence, Ruth & Lawrence Robert (2005). Breastfeeding – A Guide for the Medical Profession. Elsevier Mosby. 761-778, 1081-1093.

Tri-City Medical Center	Distribution: WOMEN AND NEWBORN SERVICES
PROCEDURE:	**FORMULA FEEDING PROCEDURE**
Purpose:	To outline an alternative method of meeting an infant's nutritional needs.
Supportive Data:	Use of commercially prepared, iron-fortified formula is an alternative method of providing neonatal nutrition. Use of formula is indicated [illegible] not to breastfeed, or when the mother or the [illegible] bottle-feeding with formula or pumped breast milk.
Equipment:	1. Appropriate commercially prepared formula. 2.1. Appropriate type of sterile nipple.

DELETE: Replace with Elsevier Online Skills: Formula Feeding Education

A. **PROCEDURE:**

1. Perform hand hygiene
2. Verify type of formula to feed newborn. Formula may be given at room temperature.
3. Assess newborn's physiologic readiness (behavioral cues) for initiation of feedings by assessing:
   a. Vital signs
   b. Activity – exhibiting rooting, sucking, or crying behaviors
   c. Muscle tone
4. Change diaper if necessary and wrap infant in blankets – perform hand hygiene after diapering and prior to feeding.
5. Newborn should be held during feedings in a semi-upright position (45 degree angle) with close physical contact and contingent responsiveness (nurturance). Do not prop bottles or use products that hold a bottle in a newborn's mouth.
   a. Propping the bottle for feeding has been associated with reflux of milk into the Eustachian tubes
6. Insert nipple into newborn's mouth, keeping the nipple full of formula in order to decrease swallowing of air.
   a. Assess if infant initiates and sustains suck and swallow coordination
   b. Assess if color and respiratory effort remain stable throughout feeding
7. Burp newborn after every half ounce (15 mL) or halfway through the feeding.
8. Allow 20 minutes for a feeding and feed on demand, or at least every four hours, or as ordered by physician.
   a. Normal infant feeding is:
      i. 1st 24 hours: 2-10 ml/feed
      ii. 24-48 hours 5-15 ml/feed
      iii. 48-72 hours 15-30 ml/feed
      iv. 72-96 hours 30-60 ml/feed
9. Discard any formula remaining in the feeding bottle.
10. Assess for signs of formula intolerance:
    a. Encourage parents to be alert for signs/symptoms prior to and after discharge, signs include:
       i. Constipation
       ii. Fussiness
       iii. Abdominal cramps
       iv. Excessive spit-up or vomiting
       v. Notify pediatrician for signs of intolerance (formula type or brand alternative)

B. **DOCUMENTATION:**

1. Document type and amount of formula for each feeding on newborn patient care record.
2. Document any abnormal events associated with this procedure in nurse's notes.

Review/Revision Date	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/03, 07/09, 01/18	n/a	08/09, 03/15, 02/18	n/a	05/13, 04/15, 03/18	06/13, 05/15	06/13, 05/15

~~C. **REFERENCES:**~~

~~1. The Academy of Breastfeeding Medicine Protocol Committee. Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2009.~~

~~2. Mattson, S., & Smith, J.E. (Eds.) (2011) Core Curriculum for Maternal Newborn Nursing (4th Ed.) Philadelphia: Saunders.~~

~~3.~~1. ~~Simpson, K., & Creehan, P. (2014). Perinatal Nursing (4thEd). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Lippincott Williams and Wilkins, PA~~

Tri-City Medical Center
Oceanside, California

Tracked Changes

WOMEN'S AND CHILDREN'S SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/94 **SUBJECT:** INFANT FEEDINGS

REVISION DATE(S): 01/00, 06/03, 12/09, 04/10, 06/14

Department Approval:	**01/18**
Department of Pediatrics Approval:	**~~05/14~~02/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/14~~03/18**
Professional Affairs Committee Approval:	**06/14**
Board of Directors Approval:	**06/14**

A. **DEFINITION(S):**

~~1. BFHI: Baby Friendly Hospital Initiative~~
~~2. EBM: Expressed Breastmilk~~
~~3. WHO: World Health Organization~~
~~4. Exclusive Breastfeeding: The optimal practice of feeding infants no food or drink other than human milk unless another food is determined to be medically necessary.~~

~~5.~~1. Skin to Skin (STS): Direct physical contact between the newborn infant and mother. After birth, the healthy term infant should be completely dried and placed naked against the mother's naked chest. The infant may wear a diaper and/or hat, but no other clothing should be between the mother's and infant's bodies. The infant and mother are then covered with a warmed blanket, keeping the infant's head uncovered. STS contact should continue, uninterrupted, until the completion of the first feeding (or for at least 1 hour if the mother is not breastfeeding). STS contact should be encouraged beyond the first hours and into the first days after birth. Another adult may hold the infant STS if/when the mother is not available.

B. **POLICY:**

1. To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process.
2. To assist families choosing to breastfeed with initiating and developing a successful and satisfying experience.
3. **This policy is adapted from the Academy of Breastfeeding Medicine (AMB): AMB Clinical Protocol # 7: Model Breastfeeding Policy (2010) which is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization (WHO), and the American Dietetic Association.**
4. ~~This policy is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization, the American Dietetic Association, and the Academy of Breastfeeding Medicine , and the UNICEF/WHO evidence based "Ten Steps to Successful Breastfeeding".~~
5. **This policy encompasses the UNICEF/WHO evidence-based Ten Steps to Successful Breastfeeding; practices that have been shown to increase breastfeeding initiation and duration.**

~~4.~~6. **Tri-City Medical Center complies with the WHO International Code of Marketing of Breastmilk Substitutes.**

C. **PROCEDURE:**

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
   a. Tri-City Medical Center staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary team comprised of physicians, midwives, nursing, lactation consultants, dietary, and outpatient providers shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. This group will evaluate data relevant to breastfeeding support services and formulate, along with administrators, a plan of action to implement needed changes.
   b. Tri-City Medical Center upholds the WHO International Code of Marketing of Breastmilk Substitutes by offering education and materials that promote human milk rather than other infant food or drink, and by refusing to accept or distribute free or subsidized supplies of breastmilk substitutes, nipples, and other feeding devices. Mothers will be protected from the promotion of breastmilk substitutes and other efforts that undermine an informed feeding choice.
   c. This written breastfeeding policy will be communicated to all health care staff members. It will be reviewed and updated every 2 years (per medical center policy) or as needed using current research as an evidence-based guide.
   d. All new Women and Newborn Services' staff and care providers will be oriented to the policy during their initial orientation. The orientation process is different for type of hire and is detailed in the Women and Newborn Services Lactation Education Checklist (see Attachment B). Staff and care providers will be expected to read and sign the policy.
   e. This policy will be readily available to all areas of Tri-City Medical Center that potentially interact with childbearing women and infants so that they may promote, protect, and support breastfeeding in all departments. Other department's polices will support, and will not countermand the medical center's infant feeding policy.
2. Train all health care staff in the skills necessary to implement this policy.
   a. The nursing leadership team will ensure that all staff working in the Women and Newborn Services department (excluding the NICU) will receive a minimum of 20 hours of education, including at least 5 hours of supervised clinical training, on the topics specified by the BFHI (see Attachment A). For new employees, this training will be completed within 6 months of hire. Details for the execution of the training are specified in a separate training plan: Baby Friendly Training Requirements (Attachment B).
   b. Upon completion of training for new employees, the staff preceptor will supervise and verify the clinical competency of the new staff member. This will be documented in the orientation checklist and maintained in the employee file. Staff will receive adequate training and mentorship to attain competence in:
      i. Counseling the feeding decision
      ii. Skin to skin (STS) in the immediate postpartum period
      iii. Comfortable and effective positioning and attachment at the breast
      iv. Assessing and documenting a latch score
      v. Maintenance of exclusive breastfeeding
      vi. Feeding cues
      vii. Rooming-in
      viii. Hand expression
      ix. Formula preparation and feeding when necessary
      x. Finding support upon discharge
   c. Documentation of all training will be maintained by the Lactation Supervisor and/or appropriate CNS on the BFHI Staff Training Documentation Checklist.
   d. Providers with privileges for labor, delivery, maternity, anesthesia, and/or newborn care will have a minimum of 3 hours of breastfeeding management education pertinent to their role. Education will be verified by successful completion of the First Latch module and a certificate of completion will be verified and maintained by a provider coordinator.

e. The content and number of hours of training for other staff will be developed based on job description and workplace exposure to breastfeeding couplets.

3. Inform all pregnant women about the benefits and management of breastfeeding.
   a. Physicians, midwives, and nurses providing prenatal services are responsible for educating pregnant women and their support people about breastfeeding. Education will cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early STS contact, early initiation of breastfeeding, rooming-in, feeding on demand, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months even after other foods are introduced. Contraindications to breastfeeding and other special medical conditions will be discussed as indicated. Education will be documented in the prenatal record.
   b. Exclusive breastfeeding is defined as providing breastmilk as the sole source of nutrition to infants. Exclusively breastfed infants receive no other liquids or solids unless medically indicated. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The planned feeding method will be documented in the prenatal record.
   c. Tri-City Medical Center does not distribute educational materials in which the use of formula or infant feeding bottles is discussed routinely.
   a.d. Tri-City Medical Center offers no group education on the use of infant formula or feeding bottles.
   e. Breastfeeding classes are offered by Tri-City Medical Center. Pregnant women who receive services at Tri-City Medical Center will receive written information regarding the benefits of breastfeeding as well as an explanation of practices implemented in the Women and Newborn Services department that support successful breastfeeding.
   f. Tri-City Medical Center fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.
   g. Tri-City Medical Center provides organizations that offer prenatal services curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding.
   h. Members of the staff at Tri-City Medical Center participate in the local breastfeeding coalition.
4. Help mothers initiate breastfeeding within one hour of birth.
   a. Immediately after delivery, all term infants, regardless of feeding preference, will be placed STS with the mother as long as the infant and mother are stable and it is not medically contraindicated.
   b. STS contact including any reasons for delaying STS will be documented in the infant's medical record.
   c. Preterm or unstable infants or infants having required resuscitation will be placed STS as soon as possible after medical stability has been established.
   d. The nursing staff present at the delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding. This encompasses placing the infant STS with mother immediately after birth (including cesarean deliveries if possible), assisting the mother in recognizing infant signs of feeding readiness, and allowing the infant the opportunity to self-attach to the breast. Vaginal delivery mother/infant couplets will be given the opportunity to initiate breastfeeding within 1 hour of birth. Cesarean delivery mother/infant couplets will be given the opportunity to initiate breastfeeding as soon as possible.
   e. Time of initiation of STS contact as well as the time this contact ends will be documented in the medical record.
   f. During the initial period of STS contact, routine newborn procedures will be postponed (up to 2 hours) until the first breastfeeding has been completed.

Assessments and procedures (including the administration of vitamin K and erythromycin eye ointment) should be performed while the infant is still STS with the mother.

g. After 24 hours of life, the stable infant may receive a bath upon parent's request.
   i. Earlier bathing may be considered in the instances of specific parental request, meconium stained infant, or malodorous amniotic fluid.
   ii. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after the delivery.
   iii. Education is provided to parents about delayed bathing to include the importance of initial bonding, STS, and establishment of breastfeeding.

h. STS contact will be encouraged throughout the hospital stay.

5. Show mothers how to breastfeed and how to maintain lactation even if separated from their infants.

a. The nurse will assess the mother's breastfeeding techniques and, if needed, will demonstrate appropriate breastfeeding positioning and attachment, optimally within 3 hours, and no later than 6 hours after birth.

b. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible during each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used. Every shift, a direct observation of the infant's position and latch during feeding will be performed and documented. If the LATCH score is < 7, the nurse will document any interventions and the infant's response to those interventions. The LATCH score will be repeated with the next feed.

c. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and the newborn channel as appropriate. If clinically indicated, the provider or nurse will make a referral to a lactation consultant. The mother will be given a breastfeeding log book and shown how to monitor feedings and diapers, as well as information about breastfeeding support groups.

d. Parents will be taught that breastfeeding infants, including cesarean-birth infants, should be put to breast at least 8 to 12 times in 24 hours. Infant feeding cues (such as increased alertness, activity, mouthing, or rooting) will be used as indicators of the infant's readiness for feeding. Breastfeeding mothers will be instructed about breastfeeding and the following principles and skills reviewed before discharge:
   i. Importance of exclusive breastfeeding
   ii. How to maintain lactation for exclusive breastfeeding for up to 6 months
   iii. Proper positioning and latch
   iv. Nutritive sucking and swallowing
   v. Milk production and release
   vi. Frequency of feeding/feeding cues
   vii. How to manually express, pump, handle, and store breastmilk
   viii. How to assess if the infant is adequately nourished
   ix. Reasons to contact the provider
   x. How to sustain lactation if separated from the infant or if not exclusively breastfeeding after discharge

e. Time limits for breastfeeding on each side will be avoided. Infants may be offered both breasts at each feeding but may be interested in feeding on only one side early on.

f. When a mother must be separated from her infant, the staff will instruct the mother to begin expressing her breastmilk within 3 hours of the separation. The mother will be taught how frequently to express her milk as well as proper storage and handling. The EBM (expressed breastmilk) will be given to the infant as soon as the infant is medically stable. The mother's EBM will be used before any supplementation with breastmilk substitutes unless otherwise contraindicated.

g. A mother discharged home without her infant due to illness or prematurity will be seen by a lactation consultant before discharge and will be given a discharge pumping plan and appropriate education:
   i. Instruction on hand expression and the electric breast pump:
      1) Expression/pumping at least 8 times per day, approximately every 3 hours for 15 minutes or until milk flow stops.
      2) The importance of continuing to pump throughout the night.
      3) For mothers who will be separated from their infants for an extended period of time, instruct to pump 6 times a day once milk supply is established.
   ii. Encouraged to breastfeed on demand as soon as the infant's condition permits.
   iii. Encouraged to practice daily STS when the infant is medically stable.
   iv. Instruction on proper storage and labeling of breastmilk.
   v. Assistance in obtaining a double set up electric breast pump prior to going home.

h. The mother who chooses to feed her infant a breastmilk substitute will be given written and verbal information regarding appropriate hygiene, preparation, storage, handling, and feeding of the substitute. This education will be documented in the medical record.
   i. Ready to feed formula or liquid concentrate is recommended for the first 2 months of life.
   ii. Families with WIC or those who will be using powdered formula will be given information regarding safe preparation. (see WHO Guidelines: How to Prepare Formula for Bottle-Feeding at Home):
      1) Powdered formula is not sterile.
      2) Mix powder with hot water (158 degrees F/70 degrees C).
      3) Allow formula to cool prior to feeding to the infant.

6. Give infants no food or drink other than breastmilk, unless medically indicated.
   a. For healthy term infants, no supplemental water or glucose water will be given.
   b. For healthy term infants, no breastmilk substitute will be given unless by a provider's order or standardized procedure. Note: Breastmilk substitutes should not be used as a prophylactic measure for anticipated weight loss, jaundice, etc.
   c. Infants who are receiving supplemental nutrition will be offered alternative feeding methods to avoid the use of bottles and nipples if acceptable to the mother and achievable according to staff. These methods include:
      i. Supplemental Nursing System (SNS)
      ii. Finger Feeding
      iii. Cup feeding
      ~~In breastfeeding infants that require supplementation, the supplementation should be given by a Supplemental Nursing System (SNS), finger feeding, or cup feeding as follows:~~
   d. EBM, if available, will be given prior to supplementation with a breastmilk substitute. If EBM is not immediately available, it will be given as soon as it is available.
   e. Each day the provider will be consulted regarding the volume and type of supplement.
   f. If formula supplementation is medically indicated, an order is needed and the nurse must document initial reason(s) and ongoing indications.
   g. If a mother requests her infant be supplemented with a breastmilk substitute, staff will explore and address the mother's concerns. The mother will be given the Risks of Formula Supplementation handout for review. If the mother's request for formula persists, the provider will be called for an order for formula. The education to the risks of formula and informed decision of the patient will be documented. The mother will be given supplies and education (refer to Mosby's Skills – Formula Feeding Education Maternal Newborn).
   h. Assessment for clinical signs of hypoglycemia and dehydration will be ongoing. Routine glucose monitoring of full term (AGA, non IDM) infants is not indicated.

a. i. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into a spoon or the infant's mouth during feeding attempts. STS contact will be encouraged. Parents will be instructed to watch closely for feeding cues, and when observed, to feed the infant. If the infant continues to feed poorly, hand expression and/or an electric breast pump (and pumping with breast massage) will be introduced and maintained approximately every 3 hours, or a minimum of 8 times per day. Any expressed colostrum or mother's milk will be fed to the infant by SNS, finger feeding, or cup feeding. The mother will be educated that it is normal not to obtain much milk or even any milk the first few times she pumps her breasts. The lactation consultant or specialist should also be consulted for these cases.

i. j. Breastfeeding is contraindicated for:

- ii. i. Mothers who are HIV-positive.
- iii. ii. Mothers who abuse illicit drugs or alcohol.
- iv. iii. Mothers who are taking certain high risk medications. (Most prescribed and over-the-counter medications are safe for the breastfeeding infant, however some may be contraindicated while breastfeeding.)
- v. iv. Mothers who have active, untreated tuberculosis (infant may safely receive EBM).
- vi. v. Infants who have galactosemia, maple syrup disease, or phenylketonuria.
- vii. vi. Mothers with active herpetic lesions on the breast(s). (The Infectious Disease Department should be consulted for any problematic infectious disease issues regarding safety of STS, direct breastfeeding, and/or EBM.)
- i. vii. Mothers with varicella that is determined to be infectious to the infant.
- ii. viii. Mothers with HTLV1 (human T-cell leukemia virus type 1)

7. Practice rooming-in – allow mothers and infants to remain together 24 hours a day.
   a. Mother/infant couplets (regardless of maternal feeding preference) will begin rooming-in immediately after delivery and will not be separated during hospitalization as long as both are medically stable and mother/family are able to care for infant.
   b. Routine newborn procedures will be done at the mother's bedside.
   c. Infants can only be admitted to couplet care or the NICU.
   d. If an infant needs to be separated from its mother, documentation of the location, reason, and the expected time period will be recorded.
   e. The infant will be reunited with the mother as soon as possible. If an infant and mother are separated, the staff will support exclusivity of breastfeeding.
   a. f. If a mother requests that her infant be taken out of the room, staff will explore the mother's reason for the request, will educate her on the benefits of continuing to room in, and will document as appropriate.
8. Encourage breastfeeding on demand.
   a. All mothers will be taught to feed their infant when the infant exhibits signs of feeding readiness. Mothers will be taught to recognize these feeding cues in the infant.
   b. Mothers will be informed of normal newborn feeding behaviors such as cluster feeding, feeding through the night, and a normal feeding schedule of at least 8-12 feedings in a 24 hour period.
   c. No limitations will be taught to mothers regarding length or number of feedings.
   5. d. Parents will be taught that both physical contact and nourishment are important parts of the feeding process.
   a. 9. Give no pacifiers or artificial nipples to breastfeeding infants.
      a. Pacifiers will not be given to healthy, full-term breastfeeding infants.
      b. Preterm infants in the NICU or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
      c. Infants undergoing painful procedures may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier.

d. Pain management interventions during uncomfortable or distressing procedures will be used whenever possible. This may include breastfeeding during a heel stick procedure for infant blood tests.
e. If a parent requests a pacifier, artificial nipples, or feeding bottles they will be educated regarding possible negative consequences as it relates to breastfeeding and this education will be documented.
f. Any supplementation should be given by SNS, finger feeding, or cup feeding before introduction of an artificial nipple or bottle.
~~6.~~g. A nipple shield may be given by the RN or lactation consultant to manage latch problems, or sore or cracked nipples. The RN or lactation consultant will document why the nipple shield was given and the infant's response to the intervention. Mothers using nipple shields will be followed by a lactation consultant.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.
a. Infants that are not feeding well should not be discharged home.
b. Before leaving the hospital breastfeeding mothers should be able to:
i. Position and latch the infant correctly at the breast with no/minimal discomfort during feeding.
ii. Recognize when the infant is swallowing milk.
iii. State that the infant should be breastfed approximately 8 to 12 times in 24 hours.
iv. State an age-appropriate elimination pattern – at least 6 voids and 3 to 4 stools per day by the fourth day of life.
v. List indications for calling the provider.
~~a.~~vi. Manually express milk from her breasts.
~~b.~~c. Prior to going home, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding including the Tri-City Medical Center breastfeeding clinic and support group.
d. All infants should be seen for follow-up within the first few days after discharge. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice, and age-appropriate elimination.

D. BREASTFED NEWBORN INPUT AND OUPUT NORMS

Age in hours	Milk volume per feeding	# feeds	# voids	# stools
0-24	0-5 mls / drops	6-8	≥ 1	≥ 1
24-48	5-10 mls / 1 tsp	≥ 8	≥ 2	≥ 2
48-72	10-20 mls / 1 tbsp	≥ 8	≥ 3	≥ 3
72-96	20-30 mls / 1 oz	≥ 8	≥ 4	≥ 4
> 96	> 30 mls / > 1 oz	≥ 8	≥ 5-12	≥ 5-12

1. Infant has 24 hours to void and 48 hours to stool after birth.
2. There may be a lull in stooling after meconium is cleared while baby waits for milk to come in.
3. Infants may feed VERY frequently before the milk comes in; even hourly for the first few nights.

E. MEDICAL INDICATIONS FOR SUPPLEMENTATION

1. When making the decision to start supplementation, it is necessary to look at all the factors involved. Weight loss alone does not imply the need for supplementation. Breastfeeding assessment, assistance, and education should be done prior to starting supplementation.
2. Possible medical indications for supplementation include:
a. Infant risk factors:
i. Asymptomatic Hypoglycemia unresponsive to appropriate, frequent breastfeeding

ii. Inadequate intake as evidenced by:
1) Clinical or laboratory evidence of clinical dehydration (high sodium, poor feeding, lethargy) that is not improved after skilled assessment and proper management of breastfeeding.
2) Excessive weight loss (≥ 10%):
a) Note that excessive newborn weight loss is correlated with positive maternal intravenous fluid balance and may not be directly indicative of breastfeeding success or failure.
b) Number of voids and stools should be taken into consideration.
3) Delayed bowel movements: < 4 stools on DOL 4, or continued meconium stools on DOL 5.

iii. Hyperbilirubinemia
1) With ongoing weight loss, limited stooling, and voiding with uric acid crystals.
~~With Bili level 20-25mg/dL~~

iv. Inborn errors of metabolism

b. Maternal risk factors:
i. Delayed secretory activation.
ii. Primary glandular insufficiency as evidenced by:
1) Abnormal breast shape
2) Poor breast growth during pregnancy
3) Prior breast surgery resulting in poor milk production

~~i.~~iii. Intolerable pain during feedings unrelieved by interventions.

F. SUPPLEMENTAL NURSING SYSTEMS (SNS) AND NIPPLE SHIELDS

1. Supplemental Nursing System (SNS):
a. Assemble the SNS tubing with a syringe or container; considered a single-use piece of equipment.
b. Gently tape the tubing to the mother's breast with the end of the tubing extending about ¼ inch beyond the end of her nipple.
c. Assist the mother in latching the infant to the breast and tubing as needed.
i. Sucking from the infant creates a siphon effect and allows supplementation from the reservoir of the syringe or SNS container kit.
d. Supplementation should be monitored accordingly.
i. Amounts of EBM or breastmilk substitute should be measured to meet the infant's needs.
ii. 10-15 ml of EBM or breastmilk substitute is considered adequate intake for the newborn infant. It is important not to overfeed. Cue-based infant feeding should be utilized.

2. Nipple shield:
a. Application of the nipple shield:
i. Assess both mother and infant to choose the correct size nipple shield. Sizing a nipple shield is dependent on both the size of the infant's mouth and the size of the mother's nipple.
ii. The nipple shield may be placed under very warm water to increase pliability and enhance adherence to the breast. Colostrum or lanolin cream may also be used to help with adherence.
iii. Handle the shield by the rim. Place the shield over the breast with the nipple centered inside the nipple portion of the shield. Support the breast with a "C" hold. Place the thumb on both the top of the breast and the top part of the shield and place the fingers below, underneath the areola.
b. Latching the infant to the breast with a nipple shield:
i. Guide the mother to stroke the infant's lower lip with the shield. When the infant's mouth opens wide, bring the infant directly onto the shield allowing the infant to take as much of the areola as possible into the mouth.

ii. Allow the infant to breastfeed on one breast as long s/he likes. Repeat on the other breast if infant shows a desire to continue breastfeeding.

c. Cleaning and care of the nipple shield:
   i. Instruct the mother to wash her hands and the nipple shield in warm, soapy water, rinsing well before each use.
   ii. Store the shield with the nipple facing upward, and keep in a clean and dry covered container.

d. Reportable conditions and referral to a lactation consultant:
   i. Continued inability to sustain latch.
   ii. Absence of audible swallow after several minutes of sucking.
   iii. Infant weight loss greater than 7% below birth weight.
   ~~7.~~iv. Signs of dehydration or anemia.

3. Follow-up:
   a. If a mother is still using a breastfeeding aid (SNS or nipple shield) at the time of discharge, she will be referred to lactation services to schedule a follow-up outpatient lactation clinic appointment within a few days of discharge.
   b. It is not uncommon for a mother to use a breastfeeding aid for up to 6 months for the following conditions:
      i. Nipple abnormalities (e.g., flat, inverted, fibrous).
      ~~i.~~ii. Premature infant.

G. SUPPLEMENTATION FREQUENCY AND QUANTITY

	Frequency	Quantity
Term Infant (≥ 37.0 weeks)	➢ DOL 1: 8 attempts (usually 4-5 successful feedings) ➢ DOL 2: 8-12 times ➢ DOL 3 & 4: 8-12 times	➢ DOL 1: 5-10 ml per feeding ➢ DOL 2: 10-20 ml per feeding ➢ DOL 3: 20-30 ml per feeding ➢ DOL 4: 30-40 ml per feeding ➢ DOL 5: 40-50 ml per feeding ➢ DOL 6: 50-60 ml per feeding ➢ DOL 7 – 1st month: 60-90 ml per feeding *Volumes may vary depending on infant's weight
Late Preterm Infant (≥ 35.0 – 36.6)	➢ At least every 3 hours, more often based on infant feeding cues. ➢ Limit total feeding time to 30 minutes in order to minimize fatigue and conserve energy. *Late preterm have immature feeding capabilities, increased calorie needs, low metabolic stores, and are high risk for hyperbilirubinemia.	➢ DOL 1: 5-10 ml per feeding ➢ DOL 2: 10-20 ml per feeding ➢ DOL 3: 20-30 ml per feeding ➢ DOL 4: 30-40 ml per feeding ➢ DOL 5: 40-50 ml per feeding ➢ DOL 6: 50-60 ml per feeding ➢ DOL 7 – 1st month: 60-90 ml per feeding *May do better with smaller volumes

H. OTHER CONSIDERATIONS

1. Drugs to specifically suppress lactation will not be given to any postpartum mother.
2. It is recommended that mothers wait 6 weeks postpartum to receive Depo-Provera, unless the OB team feels it is indicated earlier.
3. Prior to administration of any drugs that may inhibit milk production, mothers will be counseled as to the risks.
4. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch technique and will be instructed to apply expressed

colostrum or breast milk to the areola after each feeding. Lanolin cream may be used if medically indicated.

I. COMPLIANCE WITH THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES

1. Employees of manufactures or distributers of breastmilk substitutes, bottles, nipples, or pacifiers have no direct communication with pregnant women or delivered mothers.
2. Tri-City Medical Center does not receive free gifts, non-scientific literature, material, equipment, money, or support for breastfeeding education or events from manufactures of breastmilk substitutes, bottles, nipples, or pacifiers.
3. No pregnant women, delivered mothers, or families are given marketing materials, samples, or gift packs by the facility that contain breastmilk substitutes, bottles, nipples, pacifiers, or any other infant feeding equipment or coupons for the above items.
4. All educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drink other than breastmilk.

~~B. PROCEDURE:~~

~~1. Tri-City Medical Center WCS staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary, culturally appropriate team comprising physician and nursing staff, lactation consultants and specialists, nutrition staff, and other appropriate staff shall be established and maintained to identify and eliminate institutional barriers to breastfeeding support services and formulate, along with the administrators, a plan of action to implement needed changes.~~

~~2. Written breastfeeding procedures will be in place and communicated to all health care staff. The Tri-City Medical Center Lactation Services policy and breastfeeding procedures will be reviewed and updated routinely (biannually) using current research as an evidence based guide.~~

~~3. All pregnant women and their support people, as appropriate, will be provided with information on breastfeeding and counseled on the benefits of breastfeeding, contraindications to breastfeeding, and risk of formula feeding.~~

~~4. The woman's desire to breastfeed will be documented in her medical record.~~

~~5. Mothers will be supported in their choice to exclusively breastfeed unless medically contraindicated. The method of feeding will be documented in the medical record of every infant. Exclusive breastfeeding is defined as providing breast milk as the sole source of nutrition. Exclusively breastfed babies receive no other liquids or solids.~~

~~6. Supplementation criteria include:~~

~~a. Infant weight loss> 10% and maternal milk volume judged to be insufficient.~~

~~b. Baby with extreme hunger cues ("frantic", excessive weight loss, signs/symptoms of dehydration, hyperbilirubinemia judged to be secondary to poor intake) and maternal milk volume judged to be insufficient.~~

~~c. Infant more than 24 hours old and unable to latch and/or suck.~~

~~d. Hypoglycemia after breastfeeding (see hypoglycemia policy)~~

~~e. Late preterm (>37 weeks)/low birth weight/IUGR infant.~~

~~f. Maternal insistence after education.~~

~~g. Infant separation from mother such that breastfeeding is not possible: Breast pump to be set up and initiated within 3 hours. Mother of baby to receive bedside education.~~

~~7. At birth or soon thereafter all newborns, if baby and mother are stable, will be placed skin to skin with the mother. Skin to skin contact involves placing the naked (with diaper and hat) baby prone on the mother's bare chest. Mother/infant couples will be given the opportunity to initiate breastfeeding within 1 hour of birth. Post cesarean birth babies will be encouraged to breastfeed as soon as possible. The administration of vitamin K and prophylactic antibiotics to prevent ophthalmia neonatorum may be delayed for the first 1 2 hours after birth to allow uninterrupted mother infant contact and breastfeeding.~~

~~8. Breastfeeding mother infant couples will be encouraged to remain together throughout their hospital stay. Skin to skin contact will be encouraged as much as possible.~~

9. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible with each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's medical record. This documentation may include:
   a. Latch,
   b. Position
   c. Any problems encountered.
   d. For feedings not directly observed, maternal report may be used.
   e. A direct observation of the baby's position and latch-on during feeding will be performed and documented as a LATCH score at least once a shift.
10. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and video presentations, as appropriate. If clinically indicated, the pediatrician/neonatologist or nurse will make a referral to a lactation consultant. (Refer to A.4.)
11. Breastfeeding mothers will be instructed about breastfeeding and the skills reviewed before discharge:
   a. Proper positioning and latch on.
   b. Nutritive suckling and swallowing.
   c. Milk production and release.
   d. Frequency of feeding/feeding cues.
   e. Expression of breast milk and use of a pump if indicated.
   f. How to assess if infant is adequately nourished.
   g. Reasons for contacting the clinician.
12. Parents will be encouraged to breastfeed their infants, including cesarean birth babies, 8 or more times each 24 hours. Infant feeding cues (such as increased alertness or activity, mouthing, or rooting,) will be used as indicators of the baby's readiness for feeding. Breastfeeding babies will be breastfed at night.
13. Time limits for breastfeeding on each side will be avoided. Infants can be offered both breasts at each feeding but may be interested in feeding only on one side at a feeding during the early days.
14. No supplemental water, glucose water, or formula will be given unless medically indicated or by the mother's documented and informed request. Prior to non-medically indicated supplementation, mothers will be informed of the risks of supplementing. The supplement should be fed to the baby by SNS or cup. (see WCS policy on Supplementation/Alternative Feeding Methods for Newborns). Bottles will not be placed in a breastfeeding infant's crib or room.
15. Those parents who, after appropriate counseling, choose to formula feed their infants will be provided individual instruction.
16. Preterm infants in the Neonatal Intensive Care Unit or infants with specific medical conditions may be given pacifiers for non-nutritive sucking. Newborns undergoing painful procedures (eg. Circumcision) may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier. Tri City Medical Center encourages "pain-free newborn care", which may include breastfeeding during the heel stick procedure for the newborn metabolic screening tests. Pacifiers are not recommended in the first 3-4 weeks until breastfeeding is well established in healthy newborns.
17. Routine blood glucose monitoring of full term healthy appropriate for gestational age (AGA) infants of mothers who are not diabetic is not indicated. Assessment for clinical signs of hypoglycemia and dehydration will be ongoing. (Refer to PCS Standardized Procedure: Newborn Hypoglycemia).
18. Drugs to specifically suppress lactation will not be given to any postpartum mother. It is recommended that mothers wait 6 weeks postpartum to receive Depo-Provera, unless the OB team feels it is indicated earlier.
19. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch-on techniques and will be instructed to apply expressed colostrum or breast milk to the areola after each feeding.
20. Soft pliable nipple shields may be initiated by RNs or lactation consultants, to cover a mother's nipple to treat latch-on problems or for sore or cracked nipples and/or for mother's flat or inverted nipples. The use of breastfeeding aids will be followed by the lactation consulting team.

21. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into the baby's mouth during feeding attempts. Skin-to-skin contact will be encouraged. (Parents will be instructed to watch closely for feeding cues and whenever these are observed to awaken and feed the infant.) If the baby continues to feed poorly, pumping with skilled hand expression or an electric breast pump will be initiated and maintained approximately every 3 hours or a minimum of eight times per day during wakeful hours. Any expressed colostrum or mother's milk will be fed to the baby by an alternative method. The mother will be reminded that she may not obtain much milk or even any milk the first few times she pumps her breasts. Until the mother's milk is available, a collaborative decision should be made among the mother, nurse, and her pediatrician regarding the need to supplement the baby. In cases of problem feeding, the lactation consultant or specialist will be consulted when available.
22. Infants that are not latching on or feeding well should not be discharged home. If, after assessment with the Lactation and the medical team a safe home discharge plan is agreed upon, this may allow early discharge.
23. All babies should be seen for follow-up within the first few days after discharge and/or as determined by the physician. This visit should be with a pediatrician or other qualified health care provider for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice and age appropriate elimination.
24. Mothers who are separated from their sick or premature infants will be seen by a lactation consultant before maternal discharge, and given a discharge pumping plan, assurance of proper pumping equipment, cooler for milk transport, and appropriate education. (Refer to WCS/NICU Procedure: Breast Milk, Pumping, Handling, and Storage of).
    a. Instructed on how to use skilled hand expression or the electric breast pump; instructions will include expression at least eight times per day or approximately every 3 hours for 15 minutes (or until milk flow stops, whichever is greater) around the clock and the importance of not missing a pumping session during the night.
    b. Encouraged to breastfeed on demand as soon as the infant's condition permits.
    c. Taught proper storage and labeling of human milk; and assisted in learning skilled hand expression or obtaining a double set up electric breast pump prior to going home.
25. Before leaving the hospital breastfeeding mothers should be able to:
    a. Position the baby correctly at the breast with no pain during the feeding.
    b. Latch the baby to breast properly.
    c. State when the baby is swallowing milk.
    d. State that the baby should be nursed approximately 8 to 12 times every 24 hours until satiety
    e. State age-appropriate elimination patterns (at least six urinations per day and three to four stools per day by the fourth day of life).
    f. List indications for calling a clinician.
    g. Manual expression of milk from their breasts.
26. Prior to going home, mothers will be given contact name(s) and the telephone number of TCMC's lactation community outpatient clinic to contact for help with breastfeeding.
27. Tri-City Medical Center health professionals will attend educational sessions on lactation management and breastfeeding promotion to ensure that correct, current, and consistent information is provided to all mothers wishing to breastfeed.
28. Breastfeeding is contraindicated in the following situations:
    a. HIV-positive mother.
    b. Mother using illicit drugs (for example, cocaine, heroin) unless specifically approved by the infant's health care provider on a case-by-case basis.
    c. A mother taking certain medications. Although most prescribed and over-the-counter drugs are safe for the breastfeeding infant, some medications may make it necessary to interrupt breastfeeding. These include radioactive isotopes, antimetabolites, cancer chemotherapy, and a small number of other medications.
    d. Mother has active, untreated tuberculosis.
    e. Infant has galactosemia.

~~f. Mother has active herpetic lesions on her breast(s) – breastfeeding can be recommended on the unaffected breast (the Infectious Disease Service will be consulted for problematic infectious disease issues).~~
~~g. Mother with varicella that is determined to be infectious to the infant.~~
~~h. Mother has HTLV1 (human T-cell leukemia virus type 1).~~

~~29.~~ ~~Nursing will follow the Ten Steps to Success Breastfeeding that include:~~
~~a. Have a written breastfeeding policy that is routinely communicated to all health care staff.~~
~~b. Train all health care staff in skills necessary to implement this policy.~~
~~c. Inform all pregnant women about the benefits and management of breastfeeding.~~
~~d. Help mothers initiate breastfeeding within 1 hour of birth.~~
~~e. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.~~
~~f. Give newborn infants no food or drink other than breast milk, unless medically indicated. (A hospital must pay fair market price for all formula and infant feeding supplies that it uses and cannot accept free or heavily discounted formula and supplies)~~
~~g. Practice rooming in – allow mothers and infants to remain together – 24 hours a day.~~
~~h. Encourage breastfeeding on demand.~~
~~i. Give no artificial teats or pacifiers to breastfeeding infants.~~
~~j.~~a. ~~Foster the establishment of breastfeeding support groups and refer mothers to them, on discharge from the hospital or clinic.~~

~~C.~~J. **FORM(S):**
1. Risks of Formula Supplementation
2. Lactation Education Handout
3. Delayed Newborn Bathing

~~D.~~K. **RELATED DOCUMENT(S):**
1. Women and Newborn Services: Standards of Care – Newborns
2. Formula Feeding Education Maternal Newborn (Mosby's Skills)

~~E.~~L. **EXTERNAL LINK(S):**
1. www.newbornchannel.com

~~F.~~M. **REFERENCE(S):**
1. **U.S. Department of Health and Human Services: HHS Blueprint for Action on Breastfeeding. 1–31. Washington, DC, U.S. Department of Health and Human Services, Office on Women's Health, 2000.**
2. **The American Academy of Pediatrics, Work Group on Breastfeeding: Breastfeeding and the use of human milk. Pediatrics: March 2012, volume 129/issue 3.**
3. **American College of Obstetricians and Gynecologists and Committees on Health Care for Underserved Women and Obstetric Practice, Queenan, JT (ed): Breastfeeding: Maternal and Infant Aspects. Washington, DC, The American College of Obstetricians and Gynecologists. Number 361, February 2007.**
4. **The American Academy of Family Physicians. Family Physicians Supporting Breastfeeding: Breastfeeding Position Paper 2008. http://www.aafp.org/about/policies/all/breastfeeding-support.html**
5. **World Health Organization, United Nations Children's Fund: Protecting, promoting and supporting breastfeeding: The special role of maternity services (A joint WHO/UNICEF statement). Int J Gynecol Obstet31:171–183, 1990.**
6. **Position of the American Dietetic Association: Supporting and Promoting Breastfeeding. J Am Diet Assoc105, 5:810-818, 2005.**
7. **Academy of Breastfeeding Medicine Board of Directors. ABM Mission Statement. www.bfmed.org.2003.**
8. **WHO/UNICEF Joint Statement. Meeting on Infant and Young Child Feeding. J Nurse-Midwifery25:31–38, 1980.**

9. World Health Organization and United Nations Children's Fund: Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. New York UNICEF, 1990.
10. Protocol Committee Academy of Breastfeeding Medicine, Cordes R, Howard CR: Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Newborn. www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
11. Howard CR, Howard FM, Lanphear B, et al: Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 111:511–518, 2003.
12. Howard CR, de Blieck EA, ten Hoopen CB, et al: Physiologic stability of newborns during cup and bottle feeding. Pediatrics104:1–7, 1999.
13. Marinelli KA, Burke GS, Dodd VL: A comparison of the safety of cup feedings and bottle feedings in premature infants whose mothers intend to breastfeed. J Perinatol 21:350–355, 2001.
14. Protocol Committee Academy of Breastfeeding Medicine, Eidelman AI, Howard CR, Schanler RJ, Wight NE: Clinical Protocol Number 1: Guidelines for Glucose Monitoring and Treatment of Hypoglycemia in Breastfed Neonates. ABM News and Views 5:insert, 1999.
15. Protocol Committee Academy of Breastfeeding Medicine, Gartner L, Howard C R: Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Infant and Mother, "The Going Home Protocol." www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
16. Hale TW: Medications and Mother's Milk, 16th ed. Amarillo, TX, Pharmasoft Medical Publishing, 2011.
17. Lawrence RA, Lawrence RM: Breastfeeding: A guide for the medical profession, 5th ed. St. Louis, Mosby, 1999.
18. Committee on Drugs, The American Academy of Pediatrics: The transfer of drugs and other chemicals into human milk. Pediatrics108:776–789, 2001.
19. Protocol Committee Academy of Breastfeeding Medicine, Chantry C, Howard CR, McCoy RC: Clinical Protocol #5: Peripartum Breastfeeding Management for the Healthy Mother and Infant at Term. www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
20. Riordan JM, Auerbach KG: Breastfeeding and Human Lactation. Boston, Jones and Bartlett Publishers, 1993.
21. American Academy of Pediatrics. Redbook: 2015 Report of the Committee on Infectious Diseases, 30th ed. Elk Grove, Ill, American Academy of Pediatrics, 2015.
22. Merewood A, Philipp BL: Breastfeeding: Conditions and Diseases. Amarillo, TX, Pharmasoft Publishers, 2001.
23. Breastfeeding Medicine Vol 2,Number 1 2010, ABM Clinical Protocol #7: Model Breastfeeding Policy
24. WHO Guidelines: Safe Preparation, Storage, and Handling of Powdered Infant Formula: http://www.who.int/foodsafety/publications/micro/pif_guidelines.pdf
25. AAP, Wight, N.E. (2008). Best Medicine: "Human Milk in the NICU": Hale Publishing, L.P.
26. Hoag-Nann, M. (2009). Lactation Management: "Techniques, Tips, and Tools for the Health Care Provider":Serif- Buffalo, NY.
27. La Leche League International. (2006) "The Breastfeeding Answer Book: Latch on problems".
28. Manufacturer's Guidelines (2009): Medela Inc. "Nipple Shield Usage, Cleaning and Care" pamphlet.
~~1.~~29. WCS/NICU Policy # 6385-200: "LACTATION SERVICES".
~~1. American Academy of Pediatrics. (2005) Section on Breastfeeding and the use of human milk. *Pediatrics; 115:496-506.*~~
~~2. Riordan J., & Wambach K. (2009). *Breastfeeding and Human Lactation,* (4th Edition), Jones and Barlett, pgs. 350-353.~~
~~3. Lawrence, R.A. & Lawrence R.M. (2005). *A Guide for the Medical Profession* – (6th Ed). Mosby Inc.~~
~~4. American Academy of Pediatrics. (2009). Redbook: Report of the Committee on Infectious Diseases, (28th Ed.) Elk Grove, Ill.~~

Mosbys Online - OB (Tri-City Medical Center Intranet): Breastfeeding: Patient Teaching; Breast Pump.

	Objectives	Content	Method of Education
1	Discuss the rationale for professional, government, and international policies that promote, protect, and support breastfeeding in the United States.	**The BFHI: A Part of the Global Strategy** ➢ The Global Strategy for Infant and Young Child Feeding and how it fits with other activities ➢ How the BFHI can assist health care facilities to implement evidence-based practice, improve quality of care, and deliver continuity of care	✓ First Latch Module
2	Demonstrate the ability to communicate effectively about breastfeeding.	**Communication Skills** ➢ Listening and learning ➢ Skills to build confidence and give support ➢ Arranging follow-up and support suitable to the mother's situation	✓ First Latch Module ✓ 1:1 time with lactation consultant
3	Describe the anatomy and physiology of lactation and the process of breastfeeding.	**How Milk Gets from the Breast to the Infant** ➢ The parts of the breast involved in lactation ➢ Breastmilk production ➢ The infant's role in milk transfer ➢ Breast care	✓ First Latch Module
4	Identify teaching points appropriate for prenatal classes and interactions with pregnant women.	**Promoting Breastfeeding During Pregnancy** ➢ Discussing breastfeeding with pregnant women ➢ Why breastfeeding is important ➢ Antenatal breast and nipple preparation ➢ Identifying women who need extra attention	✓ First Latch Module ✓ 1:1 time with lactation consultant
5	Discuss hospital birthing policies and procedures that support exclusive breastfeeding.	**Birth Practices and Breastfeeding** ➢ Labor and birth practices to support early breastfeeding ➢ The importance of early STS contact ➢ Helping with initiation of breastfeeding ➢ Ways to support breastfeeding after cesarean ➢ BFHI practices for women who are not breastfeeding	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
6	Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	**Helping the Mother Breastfeed** ➢ How to assess breastfeeding ➢ When to assist with breastfeeding ➢ Identify optimal positioning and latch ➢ Help mothers learn to position and latch her infant ➢ Positioning for comfortable breastfeeding ➢ Identifying the infant who has difficulty attaching to the breast	✓ First Latch Module ✓ 1:1 time with a lactation consultant
7	Discuss hospital postpartum management policies and procedure that support exclusive breastfeeding.	**Practices that Promote Breastfeeding** ➢ Rooming-in ➢ STS ➢ Recognizing feeding cues, feeding on demand ➢ Management of sleepy or fussy infants ➢ Avoiding unnecessary supplementation ➢ Avoiding artificial nipples and pacifiers	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
8	Discuss methods that may increase milk production in a variety of circumstances.	**Milk supply** ➢ Addressing mother's concerns about "not enough milk" ➢ Normal growth patterns of infants ➢ Improving milk intake and milk production	✓ First Latch Module ✓ 1:1 time with a lactation consultant
9	Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	**Supporting the non-breastfeeding mother and infant** ➢ Counseling the formula choice: a pediatric responsibility ➢ Teaching/assuring safe formula preparation in the postpartum period ➢ Safe bottle feeding; issues with overfeeding and underfeeding	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant

10	Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their infants.	**Infants and Mothers with Special Needs** ➢ Breastfeeding infants who are preterm, low birth weight, and/or ill ➢ Breastfeeding more than one infant ➢ Prevention and management of common clinical concerns ➢ Medical reasons for breast milk substitutes ➢ Nutritional needs of breastfeeding women ➢ Breastfeeding and birth control ➢ Breastfeeding management when the mother is ill ➢ Medications and breastfeeding ➢ Contraindications to breastfeeding	✓ First Latch Module ✓ 1:1 time with a lactation consultant ✓ Review policies and procedures
11	Describe interventions for breast and nipple problems.	**Breast and Nipple Concerns** ➢ Examination of the mother's breasts and nipples ➢ Engorgement, blocked ducts, and mastitis ➢ Sore nipples	✓ First Latch module
12	Identify acceptable medical indications for supplementation of breast fed infants according to national and international authorities.	**If the Infant Cannot Feed at the Breast** ➢ Learning to hand express ➢ Use of donor milk ➢ Feeding EBM to the infant	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
13	Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	**Ongoing Support for Mothers** ➢ Preparing a mother for discharge ➢ Follow-up and support after discharge ➢ Protecting breastfeeding for employed women ➢ Sustained breastfeeding beyond one year	✓ First Latch Module ✓ Learn about breastfeeding support group during orientation ✓ San Diego County Breastfeeding Coalition resource guide
14	Describe strategies that protect breastfeeding as a public health goal.	**Protecting Breastfeeding** ➢ The effects of marketing on infant feeding practices ➢ The International Code of Marketing of Breastmilk Substitutes ➢ How health care workers can protect families from marketing ➢ How to respond to marketing practices ➢ Donor milk in emergency situations ➢ The role of breastfeeding in emergencies	✓ First Latch Module ✓ Review policies and procedures
15	Identify both the barriers and the solutions to implementing the Ten Steps to Successful Breastfeeding.	**Making Your Hospital or Birth Center Baby Friendly** ➢ The Ten Steps to Successful Breastfeeding ➢ What "Baby Friendly" practices are ➢ The process of becoming a "Baby Friendly" hospital or birth center	✓ First Latch Module

Baby Friendly Training Requirements	
Position	**Training Required**
Registered Nurses	First Latch Module – BFHI General Healthcare: 15 hours
Lactation Consultants	First Latch Module – BFHI General Healthcare: 15 hours
Dieticians	First Latch Module – BFHI General Healthcare: 15 hours
Occupational Therapists	First Latch Module – BFHI General Healthcare: 15 hours
Pediatricians	First Latch Module – BFHI Provider Training: 3 hours
Neonatologists	First Latch Module – BFHI Provider Training: 3 hours
Obstetricians	First Latch Module – BFHI Provider Training: 3 hours
Anesthesiologists	First Latch Module – BFHI Provider Training: 3 hours
Midwives	First Latch Module – BFHI Provider Training: 3 hours
PAs	First Latch Module – BFHI Provider Training: 3 hours
NNPs	First Latch Module – BFHI Provider Training: 3 hours
OB Techs	First Latch Module – BFHI Ancillary Training: 3 hours
Advanced Care Technicians (ACT)	First Latch Module – BFHI Ancillary Training: 3 hours
Hearing Screeners	First Latch Module – BFHI Ancillary Training: 3 hours
Social Workers	First Latch Module – BFHI Ancillary Training: 3 hours
Environmental Services (EVS)	Review and sign Ten Steps for Successful Breastfeeding
Unit Secretaries	Review and sign Ten Steps for Successful Breastfeeding
Peri Operative Aides	Review and sign Ten Steps for Successful Breastfeeding
Birth Clerks	Review and sign Ten Steps for Successful Breastfeeding
Respiratory Therapists	Review and sign Ten Steps for Successful Breastfeeding
Case Managers	Review and sign Ten Steps for Successful Breastfeeding
Newborn Photographers	Review and sign Ten Steps for Successful Breastfeeding

Tri-City Medical Center
Oceanside, California

Clean Copy

WOMEN'S AND CHILDREN'S SERVICES

ISSUE DATE: 10/94 **SUBJECT:** INFANT FEEDINGS

REVISION DATE(S): 01/00, 06/03, 12/09, 04/10, 06/14

Department Approval:	**01/18**
Department of Pediatrics Approval:	**02/18**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**03/18**
Professional Affairs Committee Approval:	**06/14**
Board of Directors Approval:	**06/14**

A. **DEFINITION(S):**

1. Skin to Skin (STS): Direct physical contact between the newborn infant and mother. After birth, the healthy term infant should be completely dried and placed naked against the mother's naked chest. The infant may wear a diaper and/or hat, but no other clothing should be between the mother's and infant's bodies. The infant and mother are then covered with a warmed blanket, keeping the infant's head uncovered. STS contact should continue, uninterrupted, until the completion of the first feeding (or for at least 1 hour if the mother is not breastfeeding). STS contact should be encouraged beyond the first hours and into the first days after birth. Another adult may hold the infant STS if/when the mother is not available.

B. **POLICY:**

1. To promote a philosophy of maternal infant care that advocates breastfeeding and supports the normal physiological functions involved in the establishment of this maternal infant process.
2. To assist families choosing to breastfeed with initiating and developing a successful and satisfying experience.
3. This policy is adapted from the Academy of Breastfeeding Medicine (AMB): AMB Clinical Protocol # 7: Model Breastfeeding Policy (2010) which is based on recommendations from the most recent breastfeeding policy statements published by the Office on Women's Health of the U.S. Department of Health and Human Services, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the World Health Organization (WHO), and the American Dietetic Association.
4.
5. This policy encompasses the UNICEF/WHO evidence-based Ten Steps to Successful Breastfeeding; practices that have been shown to increase breastfeeding initiation and duration.
6. Tri-City Medical Center complies with the WHO International Code of Marketing of Breastmilk Substitutes.

C. **PROCEDURE:**

1. **Have a written breastfeeding policy that is routinely communicated to all health care staff.**
   a. Tri-City Medical Center staff will actively support breastfeeding as the preferred method of providing nutrition to infants. A multidisciplinary team comprised of physicians, midwives, nursing, lactation consultants, dietary, and outpatient providers shall be established and maintained to identify and eliminate institutional barriers to breastfeeding. This group will evaluate data relevant to breastfeeding support services and formulate, along with administrators, a plan of action to implement needed changes.
   b. Tri-City Medical Center upholds the WHO International Code of Marketing of Breastmilk Substitutes by offering education and materials that promote human milk rather than other infant food or drink, and by refusing to accept or distribute free or subsidized supplies of breastmilk substitutes, nipples, and other feeding devices. Mothers will be protected from

the promotion of breastmilk substitutes and other efforts that undermine an informed feeding choice.

c. This written breastfeeding policy will be communicated to all health care staff members. It will be reviewed and updated every 2 years (per medical center policy) or as needed using current research as an evidence-based guide.

d. All new Women and Newborn Services' staff and care providers will be oriented to the policy during their initial orientation. The orientation process is different for type of hire and is detailed in the Women and Newborn Services Lactation Education Checklist (see Attachment B). Staff and care providers will be expected to read and sign the policy.

e. This policy will be readily available to all areas of Tri-City Medical Center that potentially interact with childbearing women and infants so that they may promote, protect, and support breastfeeding in all departments. Other department's polices will support, and will not countermand the medical center's infant feeding policy.

2. **Train all health care staff in the skills necessary to implement this policy.**

a. The nursing leadership team will ensure that all staff working in the Women and Newborn Services department (excluding the NICU) will receive a minimum of 20 hours of education, including at least 5 hours of supervised clinical training, on the topics specified by the BFHI (see Attachment A). For new employees, this training will be completed within 6 months of hire. Details for the execution of the training are specified in a separate training plan: Baby Friendly Training Requirements (Attachment B).

b. Upon completion of training for new employees, the staff preceptor will supervise and verify the clinical competency of the new staff member. This will be documented in the orientation checklist and maintained in the employee file. Staff will receive adequate training and mentorship to attain competence in:

i. Counseling the feeding decision
ii. Skin to skin (STS) in the immediate postpartum period
iii. Comfortable and effective positioning and attachment at the breast
iv. Assessing and documenting a latch score
v. Maintenance of exclusive breastfeeding
vi. Feeding cues
vii. Rooming-in
viii. Hand expression
ix. Formula preparation and feeding when necessary
x. Finding support upon discharge

c. Documentation of all training will be maintained by the Lactation Supervisor and/or appropriate CNS on the BFHI Staff Training Documentation Checklist.

d. Providers with privileges for labor, delivery, maternity, anesthesia, and/or newborn care will have a minimum of 3 hours of breastfeeding management education pertinent to their role. Education will be verified by successful completion of the First Latch module and a certificate of completion will be verified and maintained by a provider coordinator.

e. The content and number of hours of training for other staff will be developed based on job description and workplace exposure to breastfeeding couplets.

3. **Inform all pregnant women about the benefits and management of breastfeeding.**

a. Physicians, midwives, and nurses providing prenatal services are responsible for educating pregnant women and their support people about breastfeeding. Education will cover the importance of exclusive breastfeeding, non-pharmacologic pain relief methods for labor, the importance of early STS contact, early initiation of breastfeeding, rooming-in, feeding on demand, frequent feeding to help assure optimal milk production, effective positioning and attachment, exclusive breastfeeding for the first 6 months, and that breastfeeding continues to be important after 6 months even after other foods are introduced. Contraindications to breastfeeding and other special medical conditions will be discussed as indicated. Education will be documented in the prenatal record.

b. Exclusive breastfeeding is defined as providing breastmilk as the sole source of nutrition to infants. Exclusively breastfed infants receive no other liquids or solids unless medically indicated. Mothers will be encouraged to exclusively breastfeed unless medically contraindicated. The planned feeding method will be documented in the prenatal record.

c. Tri-City Medical Center does not distribute educational materials in which the use of formula or infant feeding bottles is discussed routinely.
d. Tri-City Medical Center offers no group education on the use of infant formula or feeding bottles.
e. Breastfeeding classes are offered by Tri-City Medical Center. Pregnant women who receive services at Tri-City Medical Center will receive written information regarding the benefits of breastfeeding as well as an explanation of practices implemented in the Women and Newborn Services department that support successful breastfeeding.
f. Tri-City Medical Center fosters the development of community-based programs that make available individual counseling or group education on breastfeeding and collaborates with community-based programs to coordinate breastfeeding messages.
g. Tri-City Medical Center provides organizations that offer prenatal services curriculum that includes essential information to be taught to the pregnant woman regarding breastfeeding.
h. Members of the staff at Tri-City Medical Center participate in the local breastfeeding coalition.

4. **Help mothers initiate breastfeeding within one hour of birth.**
   a. Immediately after delivery, all term infants, regardless of feeding preference, will be placed STS with the mother as long as the infant and mother are stable and it is not medically contraindicated.
   b. STS contact including any reasons for delaying STS will be documented in the infant's medical record.
   c. Preterm or unstable infants or infants having required resuscitation will be placed STS as soon as possible after medical stability has been established.
   d. The nursing staff present at the delivery has the responsibility to create the optimal environment for transition of the infant and initiation of the first breastfeeding. This encompasses placing the infant STS with mother immediately after birth (including cesarean deliveries if possible), assisting the mother in recognizing infant signs of feeding readiness, and allowing the infant the opportunity to self-attach to the breast. Vaginal delivery mother/infant couplets will be given the opportunity to initiate breastfeeding within 1 hour of birth. Cesarean delivery mother/infant couplets will be given the opportunity to initiate breastfeeding as soon as possible.
   e. Time of initiation of STS contact as well as the time this contact ends will be documented in the medical record.
   f. During the initial period of STS contact, routine newborn procedures will be postponed (up to 2 hours) until the first breastfeeding has been completed. Assessments and procedures (including the administration of vitamin K and erythromycin eye ointment) should be performed while the infant is still STS with the mother.
   g. After 24 hours of life, the stable infant may receive a bath upon parent's request.
      i. Earlier bathing may be considered in the instances of specific parental request, meconium stained infant, or malodorous amniotic fluid.
      ii. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after the delivery.
      iii. Education is provided to parents about delayed bathing to include the importance of initial bonding, STS, and establishment of breastfeeding.
   h. STS contact will be encouraged throughout the hospital stay.

5. **Show mothers how to breastfeed and how to maintain lactation even if separated from their infants.**
   a. The nurse will assess the mother's breastfeeding techniques and, if needed, will demonstrate appropriate breastfeeding positioning and attachment, optimally within 3 hours, and no later than 6 hours after birth.
   b. Breastfeeding assessment, teaching, and documentation will be done on each shift and whenever possible during each staff contact with the mother. After each feeding, staff will document information about the feeding in the infant's medical record. This documentation may include the latch, position, and any problems encountered. For feedings not directly observed, maternal report may be used. Every shift, a direct observation of the infant's

position and latch during feeding will be performed and documented. If the LATCH score is < 7, the nurse will document any interventions and the infant's response to those interventions. The LATCH score will be repeated with the next feed.

c. Mothers will be encouraged to utilize available breastfeeding resources including classes, written materials, and the newborn channel as appropriate. If clinically indicated, the provider or nurse will make a referral to a lactation consultant. The mother will be given a breastfeeding log book and shown how to monitor feedings and diapers, as well as information about breastfeeding support groups.

d. Parents will be taught that breastfeeding infants, including cesarean-birth infants, should be put to breast at least 8 to 12 times in 24 hours. Infant feeding cues (such as increased alertness, activity, mouthing, or rooting) will be used as indicators of the infant's readiness for feeding. Breastfeeding mothers will be instructed about breastfeeding and the following principles and skills reviewed before discharge:
   i. Importance of exclusive breastfeeding
   ii. How to maintain lactation for exclusive breastfeeding for up to 6 months
   iii. Proper positioning and latch
   iv. Nutritive sucking and swallowing
   v. Milk production and release
   vi. Frequency of feeding/feeding cues
   vii. How to manually express, pump, handle, and store breastmilk
   viii. How to assess if the infant is adequately nourished
   ix. Reasons to contact the provider
   x. How to sustain lactation if separated from the infant or if not exclusively breastfeeding after discharge

e. Time limits for breastfeeding on each side will be avoided. Infants may be offered both breasts at each feeding but may be interested in feeding on only one side early on.

f. When a mother must be separated from her infant, the staff will instruct the mother to begin expressing her breastmilk within 3 hours of the separation. The mother will be taught how frequently to express her milk as well as proper storage and handling. The EBM (expressed breastmilk) will be given to the infant as soon as the infant is medically stable. The mother's EBM will be used before any supplementation with breastmilk substitutes unless otherwise contraindicated.

g. A mother discharged home without her infant due to illness or prematurity will be seen by a lactation consultant before discharge and will be given a discharge pumping plan and appropriate education:
   i. Instruction on hand expression and the electric breast pump:
      1) Expression/pumping at least 8 times per day, approximately every 3 hours for 15 minutes or until milk flow stops.
      2) The importance of continuing to pump throughout the night.
      3) For mothers who will be separated from their infants for an extended period of time, instruct to pump 6 times a day once milk supply is established.
   ii. Encouraged to breastfeed on demand as soon as the infant's condition permits.
   iii. Encouraged to practice daily STS when the infant is medically stable.
   iv. Instruction on proper storage and labeling of breastmilk.
   v. Assistance in obtaining a double set up electric breast pump prior to going home.

h. The mother who chooses to feed her infant a breastmilk substitute will be given written and verbal information regarding appropriate hygiene, preparation, storage, handling, and feeding of the substitute. This education will be documented in the medical record.
   i. Ready to feed formula or liquid concentrate is recommended for the first 2 months of life.
   ii. Families with WIC or those who will be using powdered formula will be given information regarding safe preparation. (see WHO Guidelines: How to Prepare Formula for Bottle-Feeding at Home):
      1) Powdered formula is not sterile.
      2) Mix powder with hot water (158 degrees F/70 degrees C).
      3) Allow formula to cool prior to feeding to the infant.

6. **Give infants no food or drink other than breastmilk, unless medically indicated.**
   a. For healthy term infants, no supplemental water or glucose water will be given.
   b. For healthy term infants, no breastmilk substitute will be given unless by a provider's order or standardized procedure. Note: Breastmilk substitutes should not be used as a prophylactic measure for anticipated weight loss, jaundice, etc.
   c. Infants who are receiving supplemental nutrition will be offered alternative feeding methods to avoid the use of bottles and nipples if acceptable to the mother and achievable according to staff. These methods include:
      i. Supplemental Nursing System (SNS)
      ii. Finger Feeding
      iii. Cup feeding
   d. EBM, if available, will be given prior to supplementation with a breastmilk substitute. If EBM is not immediately available, it will be given as soon as it is available.
   e. Each day the provider will be consulted regarding the volume and type of supplement.
   f. If formula supplementation is medically indicated, an order is needed and the nurse must document initial reason(s) and ongoing indications.
   g. If a mother requests her infant be supplemented with a breastmilk substitute, staff will explore and address the mother's concerns. The mother will be given the Risks of Formula Supplementation handout for review. If the mother's request for formula persists, the provider will be called for an order for formula. The education to the risks of formula and informed decision of the patient will be documented. The mother will be given supplies and education (refer to Mosby's Skills – Formula Feeding Education Maternal Newborn).
   h. Assessment for clinical signs of hypoglycemia and dehydration will be ongoing. Routine glucose monitoring of full term (AGA, non IDM) infants is not indicated.
   i. Before 24 hours of life, if the infant has not latched on or fed effectively, the mother will be instructed to begin breast massage and hand expression of colostrum into a spoon or the infant's mouth during feeding attempts. STS contact will be encouraged. Parents will be instructed to watch closely for feeding cues, and when observed, to feed the infant. If the infant continues to feed poorly, hand expression and/or an electric breast pump (and pumping with breast massage) will be introduced and maintained approximately every 3 hours, or a minimum of 8 times per day. Any expressed colostrum or mother's milk will be fed to the infant by SNS, finger feeding, or cup feeding. The mother will be educated that it is normal not to obtain much milk or even any milk the first few times she pumps her breasts. The lactation consultant or specialist should also be consulted for these cases.
   j. Breastfeeding is contraindicated for:
      i. Mothers who are HIV-positive.
      ii. Mothers who abuse illicit drugs or alcohol.
      iii. Mothers who are taking certain high risk medications. (Most prescribed and over-the-counter medications are safe for the breastfeeding infant, however some may be contraindicated while breastfeeding.)
      iv. Mothers who have active, untreated tuberculosis (infant may safely receive EBM).
      v. Infants who have galactosemia, maple syrup disease, or phenylketonuria.
      vi. Mothers with active herpetic lesions on the breast(s). (The Infectious Disease Department should be consulted for any problematic infectious disease issues regarding safety of STS, direct breastfeeding, and/or EBM.)
      vii. Mothers with varicella that is determined to be infectious to the infant.
      viii. Mothers with HTLV1 (human T-cell leukemia virus type 1)
7. **Practice rooming-in – allow mothers and infants to remain together 24 hours a day.**
   a. Mother/infant couplets (regardless of maternal feeding preference) will begin rooming-in immediately after delivery and will not be separated during hospitalization as long as both are medically stable and mother/family are able to care for infant.
   b. Routine newborn procedures will be done at the mother's bedside.
   c. Infants can only be admitted to couplet care or the NICU.
   d. If an infant needs to be separated from its mother, documentation of the location, reason, and the expected time period will be recorded.

e. The infant will be reunited with the mother as soon as possible. If an infant and mother are separated, the staff will support exclusivity of breastfeeding.
f. If a mother requests that her infant be taken out of the room, staff will explore the mother's reason for the request, will educate her on the benefits of continuing to room in, and will document as appropriate.

8. **Encourage breastfeeding on demand.**
   a. All mothers will be taught to feed their infant when the infant exhibits signs of feeding readiness. Mothers will be taught to recognize these feeding cues in the infant.
   b. Mothers will be informed of normal newborn feeding behaviors such as cluster feeding, feeding through the night, and a normal feeding schedule of at least 8-12 feedings in a 24 hour period.
   c. No limitations will be taught to mothers regarding length or number of feedings.
   d. Parents will be taught that both physical contact and nourishment are important parts of the feeding process.
9. **Give no pacifiers or artificial nipples to breastfeeding infants.**
   a. Pacifiers will not be given to healthy, full-term breastfeeding infants.
   b. Preterm infants in the NICU or infants with specific medical conditions may be given pacifiers for non-nutritive sucking.
   c. Infants undergoing painful procedures may be given a pacifier as a method of pain management during the procedure. The infant will not return to the mother with the pacifier.
   d. Pain management interventions during uncomfortable or distressing procedures will be used whenever possible. This may include breastfeeding during a heel stick procedure for infant blood tests.
   e. If a parent requests a pacifier, artificial nipples, or feeding bottles they will be educated regarding possible negative consequences as it relates to breastfeeding and this education will be documented.
   f. Any supplementation should be given by SNS, finger feeding, or cup feeding before introduction of an artificial nipple or bottle.
   g. A nipple shield may be given by the RN or lactation consultant to manage latch problems, or sore or cracked nipples. The RN or lactation consultant will document why the nipple shield was given and the infant's response to the intervention. Mothers using nipple shields will be followed by a lactation consultant.
10. **Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.**
    a. Infants that are not feeding well should not be discharged home.
    b. Before leaving the hospital breastfeeding mothers should be able to:
       i. Position and latch the infant correctly at the breast with no/minimal discomfort during feeding.
       ii. Recognize when the infant is swallowing milk.
       iii. State that the infant should be breastfed approximately 8 to 12 times in 24 hours.
       iv. State an age-appropriate elimination pattern – at least 6 voids and 3 to 4 stools per day by the fourth day of life.
       v. List indications for calling the provider.
       vi. Manually express milk from her breasts.
    c. Prior to going home, mothers will be given the names and telephone numbers of community resources to contact for help with breastfeeding including the Tri-City Medical Center breastfeeding clinic and support group.
    d. All infants should be seen for follow-up within the first few days after discharge. This visit should be with a pediatrician or other qualified health care practitioner for a formal evaluation of breastfeeding performance, a weight check, assessment of jaundice, and age-appropriate elimination.

D. **BREASTFED NEWBORN INPUT AND OUPUT NORMS**

Age in hours	Milk volume per feeding	# feeds	# voids	# stools
0-24	0-5 mLs / drops	6-8	≥ 1	≥ 1
24-48	5-10 mLs / 1 tsp	≥ 8	≥ 2	≥ 2
48-72	10-20 mLs / 1 tbsp	≥ 8	≥ 3	≥ 3
72-96	20-30 mLs / 1 oz	≥ 8	≥ 4	≥ 4
> 96	> 30 mLs / > 1 oz	≥ 8	≥ 5-12	≥ 5-12

1. Infant has 24 hours to void and 48 hours to stool after birth.
2. There may be a lull in stooling after meconium is cleared while baby waits for milk to come in.
3. Infants may feed VERY frequently before the milk comes in; even hourly for the first few nights.

E. **MEDICAL INDICATIONS FOR SUPPLEMENTATION**

1. When making the decision to start supplementation, it is necessary to look at all the factors involved. Weight loss alone does not imply the need for supplementation. Breastfeeding assessment, assistance, and education should be done prior to starting supplementation.
2. Possible medical indications for supplementation include:
    a. Infant risk factors:
        i. Asymptomatic Hypoglycemia unresponsive to appropriate, frequent breastfeeding
        ii. Inadequate intake as evidenced by:
            1) Clinical or laboratory evidence of clinical dehydration (high sodium, poor feeding, lethargy) that is not improved after skilled assessment and proper management of breastfeeding.
            2) Excessive weight loss (≥ 10%):
                a) Note that excessive newborn weight loss is correlated with positive maternal intravenous fluid balance and may not be directly indicative of breastfeeding success or failure.
                b) Number of voids and stools should be taken into consideration.
            3) Delayed bowel movements: < 4 stools on DOL 4, or continued meconium stools on DOL 5.
        iii. Hyperbilirubinemia
            1) With ongoing weight loss, limited stooling, and voiding with uric acid crystals.
        iv. Inborn errors of metabolism
    b. Maternal risk factors:
        i. Delayed secretory activation.
        ii. Primary glandular insufficiency as evidenced by:
            1) Abnormal breast shape
            2) Poor breast growth during pregnancy
            3) Prior breast surgery resulting in poor milk production
        iii. Intolerable pain during feedings unrelieved by interventions.

F. **SUPPLEMENTAL NURSING SYSTEMS (SNS) AND NIPPLE SHIELDS**

1. Supplemental Nursing System (SNS):
    a. Assemble the SNS tubing with a syringe or container; considered a single-use piece of equipment.
    b. Gently tape the tubing to the mother's breast with the end of the tubing extending about ¼ inch beyond the end of her nipple.
    c. Assist the mother in latching the infant to the breast and tubing as needed.
        i. Sucking from the infant creates a siphon effect and allows supplementation from the reservoir of the syringe or SNS container kit.
    d. Supplementation should be monitored accordingly.
        i. Amounts of EBM or breastmilk substitute should be measured to meet the infant's needs.

ii. 10-15 ml of EBM or breastmilk substitute is considered adequate intake for the newborn infant. It is important not to overfeed. Cue-based infant feeding should be utilized.

2. Nipple shield:
   a. Application of the nipple shield:
      i. Assess both mother and infant to choose the correct size nipple shield. Sizing a nipple shield is dependent on both the size of the infant's mouth and the size of the mother's nipple.
      ii. The nipple shield may be placed under very warm water to increase pliability and enhance adherence to the breast. Colostrum or lanolin cream may also be used to help with adherence.
      iii. Handle the shield by the rim. Place the shield over the breast with the nipple centered inside the nipple portion of the shield. Support the breast with a "C" hold. Place the thumb on both the top of the breast and the top part of the shield and place the fingers below, underneath the areola.
   b. Latching the infant to the breast with a nipple shield:
      i. Guide the mother to stroke the infant's lower lip with the shield. When the infant's mouth opens wide, bring the infant directly onto the shield allowing the infant to take as much of the areola as possible into the mouth.
      ii. Allow the infant to breastfeed on one breast as long s/he likes. Repeat on the other breast if infant shows a desire to continue breastfeeding.
   c. Cleaning and care of the nipple shield:
      i. Instruct the mother to wash her hands and the nipple shield in warm, soapy water, rinsing well before each use.
      ii. Store the shield with the nipple facing upward, and keep in a clean and dry covered container.
   d. Reportable conditions and referral to a lactation consultant:
      i. Continued inability to sustain latch.
      ii. Absence of audible swallow after several minutes of sucking.
      iii. Infant weight loss greater than 7% below birth weight.
      iv. Signs of dehydration or anemia.
3. Follow-up:
   a. If a mother is still using a breastfeeding aid (SNS or nipple shield) at the time of discharge, she will be referred to lactation services to schedule a follow-up outpatient lactation clinic appointment within a few days of discharge.
   b. It is not uncommon for a mother to use a breastfeeding aid for up to 6 months for the following conditions:
      i. Nipple abnormalities (e.g., flat, inverted, fibrous).
      ii. Premature infant.

G. SUPPLEMENTATION FREQUENCY AND QUANTITY

	Frequency	Quantity
Term Infant (≥ 37.0 weeks)	➢ DOL 1: 8 attempts (usually 4-5 successful feedings) ➢ DOL 2: 8-12 times ➢ DOL 3 & 4: 8-12 times	➢ DOL 1: 5-10 ml per feeding ➢ DOL 2: 10-20 ml per feeding ➢ DOL 3: 20-30 ml per feeding ➢ DOL 4: 30-40 ml per feeding ➢ DOL 5: 40-50 ml per feeding ➢ DOL 6: 50-60 ml per feeding ➢ DOL 7 – 1st month: 60-90 ml per feeding *Volumes may vary depending on infant's weight
Late Preterm Infant (≥ 35.0 – 36.6)	➢ At least every 3 hours, more often based on infant feeding cues.	➢ DOL 1: 5-10 ml per feeding ➢ DOL 2: 10-20 ml per feeding ➢ DOL 3: 20-30 ml per feeding

	➢ Limit total feeding time to 30 minutes in order to minimize fatigue and conserve energy. *Late preterm have immature feeding capabilities, increased calorie needs, low metabolic stores, and are high risk for hyperbilirubinemia.	➢ DOL 4: 30-40 ml per feeding ➢ DOL 5: 40-50 ml per feeding ➢ DOL 6: 50-60 ml per feeding ➢ DOL 7 – 1st month: 60-90 ml per feeding *May do better with smaller volumes

H. **OTHER CONSIDERATIONS**

1. Drugs to specifically suppress lactation will not be given to any postpartum mother.
2. It is recommended that mothers wait 6 weeks postpartum to receive Depo-Provera, unless the OB team feels it is indicated earlier.
3. Prior to administration of any drugs that may inhibit milk production, mothers will be counseled as to the risks.
4. Routine use of nipple creams, ointments, or other topical preparations will be avoided unless such therapy has been indicated for a dermatological problem. Mothers with sore nipples will be observed for latch technique and will be instructed to apply expressed colostrum or breast milk to the areola after each feeding. Lanolin cream may be used if medically indicated.

I. **COMPLIANCE WITH THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES**

1. Employees of manufactures or distributers of breastmilk substitutes, bottles, nipples, or pacifiers have no direct communication with pregnant women or delivered mothers.
2. Tri-City Medical Center does not receive free gifts, non-scientific literature, material, equipment, money, or support for breastfeeding education or events from manufactures of breastmilk substitutes, bottles, nipples, or pacifiers.
3. No pregnant women, delivered mothers, or families are given marketing materials, samples, or gift packs by the facility that contain breastmilk substitutes, bottles, nipples, pacifiers, or any other infant feeding equipment or coupons for the above items.
4. All educational materials distributed to breastfeeding mothers are free from messages that promote or advertise infant food or drink other than breastmilk.

J. **FORM(S):**

1. Risks of Formula Supplementation
2. Lactation Education Handout
3. Delayed Newborn Bathing

K. **RELATED DOCUMENT(S):**

1. Women and Newborn Services: Standards of Care – Newborns
2. Formula Feeding Education Maternal Newborn (Mosby's Skills)

L. **EXTERNAL LINK(S):**

1. www.newbornchannel.com

M. **REFERENCE(S):**

1. U.S. Department of Health and Human Services: HHS Blueprint for Action on Breastfeeding. 1–31. Washington, DC, U.S. Department of Health and Human Services, Office on Women's Health, 2000.
2. The American Academy of Pediatrics, Work Group on Breastfeeding: Breastfeeding and the use of human milk. Pediatrics: March 2012, volume 129/issue 3.
3. American College of Obstetricians and Gynecologists and Committees on Health Care for Underserved Women and Obstetric Practice, Queenan, JT (ed): Breastfeeding: Maternal and Infant Aspects. Washington, DC, The American College of Obstetricians and Gynecologists. Number 361, February 2007.

4. The American Academy of Family Physicians. Family Physicians Supporting Breastfeeding: Breastfeeding Position Paper 2008. http://www.aafp.org/about/policies/all/breastfeeding-support.html
5. World Health Organization, United Nations Children's Fund: Protecting, promoting and supporting breastfeeding: The special role of maternity services (A joint WHO/UNICEF statement). Int J Gynecol Obstet31:171–183, 1990.
6. Position of the American Dietetic Association: Supporting and Promoting Breastfeeding. J Am Diet Assoc105, 5:810-818, 2005.
7. Academy of Breastfeeding Medicine Board of Directors. ABM Mission Statement. www.bfmed.org.2003.
8. WHO/UNICEF Joint Statement. Meeting on Infant and Young Child Feeding. J Nurse-Midwifery25:31–38, 1980.
9. World Health Organization and United Nations Children's Fund: Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. New York UNICEF, 1990.
10. Protocol Committee Academy of Breastfeeding Medicine, Cordes R, Howard CR: Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Newborn. www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
11. Howard CR, Howard FM, Lanphear B, et al: Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 111:511–518, 2003.
12. Howard CR, de Blieck EA, ten Hoopen CB, et al: Physiologic stability of newborns during cup and bottle feeding. Pediatrics104:1–7, 1999.
13. Marinelli KA, Burke GS, Dodd VL: A comparison of the safety of cup feedings and bottle feedings in premature infants whose mothers intend to breastfeed. J Perinatol 21:350–355, 2001.
14. Protocol Committee Academy of Breastfeeding Medicine, Eidelman AI, Howard CR, Schanler RJ, Wight NE: Clinical Protocol Number 1: Guidelines for Glucose Monitoring and Treatment of Hypoglycemia in Breastfed Neonates. ABM News and Views 5:insert, 1999.
15. Protocol Committee Academy of Breastfeeding Medicine, Gartner L, Howard C R: Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Infant and Mother, "The Going Home Protocol." www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
16. Hale TW: Medications and Mother's Milk, 16th ed. Amarillo, TX, Pharmasoft Medical Publishing, 2011.
17. Lawrence RA, Lawrence RM: Breastfeeding: A guide for the medical profession, 5th ed. St. Louis, Mosby, 1999.
18. Committee on Drugs, The American Academy of Pediatrics: The transfer of drugs and other chemicals into human milk. Pediatrics108:776–789, 2001.
19. Protocol Committee Academy of Breastfeeding Medicine, Chantry C, Howard CR, McCoy RC: Clinical Protocol #5: Peripartum Breastfeeding Management for the Healthy Mother and Infant at Term. www.bfmed.org. Academy of Breastfeeding Medicine, 2002.
20. Riordan JM, Auerbach KG: Breastfeeding and Human Lactation. Boston, Jones and Bartlett Publishers, 1993.
21. American Academy of Pediatrics. Redbook: 2015 Report of the Committee on Infectious Diseases, 30th ed. Elk Grove, Ill, American Academy of Pediatrics, 2015.
22. Merewood A, Philipp BL: Breastfeeding: Conditions and Diseases. Amarillo, TX, Pharmasoft Publishers, 2001.
23. Breastfeeding Medicine Vol 2,Number 1 2010, ABM Clinical Protocol #7: Model Breastfeeding Policy
24. WHO Guidelines: Safe Preparation, Storage, and Handling of Powdered Infant Formula: http://www.who.int/foodsafety/publications/micro/pif_guidelines.pdf
25. AAP, Wight, N.E. (2008). Best Medicine: "Human Milk in the NICU": Hale Publishing, L.P.
26. Hoag-Nann, M. (2009). Lactation Management: "Techniques, Tips, and Tools for the Health Care Provider":Serif- Buffalo, NY.
27. La Leche League International. (2006) "The Breastfeeding Answer Book: Latch on problems".
28. Manufacturer's Guidelines (2009): Medela Inc. "Nipple Shield Usage, Cleaning and Care" pamphlet.
29. WCS/NICU Policy # 6385-200: "LACTATION SERVICES".

	Objectives	Content	Method of Education
1	Discuss the rationale for professional, government, and international policies that promote, protect, and support breastfeeding in the United States.	**The BFHI: A Part of the Global Strategy** ➢ The Global Strategy for Infant and Young Child Feeding and how it fits with other activities ➢ How the BFHI can assist health care facilities to implement evidence-based practice, improve quality of care, and deliver continuity of care	✓ First Latch Module
2	Demonstrate the ability to communicate effectively about breastfeeding.	**Communication Skills** ➢ Listening and learning ➢ Skills to build confidence and give support ➢ Arranging follow-up and support suitable to the mother's situation	✓ First Latch Module ✓ 1:1 time with lactation consultant
3	Describe the anatomy and physiology of lactation and the process of breastfeeding.	**How Milk Gets from the Breast to the Infant** ➢ The parts of the breast involved in lactation ➢ Breastmilk production ➢ The infant's role in milk transfer ➢ Breast care	✓ First Latch Module
4	Identify teaching points appropriate for prenatal classes and interactions with pregnant women.	**Promoting Breastfeeding During Pregnancy** ➢ Discussing breastfeeding with pregnant women ➢ Why breastfeeding is important ➢ Antenatal breast and nipple preparation ➢ Identifying women who need extra attention	✓ First Latch Module ✓ 1:1 time with lactation consultant
5	Discuss hospital birthing policies and procedures that support exclusive breastfeeding.	**Birth Practices and Breastfeeding** ➢ Labor and birth practices to support early breastfeeding ➢ The importance of early STS contact ➢ Helping with initiation of breastfeeding ➢ Ways to support breastfeeding after cesarean ➢ BFHI practices for women who are not breastfeeding	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
6	Demonstrate the ability to identify the hallmarks of milk transfer and optimal breastfeeding.	**Helping the Mother Breastfeed** ➢ How to assess breastfeeding ➢ When to assist with breastfeeding ➢ Identify optimal positioning and latch ➢ Help mothers learn to position and latch her infant ➢ Positioning for comfortable breastfeeding ➢ Identifying the infant who has difficulty attaching to the breast	✓ First Latch Module ✓ 1:1 time with a lactation consultant
7	Discuss hospital postpartum management policies and procedure that support exclusive breastfeeding.	**Practices that Promote Breastfeeding** ➢ Rooming-in ➢ STS ➢ Recognizing feeding cues, feeding on demand ➢ Management of sleepy or fussy infants ➢ Avoiding unnecessary supplementation ➢ Avoiding artificial nipples and pacifiers	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
8	Discuss methods that may increase milk production in a variety of circumstances.	**Milk supply** ➢ Addressing mother's concerns about "not enough milk" ➢ Normal growth patterns of infants ➢ Improving milk intake and milk production	✓ First Latch Module ✓ 1:1 time with a lactation consultant
9	Identify teaching points to include when educating or counseling parents who are using bottles and/or formula.	**Supporting the non-breastfeeding mother and infant** ➢ Counseling the formula choice: a pediatric responsibility ➢ Teaching/assuring safe formula preparation in the postpartum period ➢ Safe bottle feeding; issues with overfeeding and underfeeding	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant

10	Discuss contraindications to breastfeeding in the United States as well as commonly encountered areas of concern for breastfeeding mothers and their infants.	**Infants and Mothers with Special Needs** ➢ Breastfeeding infants who are preterm, low birth weight, and/or ill ➢ Breastfeeding more than one infant ➢ Prevention and management of common clinical concerns ➢ Medical reasons for breast milk substitutes ➢ Nutritional needs of breastfeeding women ➢ Breastfeeding and birth control ➢ Breastfeeding management when the mother is ill ➢ Medications and breastfeeding ➢ Contraindications to breastfeeding	✓ First Latch Module ✓ 1:1 time with a lactation consultant ✓ Review policies and procedures
11	Describe interventions for breast and nipple problems.	**Breast and Nipple Concerns** ➢ Examination of the mother's breasts and nipples ➢ Engorgement, blocked ducts, and mastitis ➢ Sore nipples	✓ First Latch module
12	Identify acceptable medical indications for supplementation of breast fed infants according to national and international authorities.	**If the Infant Cannot Feed at the Breast** ➢ Learning to hand express ➢ Use of donor milk ➢ Feeding EBM to the infant	✓ First Latch Module ✓ Review policies and procedures ✓ 1:1 time with lactation consultant
13	Describe essential components of support for mothers to continue breastfeeding beyond the early weeks.	**Ongoing Support for Mothers** ➢ Preparing a mother for discharge ➢ Follow-up and support after discharge ➢ Protecting breastfeeding for employed women ➢ Sustained breastfeeding beyond one year	✓ First Latch Module ✓ Learn about breastfeeding support group during orientation ✓ San Diego County Breastfeeding Coalition resource guide
14	Describe strategies that protect breastfeeding as a public health goal.	**Protecting Breastfeeding** ➢ The effects of marketing on infant feeding practices ➢ The International Code of Marketing of Breastmilk Substitutes ➢ How health care workers can protect families from marketing ➢ How to respond to marketing practices ➢ Donor milk in emergency situations ➢ The role of breastfeeding in emergencies	✓ First Latch Module ✓ Review policies and procedures
15	Identify both the barriers and the solutions to implementing the Ten Steps to Successful Breastfeeding.	**Making Your Hospital or Birth Center Baby Friendly** ➢ The Ten Steps to Successful Breastfeeding ➢ What "Baby Friendly" practices are ➢ The process of becoming a "Baby Friendly" hospital or birth center	✓ First Latch Module

Baby Friendly Training Requirements	
Position	**Training Required**
Registered Nurses	First Latch Module – BFHI General Healthcare: 15 hours
Lactation Consultants	First Latch Module – BFHI General Healthcare: 15 hours
Dieticians	First Latch Module – BFHI General Healthcare: 15 hours
Occupational Therapists	First Latch Module – BFHI General Healthcare: 15 hours
Pediatricians	First Latch Module – BFHI Provider Training: 3 hours
Neonatologists	First Latch Module – BFHI Provider Training: 3 hours
Obstetricians	First Latch Module – BFHI Provider Training: 3 hours
Anesthesiologists	First Latch Module – BFHI Provider Training: 3 hours
Midwives	First Latch Module – BFHI Provider Training: 3 hours
PAs	First Latch Module – BFHI Provider Training: 3 hours
NNPs	First Latch Module – BFHI Provider Training: 3 hours
OB Techs	First Latch Module – BFHI Ancillary Training: 3 hours
Advanced Care Technicians (ACT)	First Latch Module – BFHI Ancillary Training: 3 hours
Hearing Screeners	First Latch Module – BFHI Ancillary Training: 3 hours
Social Workers	First Latch Module – BFHI Ancillary Training: 3 hours
Environmental Services (EVS)	Review and sign Ten Steps for Successful Breastfeeding
Unit Secretaries	Review and sign Ten Steps for Successful Breastfeeding
Peri Operative Aides	Review and sign Ten Steps for Successful Breastfeeding
Birth Clerks	Review and sign Ten Steps for Successful Breastfeeding
Respiratory Therapists	Review and sign Ten Steps for Successful Breastfeeding
Case Managers	Review and sign Ten Steps for Successful Breastfeeding
Newborn Photographers	Review and sign Ten Steps for Successful Breastfeeding

Albuterol/Ipratropium (Combivent Respimat): Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Albuterol ipratropium (Combivent) is a combination long acting antimuscarinic/beta agonist used for the chronic management of asthma and COPD

Background: Combivent is offered as a "respimat" inhaler device which administers a fine mist that is inhaled twice daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

Assessment:

- Each Combivent device costs $291
- A therapeutically equivalent medication, albuterol/ipratropium nebulized solution costs $0.29 per dose
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of Combivent to an equipotent dose of albuterol/ipratropium nebulized solution
- A conversion from Combivent to albuterol/ipratropium nebulized solution would save TCMC approximately $12,000 annually

Recommendation(s):

- P&T Committee approved the Pharmacy Service recommendation that all orders for Combivent be restricted to Pulmonologists only.
  - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized albuterol/ipratropium solution would be administered in the interim
- All other orders for Comibvent will be converted to an equivalent dose of albuterol/ipratropium nebulized solution as per the Automatic Therapeutic Interchange Policy
- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

Bupropion SR (Wellbutrin SR): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Bupropion is an antidepressant indicated for the treatment of major depressive disorder and smoking cessation assistance

Background: Bupropion is available as an immediate release tablet, a sustained-release tablet, and as an extended-release tablet.

Assessment:

- Having two long-acting formulations (XL and SR) is not cost-effective and has resulted in medication errors at TCMC
- Bupropion SR is less expensive than bupropion XL
- There is no therapeutic advantage in using one long-acting agent over the other. In the outpatient setting, using the once-daily XL formulation may assist with compliance
- The Pharmacy Service has recommended an update to the Automatic Therapeutic Interchange policy which includes an automatic conversion from bupropion XL to an equivalent daily dosage of bupropion SR

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of bupropion XL be removed from the TCMC formulary at this time given automatic conversion process to a therapeutic equivalent
- All future orders for bupropion XL will be converted to bupropion SR as per the Automatic Therapeutic Interchange Policy

Combivir (lamivudine and zidovudine) tablet: Recommendation for formulary removal

Requestor: Manuel Escobar, PharmD

Declared conflicts of interest: None

Situation: Combivir (lamivudine and zidovudine) is a combination tablet that is no longer commonly prescribed for the treatment of HIV-1 infection

Background: Combivir (lamivudine and zidovudine) is an oral HIV Nucleoside reverse transcriptase inhibitor combination tablet used with other antiretroviral agents for the treatment of HIV-1 infection. Other products in this class considered better tolerated are available to replace Combivir (lamivudine and zidovudine).

Assessment: Combivir (lamivudine and zidovudine) is no longer commonly prescribed for the treatment of HIV-1 infection given the availability of new options in this drug class. TCMC formulary includes the individual components of this tablet if needed.

Recommendation(s):

- P&T Committee approved the Pharmacy and ID Service recommendation for removal of Combivir (lamivudine and zidovudine) from the hospital formulary to reduce drug costs and waste

Prezista (Darunavir): Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

Declared conflicts of interest: None

Situation: Darunavir is an protease inhibitor

Background: Darunavir is FDA approved to be used in with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients 3 years of age or older

Dosing Recommendations: Treatment-naïve and treatment-experienced adult patients with no darunavir resistance associated substitution: 800 mg taken with ritonavir 100 mg once daily

Treatment-experienced adult patients with at least one darunavir resistance associated substitution: 600 mg taken with ritonavir 100 mg twice daily

Assessment:

- Darunavir is a commonly prescribed anti-retroviral in the outpatient setting. In order to provide continuity of care, the drug has been purchased for use frequently on a non-formulary basis
- Efficacy has been demonstrated in treatment-naïve and treatment experienced patients receiving darunavir plus ritonavir in combination with tenofovir/emtricitabine.
- FDA Black Box warnings: None
- Cost impact: 600 mg & 800 mg tablets ($1,377 per #30 count bottle)

Recommendation(s):

- The Pharmacy Service in cooperation with the ID Service recommended addition of darunavir to the formulary with the following criteria for use:
  - Restricted to patients already taking darunavir for continuity of outpatient care during admission
  - Restricted to ID physicians for new starts
- The P&T Committee approved the above recommendations and criteria for use. Per discussion by Committee members, including Dr. Smith (Infectious Diseases), darunavir would not be routinely stocked but ordered when needed for qualifying patients.

Droperidol Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Droperidol injection has been on continued shortage since 2015 and product has never been available for purchase in that time. There are no plans from manufacturers to resume production at this time

Background: Droperidol is an anesthetic adjunct and antiemetic.

Assessment:

- In 2015, Hospira cited lack of raw materials as the reason for the shortage
- Given the complete lack of product, even in small quantities it is unlikely that droperidol will return to the market
- Due to its formulary status, droperidol is ordered with some regularity due to its inclusion in Power Plans resulting in phone calls from Pharmacists to providers requesting permission to discontinue the order. Nurses are also required to conduct annual competency training on a droperidol standardized procedure for which there is little benefit given the lack of drug availability.

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that droperidol be removed from the TCMC formulary due to current and anticipated future unavailability. Formulary status may be reassessed at a future date if this drug ever becomes available on the market again

Exparel (liposomal bupivacaine): Expansion of approved indication and ordering privileges

Requestor: Dr. Seif/Dr. Gandhi

Declared conflicts of interest: None

Situation: Exparel is liposomal formulation of bupivacaine which is an amide-type anesthetic.

Background: Exparel is a long-acting formulation of bupivacaine. Exparel is not recommended for epidural, intrathecal, intravascular, or intra-articular administration. Use for regional nerve blocks is also not recommended.

Exparel was approved by the P&T Committee in 2017 for use by CT Surgery during VATS procedures to eliminate the need for epidural placements. No other indications or provider groups have been approved to order this drug to date.

The Anesthesia and Surgery Services requested that liposomal Exparel be approved for the indication of TAP (transverse abdominis plane) blocks in the setting of minimally invasive robotic colorectal procedures. The request is part of more comprehensive approach to pain management and quicker post-operative recovery being put together by a collaborative group of physicians, nurses, and pharmacists (Peri-Surgical Home Model).

Assessment:

- Exparel has established efficacy in a prospective randomized controlled trial and a retrospective analysis when administered as a TAP block, reducing opioid use and maintaining lower pain scores in the first 24-48 hours post-surgery

- Cost Impact
  - Exparel 10 mL vial ($157), 20 mL vial ($315). Comparator arm is epidural placement which is estimated at ~$400 per case

  - Peri-Surgical Home Model pilot program estimates patients to be discharged from the hospital 1-2 days earlier when compared against current practice. A value estimated to $3,000 saved per admission-free day

Recommendation(s):

- The P&T Committee approved the request to expand Exparel's approved indications to include TAP block placement during minimally-invasive colorectal surgery as part of the Peri-Surgical Home Model pilot program

- Per the requestors, ordering privileges for this indication are to be restricted to Dr. Fierer, Dr. Gandhi, and Dr. Hannah

Fluticasone Inhaler (Flovent): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Inhaled corticosteroids are used for the chronic management of asthma and COPD

Background: Several inhaled corticosteroids are currently on the TCMC formulary including beclomethasone (QVAR) and two strengths of fluticasone (Flovent).

Assessment:

- It is not cost effective to carry multiple inhaled corticosteroids on the formulary as they are equally effective at equipotent doses
- Beclomethasone (QVAR) is currently the lowest cost option at $191 per inhaler
    - Fluticasone 110 mcg is $217 per inhaler
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of all ordered inhaled corticosteroids to an equipotent dose of inhaled beclomethasone

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that fluticasone inhalers be removed from the TCMC formulary at this time and that beclomethasone remain as the formulary preferred product
- All future inpatient orders for fluticasone inhalers will be converted to an equivalent dose of inhaled beclomethasone 40 mcg as per the Automatic Therapeutic Interchange Policy
- All recommendations were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

Fluticasone/Salmeterol (Advair Diskus): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Fluticasone/salmeterol is a combination beta-agonist/inhaled corticosteroid used for the chronic management of COPD and asthma.

Background: Fluticasone/salmeterol is supplied as a "diskus" device which dispenses a dry powder that is inhaled twice daily. Devices may not be shared between patients and may not be sent home with the patient upon discharge.

Assessment:

- Each fluticasone/salmeterol device costs approximately $130
- The Pharmacy Service has recommended an update to the Automatic Therapeutic Interchange policy which includes an automatic conversion from fluticasone/salmeterol to an equivalent daily dosage of budesonide/formoterol (Symbicort)
- The estimated cost savings associated with a conversion of all fluticasone/salmeterol patients to budesonide/formoterol is approximately $49,000 annually

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of fluticasone/salmeterol (100 mcg/50 mcg, 250 mcg/50 mcg, 500 mcg/50 mcg) be removed from the TCMC formulary at this time
- All future orders for fluticasone/salmeterol will be converted to budesonide/formoterol as per the Automatic Therapeutic Interchange Policy
- All recommendations were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

Genvoya (emtricitabine, tenofovir, elvitegravir, cobicistat) Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

Declared conflicts of interest: None

Situation: Genvoya is a combination antiretroviral product consisting of 2 HIV nucleoside reverse transcriptase inhibitors, a HIV integrase inhibitor, and a cytochrome P450 inhibitor.

Background: Genvoya is a complete regimen for treatment of HIV-1 infection for adults and pediatric patients (at least 25 kg) who are treatment-naïve or to replace a current, stable (meaning the patient had been taking the regimen for at least 6 months) antiretroviral regimen in a virologically-suppressed patient (HIV-1 RNA less than 50 copies per milliliter) without a history of treatment failure or mutations that confer resistance to any of the individual agents of Genvoya.

Dose: 1 tablet PO daily with food

Assessment:

- Combination HIV anti-retroviral treatment has become a more standardized approach to treatment in the community. When patients prescribed these medications are admitted to the hospital, it is not possible to substitute with alternative agents

- FDA Black Box warnings: Genvoya has a boxed warning for severe, acute exacerbations of hepatitis B. This risk is for patients co-infected with both HIV and hepatitis B and applies if they discontinue products containing emtricitabine and tenofovir (either tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide).

- Cost impact: $2,591 for #30 count bottle

Recommendation(s):

- The Pharmacy Service in cooperation with the ID Service recommended addition of Genvoya to the formulary with the following criteria for use:
    - Restricted to patients already taking Genvoya (or comparable agent Stribild) for continuity of outpatient care during admission
    - Restricted to ID physicians for new starts

- The P&T Committee approved the above recommendations and criteria for use. Per discussion by Committee members, including Dr. Smith (Infectious Diseases), Genvoya would not be routinely stocked but ordered when needed for qualifying patients.

Ipratropium Metered Dose Inhaler (Atrovent): Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Ipratropium is a short-acting antimuscarinic used for the chronic management of COPD and asthma exacerbations

Background: Ipratropium is offered as a metered dose inhaler (MDI) device which administers a fine mist that is inhaled up to 12 times daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

Assessment:

- Each ipratropium MDI costs $338
- A therapeutically equivalent medication, ipratropium 0.02% nebulized solution costs $0.13 per dose
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of ipratropium MDI to an equipotent dose of ipratropium 0.02% nebulized solution
- A conversion from ipratropium MDI to ipratropium nebulized solution would save TCMC approximately $9,400 annually

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all orders for Atrovent be restricted to Pulmonologists only.
  - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized ipratropium solution would be administered in the interim
- All other orders for Atrovent will be converted to an equivalent dose of ipratropium nebulized solution as per the Automatic Therapeutic Interchange Policy
- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

Lansoprazole solu-tab: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Lansoprazole solu-tabs are no longer on contract through the hospital GPO Vizient and now costs $130 per tablet

Background: Lansoprazole is a proton pump inhibitor (PPI). The solu-tab formulation was added to the formulary in an effort to reduce drug costs by converting patients on intravenous pantoprazole to an oral formulation which could be administered via gastric tube. Oral pantoprazole is not an option for gastric tube administration as it cannot be crushed.

Assessment:

- Intravenous pantoprazole costs $3 for a standard 40 mg dose. The conversion from IV pantoprazole to lansoprazole solu-tab via gastric tube is no longer a cost effective process
- There is no therapeutic advantage to converting patients from IV pantoprazole to an oral PPI. The only benefit was cost, therefore it is appropriate to delay any conversion until the patient can tolerate oral pantoprazole given PPI therapy is still warranted
- >90% of orders for lansoprazole were placed by Pharmacists as part of the Automatic IV to PO policy in an effort to reduce drug costs in qualifying patients

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that lansoprazole solu-tabs be removed from the TCMC formulary due to current and anticipated future unavailability
- The P&T Committee approved the Pharmacy Service recommendation to work on amending the Pharmacy Automatic IV to PO protocol to remove the recommended conversion from IV pantoprazole or PO lansoprazole solu-tabs

Medium Chain Triglycerides: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Medium chain triglyceride (MCT) oil is a nutritional supplement. It has not been ordered/dispensed in over 3 years

Background: MCT oil was primarily utilized by neonatologists as a nutritional supplement in the NICU population

Assessment:

- Dr. Movahhedian (Chief, Neonatology) has indicated that this supplement is not currently needed given other nutritional supplements on formulary
- Current supply currently expires on the shelf on a routine basis ($65/bottle)

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that MCT oil be removed from the TCMC formulary at this time

Mepivacaine Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: A substantial supply of mepivacaine expired in late 2017.

Background: Mepivacaine is an amide anesthetic used as a nerve block for pain procedures

Assessment:

- Mepivacaine 1.5% (30 mL) vials and mepivacine 3% (1.7 mL cartridges) are on the TCMC formulary
- Neither product has been dispensed for at least 2 years and were stocked only in the Surgery department
- The Anesthesia Service acknowledged that the product is not necessary for daily patient care and feels that it could be removed from the formulary

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that mepivacaine in all strengths and formulations be removed from the TCMC formulary due to lack of use and agreement from the Anesthesia Service

Nitroglycerin 0.3 mg/0.6 mg tablets: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Nitroglycerin sublingual tablets are currently stocked in three strengths: 0.3 mg, 0.4 mg, 0.6 mg

Background: When nitroglycerin was historically added to the TCMC formulary, no stipulation was made on the specific doses that would be stocked

Assessment:

- Nitroglycerin 0.4 mg is the gold standard dose for this medication when administered sublingually
- Nitroglycerin 0.3 mg and 0.6 mg tablets routinely expire on the shelf due to non-use

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that nitroglycerin 0.3 mg and 0.6 mg sublingual tablets be removed from the TCMC formulary at this time
- Sublingual nitroglycerin 0.4 mg tablets remain available for use on the formulary

Nitroglycerin 0.4 mg Spray: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Nitroglycerin spray has increased in price to $100 per bottle. For regulatory reasons, bottles cannot be shared between patients

Background: Nitroglycerin spray is stocked in STEMI kits, ED, and Cath Lab

Assessment:

- Nitroglycerin when administered as a spray has no documented clinical advantage when compared to the standard sublingual tablet
- The use of sublingual tablets is the gold standard in ambulatory and emergency settings and is often the only formulation carried by most hospitals
- Nitroglycerin 0.4 mg tablets cost $0.28 each
- The Cardiology Service and Emergency Department where this formulation is used supported this formulary recommendation

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that nitroglycerin 0.4 mg spray be removed from the TCMC formulary at this time
- Sublingual nitroglycerin 0.4 mg tablets remain available for use on the formulary

Raltegravir (Isentress) tablet: Recommendation for formulary removal

Requestor: Manuel Escobar, PharmD

Declared conflicts of interest: None

Situation: Dolutegravir (Tivicay) has been recommended for addition to the formulary as the preferred integrase inhibitor and in place of raltegravir (Isentress).

Background: Raltegravir is an oral HIV integrase inhibitor used in combination with other antiretroviral agents for the treatment of HIV-1 infection.

Assessment: Dolutegravir has demonstrated non inferiority to raltegravir and is increasingly being used as the preferred integrase inhibitor in the outpatient setting.

Recommendation(s):

- Given the recommendation to add dolutegravir (Tivicay) as the preferred integrase inhibitor, the P&T Committee approved the Pharmacy Service recommendation to remove raltegravir (Isentress) from the hospital formulary

Salmeterol (Serevent) Recommendation for formulary restriction

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Salmeterol is a long acting beta agonist indicated for the chronic management of COPD and asthma

Background: Salmeterol is offered as a "diskus" device which administers a powder that is inhaled twice daily. The medication may not be shared between patients nor can it be sent home with the patient upon discharge.

Assessment:

- Each salmeterol device costs $206
- A therapeutically equivalent medication, formoterol nebulized solution costs $4 each
- The Pharmacy Service has recommended a revision to the Automatic Therapeutic Interchange policy to permit the conversion of salmeterol to an equipotent dose of formoterol nebulized solution
- A conversion from salmeterol to formoterol nebulized solution would save TCMC approximately $1000 annually

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all orders for salmeterol inhalers be restricted to Pulmonologists only.
    - Per this agreement, Pharmacy will not routinely stock this inhaler with the understanding that therapy would be delayed until the next day when the inhaler could be ordered and delivered. Nebulized formoterol solution would be administered in the interim

- All other orders for salmeterol inhalers will be converted to an equivalent dose of formoterol nebulized solution as per the Automatic Therapeutic Interchange policy pending P&T approval

- Both recommendations above were reviewed and agreed upon by Dr. Yamanaka (Pulmonary) and Amy Waldrop (Manager, Respiratory Therapy)

Tivicay (dolutegravir): Recommendation for formulary addition

Requestor: Manuel Escobar, PharmD, Infectious Diseases Pharmacist

Declared conflicts of interest: None

Situation: Tivicay is an HIV integrase inhibitor

Background: Tivicay is approved to be used in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 30 kg

Dose: Treatment-naive or treatment-experienced but integrase strand inhibitor-naïve: 50 mg orally once daily

Integrase strand inhibitor (INSTI)-experienced with known or suspected INSTI-associated resistance: 50 mg orally twice daily

Assessment:

- In clinical trials, Tivicay has demonstrated efficacy in combination with an effective background regimen in treatment naive and antiretroviral-experienced HIV infection
- FDA Black Box warnings: None
- Cost impact: $1,444 for #30 count bottle

Recommendation(s):

- The Pharmacy Service in cooperation with the ID Service recommended addition of Tivicay to the formulary with the following criteria for use:
  - Restricted to patients already taking Tivicay for continuity of outpatient care during admission
  - Restricted to ID physicians for new starts
- The P&T Committee approved the above recommendations and criteria for use. Per discussion by Committee members, including Dr. Smith (Infectious Diseases), Tivicay would not be routinely stocked but ordered when needed for qualifying patients.

Verapamil Sustained Release (Calan SR): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD

Declared conflicts of interest: None

Situation: Verapamil is a non-dihydropyridine type calcium channel blocker with vasodilating and negative chronotropic effects. It is used for the management of hypertension, PSVT, and atrial fibrillation/flutter.

Background: Verapamil is offered as an immediate release, sustained-release, and extended release product. Currently all three formulations are on the TCMC formulary.

Assessment:

- The availability of multiple long-acting preparations of verapamil is not cost efficient and has resulted in medication errors
- The various long-acting verapamil preparations are considered clinically identical in efficacy
- The Pharmacy Service is recommending a revision to the Automatic Therapeutic Interchange policy in which orders for verapamil sustained-release (Calan SR/Isoptin SR) would be converted to an equivalent dose of verapamil extended release (Verelan ER)

Recommendation(s):

- The P&T Committee approved the Pharmacy Service recommendation that all strengths of verapamil sustained-release (Calan SR/Isoptin SR) be removed from the TCMC formulary at this time given conversion to therapeutically equivalent product is possible
- All future orders for verapamil sustained-release (Calan SR/Isoptin SR) will be converted to an equivalent dose of verapamil extended release (Verelan ER) as per the Automatic Therapeutic Interchange Policy