UNIVERSITY OF CHICAGO MEDICAL CENTER

APRIL 2009 TO APRIL 2010

Center for Nursing Professional Practice and Research

Orientation Manual for Contract Nurses

Introduction

Welcome to the University of Chicago Medical Center. In order to facilitate a smooth transition to the bedside and ensure a safe delivery of care, we require you read and understand the following policies, procedures and general information. Please read the enclosed information, sign the acknowledgement receipt and give the receipt to Sally Pirowski in the Staffing Resource Office. This must be completed prior to starting direct patient care.

Once again, welcome to the University of Chicago Medical Center.

Center for Nursing Professional Practice and Research

- The contents of this manual expire 4/2010.

- Please contact the Center for Nursing Professional Practice and Research for updates.

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AIDET: Meeting Patient/Families' Expectations

Acknowledge

Whether you acknowledge the patient by name or with a friendly smile, the patient knows that you have connected with them. Acknowledging includes putting down paperwork and making the patient your focus. Eye contact, a pat on the shoulder, and a smile are all nonverbal ways of acknowledging a patient or family member.

Introduce

Introduce yourself by name; state the department you work in and what you are going to do. This also is an excellent time to use your experience to put the patient at ease. Example: *"Good morning Mr. Jones. My name is Mary, and I am here to start your IV. I am a nurse on the special IV team. I've been working here for five years. I will do everything to make this as comfortable as possible for you."*

Duration

Give an estimate of the time it will take to complete the procedure or how long they will have to wait. Example: *"It should only take me about 5 minutes to register you." o*r *"The chest x-ray should only take about 10 minutes. However, I would ask that you stay here in the room so that I can run the film through processing and make sure that I have a good clear picture. That should add about another 20 minutes and then you should be able to go. We will have the results to your physician's office by 3:00pm today."*

Explanation

Give an explanation of what you are going to do to or for the patient. Ask if they have ever had this X-ray done before, or lab work drawn before, etc. Ask if the patient has any concerns or questions before you start or any information that may make the testing easier. Explain all along the way. Realize that you may do this procedure many times a day. However, for the patient, it may be the only time he/she has ever experienced it. If it is going to hurt, let the patient know. You can also integrate patient safety into the discussion. For example, before drawing blood, the phlebotomist can say: "*For your safety, I am going to check the test label against your ID wrist band."*

Thank You

Thank the patient for choosing your hospital to have their test/treatment done. If the patient is an inpatient, ask *"Is there anything else that I can do for you?"* or, "*Do you have any questions that I can answer for you?"*

ACKNOWLEDGEMENT RECEIPT

PLEASE SIGN AND RETURN THIS PAGE TO THE STAFFING RESOURCE OFFICE.

I acknowledge receipt of the Orientation Manual for Contract Nurses. I have read and understand the information given.

Print Name:

_____

Signature:

_____

Date: _____

Name of agency: _____

The University of Chicago Hospitals
Policy and Procedure Manual

The University of Chicago Medical Center
Policy and Procedure Manual

Blood Products, Procurement and Administration

Issue Date: August 1976
Revised Date: December 2008
Review Date: November 2008

PURPOSE:
1. To provide guidelines to safely administer blood products at The University
of Chicago Medical Center (UCMC).

2. To clarify regulations regarding procurement of blood products from Blood
Bank by authorized personnel and standard direct IV administration of blood
products by Registered Nurse, Licensed Perfusionist, or Physician.

3. To clarify regulations regarding procurement of blood products from Blood
Bank by authorized personnel and administration of blood products in the
extracorporeal circuit during automated procedures involving mechanical
processing of blood by Registered Nurse, Licensed Perfusionist, Physician, as
well as UCMC policy related to monitoring of blood products in the
extracorporeal circuit during automated procedures involving mechanical
processing of blood by Clinical Technicians ("**Clinical Technician**" shall
include apheresis, dialysis, and ECMO technicians, as well as respiratory care
practitioners. The use of the term "respiratory care practitioner" is restricted to
individuals who are licensed in accordance with 225 ILCS 106/ *et seq*.) who
have demonstrated appropriate competencies.

POLICY:

1. A physician's or nurse practitioner's order is required before a blood product
may be administered; the order must specify the blood product to be used, the
amount to be given, and the rate to be administered or transfusion time. The
order may also specify the use of a blood warmer, any premedication and the
timing of such medication, is appropriate. In Pediatrics, the written order
should include the calculation in mL/kg over time. Physician Assistants may

write orders for blood product administration only if this duty is explicitly delegated by the supervising physician in the Physician Assistant's written Practice Guidelines and approved by Illinois Department of Financial and Professional Regulation (IDFPR). Such Practice Guidelines are available from the Medical Staff Office (MSO).

2. A signed informed consent is required prior to transfusion of blood products. It is the physician's responsibility to obtain the consent. A consent under this policy does not expire within any specific time period. For example, a consent unless otherwise withdrawn is valid for a single admission or on-going course of therapy. It may be obtained in a clinical setting prior to the admission for the procedure and be valid as long as the risk/benefit assessment has not changed since the consent was obtained. However, a patient's situation must be considered to determine if a previously executed consent is valid or whether a new consent is required. The factors to consider include (a) a relevant change in the patient's condition or prognosis since the time of consent, (b) a significant passage of time, especially if there has been no or limited contact between the patient and provider, and (c) the availability of a new alternative or information about risks and benefits. Refusal for blood product transfusion must also be documented in the medical record. If there are questions about whether a consent is valid, please contact the Office of Medical-Legal Affairs (2-1057).

3. A pretransfusion sample and Identaband bracelet are necessary for all red blood cell containing products and are good for twenty-one (21) days if the patient has not been transfused or pregnant within the past three (3) months. The Identaband form must clearly state that the sample needs to be held for twenty-one (21) days. If the patient has been transfused or pregnant within the past three months, then the specimen is only good for three days starting from 12:01 a.m. of the next day. The authorized person who draws the sample must label the specimen at the bedside in the presence of the patient. One Identaband should be placed on all adult medical patients. Two (2) Identabands should be placed on different extremities of all surgical patients and all pediatric patients, preferably wrist and ankle, by whomever draws the specimen.

4. Blood products accompanying patients coming from other institutions are not to be transfused at UCMC. The blood products accompanying patients from other institutions must be sent to the UCMC Blood Bank.

5. Registered Nurses, Licensed Perfusionists, or Physicians may assume responsibility for standard direct IV administration of blood products per physician order. (If exchange transfusion, individual platelet units, or cryoprecipitate are ordered to be given by IV push, the physician or Nurse

Practitioner must administer these products.) Clinical Technicians who have demonstrated competencies may perform the monitoring of the blood and equipment oversight (but **not** the initiation of the blood product) if the patient will be undergoing an automated mechanical processing of blood while the blood is being administered into an extracorporeal blood circuit.

6. Blood product transfusion must be completed within four (4) hours of initiation. The Registered Nurse or Licensed Perfusionist should question the physician or nurse practitioner about any order for blood products to be transfused over a period greater than four (4) hours. If the order is correct, call the Blood Bank and ask to have the blood product split. Each half can then be transfused within four (4) hours (1).

7. Generally, one (1) blood product is requested and transfused for (1) patient at a given time to provide optimal transfusion conditions. In emergent or surgical situations, when the patient has multiple IVs running, multiple blood products may be requested and/or transfused simultaneously.

8. The blood product must be used immediately or returned to the Blood Bank within thirty (30) minutes unless the product has been stored in a monitored blood bank refrigerator. Blood products, which have been returned to the Blood Bank more than thirty (30) minutes after being issued, are discarded unless the product has been stored in a monitored Blood Bank refrigerator. Monitored refrigerators are located in designated areas. The medication refrigerators on units are not monitored; therefore, blood products must not be stored in them. It should be indicated on the bottom of the Report of Blood Transfusion (20.52), attached, that the blood product was returned to the Blood Bank. A separate note should also be sent with the product, indicating the reason for return (1,2). The requirements under this section do not apply to platelets as they cannot be refrigerated.

9. The signed Report of Blood Transfusion is a confirmation of identity, verification of appropriate product that has not expired, and indicates the reason for transfusion. A tag or label with the name and identification number of the intended recipient, the component unit number, and the interpretation of compatibility tests (if performed) must be securely attached to the blood container. The appearance of the unit is checked before administration. The Report of Blood Transfusion must be placed in the patient's chart (1).

10. Patients receiving transfusions of blood or blood products must be accompanied by a nurse or physician on off-unit transports. If the patient is being transported to a diagnostic or treatment area with blood products

infusing, the level of care and monitoring of the patient and transfusion must remain the same (i.e. transferred to a professional caregiver appropriately licensed to administer and monitor IV medications, including, without limitation, RN, APN, MD).

PEDIATRIC PATIENTS

A general rule in stable pediatric patients is that PRBCs are administered at 2-3 mL/kg/hr. (7). The transfusion is usually administered over one (1) to two (2) hours but must be completed within four (4) hours. The rate can be adjusted according to the patient's clinical status and needs (3). The rate of infusion in pediatric patients should be validated by two (2) registered nurses at the beginning of the transfusion and with each adjustment in rate, and documented in the medical record.

The sample and Identaband for any infant are both good for the duration of the hospitalization while that infant is four (4) months or younger. For pediatric patients above 4 months of age, a pretransfusion sample and Identaband bracelet are necessary for all red blood cell containing products and are good for twenty-one (21) days if the patient has not been transfused or pregnant within the past three (3) months. The Identaband form must clearly state that the sample needs to be held for twenty-one (21) days. If the patient has been transfused or pregnant within the past three months, then the specimen is only good for three days starting from 12:01 a.m. of the next day. In the event that two (2) blood Identabands (at least one (1) cannot be placed on the pediatric patient's extremities, they (or the second band) should be taped to the bed/crib. When a pediatric patient who has had a "type and screen" or "type and crossmatch" goes to OR, two (2) current blood Identabands should be attached (taped) to different extremities of the patient (Note: In NICU, every effort should be made to attach at least one (1) current blood band to the patient; the blood bands may be taped to the bed if attachment to the patient is absolutely impossible.)

All blood products must be infused via a pump for pediatric patients. It is important that mechanical systems be tested and validated for use with the blood components (1).

ADDITIONAL GUIDELINES

1. Obtain equipment/supplies:

a. Physician Order Form (75.02)

b. Blood Bank Transfusion Identaband requisition (20.25), attached, and bracelet(s)

c. IV infusion pump, if indicated.

d. Blood Warmer, if ordered

e. Pretransfusion medication, if ordered

f. Order/Receipt Form for Blood Products, attached

g. Report of Blood Transfusion (20.52), attached

2. Physician/nurse practitioner/physician assistant completes the medical order with component, quantity needed, and rate of administration or transfusion time.

3. To Order Blood Products:

a. Check patient's record for signed consent for blood products.

b. Transcribe the information from the physician's/nurse practitioner's/physician assistant's order onto an Order/Receipt Form for Blood Products, attached, and send it to Blood Bank.

Note: If the first product is to be infused now, it should be indicated on that form and a second form is not needed. Another Order/Receipt Form is needed for subsequent products.

1) Complete name, medical history number and BHIS number

2) Location of patient

3) Blood component, quantity needed

4) Any special instructions

5) Physician's/NP's/PA's name and beeper number. Do not send a carbon copy of the medical order to the Blood Bank.

4. Procurement of Blood Products by Authorized Personnel:

a. Send a completed Order/Receipt Form for Blood Products, attached, to the Blood Bank via pneumatic tube (station 402).

b. Upon receiving the Order Receipt Form for Blood Products, the Blood Bank will send by return pneumatic tube system:

1) The blood product ordered with attached Unit Tag and the Report of Blood Transfusion (form #20.52).

Note: One (1) of the two (2) unit tags is detached from the Report of Blood Transfusion and is retained by Blood Bank; the other unit tag is attached to the blood product.

5. Preparation to Administer Product to the Patient

a. A patent IV should be in progress before blood products are requested from the Blood Bank; a 20-gauge angiocath/needle or larger should be used for adults (4,5) and usually a 22-24 gauge angiocath/needle for pediatric patients, depending upon the size of the child (1, 3, 6). This requirement does not apply to the outpatient surgical and procedural settings where blood products may be ordered prior to the placement of an IV in certain circumstances.

b. Vital signs (temperature, pulse, respirations, and blood pressure) must be taken and recorded on the Report of Blood Transfusion **minimally** before initiating blood product, within fifteen (15) minutes after initiating blood product, and after the transfusion is completed. For blood products administered in fifteen minutes or less, vital signs are taken before administering the blood product and after the transfusion is completed (4, 5, 6). <u>Note</u>: In ICUs, Intermediate Care Units, ORs/RRs, ERs, Dialysis and Blood Bank vital signs may be recorded on the area's specialty flowsheet instead of the Report of Blood Transfusion form. If this option is used, notation should be made on the Report of Blood Transfusion form to refer to the flowsheet.

6. Preparation and Administration of Blood Products by the Registered Nurse, Licensed Perfusionist, or Physician:

a. Infusion of blood product must be started within thirty (30) minutes of arrival of product on unit; if not it must be returned to the Blood Bank (1, 2).
b. The infusion of blood products must be completed within four (4) hours, but preferably within two (2) hours (1, 2).
<u>Note</u>: A slower rate of infusion may be required for some cardiac patients or pediatric patients; in such cases, aliquots or split blood products may be prepared by the Blood Bank upon request
(1, 2, 3).
c. Only a blood administration set with filter may be used for a transfusion.
<u>If blood is administered continuously, regardless of add-on devices, change the set at the end of 4 hours. If a single unit of blood is administered intermittently, regardless of add-on devices, change the set after each unit. (1, 8)</u>
d. Fresh frozen plasma must be infused immediately when received on the unit (1).
e. Aseptic technique and standard precautions must be used to spike the blood bag (1, 2, 3).
Note: Bag should not be spiked prior to taking vital signs, performing patient

assessment, and determining IV patency.

f. The IV tubing/catheter must be flushed with normal saline before the transfusion is started. Do not mix any solution other than 0.9 % Normal Saline with blood products (1).

g. Before initiating a Blood Product transfusion, the Registered Nurse, Licensed Perfusionist, or Physician will verify the following information with another Registered Nurse, Licensed Perfusionist, Licensed Practical Nurse, or Physician who has received appropriate education in such verification: (as such two qualified individuals are verifying the blood or blood product.) One individual conducting the identification verification must be the qualified individual who will administer the blood or blood component to the patient.

1) The patient is objectively matched to the blood or blood component during a two-person bedside or chair-side verification process. At least two unique identifiers are used in the process, and it is conducted after the blood or blood component that matches the order has been issued or dispensed.

2) Check patient's medical record for signed consent and indicate verification on the Report of Blood Transfusion (20.52).

3) Check medical order for patient name and medical record number and indicate verification on the Report of Blood Transfusion.

4) Check the following information on the Unit Tag and Report of Blood Transfusion against the patient's Hospital ID wrist

bracelet and against the medical order written in the medical record:

- Patient's full name. Ask the patient to identify self by stating his/her name, if appropriate; never ask, "are you Mr./Mrs./Miss _____?"
- Medical history number.

5) If the blood product to be transfused requires Identaband number, the patient must be wearing a bracelet with the same Identaband number that is on the Unit Tag and the Report of Blood Transfusion.
Note: Do not begin transfusion if there are any discrepancies and return blood products to the blood bank.

h. One of the two (2) checkers will then read aloud from the Report of Blood Transfusion while the other checker verifies the information on the blood product bag and Unit Tag or each independently verifies the information:

1) Donor unit number on the Report of Blood Transfusion is the same as on the blood product bag and Unit Tag.

2) ABO and RH type on the Report of Blood Transfusion are the same as on the blood product bag and Unit Tag.

3) Compatibility results as indicated on the Report of Blood Transfusion and the Unit Tag are the same.

4) Component type (e.g. red blood cells) on blood product bag, Unit Tag, and Report of Blood

Transfusion is the same as the physician's order.

5) Special instructions (e.g. irradiated) indicated on the blood product bag, Unit Tag, and Report of Blood Transfusion are the same.

<u>Note</u>: Expiration date and (time when required) is on the blood product bag and must be verified by both checkers prior to starting the transfusion. The blood product may be hung up to the expiration time and must be completed within four (4) hours of the expiration. Indicate on Report of Blood Transfusion that blood product expiration date has been checked and is current.

i. Each checker must sign the Report of Blood Transfusion (20.52) to verify that this information was checked and verified and that the blood expiration date and (time when required) was checked on the bag.

<u>Note</u>: If any discrepancies are noted, return the blood product and the Report of Blood Transfusion to the Blood Bank for investigation and correction of the discrepancy. Do not hang blood.

j. Assess the patient before beginning the transfusion and document as indicated on Report of Blood Transfusion (see attached form). Ask the patient if he/she has ever had prior transfusion reactions. Be sure that the code specifying the reason for the transfusion has been indicated. The RN/Licensed Perfusionist should obtain this information from the physician/nurse practitioner if he/she has been unable to determine the indication.

k. Assure that blood product is filtered before it infuses into the patient.

l. The rate of RBC infusion during the first fifteen (15) minutes of an elective transfusion should be 1-2ml/min. for adults; thereafter the rate may be more rapid (4,5).

7. Assessment and Documentation of Patient Status during Transfusion

a. Ask the patient if he/she is feeling symptoms such as nausea, back or substernal pain, etc., as indicated on Report of Blood Transfusion and complete assessments as indicated on Report of Blood Transfusion.
b. Monitor carefully for signs of reaction: 1) Observe the patient for the first five (5) to fifteen (15) minutes of the transfusion and periodically thereafter.
2) Assess for elevated temperature or change in blood pressure, rash, urticaria (hives), restlessness, back pain, substernal pain, chills, fever, pink or red urine, substernal or back pain, bleeding, shock, vomiting, or shortness of breath while blood is running. Refer to Report of Blood Transfusion indicating that the patient is having an adverse reaction to the blood.
c. The Registered Nurse, Licensed Perfusionist, or Physician discontinuing the transfusion completes the documentation on the Report of Blood Transfusion.
▪ Place the Report of Blood Transfusion in the patient's chart as soon as the transfusion is finished.
d. When the final unit of the blood product has been infused and patient is to continue on IV therapy, flush the IV line with sterile normal saline solution, change the blood filter administration set to an IV administration set, and continue with IV as ordered.
e. When transfusion is completed, dispose of a blood product bag (and any residual blood product remaining in bag) by placing it in an impervious bio-hazard container.
f. Record in the patient's medical record the blood product transfused, the amount, and patient's condition post transfusion.

EMERGENCY PROCUREMENT OF BLOOD PRODUCTS

To Order Blood Products in an Emergency:

a. The physician in charge states there is a Blood Emergency.
b. A designated person from the area of the emergency calls the Blood Bank Supervisor (2-6827) and:
▪ Identifies self
▪ States Blood Emergency in _____ (location)
▪ Patient's name
▪ Patient's medical history number
▪ Patient's diagnosis
▪ Quantity and name of blood products requested
c. The Blood Bank Supervisor will coordinate the release of the blood products and emergency release forms, if needed to the site of the emergency.
d. The physician, perfusionist or nurse must directly obtain the blood products

from the Blood Bank.

e. The Blood Bank Supervisor will coordinate the release of the blood products and emergency release forms, if needed, to the site of the emergency situation, via pneumatic tube. If the pneumatic tube system is not working, the unit will be notified, via telephone, that someone will have to pick up the blood products from the Blood Bank (TW003) Bottom of Form 1.

ADVERSE BLOOD REACTION

If reaction signs occur:

a. Immediately stop blood product; clamp tubing.
b. Replace blood filter administration set with IV administration set, and keep IV open with sterile normal saline solution.
c. Initiate emergency resuscitation if needed.
d. Notify physician immediately.
e. Immediately collect a urine specimen. Enter lab into computer as: U/A, "micro," and "Transfusion Reaction." Send to Hematology (TW-051, station 3).
f. Recheck patient's identification against the Unit Tag and Report of Blood Transfusion and the blood product bag against the Unit Tag and Report of Blood Transfusion. Check IV tubing and solution.
g. Check that tubing is clamped and securely cap the end of the IV tubing using a needless system cap. Do not use a needle for capping. Do not discard tubing or blood product.
h. The RN should draw a new type and screen sample from the patient in a lavender top (EDTA) tube as soon as possible, and label appropriately. Send the new blood specimen with the blood bank transfusion Identaband requisition (20.25), the remaining blood product with attached IV tubing and completed Transfusion Reaction form (20.16) to the blood bank as soon as possible. (The chart copy of the transfusion reaction form will be returned to the chart with reaction workup and transfusion recommendations).
i. Record nursing note of blood transfusion reaction in the medical record.
j. Complete a patient safety report or call the patient safety hotline 2-5544 to report the incident.

REFERENCES

1. American Association of Blood Banks, Technical Manual, Fifteenth Edition, 2005.

2. American Association of Blood Banks, A Physician's Handbook on Blood Transfusion Therapy, Eighth Edition, 2005.

3. American Association of Blood Banks, <u>A Physician's Handbook on Pediatric Transfusion</u>, First Edition, 2003.

4. Lynn-McHale, D. and Carlson, K., <u>AACN Procedure Manual for Critical Care</u>, Fifth Edition, 2005.

5. Smith, S., Duell, D., and Martin, B., <u>Clinical Nursing Skills Basic to Advanced Skills</u>, Sixth Edition, 2004.

6. Wong, D., <u>Nursing Care of Infants and Children</u>, Seventh Edition, 2003.

7. <u>Johns Hopkins: The Harriet Lane Handbook: A Manual for Pediatric House Officers</u>,Seventeenth Edition, 2005.

8. <u>Infusion Nurses Society.(2006) *Policy and procedures for infusion nursing* (3rd ed.).</u>

Interpretation, Implementation and Revision:
The Nursing Department and Transfusion Committee are responsible for revisions to this policy. They may delegate this to a responsible person at the time of review.

_____
Jamie O'Malley, RN MS
Chief Nursing Officer

_____
Harvey Golomb, MD
Chief Medical Officer

_____
David Hefner
President

_____
J. Richard Thistlethwaite, MD
President Medical Staff

4 forms follow:

Blood Bank Transfusion Identaband requisition (20.25) u20 25-blood-bank.pdf

Order/Receipt Form for Blood Products blood product order receipt form.pdf

Report of Blood Transfusion (20.52) report of blood transfusion.pdf

Transfusion Reaction Form (20.16) transfusion reaction form.pdf

Chemotherapy

Policy: PC 33
Issued: January 1996
Revised: October 2008
Reviewed: July 2008

Policy

It is the policy of the University of Chicago Medical Center to maintain standardized policies for the prescribing, preparing, and administration of antineoplastic medications to maximize patient safety. This policy applies to all routes of administration.

Definitions:

I. CPIT: **Chemotherapy** Performance Improvement Team set up as a subcommittee of the Executive Committee of the Medical Staff to oversee **chemotherapy** policies, practices and adverse events including near miss occurrences that do not result in patient harm.

Procedure
I. Ordering Chemotherapy
A. **Who May Write Orders**

1. **Chemotherapy** orders may be written by a mid-level practitioner (APN or PA), fellow or attending physician. However, for services in which there are no regularly assigned fellows, a resident (PGY2 or higher) may write **chemotherapy** orders. In addition, if requested by an attending physician, appropriately qualified RNs may transcribe **chemotherapy** notes and orders for services in which there are no assigned fellows. The RN will not be allowed to complete the dose/m2, dose/kg, dose based on area under the curve (AUC), actual dose and the total number of doses. These must be calculated and completed by the attending physician only. All **chemotherapy** orders (both inpatient and outpatient) require the co-signature of an attending physician before the drug will be dispensed by pharmacy.

> 2. Telephone orders will be accepted by the nurse or pharmacist, from the mid-level practitioner (APN or PA) fellow or attending, to hold, stop or decrease the dose of **chemotherapy**. Housestaff may stop **chemotherapy** on an emergency basis.

> 3. In extreme emergencies, if a patient needs specific **chemotherapy** (e.g.,

SVC syndrome, hyperleukocytosis, solid organ transplant during the overnight hours), a telephone order from an attending physician will be accepted.

a. A second nurse or pharmacist will verify all telephone orders. A note must be written in the chart within 24 hours by the attending physician documenting any of the above telephone orders or emergency actions.
b. In addition, the attending physician must sign all orders for emergency **chemotherapy** within 24 hours of the telephone order.
4. A physician's assistant and/or an Advanced Practice Nurse may write an order or give a telephone order to start, dose reduce, or modify the rate of **chemotherapy** administration. In the outpatient areas, a research nurse and/or physician resource nurse in consultation with a Physician is allowed to give a verbal order to initiate or hold **chemotherapy** on the basis of lab values.
5. A new **chemotherapy** order and note are required for any dosage increase or extension of therapy on existing **chemotherapy** orders. A decrease in dose or frequency may be written on a regular Physician order form by an attending, fellow, Physician Assistant or Advanced Practice Nurse or resident (PGY2 or higher for services in which there are no regularly assigned fellows).

B. **Physicians Responsibility** - The attending physician supplying the co-signature will verify the accuracy and appropriateness of the order against either the **chemotherapy** note (if a non-CPIT) approved Lotus Note or **chemotherapy** protocol.

C. **All Chemotherapy Orders Will Include**:
1. Patient's diagnosis
2. Age

3. Dose per kilogram or meter squared or area under the curve (AUC)

4. Actual calculated dose for the patient

5. Frequency

6. Duration of therapy

7. The total number of doses in the cycle

8. Route of administration and other administration parameters

9. Height, Weight, Calculated body surface area (BSA), and cycle number must be filled in completely, if applicable.

10. Preprinted orders will be printed on the Standard **Chemotherapy** Order Form, or on a CPIT approved **chemotherapy** note/order.

11. Alemtuzumab and rituximab when given for solid organ transplantation or other non-malignant conditions, DO NOT fall under the UCMC **Chemotherapy** Policy.
a. Alemtuzumab and rituximab given for these indications can be administered by a non-**chemotherapy** competent RN and can be ordered on a regular physician order; *however*, the order **must** be written by an attending physician of the primary managing service. In the event the order is written by a fellow or residents, the attending's co-signature is required before the drug can be dispensed.
b. In extreme emergencies, if a patient needs specific **chemotherapy** (e.g., SVC syndrome, hyperleukocytosis, solid organ transplant during the overnight hours), a telephone order from an attending physician will be accepted.
i A second nurse or pharmacist will verify all telephone orders. A note must be written in the chart within 24 hours by the Attending Physician documenting any of the above telephone orders or emergency actions.

ii In addition, the Attending Physician must sign all orders for emergency **chemotherapy** within 24 hours of the telephone order.
12. Besides the noted exceptions for Solid Organ Transplant and other non-malignant conditions requiring alemtuzumab and rituximab, all other **chemotherapy** orders must be written on the Standard **Chemotherapy** Order Form.

D. **Daily Reassessment -** Each day after the first day of a **chemotherapy** course, the attending on service, will:
1. Review the medication administration record (MAR) for accuracy (relative to the initial order and note)
2. Assess the patient's reactions to the treatment being administered, and

3. Write a brief note indicating that the patient's **chemotherapy** regimen and the plan of management has been reviewed.

4. A daily assessment evaluating both subjective and objective data, including psychosocial assessment, with documentation, must continue until the patient is discharged.

E. **Day Hours Preferred** -
Orders for **chemotherapy** must be submitted to the nursing staff by 1900 and

subsequently to pharmacy by 2100 in order to be executed. In the event **chemotherapy** orders are submitted past these established cut off times, nursing and/or pharmacy will contact the attending to discuss the situation. The attending will be consulted to establish whether administration of the **chemotherapy** can be held until 0900 the following morning or whether the **chemotherapy** must be administered as soon as possible. If the decision is made that administration of **chemotherapy** be held until the following morning, nursing will still be required to process and submit the orders to pharmacy. Only the actual administration will be held until the next morning.

While our hope is to minimize the number of orders submitted past 1900, "emergency" **chemotherapy** (e.g. SVC, blast crisis), which require immediate **chemotherapy** administration will be honored per policy. All "emergency" **chemotherapy** orders will be reviewed by CPIT.

F. **Additional Verifications** –
1. If a CPIT approved Note/Order is submitted for an inpatient, a separate **chemotherapy** order sheet is not required to be submitted. CPIT approved notes cannot be used for anything other than what is specified in the title and/or protocol #.
2. For outpatient use, both CPIT approved Lotus Note and a separate **chemotherapy** order must be submitted.

3. All other non-CPIT approved **chemotherapy** orders must be submitted on the standard **Chemotherapy** Order Form accompanied by a **chemotherapy** note, calculation sheet, or road map.

4. All **chemotherapy** doses will be recalculated and verified by pharmacy and nursing based on the information provided on the **Chemotherapy** Order Form and the **chemotherapy** note, calculation sheet or road map, as an additional check mechanism.
• The **chemotherapy** note, calculation sheet, or road map must be signed by the attending physician and/or fellow or mid-level practitioner (APN or PA).
G. **Pharmacy Policy and Procedure Manual [Inpatient and Outpatient]** - Refer to the Pharmacy Policy and Procedure Manual for all policies on **chemotherapy** preparation.
1. Two pharmacists must recalculate the BSA and recalculate the drug doses to assure accuracy. If this calculation results in a discrepancy in the **chemotherapy** dose of more than 10 percent for adult patients and 5 percent for pediatric patients, the pharmacist will notify the prescriber to resolve the difference.

2. If the dose exceeds any of the maximum dosage recommendations on the Adult or Pediatric Maximum Dose Chart for Chemotherapeutic Agents, the pharmacy will not dispense the dose until the attending physician is contacted, unless the attending physician has already documented in the medical record or on the **chemotherapy** order/note that the prescribed **chemotherapy** dose(s) exceeds the maximum dose.
a. The doses listed on the Adult and Pediatric Maximum Dose Chart for Chemotherapeutic Agents **do not** apply to any IRB approved protocols. Thus, the attending physician **does not** have to contact pharmacy or write a note in the medical record indicating that the dose(s) prescribed exceeds the UCMC **Chemotherapy** Maximum Dose Chart.
b. It should be noted that the UCMC **Chemotherapy** Maximum Dose Chart only applies to off protocol patients.
3. Doses dispensed outside the range listed on the Adult or Pediatric Maximum Dose Chart will be reviewed periodically by the Subcommittee of Pharmacy and Therapeutics, unless the dosage level has already been approved by the IRB. It should be noted that the Adult or Pediatric Maximum Dose Charts for Chemotherapeutic Agents are not intended as drug dosing guidelines. The Chart is organized to provide a quick reference for the usual maximum standard single dose, dose per course, minimum time between courses, stem cell dose, lifetime dose or dosing exception for a particular **chemotherapy** drug.
4. All orders, **chemotherapy** notes, calculation sheets, or road maps will be double checked by two pharmacists. Both pharmacists will independently recalculate the drug dose and check for accuracy and consistency using the Pharmacy **Chemotherapy** Order Entry Checklist as a guide.

II. NURSING PROCEDURE
A. **FOR INPATIENTS: Two RNs Check and Recheck/24-Hour Chart Notes Required**
1. If a CPIT approved **Chemotherapy** Note/Order is submitted, this serves as the order and a separate **chemotherapy** order sheet is not required to be submitted.

2. The CPIT approved **Chemotherapy** Note/Order is valid for 21 days from when the attending physician signed the order, provided that current laboratory parameters are cleared.

3. An RN must recalculate the BSA and the drug doses.
a. If this calculation results in a discrepancy in the **chemotherapy** dose from the original order of more than 10 percent for adult patients and 5 percent for pediatric patients, the nurse will notify the prescriber to correct or adjust the discrepancy.

b. If the **chemotherapy** note, calculation sheet and orders match, the RN signs the **chemotherapy** note and order sheets. A second RN must check the orders and follow the same procedure; however, orders may be submitted to the pharmacy before the second nurse checks the order.

4. Prior to administration of the first dose of **chemotherapy**, or whenever an order is changed, two RNs will check the dose against the original Physician order and the eMAR.

        a. Prior to administration all **chemotherapy** and supportive care medications must be verified by an RN when pharmacy has entered them on the eMAR.

        b. Subsequent doses will be checked against the eMAR by two nurses.
        c. The exact time of **chemotherapy** administration must be documented on the eMAR.

5. Prior to drug administration, two RNs will verify that the **chemotherapy** is labeled for the correct patient, and that the drug, dose, route and volume of **chemotherapy** match the original Physician order. This process takes place at the patient's bedside.
a. If an infusion pump is being used two RNs will verify that the **chemotherapy** is infusing at the correct rate.

b. Any change in the rate of infusion will be verified by two RN's.

6. All patients on **chemotherapy** require a plan of care addressing the individual **chemotherapy** agents and a note in the chart at least every 24 hours describing the patient's response to the drugs and interventions utilized to minimize side effects. In addition, a psychosocial assessment must be documented every 24 hours.

B. Patient Transfers and Admissions While On **Chemotherapy**
1. When a patient receiving **chemotherapy** is transferred between units or services, the **chemotherapy** orders do not need to be rewritten.
2. When a patient is admitted while receiving an ongoing **chemotherapy** schedule, with their own medication from home whether oral or intravenous, the resident or mid-level practitioner (APN or PA) can order continuation of the **chemotherapy** on a Physician order sheet (specifying drug name, dosage, route, frequency and other normal prescribing information), but must indicate in the medical record (on a note) that "the continuation of **chemotherapy** was

discussed with the attending". A **chemotherapy** order and accompanying **chemotherapy** note, calculation sheet or road map must be written, and signed by the attending, and submitted within 24 hours. When admitted from home with their own medication, the "Patient's Own Medication" policy will be followed. This policy can be found on the UCMC intranet under UCMC Formulary of Accepted Drugs.

3. When a patient is admitted to an inpatient service while receiving **chemotherapy** in the DCAM **Chemotherapy** Clinic, **chemotherapy** orders do not have to be rewritten. The outpatient **chemotherapy** order and corresponding **chemotherapy** note should be copied and placed in the inpatient chart and the fellow (or resident for services which do not have a fellow) must write a note which is dated and timed, stating that the "**chemotherapy** orders and note were reviewed and case was discussed with the attending. Continue **chemotherapy** as previously ordered." The inpatient attending physician must countersign the order within 24 hours.

C. **FOR OUTPATIENTS: - Two RNs Check And Recheck/Chemo Note to Pharmacy**
1. The original **chemotherapy** order is checked by the RN administering the dose against the **chemotherapy** drugs to be given. If any discrepancies are noted, the prescribing Physician or the pharmacist is notified immediately.
2. All patients receiving **chemotherapy** in OPD must have a **chemotherapy** note on file addressing the planned **chemotherapy** regimen which includes all elements specified earlier.

3. The **chemotherapy** note must accompany the **chemotherapy** orders to pharmacy.

4. If the planned regimen changes, including dosing changes from the original order, a new **chemotherapy** note must be written and accompany the new orders.

5. A new note does not have to be written if the dose is decreased and it is documented in the dose modification section of the **chemotherapy** order. A second RN must check the order and follow the same procedure as specified above.
6. Prior to drug administration, two RNs will verify that the **chemotherapy** is labeled for the correct patient, and that the drug, dose, route and volume of **chemotherapy** match the original Physician order. This process takes place at the patient's bedside. If an infusion pump is being used two RNs will verify that the **chemotherapy** is infusing at the correct rate. Any change in the rate of

infusion will be verified by two RN's.

D. **Episodic Reassessment** - For each episode of **chemotherapy** administration, the patient must be reassessed by a Physician or appropriately trained nurse. Documentation to support this assessment will include the patient's response to the drugs, interventions done to minimize side effects, and the patient's/family's psychosocial response.

E. **Ambulatory Infusion Device** - When **chemotherapy** is administered via an ambulatory infusion device, the programming of the infusion device will be checked by a second nurse or Physician with subsequent documentation in the patient's chart prior to beginning the infusion and prior to discharging the patient.

F. **Intrathecal Chemotherapy [Inpatient and Outpatient Administration –**
1. When intrathecal **chemotherapy** is administered, the administering Physician or Hem/Onc Advanced Practice Nurse or Physician Assistant and a registered nurse (or another Physician) must verify the patient's identification and check the syringe with the **chemotherapy** order to verify the accuracy of the drug(s), dose(s), volume, date, and that it is a preservative-free preparation.
2. The physician, Hem/Onc Advanced Practice Nurse or Physician Assistant administering the medication and the second licensed medical personnel verifying the above must document the date and time of administration on the eMAR (inpatient) or **chemotherapy** order form (outpatient).

3. Administration of Intrathecal **Chemotherapy** is to be done by Hem/Onc attending or fellow, a Hem/Onc Advanced Practice Nurse or Physician Assistant.

G. **Chemotherapy Administered in DCAM OR and GOR** –
1. When **chemotherapy** is administered as part of an outpatient procedure (e.g.: topically, subconjuctival, administered for subglottic stenosis, pterygium, trabeculectom, lacrimal drainage system surgery or any other procedure performed by a Physician), the administering Physician and a registered nurse or a perfusionist (or another Physician) must verify the patient's identification and check the **chemotherapy** preparation with the **chemotherapy** order to verify the accuracy of the drugs(s), dose(s), volume and date.
2. The signature of the Physician administering the medication and the second licensed medical personnel verifying the above must be documented on the **chemotherapy** order form.

H. **BSA Calculation** - All BSA calculations for adult patients are encouraged

to be calculated to 1 decimal point only. When the second decimal point is greater than or equal to 5, the first decimal point will be rounded up by 1 digit. When the second decimal point is less than 5, the first decimal point will remain the same. An example is provided for illustration:

- BSA 1.76 m2 will be rounded up and recorded as 1.8 m2
- BSA 1.75 m2 will be rounded up and recorded as 1.8 m2
- BSA 1.74 m2 will be recorded as 1.7 m2

INTERPRETATION, IMPLEMENTATION, AND REVISION

The Pharmacy and Therapeutics Subcommittee of the Quality Improvement Committee is responsible for revisions to this policy. It may delegate this to the **Chemotherapy** Performance Improvement Team.

Reference:

Polovich, M. (ed.), Blecher, C., Glynn-Tucker, E., McDiarmid, M., and Newton, S. Safe Handling of Hazardous Drugs. Pittsburg, PA: Oncology Nursing Society, 2003.

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Medical Staff President

Policy: PC 33
Issued: January 1996
Revised: October 2008
Reviewed: July 2008

AGENTS WHICH MUST COMPLY WITH THE UNIVERSITY OF CHICAGO MEDICAL CENTER CHEMOTHERAPY POLICY

Alemtuzumab (*Campath*®)***** **Note exception below*****
Altretamine (*Hexalen*)
Azacytadine (*Vidaza*)
Bevacizumab (*Avastin*)
Bexarotene (*Targretin*)
Bleomycin (*Blenoxane*)
Bortezomab (*Velcade*®)
Busulfan (*Myleran, Busulfex*)
Capecitabine (*Xeloda*)
Carboplatin (*Paraplatin*)
Carmustine (BCNU, *BiCNU, Gliadel Wafer)*
Cetuximab (*Erbitux*)
Chlorambucil (*Leukeran)*
Cisplatin (*Platinol*)
Cladrabine (2-CDA, *Leustatin*)
Cyclophosphamide (*Cytoxan*)
Cytarabine (Ara-C, *Cytosar-U*)
Dactinomycin (Actinomycin C, *Cosmogen*)
Denileukin (*Ontak*)
Docetaxel (*Taxotere*)
Dacarbazine (DTIC, *DTIC-Dome*)
Daunorubicin (*Cerubidine*)
Doxorubicin (Adria, *Adriamycin*)
Epirubicin (*Ellence*)
Erlotinib (*Tarceva*®)
Etoposide (VP16, *Vepesid*)
Fludarabine (*Fludara*)
Fluorouracil (5-FU, *Adrucil*)
Floxuridine (*FUDR*)
Gemcitabine (*Gemzar*)

Gemtuzumab ozogamycin (*Mylotarg*)
Gefitinib (*Iressa®*)
Hydroxyurea (*Hydrea*)
Idarubicin (*Idamycin*)
Imatinib (*Gleevec®*)
Interferon alfa-2B *(Intron A)*
Ifosfamide (*Ifex*)
Irinotecan (CPT11, *Camptosar*)
Iritumomab (*Zevalin*)
L-asparaginase (*Elspar*)
Liposomal doxorubicin *(Doxil)*
Lomustine (CCNU, *CeeNU)*
Mechlorethamine hydrochloride (*Mustragen*)
Melphalan (*Alkeran*)
Mercaptopurine (6-MP, *Purinethol*)
Methotrexate (*Folex*, MTX)
Mitomycin (Mitomycin C, *Mutamycin*)
Mitotane (*Lysodren*)
Mitoxantrone (*Novantrone*)
Oxaliplatin (*Eloxatin*)
Paclitaxel (*Taxol*)
Paclitaxel protein-bound particles *(Abraxane)*
Pegasparaginase (*Oncospar*)
Pemetrexed (*Alimta*)
Pentostatin (*Nipent*)
Plicamycin (Mithramycin, Mithracin®)
Procarbazine (*Matulane*)
Rituximab (Rituxan)***** Note exception below*****
Semustine (methyl-CCNU)
Streptozocin (*Zanosar*)
Temozolomide (*Temodar*)
Tenoposide (VM26, *Vumon*)
Thalidomide (*Thalomid*)
Thioguanine (6-TG)
Thiotepa (*Thioplex*)
Topotecan (*Hycamptin*)
Trastuzumab (*Herceptin*)
Tretinoin (ATRA, *Vesanoid*)
Trimetrexate (*Neutrexin*)
Valrubicin (*Valstar*)
Vinblastine (*Velban*)

Vincristine (*Oncovin*)
Vinorelbine (*Navelbine*)
Plicamycin (*Mithracin*)

***NOTE:
Alemtuzumab and rituximab when given for solid organ transplantation or other non-malignant conditions, DO NOT fall under the UCMC **Chemotherapy** Policy. <u>Alemtuzumab and</u> rituximab given for this indication can be administered by a non-**chemotherapy** competent RN and can be ordered on a regular Physician order; however, the order must be written by an attending Physician from the primary managing service. In the event the order is written by a fellow or residents, the attending's co-signature is required before the drug can be dispensed.

<u>AGENTS WHICH REQUIRE SAFE HANDLING PRECAUTIONS BUT DO NOT NEED TO COMPLY WITH UNIVERSITY OF CHICAGO MEDICAL CENTER CHEMOTHERAPY POLICY</u>

Azathioprine (*Imuran*®)
Ganciclovir (DHPG, *Cytovene*)
Isotretinoin (*Accutane*)
Mycophenolate mofetil (MMF, *Cellcept*)

<u>SELECT AGENTS WHICH NEED NOT COMPLY WITH UNIVERSITY OF CHICAGO MEDICAL CENTER CHEMOTHERAPY POLICY AND DO NOT REQUIRE SAFE HANDLING PRECAUTIONS</u>

Cyclosporin (CSA, *Neoral*®*, Sandimmune*®)
Filgrastim (g-csf, *Neupogen*®)
Infliximab (Remicade®)
Immune Globulin (IVIG, various brand names)
Leucovorin
Lupron and other LHRH agents
Lymphocyte Immune Globulin (*Atgam*®)
Mesna
Natalizumab
Oprelvekin *(Neumega, IL-11)*
Sargramostim (gm-csf, *Leukine*®)
Tacrolimus (FK506, *Prograf*®)
Tamoxifen and other antiestrogens

FOR FURTHER INFORMATION, PLEASE CONSULT THE UNIVERSITY OF CHICAGO MEDICAL CENTER *FORMULARY OF ACCEPTED DRUGS.* **EACH INDIVIDUAL DRUG MONOGRAPH WILL INDICATE UNDER THE "RESTRICTIONS" CATEGORY WHETHER THE CHEMOTHERAPY POLICY APPLIES.**

Refer to Code Triage red three ring binder book when Code Triage 1 or 2 is called on overhead paging system. Report to Charge Nurse for added instructions.

Charge Nurse Unit Disaster Report

Nursing Disaster Headquarters

Phone:_____   Location
TN202
Chg RN: _____   Phone
2-3525
Date:_____   Fax: 4-
3897
Time: _____

Step I: **Please note the following on the census and then send updated census information to TN202 via FAX every 2 hrs**
1. **Print Census and ensure it is current. Make any correction or transfer by hand.**
2. **Please code each patient on the census using the following key;**

General Units		**Critical Care Units**		**Clinics**	
DC	**Could be discharged home**	**RU**	**Must remain on the unit**	**RO**	**Clinic must remain open**
DC 24	**Could be discharged home within 24 hours**	**TR floor**	**Could be transfer to floor**	**MC**	**Clinic may close if**
RU	**Must remain on the unit**	**TR SD/tele**	**Could be transferred stepdowned**		**necessary**
TRT	**Could be taken off telemetry**		**or telemetry**		**ADM Clinic has**

patients to admit

Step II: Please note the following on the census
1. **Note your negative pressure rooms (air borne isolation)**
2. **Are they occupied Yes/No**
3. **If yes what is the requirement for isolation (i.e. Contact MRSA)**

Step III: Complete Staff and Equipment Roster

Staff Roster

Staff Title	**# of staff on duty**		**# UCH staff available for reassignment**		**Staff reassignment Name/title/location**
	UCH staff	**Agency staff**	**UCH staff**	**Agency staff**	
RN's					
LPN's					
Nurse externs					
PCT's (peds)					
NSA's					
PSC's					
other (specify)					

Step IV: Identify available equipment

Equipment Roster (available to relocate)

#s LBL		#'s		#'s		#'s	List any other
Wheel Chairs		Doppler		O2 tanks		Dynamaps	**List any other**
Stretchers/carts		Thermometers		EKG machine			
IV poles		Infusion Pumps		Pulse oximeters			

Deliver this form with attached census to TN 202 within 15 minute of Code Triage being called

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Code Triage, Phase 2: Nursing
External Disaster Plan - Pediatrics

Issued: **November, 2006;**   **Safety Policy S05-23-01**
Revised: **June 4, 2007, April 26, 2007**
Reviewed:

I.   Purpose

The purposes of this policy and procedure are to:
➢ Establish guidelines for appropriate Pediatric nursing response to external disasters when victims are expected to come for care at UCMC.
➢ Integrate the Pediatric nursing response into the hospital's disaster response and incident command system.

II.   Applies To

This policy and procedure applies to Comer Children's Hospital and the Pediatric Clinics' Nursing personnel.

III.   Policy

Pediatric nursing leadership will facilitate and oversee the emergency management efforts within the nursing department upon activation of Code Triage, Phase 2 Pediatrics, External Disaster Plan.

Three roles within the Pediatric nursing department are members of the Code Triage, Phase 2 Team.
➢ **Comer 5 Charge Nurse (or PCM or Director)** who will serve as the **Command Nurse**, and is a member of the 999 team.
➢ **Charge Nurse of PICU (or PCM or Director)** who will serve as the **Pediatric Operations Nurse**.
➢ **Comer 6 Charge Nurse (or PCM)** who will serve as the **Discharge Nurse**.

The Code Triage roles of the three nurses will be activated upon overhead page of :"Code Triage, Phase 2 Pediatrics. '999' Team to the Pediatric Incident Command Post, Comer Hospital Room K-160." The Operations Nurse will ensure that the Nursing Directors and On Call Bed Access Center Nurse are called upon activation of the Code Triage, Phase 2 Pediatrics to ensure that all areas are aware of its activation.

IV.   Goals of Policy

1.   To provide nursing care to disaster patients and families.
2.   To coordinate and facilitate the discharge of patients who are required to be discharged upon activation of the Code Triage, Phase 2 Pediatrics.
3.   To relocate patients from the Critical Care and Specialty areas, as appropriate.
4.   To maintain nursing care of patients too ill to be moved from the hospital.

V. Definitions

Pediatric Incident Command Post (PICP): The Pediatric Incident Command Post is located in the Comer Hospital Administrative Suite, K-160 and is the area where key people share information and make decisions. (**NOTE**: **In the event that a Code Triage, Phase 2 Pediatrics is called during the Code-Bio, the Command Nurse reports to the Nursing Disaster Headquarters in room TN-208).** The **Command Nurse** (Command-RN) staffs the Pediatric Incident Command Post along with other key administrative personnel. The Command Nurse is responsible for coordinating bed availability with the Nursing Disaster Headquarters; coordinating OR, anesthesia, and intensive care resources; and for assuring adequate nursing support, depending upon the type and magnitude of the disaster. Phone numbers for the Pediatric Incident Command Post are: **2-6239, 2-6205, 2-6410. Fax number: 2-4753**

Nursing Disaster Headquarters: The Nursing Disaster Headquarters (NDH) is located in **K-160** and is the area where all inpatient and outpatient nursing disaster responses are coordinated. The Nursing Disaster Headquarters is staffed by the **Operations Nurse** (Ops-RN), Staffing Resource Office Clerks and other clerical staff as needed. The NDH is the communication center among all inpatient units and between inpatient units and the PICP. Nursing personnel and equipment are managed through this site based upon information obtained from the staff equipment rosters (Comer charge nurse unit disaster report). Phone numbers for the Nursing Disaster Headquarters are: **2-6239, 2-6205, 2-6410. Fax number: 2-4753**

Discharge Coordination Center: In a disaster of great magnitude the Incident Commander and Command Nurse may decide to set up a Discharge Coordination Center to coordinate the discharge or transfer of pre-disaster inpatients, if such action is necessary to provide additional beds for disaster victims. The Discharge Coordination Center is located in **K-145** and is the area where the discharge and transfer of our inpatients that are not disaster victims is managed. The Discharge Coordination Center is staffed by the **Discharge Nurse** (DC-RN), Social Services, and other personnel as determined by the Operations Nurse. The phone numbers for the Discharge Coordination Center are: **2-6435; 2-5444; 5-0335; 5-8723; Fax = 4-0748**

In coordination with the Operations Nurse, the Discharge Nurse will assign personnel to staff K-145, the room from which inpatient discharges will be coordinated. Patients awaiting discharge are to be transported to K-145 via escort (patient transportation aid, nursing services assistant, nurse, and/or volunteer) with their medical record. After the discharge is completed, patients may leave the hospitals or await pick up in K-145.

The Command Nurse brings walkie-talkies from the DCP. The Command Nurse, Operations Nurse, and Discharge Nurse communicate via walkie-talkies.

Coordination between the Pediatric nursing disaster headquarters and the Mitchell nursing disaster headquarters will be via walkie-talkie.

VI. Job Action Sheets

➢ Three Job Action Sheets, which define the functions of the _Command Nurse_, _Operations Nurse,_ and _Discharge Nurse_ are available in the Pediatric Incident Command Post, K-160.

➢ Five Job Action Sheets, which define the functions of the _Inpatient Nursing Unit Charge Nurse_, _Patient Care Manager_, _Care Center Director, Pediatric Specialty Clinic Manager_, and _Bed Access Center Nurse,_ are available in the Pediatric Incident Command Post, K-160.

VII.   Readiness/Mobilization of Nursing Staff

➢ All nursing staff assigned to inpatient care units, including Patient Care Managers and Nurse Case Managers, will report to their unit immediately. If a Code Triage Phase 2 Pediatrics occurs at the time of change of shift, staff shall remain on the nursing units until released by the Operations Nurse in the Nursing Disaster Headquarters.

➢ All nursing personnel employed by The UCMC not assigned to inpatient care units (Clinical Specialists, Clinical Educators, Nurse Associates and Clinical Nurses) shall report to the Nursing Disaster headquarters in K-160 to receive work assignments.

➢ All Nursing Directors, Patient Care Managers, Case Managers, Clinical Nurse Specialists, Clinical Nurse Educators, Nurse Associates, and Clinic Nurses shall remain on duty until "Code Triage: All Clear" is announced or they are dismissed by the Operations Nurse.

VIII.   Termination of Disaster

Key personnel from the Pediatric Incident Command Post in the Comer Hospital Emergency Department will formally terminate the Code Triage Phase 2 Pediatrics. A "Code Triage: All Clear" will be announced over telepage, signifying the termination of the disaster. The Operations Nurse and the Pediatric Operations Nurse will ensure that all Nursing Directors or their designees are notified by phone or page of the "Code Triage: All Clear"

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Command Nurse (Peds)

Position: 1. Comer 5 Charge Nurse (pager 5101)
                   2. Comer 5 PCM (pager 4671, 4497, or 8314)
                   3. Comer 5 Director (pager (4011)

Responds To: Pediatric Incident Command Post in the Comer administrative suite, K-160;
                   phone numbers : 2-6239, 2-6205, 2-6410
                   In a Code Bio Disaster – Reports to TN202; phone numbers: 2-6963; 5-8041;
                   5-8042; 5-8043

Job Actions:

_____   1. Immediately reports to the Incident Commander (Comer VP, Exec. Director of Comer Nursing, Senior AOC/HOA) in the Pediatric Incident Command Post to assist in directing the hospital's response to the disaster.

_____   2. Obtains nursing envelope and follows Job Action Sheet.

_____   3   Confirms with the Hospital Call Center that the Code Triage Group page has gone out to all Nursing Directors. Confirms that the KidsFirst group page has been gone out.

_____   4. Assures that the Nursing Disaster Headquarters (**2-6435; 2-5444; 5-0335; 5-8723. Fax number: 4-0748)** is established in K-160 and is staffed by the Operations Nurse (PICU charge nurse at pager 1252), a Bed Access Center Nurse (at pager 3333 or extension 4-BEDS), an Environmental Services Supervisor (at pager 6183), and adequate clerical staff (Staffing Resource Office Clerk and NICU PSC at extension 2-6681 and/or Women's Care Center PSC at pager 6222).

_____   5. Obtains the Patient Log Sheet, which includes the patient name and diagnosis, from the Emergency Department staff.

_____   6. Obtains 3 walkie-talkies from Security. Distributes 2 walkie-talkies to the Operations Nurse (1 for the Operations Nurse and 1 for the Discharge Nurse) and keeps 1 for her/himself to communicate with the Operations Nurse and Discharge Nurse.

_____   7. Communicates with Operations Nurse, in the Nursing Disaster Headquarters, about Emergency Department admissions and obtains patient room/bed assignments. Documents patient room and bed assignments on the Patient Log Sheet. Phone numbers for the Nursing Disaster Headquarters: are **2-6239, 2-6205, 2-6410. Fax: 2-4753**

_____   8. Communicates patient room/bed assignments to Comer Emergency Department Charge Nurse **2-3415**

_____   9. Communicates with Operations Nurse, in the Nursing Disaster Headquarters, any needs for additional staff and equipment in the Emergency Department.

_____   10. Assists Incident Commander with additional tasks, as needed.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Operations Nurse (Peds)

Position: 1. PICU Charge Nurse (pager 1252)
2. PICU PCM (pager 3979, 3980, 5245, 7536, or 7378)
3. PICU Director (pager 8466)

Responds To: Nursing Disaster Headquarters (Room K-160)
Phone numbers are **2-6239, 2-6205, 2-6410. Fax: 2-4753**

Job Actions:

_____   1. Reports to K-160. (Security to open door, if locked.)

_____   2. Obtains Disaster Manual from Staffing Resource Office.

_____   3. Establishes the Nursing Disaster Headquarters.

_____   4. Receives walkie-talkies from the Command Nurse for the Operations Nurse and Discharge Nurse.

_____   5. In the event the Code Triage Phase 2 Pediatrics occurs after business hours, arranges to have the following key personnel called at home. (Roster of home phone numbers can be found in the disaster cabinet in K-160.)

_____   Executive Director of Comer Nursing
_____   Director, Pediatric ED
_____   Director of General Pediatrics
_____   Pediatrics Program Director
_____   Comer Operations Director
_____   Child Life Director

_____   6. Organizes Disaster Forms (Comer Charge Nurse Unit Disaster Report) received from the nursing units and Pediatric clinics for tracking staff and equipment.

_____   7. Monitors submission of Disaster Forms. Calls nursing units and Pediatric clinics that do not submit Forms within 20 minutes.

_____   8. Documents updated census to the Bed Access Nurse every two hours.

_____   9. Documents individual unit information onto master copy.

____   10. Communicates with Pediatric Incident Command Post about admissions.

_____   11. Evaluates bed availability on an ongoing basis and facilitates the admission, discharge, and transfer processes. Coordinates Emergency Department admissions and current inpatient transfers with Bed Access Center Nurse.

_____   12. Informs **Command Nurse** of room/bed assignments of Emergency Department patients/disaster victims.

_____ 13. Assures adequate nurse staffing. Deploys staff, as needed, based on requests from the PICP, Command Nurse, Discharge Coordination Center, or other nursing units.

_____ 14. Coordinates equipment requests. Directs equipment redistribution, as needed.

_____ 15. Communicates with the **Discharge Nurse** who documents patient discharges

_____ 16. Designates one staff person (e.g., clerical, transporter, EVS, etc.) from each Care Center to function as runners to collect the logs of patients discharged from every nursing unit.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Discharge Nurse (Peds)

Position: 1. Comer 6 Charge Nurse (pager 4104)
                     2. Comer 6 PCM (pager 3976 or 3931)

Responds To: Discharge Coordination Center – (**Room K-145; phone numbers 5-6580; 2-5826; 2-3515).**

Job Actions:

_____   1. Reports to Nursing Disaster Headquarters, K-160.

_____   2. Establishes the Discharge Coordination Center

_____   3. Receives walkie-talkie from the Operations Nurse and uses to communicate with Operations Nurse and Command Nurse.

_____   4. In conjunction with the Operations Nurse, determines when to open the Patient Discharge Center (K-145), the centralized location from which Comer patients will be discharged.   If locked Security may unlock.

_____   5. Upon direction of the Operations Nurse, supervises the Staffing Resource Office Clerk fulfilling the Bed Access Nurse function until the arrival of the On Call Bed Access Nurse.

_____   6. Contacts the Operations Nurse when additional personnel (Nurses, Nurse Case Managers, Social Workers, Physicians, etc.) are needed to help staff the Patient Discharge Room and facilitate patient discharges. Assigns additional staff to work in K-145 to help with patient discharges.

_____   7. Communicates with the Nursing Disaster Headquarters to obtain a patient roster of possible discharges.

_____   8. Contacts Patient Transportation Services (2-6734) to arrange escort of patients to be taken to K-145 for discharge. Instructs Patient Transport to bring the patient's medical record along with the patient.

_____   9. Coordinates with the Emergency Department to discharge non-disaster victim Emergency Department patients through the Discharge Coordination Center.

_____   10. Ensures that all patients to be discharged have written discharge orders in the medical record, either from a physician on the nursing unit or a physician posted in the Discharge Coordination Center.

_____   11. Ensures that the nurse case manager or social worker arranges for the transportation of discharged patients from the hospitals. Ensures that transportation arrangements have been documented in the medical record.

_____ 12. Ensures that nurses, either on the nursing units or in the Discharge Coordination Center, provide appropriate patient education prior to the patient's discharge. Ensures that patient teaching has been documented in the medical record.

_____ 13. Ensures that all documentation (discharge orders, transportation arrangements, patient education, any given treatments, any medications administered, the patient's condition, and discharge time) is complete prior to the patient's discharge from the hospitals.

_____ 14. Ensures that patients are given tokens or money for transportation (through the Staffing Resource Office), as needed.

_____ 15. Ensures that hospital staff accompanies patients requiring wheelchair transport to the hospital's main entrance. Alternatively, patients may wait in the Discharge Center.

_____ 16. Ensures Bed Access Center Nurse is notified of all patients discharged through the Discharge Coordination Center and maintains a copy of all discharges made through the Discharge Center.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Inpatient Nursing Unit Charge Nurse (Peds)

Position: Charge Nurse of every inpatient nursing unit will be notified of Code Triage Phase 2 - Pediatrics by overhead page.

Responds To: Remains on assigned nursing unit to oversee all unit operations until the arrival of the Patient Care Manager, unless designated as a member of the Code Triage Phase 2 - Pediatrics – team (Charge Nurses of Comer 5 and PICU), in which case they would assign a new Charge Nurse for these areas and respond immediately to their assigned disaster roles.

Responsibilities: Prepares to function with minimal safe staffing and designates which members of the nursing staff may be released for emergency reassignment. (Personnel available for immediate release will remain on their assigned nursing units until reassigned through personnel in the Nursing Disaster Headquarters in K-160.)

Job Actions:

_____   1. Immediately obtains a census report. Checks the document to ensure that all current patients and available beds are listed accurately. Indicates patient status on the census report using the following codes.
For General Units:

DC:	Could be discharged home
DC24:	Could be discharged home within 24 hours
RU:	Must remain on unit
TR:	Could be transferred to another unit or taken off tele.

For Critical Care Units:

RU:	Must remain on unit
TR Floor:	Could be transferred to the floor
TR SD/TELE:	Could be transferred to step down or telemetry

(When possible, this initial patient assessment should be made in consultation with the Senior Resident. If s/he is not available the Charge Nurse will complete the coding. Any subsequent changes to the coding shall be phoned to the Nursing Disaster Headquarters in K-160 at phone numbers **2-6239, 2-6205, 2-6410. Fax number: 2-4753**.)

_____   2. Completes Charge Nurse Unit Disaster Report .

_____   3. Ensures that the completed Charge Nurse Unit Disaster Report and the initial updated census report are hand delivered to the Nursing Disaster Headquarters in K-160 within 10 minutes of the Code Triage Phase 2 Pediatrics being called.

_____   4. Completes an updated census and makes necessary changes every 2 hours. Fax census to Nursing Disaster Headquarters at fax number 2-4753.

_____   5. Contacts the Nursing Disaster Headquarters, by telephone 2-6239; 2-6205; 26410 if unit staffing requirements change.

_____   6. Ensures that all patient transactions (admissions, discharges, transfers to/from the unit, and changes in clinical condition) are logged in their existing patient tracking form.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Pediatric Specialty Clinic Manager

Position: Manager will be notified of Code Triage Phase 2 – Pediatrics activation by overhead page.

Responds To: Remains at assigned clinic to oversee all unit operations.

Responsibilities: Prepares to function with minimal safe staffing and designates which members of the nursing staff may be released for emergency reassignment. Managers must determine which clinics may close and which patients must be seen. (Personnel available for immediate release will remain at their assigned clinics until reassigned through personnel in the Nursing Disaster Headquarters in K-160.)

Job Actions:

_____   1. Immediately obtains a census report. Indicates patient status on the census report using the following codes.

> ADM Clinic has patients to admit
> MC Clinic may close if necessary
> RO Clinic must remain open

(When possible, this initial patient assessment should be made in consultation with the Attending. If s/he is not available the manager will complete the coding. Any subsequent changes to the coding shall be phoned to the Nursing Disaster Headquarters in K-160 at phone **2-6239, 2-6205, 2-6410. Fax number: 2-4753**.)

_____   2. Completes Charge Nurse Unit Disaster Report .

_____   3. Ensures that the completed Charge Nurse Unit Disaster Report and the initial updated census report are hand delivered to the Nursing Disaster Headquarters in K-160 within 10 minutes of the Code Triage, Phase 2 being called.

_____   4. Contacts the Nursing Disaster Headquarters, by telephone **2-6239, 2-6205, 2-6410** if unit staffing requirements change.

_____   5. Ensures that all patient transactions are logged in their existing patient tracking form.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Patient Care Manager (Peds)

Position: Patient Care Manager of every inpatient nursing unit. (Will be notified by overhead page during customary working hours or through activation of the Care Center's telephone-calling tree at the direction of the Care Center Director.)

Responds To: Remains on assigned nursing unit to oversee all unit operations. Checks in with Care Center Director to receive any special assignment(s). In the absence of the Care Center Director, the Patient Care Manager carrying the leadership pager will function as the Care Center Director until the Care Center Director arrives on site.

Responsibilities: Collaborates with the charge nurse or may act as the charge nurse in order to prepare to function with minimal safe staffing and designate which members of the nursing staff may be released for emergency reassignment. (Personnel available for immediate release will remain on their assigned nursing units until reassigned through personnel in the Nursing Disaster Headquarters in K-160.)

Job Actions:

_____ 1. Ensures that the charge nurse has taken a unit census and completed the census report and Charge Nurse Unit Disaster Report and has sent these documents to the Nursing Disaster Headquarters and continues to fax report.

_____ 2. Ensures that adequate numbers of staff and equipment remain on the nursing unit to care for existing patients and expected non-disaster related admissions.

_____ 3. Assures that the PSC or other designated staff person logs patient admissions, discharges, and transfers in the unit-based patient tracking system.

_____ 4. Communicates with the Operations Nurse in the Nursing Disaster Headquarters regarding needs for personnel, equipment, and supplies. Phone numbers for the Nursing Disaster Headquarters are: **2-6239, 2-6205, 2-6410. Fax number: 2-4753**.

_____ 5. Communicates with the Discharge Nurse in the Discharge Coordination Center regarding discharge and transfer of patients on the nursing unit. Deploys unit staff to the Discharge Coordination Center at the request of the Discharge Nurse. The phone numbers for the Discharge Coordination Center are **2-6435; 2-5444; 5-0335; 5-8723; Fax = 4-0748**

_____ 6. Collaborates with the nursing unit charge nurse in making new patient care assignments (based upon staffing changes and patient admissions, discharges, and transfers).

_____ 7. Communicates with his/her Care Center Director regarding all unit needs/issues.

_____ 8. Responds to calls for assistance from her/his Care Center Director, the Discharge Nurse, and the Operations Nurse.

_____ 9. May serve as charge nurse, at the discretion of the Care Center Director.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Care Center Director (Peds)

Position: Care Center Director. (Will be notified by telepage by the Command Nurse.)

> ➢ Director NICU covers PICU when the PICU Director of Nursing is functioning as the **Operations Nurse**.

Responds To: Remains on assigned care center to oversee all nursing unit operations. Checks in with the Operations Director in the Nursing Disaster Headquarters to receive any special assignment(s). Phone numbers for the Nursing Disaster Headquarters are: **2-2-6239, 2-6205, 2-6410. Fax number: 2-4753**

Responsibilities: Ensures continued operation of all nursing units within assigned care center.

Job Actions:

_____   1. Phones the Staffing Resource Office (2-3525) upon receipt of Code Triage Phase 2 Pediatrics page.. Comes into the hospitals upon receipt of the page.

_____   2. Activates care center leadership staff and staff calling trees, as necessary.

_____   3. Ensures call up of off-duty staff to work occurs when directed by the Operations Nurse in the Nursing Disaster Headquarters.

_____   4. Assures that patient care services continue to be provided to all patients in assigned care center.

_____   5. Responds to directives/assignments from the Operations Nurse in the Nursing Disaster Headquarters.

_____   6. Responds to special requests for assistance from the Discharge Nurse in the Discharge Coordination Center.

The University of Chicago Hospital Medical Center
Departmental Disaster Mobilization Plan

Bed Access Center Nurse
Job Action Sheet

Position: Bed Access Center Nurse **(Pager On Call 24/7)**

Responds To: Nursing Disaster Headquarters
(Room K-160; phone 2-6239, 2-6205, 2-6410. Fax number: 2-4753)

Responsibilities: Tracks the disposition (admissions, discharges, and transfers) of all patients and disaster victims.

NOTE: ***IN THE ABSENCE OF THE BED ACCESS NURSE, THE HOA ADMINISTRATOR WILL SERVE AS THE BED ACCESS NURSE UNTIL THE ON-CALL BED ACCESS CHARGE NURSE ARRIVES.   (THIS SITUATION IS LIKELY TO OCCUR AT THE FOLLOWING TIMES: MONDAY - FRIDAY 1200 - 0600 AND SATURDAY, SUNDAY, AND HOLIDAYS 1830 - 0800.)***

Job Actions:

_____   1. Reports to the Operations Nurse in the Nursing Disaster Headquarters to hear overall initial information.

_____   2. Assigns beds to disaster victims as communicated by the Disaster Headquarters through the Operations Nurse.

_____   3. Assigns bed from Ambulatory areas, transfers, as prioritized by Operations Nurse.

_____   4. Receives the updated census every two hours from the Operations Nurse.

_____   5. Tracks all admissions, transfers, and discharges.

mf/ms 4/2007; jr/jc11/2006;

POLICY NAME: CODE TRIAGE PHASE 1, EXTERNAL DISASTER PLAN
POLICY NUMBER: S05-21
ISSUE DATE: JANUARY 3, 2002
REVISED DATE: JULY 11, 2008; OCTOBER 12, 2006
REVIEW DATE:

POLICY:

A *Code Triage Phase 1* is activated when the University of Chicago Medical Center (UCMC) is notified of a Chicago or Illinois Department of Health (IDPH) plan activation. If disaster victims are en route to the Medical Center the *Code Triage Phase 2 Plan* may be activated.
The UCMC information relevant to the Hospital Health Alert Network (HHAN) is updated in the frequency requested by IDPH.

DEFINITIONS:

Hospital Health Alert Network (HHAN) is a network maintained by the Illinois Department of Health (IDPH). It provides secure web-based communication and information sharing capabilities from IDPH to Illinois hospitals and vice versa. On a daily schedule, the Hospitals Operations Administrator (HOA) or Bed Access enters the required the data on bed and other resource availability for the University of Chicago Medical Center (UCMC) into the HHAN. The HOA or Bed Access communicates ambulance diversions to the HHAN in accordance with policy A04-01 Emergency Department Resource Limitation/Ambulance Diversion

Mitchell Emergency Department Telemetry (Telemetry)
Telemetry has the designated communication equipment and authorized staff to communicate with the Chicago Fire Department Emergency Medical Services (CFD-EMS). Telemetry routes pertinent incoming information to the Comer ED and Mitchell ED staff. In case of a declared disaster Telemetry communicates with CFD-EMS and the participating Southside hospitals of the IDPH Region 11.

PROCEDURES:

1. **Emergency Room Telemetry Response**
   Upon activation of the IDPH Phase 1 or Phase 2 Plan activation, Telemetry personnel pages the Senior AOC (page 7502) and the individual on-call for EMS (pager 9944) to the Mitchell Emergency Room.

   Mitchell ED Telemetry notifies the participating Southside hospitals emergency departments of the disaster phase and instructs them to update their entry in the HHAN. Telemetry continues to provide updates to participating hospitals throughout the disaster phase until the disaster is declared over.

2. **Senior AOC/HOA Response**
    The Senior AOC proceeds to the Mitchell Emergency Room and based on the information available, determines if the Medical Center is likely to receive patients within the next 4 hours. If so, the Senior AOC/AOC may, in conjunction with the Adult or Pediatrics ED Medical Director, activate the S05-22 Code Triage Phase 2, External Disaster Plan or the S05-23 Code Triage Phase 2, Pediatrics External Disaster Plan.
    The HOA or Bed Access updates the HHAN for UCMC as requested by IDPH.

RELATED POLICIES

>   A04-01 Emergency Department Resource Limitation/Ambulance Diversion
>   S05-22 Code Triage Phase 2, Adults External Disaster Plan
>   S05-23 Code Triage Phase 2, Pediatric - External Disaster Plan

INTERPRETATION, IMPLEMENTATION, AND REVISION:

>   This policy is reviewed at least annually by the Chairperson of the Emergency Preparedness Subcommittee.

_____
David Hefner
President
University of Chicago Medical Center

Within 15 minutes of Code Triage, Pediatrics being called, complete this form and fax or deliver to K-160 (fax: 2-4753)

		Enter the number of staff currently on duty and the number who can be re-assigned							
Unit	Phone Number	Number of RNs on Duty	Number of RNs who can be re-assigned	Number of PSAs on duty	Number of PSAs who can be re-assigned	Number of PSCs on duty	Number of PSCs who can be re-assigned	Number of available rooms	
NICU	2-1048								
CTCU	2-1048								
PICU	2-0001								
CICU	2-0001								
Comer 5	2-1041								
Comer 6	2-0188								
PER	2-3415								

Patients sent to Discharge Center, K-145			Identify equipment that can be relocated to assist with the Code Triage					
K-		Unit	Wheel Chairs	Stretchers	IV poles	Syringe pumps	O2 Tanks	Monitors
K-		NICU						
K-		CTCU						
K-		PICU						
K-		CICU						
K-		Comer 5						
K-		Comer 6						
K-		PER						
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		Type of Disaster/Incident:	
Comer Incident Command Center K-160 2-6239		Form completed by (enter name and phone number):	
Comer Discharge Center, K-145: 2-6435			

The University of Chicago Medical Center
Institutional Safety and Environment of Care Manual

Departmental Disaster Mobilization Plan

Code Triage, Phase 2: Nursing
External Disaster Plan - Adults

Issued: **July 1994;**   **Safety Policy SO5-22-01**
Revised: **June 4, 2007, April 27, 2007, October 2002**
Reviewed: **September 2003**

I.   Purpose

The purposes of this policy and procedure are to:
➢ Establish guidelines for appropriate Adult nursing response to external disasters, when victims are
   expected to come for care at UCMC.
➢ Integrate the Adult nursing response into the hospital's disaster response and incident command
   system.

II.   Applies To

This policy and procedure applies to all University of Chicago Mitchell Hospital, Lying-In Hospital, and
Duchossois Center for Advanced Medicine Nursing personnel.

III.   Policy

Adult Nursing leadership will facilitate and oversee the emergency management efforts within the nursing
department upon activation of Code Triage, Phase 2 Adults, External Disaster Plan.

Three roles within the nursing department are members of the Code Triage, Phase 2 Adults Team.
➢ **Charge Nurse of 4NW** who will serve as the **Command Nurse**, and is a member of the 999 team.
➢ **Charge Nurse of D3** who will serve as the **Operations Nurse**.
➢ **Charge Nurse of Mother-Baby** who will serve as the **Discharge Nurse**.

The overhead Code Triage, Phase 2, Adults External Disaster page activates the roles of the three charge
nurses: "CODE TRIAGE PHASE 2 ADULTS ACTIVATION. 999 TEAM TO THE
DISASTER COMMAND POST, MITCHELL EMERGENCY DEPARTMENT,
EXPRESS CARE."
  The Operations Nurse will ensure that the Nursing Directors and On Call Bed Access Center Nurse are
called upon activation of the Code Triage, Phase 2 Adults to ensure that all areas are aware of its activation.

IV.   Goals of Policy

1.   To provide nursing care to disaster patients and families.
2.   To coordinate and facilitate the discharge of patients who are required to be discharged upon
         activation of the Code Triage, Phase 2 Adults.
3.   To relocate patients from the Critical Care and Specialty areas, as appropriate.
4.   To maintain nursing care of patients too ill to be moved from the hospital.

V.   Definitions

Disaster Command Post: The UCH Disaster Command Post is located in the Mitchell Hospital Emergency Department Express Care and is the area where key people share information and make decisions. (**NOTE**: **In the event that a Code Triage, Phase 2 Adults is called during the Code-Bio, the Command Nurse reports to the Nursing Disaster Headquarters in room TN-208 and NOT the Mitchell Express Care).** The **Command Nurse** staffs the UCMC Disaster Command Post along with other key administrative personnel. The Command Nurse is responsible for coordinating bed availability with the Nursing Disaster Headquarters; coordinating OR, anesthesia, and intensive care resources; and for assuring adequate nursing support, depending upon the type and magnitude of the disaster. Phone numbers for the UCMC Disaster Command Post are: **2-6963; 5-8041; 5-8042; 5-8043.**

Nursing Disaster Headquarters: The Nursing Disaster Headquarters (NDH) is located in **TN202** (the Staffing Resource Office) and is the area where all inpatient and outpatient nursing disaster responses are coordinated. The Nursing Disaster Headquarters is staffed by the **Operations Nurse** , Staffing Resource Office Clerks and other clerical staff as needed. The NDH is the communication center among all inpatient units and between inpatient units and the UCMC Disaster Command Post in the Mitchell Emergency Department. Nursing personnel and equipment are managed through this site based upon information obtained from the staff equipment rosters (Form A and Form B). Phone numbers for the Nursing Disaster Headquarters are: **5-2361; 5-2362; 5-2984; 2-3525**.

Discharge Coordination Center: In a disaster of great magnitude the Senior Administrator and Command Nurse may decide to set up a Discharge Coordination Center to coordinate the discharge or transfer of pre-disaster inpatients, if such action is necessary to provide additional beds for disaster victims. The Discharge Coordination Center is located in **TN202** (the Staffing Resource Office) and is the area where the discharge and transfer of inpatients that are not disaster victims are managed. The Discharge Coordination Center is staffed by the **Discharge Nurse**, Social Services, and other personnel as determined by the Operations Nurse. The phone numbers for the Discharge Coordination Center are: **5-2361; 5-2362; 5-2984; 2-3525**.

In coordination with the Operations Nurse, the Discharge Nurse will assign personnel to staff TN208, the room from which inpatient will be discharged. Patients awaiting discharge are to be transported to TN208 via escort (patient transportation aid, nursing services assistant, nurse, and/or volunteer) with their medical record. After the discharge is completed, patients may leave the hospitals or await pick up in TN-208 Tel. 5-2204.

The Command Nurse brings walkie-talkies from the DCP.   The Command Nurse, Operations Nurse, and Discharge Nurse communicate via walkie-talkies.

Coordination between the Pediatric nursing disaster headquarters and the Mitchell nursing disaster headquarters will be via walkie-talkie.

VI.   Job Action Sheets

➤   Three Job Action Sheets, which define the functions of the *Command Nurse*, *Operations Nurse*, and *Discharge Nurse* are available in the Mitchell Express Care disaster cabinet.

➤   Five Job Action Sheets, which define the functions of the *Inpatient Nursing Unit Charge Nurse*, *Patient Care Manager*, *Care Center Director, DCAM Manager*, and *Bed Access Center Nurse* are available in the Nursing Disaster Headquarters.

VII.   Readiness/Mobilization of Nursing Staff

➢ All nursing staff assigned to inpatient care units, including Patient Care Managers and Nurse Case Managers, will report to their unit immediately. If a Code Triage Phase 2 Adults occurs at the time of change of shift, staff shall remain on the nursing units until released by the Operations Nurse in the Nursing Disaster Headquarters.

➢ All nursing personnel employed by The UCMC not assigned to inpatient care units (Clinical Specialists, Clinical Educators, Nurse Associates and Clinical Nurses) shall report to the Nursing Disaster Headquarters in TN202 to receive work assignments.

➢ All Nursing Directors, Patient Care Managers, Case Managers, Clinical Nurse Specialists, Clinical Nurse Educators, Nurse Associates, and Clinic Nurses shall remain on duty until "Code Triage: All Clear" is announced or they are dismissed by the Operations Nurse.

VIII.   Termination of Code Triage Phase 2 Adults

Key personnel from the Disaster Command Post in the Mitchell Hospital Emergency Department will formally terminate the Code Triage Phase 2 Adults. A "Code Triage: All Clear" will be announced over telepage, signifying the termination of the disaster. The Operations Nurse will ensure that all Nursing Directors or their designees are notified by phone or page of the "Code Triage: All Clear"

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Command Nurse (Adults)

Position: 1. Director of Mitchell 4 (pager 8337)
                       2. On-site Mitchell 4 Patient Care Manager (pager 4444)
                       3. Charge Nurse of 4NW (Member of the Code 999 Team.)

Responds To: UCMC Disaster Command Post (DCP) in Mitchell Express Care
(phone numbers 2-6963; 5-8041; 5-8042; 5-8043).
In a Code Bio Disaster – report to TN202 (5-2361, 5-2362, 5-2984, 2-3525)

Job Actions:

_____   1. Immediately reports to the Senior Administrator On Call and/or the Hospital
Operations Administrator (AOC/HOA) in the Mitchell Emergency Department to assist
in directing the hospital's response to the disaster.

_____   2. Obtains Nursing envelope and follows Job Action Sheet.

_____   3 Confirms with the Hospital Call Center that the Code Triage Group page has gone out
to all Nursing Directors.

_____   4. Assures that the Nursing Disaster Headquarters (**5-2361; 5-2362; 5-2984; 2-3525**) is
established in TN202 and is staffed by the Operations Nurse (D3 Charge Nurse at
extension 2-6544), a Bed Access Center Nurse (at pager 3333 or extension
4-BEDS), an Environmental Services Supervisor (at pager 6183), and adequate clerical
staff (Staffing Resource Office Clerk and/or Women's Care Center PSC at pager 6222).

_____   5. Obtains the Patient Log Sheet, which includes the patient name and diagnosis, from
the Emergency Department staff.

_____   6. Obtains three walkie-talkies from Security in the DCP in the Emergency Department.
Distributes 2 walkie-talkies to the Operations Nurse (1 for the Operations Nurse and 1 for
the Discharge Nurse) and keeps 1 for her/himself, and uses to communicate with the
Operations Nurse and Discharge Nurse.

_____   7. Communicates with Operations Nurse, in the Nursing Disaster Headquarters, about
Emergency Department admissions and obtains patient room/bed assignments.
Documents patient room and bed assignments on the Patient Log Sheet. Phone numbers
for the Nursing Disaster Headquarters are: **5-2361; 5-2362; 5-2984; 2-3525**.

_____   8. Communicates patient room/bed assignments to Emergency Department Charge
Nurse. Phone numbers for the UCH Disaster Command Post are: **2-6963; 5-8041;
5-8042; 5-8043.**

_____   9. Communicates with Operations Nurse, in the Nursing Disaster Headquarters, any
needs for additional staff and equipment in the Emergency Department.

_____   10. Assists the Incident Commander with additional tasks, as needed.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Operations Nurse (Adults)

Position: Charge Nurse of D3

Responds To: Nursing Disaster Headquarters
(Room TN202; phone numbers 5-2361; 5-2362; 5-2984; 2-3525).

Job Actions:

_____   1. Reports to TN202. (Security to open door, if locked.)

_____   2. Obtains Disaster Manual from Staffing Resource Office.

_____   3. Establishes the Nursing Disaster Headquarters.

_____   4. Receives walkie-talkies from the Command Nurse for the Operations Nurse and the Discharge Nurse

_____   5. In the event the Code Triage Phase 2 Adults occurs after business hours, arranges to have key personnel called at home (Roster of home phone numbers can be found in the Staffing Resource Office.)

        _____   Vice President of Patient Care Services
        _____   Mitchell 4 Care Center Director
        _____   Cardiology/General Medicine Care Center Director
        _____   Critical Care Center Director
        _____   Hematology/Oncology Care Center Director
        _____   Women's Care Center Director
        _____   Psychiatry Care Center Director
        _____   Perioperative Services Director
        _____   Professional Development Director
        _____   Operations Director
        _____   Director of Nurse Recruitment
        _____   Director of Special Projects
        _____   DCAM Administrator
        _____   Critical Care/Women's Care Adminstrative Director
        _____   Medical/Surgical Administrative Director
        _____   Director of Nursing Informatics
        _____   Director of Nursing Informatics
        _____   Director of Bed Access and Case Management

_____   6. Organizes Disaster Forms (Charge Nurse Unit Disaster Report) received from the nursing units and DCAM clinics for tracking staff and equipment.

_____   7. Monitors submission of Disaster Forms. Calls nursing units and DCAM clinics that do not submit Form A within 20 minutes.

_____   8. Documents updated census to the Bed Access Nurse every two hours.

_____   9. Documents individual unit information onto master copy.

_____   10. Communicates with Emergency Department Disaster Command Post about admissions.

_____   11. Evaluates bed availability on an ongoing basis and facilitates the admission, discharge, and transfer processes. Coordinates Emergency Department admissions and current inpatient transfers with Bed Access Center Nurse.

_____   12. Informs Command Nurse of room/bed assignments of Emergency Department patients/disaster victims.

_____   13. Assures adequate nurse staffing. Deploys staff, as needed, based on requests from the Emergency Department Disaster Command Post, Command Nurse, Discharge Coordination Center, or other nursing units.

_____   14. Coordinates equipment requests. Directs equipment redistribution, as needed.

_____   15. Communicates with the Discharge Nurse who documents patient discharges

_____   16. Designates one staff person (e.g., clerical, transporter, EVS, etc.) from each Care Center to function as runners to collect the logs of patients discharged from every nursing unit.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Discharge Nurse (Adults)

Position: Charge Nurse of Mother-Baby

Responds To: Discharge Coordination Center – (**Room TN202; phone numbers 5-2361; 5-2362; 5-2984; 2-3525).**
Patient Discharge Room - (**Room TN208; phone number 5-2204).**

Job Actions:

_____ 1. Reports to TN202.

_____ 2. Establishes the Discharge Coordination Center.

_____ 3. Receives walkie-talkie from the Operations Nurse and uses it to communicate with Operations Nurse and Command Nurse.

_____ 4. In conjunction with the Operations Nurse, determines when to open the Patient Discharge Room (TN208), the centralized location from which patients will be discharged from the hospitals. (If locked, Security may unlock.)

_____ 5. Upon direction of the Operations Nurse, supervises the Staffing Resource Office Clerk fulfilling the Bed Access Nurse function until the arrival of the On Call Bed Access Nurse.

_____ 6. Contacts the Operations Nurse when additional personnel (Nurses, Nurse Case Managers, Social Workers, Physicians, etc.) are needed to help staff the Patient Discharge Room and facilitate patient discharges. Assigns additional staff to work in TN208 to help with patient discharges.

_____ 7. Communicates with the Nursing Disaster Headquarters to obtain a patient roster of possible discharges.

_____ 8. Contacts Patient Transportation Services (2-6734) to arrange escort of patients to be taken to TN208 for discharge. Instructs Patient Transport to bring the patient's medical record along with the patient.

_____ 9. Coordinates with the Emergency Department to discharge non-disaster victim Emergency Department patients through the Discharge Coordination Center.

_____ 10. Ensures that all patients to be discharged have written discharge orders in the medical record, either from a physician on the nursing unit or a physician posted in the Discharge Coordination Center.

_____ 11. Ensures that the nurse case manager or social worker arranges for the transportation of discharged patients from the hospitals. Ensures that transportation arrangements have been documented in the medical record.

_____   12. Ensures that nurses, either on the nursing units or in the Discharge Coordination Center, provide appropriate patient education prior to the patient's discharge. Ensures that patient teaching has been documented in the medical record.

_____   13. Ensures that all documentation (discharge orders, transportation arrangements, patient education, any given treatments, any medications administered, the patient's condition, and discharge time) is complete prior to the patient's discharge from the hospitals.

_____   14. Ensures that patients are given tokens or money for transportation (through the Staffing Resource Office), as needed.

_____   15. Ensures that hospital staff accompanies patients requiring wheelchair transport to the hospital's main entrance. Alternatively, patients may wait in the Discharge Lounge.

_____   16. Ensures Bed Access Center Nurse is notified of all patients discharged through the Discharge Coordination Center and maintains a copy of all discharges made through the Discharge Center.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Charge Nurse (Adults)

Position: Charge Nurse of every inpatient nursing unit will be notified of Code Triage, Phase 2 Adults by overhead page.

Responds To: Remains on assigned nursing unit to oversee all unit operations until the arrival of the Patient Care Manager, unless designated as a member of the CodeTriage – Phase 2 Adults team. (Charge Nurses of 4NW, D3, Mother-Baby Unit), in which case they would assign a new Charge Nurse for these areas and respond immediately to their assigned disaster roles.

Responsibilities: Prepares to function with minimal safe staffing and designates which members of the nursing staff may be released for emergency reassignment. (Personnel available for immediate release will remain on their assigned nursing units until reassigned through personnel in the Nursing Disaster Headquarters in TN202.)

Job Actions:

_____ 1. Immediately obtains a census report. Checks the document to ensure that all current patients and available beds are listed accurately. Indicates patient status on the census report using the following codes.
For General Units:

DC:	Could be discharged home
DC24:	Could be discharged home within 24 hours
RU:	Must remain on unit
TR:	Could be transferred to another unit or taken off telemetry

For Critical Care Units:

RU:	Must remain on unit
TR Floor:	Could be transferred to the floor
TR SD/TELE:	Could be transferred to step down or telemetry

(When possible, this initial patient assessment should be made in consultation with the residents). If the Resident is not available the Charge Nurse will complete the coding. Any subsequent changes to the coding shall be phoned to the Nursing Disaster Headquarters in TN202 at phone numbers 5-2361; 5-2362; 5-2984; 2-3525.)

_____ 2. Completes Charge Nurse Unit Disaster Report .

_____ 3. Ensures that the completed Charge Nurse Unit Disaster Report and the initial updated census report are hand delivered to the Nursing Disaster Headquarters in TN202 within 10 minutes of the Code Triage, Phase 2 Adults being called.

_____ 4. Completes an updated census and makes necessary changes every 2 hours. Fax census to Nursing Disaster Headquarters at fax number 4-3897.

_____ 5. Contacts the Nursing Disaster Headquarters, by telephone, (at phone numbers 5-2361; 5-2362; 5-2984; 2-3525) if unit staffing requirements change.

_____   6. Ensures that all patient transactions (admissions, discharges, transfers to/from the unit, and changes in clinical condition) are logged in their existing patient tracking form.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
DCAM Managers (Adults)

Position: DCAM Managers will be notified of Code Triage, Phase 2 Adults Activation by overhead page.

Responds To: Remains on assigned clinic to oversee all unit operations.

Responsibilities: Prepares to function with minimal safe staffing and designates which members of the nursing staff may be released for emergency reassignment. Managers must determine which clinics may close and which patients must be seen. (Personnel available for immediate release will remain at their assigned clinics until reassigned through personnel in the Nursing Disaster Headquarters in TN202.)

Job Actions:

_____   1. Immediately obtains a census report. Indicates patient status on the census report using the following codes.

> ADM   Clinic has patients to admit
> MC   Clinic may close if necessary
> RO   Clinic must remain open

(When possible, this initial patient assessment should be made in consultation with the Attending. If the Attending is not available the manager will complete the coding. Any subsequent changes to the coding shall be phoned to the Nursing Disaster Headquarters in TN202 at phone numbers 5-2361; 5-2362; 5-2984; 2-3525.)

_____   2. Completes Charge Nurse Unit Disaster Report .

_____   3. Ensures that the completed Charge Nurse Unit Disaster Report and the initial updated census report are hand delivered to the Nursing Disaster Headquarters in TN202 within 10 minutes of the Code Triage, Phase 2 being called.

_____   4. Contacts the Nursing Disaster Headquarters, by telephone, (at phone numbers 5-2361; 5-2362; 5-2984; 2-3525) if unit staffing requirements change.

_____   5. Ensures that all patient transactions are logged in their existing patient tracking form.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Patient Care Manager (Adults)

Position: Patient Care Manager of every inpatient nursing unit. (Will be notified by overhead page during customary working hours or through activation of the Care Center's telephone-calling tree at the direction of the Care Center Director.)

Responds To: Remains on assigned nursing unit to oversee all unit operations. Checks in with Care Center Director to receive any special assignment(s). In the absence of the Care Center Director, the Patient Care Manager carrying the leadership pager will function as the Care Center Director until the Care Center Director arrives on site.

Responsibilities: Collaborates with the charge nurse or may act as the charge nurse in order to prepare to function with minimal safe staffing and designate which members of the nursing staff may be released for emergency reassignment. (Personnel available for immediate release will remain on their assigned nursing units until reassigned through personnel in the Nursing Disaster Headquarters in TN202.)

Job Actions:

_____   1. Ensures that the charge nurse has taken a unit census and completed the census report and Charge Nurse Unit Disaster Report and has sent these documents to the Nursing Disaster Headquarters and continues to fax report.

_____   2. Ensures that adequate numbers of staff and equipment remain on the nursing unit to care for existing patients and expected non-disaster related admissions.

_____   3. Assures that the PSC or other designated staff person logs patient admissions, discharges, and transfers in the unit-based patient tracking system.

_____   4. Communicates with the Operations Nurse in the Nursing Disaster Headquarters regarding needs for personnel, equipment, and supplies. Phone numbers for the Nursing Disaster Headquarters are: **5-2361; 5-2362; 5-2984; 2-3525**.

_____   5. Communicates with the Discharge Nurse in the Discharge Coordination Center regarding discharge and transfer of patients on the nursing unit. Deploys unit staff to the Discharge Coordination Center at the request of the Discharge Nurse. The phone number for the Discharge Coordination Center is: **5-2204**.

_____   6. Collaborates with the nursing unit charge nurse in making new patient care assignments (based upon staffing changes and patient admissions, discharges, and transfers).

_____   7. Communicates with his/her Care Center Director regarding all unit needs/issues.

_____   8. Responds to calls for assistance from her/his Care Center Director, the Discharge Nurse, and the Operations Nurse.

_____   9. May serve as charge nurse, at the discretion of the Care Center Director.

The University of Chicago Medical Center
Departmental Disaster Mobilization Plan

Job Action Sheet
Care Center Director (Adults)

Position: Care Center Director. (Will be notified by telepage by the Command Nurse.)

Responds To: Remains on assigned care center to oversee all nursing unit operations. Checks in with
the Operations Nurse in the Nursing Disaster Headquarters to receive any special
assignment(s). Phone numbers for the Nursing Disaster Headquarters are: **5-2361;
5-2362; 5-2984; 2-3525**.

Responsibilities: Ensures continued operation of all nursing units within assigned care center.

Job Actions:

_____   1. Phones the Staffing Resource Office (2-3525) upon receipt of Code Triage, Phase 2
Adults page. Comes into the hospitals upon receipt of the page.

_____   2. Activates care center leadership staff and staff calling trees, as necessary.

_____   3. Ensures call up of off-duty staff to work occurs when directed by the Operations
Nurse in the Nursing Disaster Headquarters.

_____   4. Assures that patient care services continue to be provided to all patients in assigned
care center.

_____   5. Responds to directives/assignments from the Operations Nurse in the Nursing Disaster
Headquarters.

_____   6. Responds to special requests for assistance from the Discharge Nurse in the Discharge
Coordination Center.

The University of Chicago Hospital Medical Center
Departmental Disaster Mobilization Plan

Bed Access Center Nurse
Job Action Sheet

Position: Bed Access Center Nurse **(Pager On Call 24/7)**

Responds To: Nursing Disaster Headquarters
(Room TN202; phone numbers 5-2361; 5-2362; 5-2984; 2-3525)

Responsibilities: Tracks the disposition (admissions, discharges, and transfers) of all patients and disaster
victims.

NOTE: ***IN THE ABSENCE OF THE BED ACCESS NURSE, THE HOA ADMINISTRATOR
WILL SERVE AS THE BED ACCESS NURSE UNTIL THE ON-CALL BED
ACCESS CHARGE NURSE ARRIVES.   (THIS SITUATION IS LIKELY TO OCCUR
AT THE FOLLOWING TIMES: MONDAY - FRIDAY 1200 - 0600 AND SATURDAY,
SUNDAY, AND HOLIDAYS 1830 - 0800.)***

Job Actions:

_____   1. Reports to the Operations Nurse in the Nursing Disaster Headquarters to hear overall
initial information.

_____   2. Assigns beds to disaster victims as communicated by the Disaster Headquarters
through the Operations Nurse.

_____   3. Assigns bed from Ambulatory areas, transfers, as prioritized by Operations Nurse.

_____   4. Receives the updated census every two hours from the Operations Nurse.

_____   5. Tracks all admissions, transfers, and discharges.

Mf/ms 4/27/07; dstrp&p5
3/24/03

Code Triage Phase 2, Pediatric - External Disaster Plan

Issued: September 2006 Safety Policy S05-23-00
Revised: January 21, 2008; November 27, 2006
Reviewed: June 12, 2008; March 12, 2008, June 4, 2007, April 26, 2007; March 6, 2007

S05-23 Code Triage Phase 2 - Pediatrics.doc   Copy (1) of Peds Code Triage 2 Chart.jpg   RedCrossDataCollectionForm.pdf

CODE TRIAGE 008- KIDS FIRST 11017-JUNE2008.xls   Comer Operations Nurse Unit Report Code Triage 2 Pediatrics.xls

Job Action Sheets

Job Action - Admitting Bed Desk S05-23new.doc   Job Action - Anesthesia & Critical Care Resident on Call S05-23.doc

Job Action - Materials Management S05-23.doc   Job Action - Patient Transportation S05-23new.doc

Job Action - Pediatric ED Coordinator S05-23new.doc   Job Action - Pediatric ED Attending or designee S05-23new.doc

Job Action - Pediatric ED Charge Nurse S05-23new.doc   Job Action - Pediatric Bed Access Center Nurse S05-23.doc

Job Action - Pediatric Care Center Director S05-23.doc   Job Action - Pediatric Command Nurse S05-23.doc

Job Action - Pediatric Discharge Nurse S05-23.doc   Job Action - Pediatric ED Medical Director S05-23new.doc

Job Action - Pediatric ED Telemetry S05-23new.doc   Job Action - Pediatric ED Triage Nurse S05-23new.doc

Job Action - Pediatric Sepcialty Clinic Manager S05-23.doc

Job Action - Pediatric Inpatient Nursing Unit Charge Nurse S05-23.doc   Job Action - Pediatric Operations Nurse S05-23.doc

Job Action - Pediatric Patient Care Manager S05-23.doc   Job Action - Pediatric Surgery Resident S05-23.doc

Job Action - Pharmaceutical Services S05-23new.doc   Job Action - Public Affairs S05-23.doc

Job Action - Respiratory Therapy S05-23new.doc   Job Action - Security Department S05-23.doc

Job Action - Social Services & Spiritual Care S05-23.doc   Human Resources Pnew.doc

Pediatric Incident Commander Sen AOC Job Action Sheetnew.doc

STAFF NURSE QUIZ

CONTROLLED SUBSTANCES PC109
As a staff nurse, what do you do if you suspect diversion or theft of controlled substances?

    a. confront the individual you suspect of diversion
    b. report incident to Care Center Director/designee or HOA on-call immediately
    c. report the incident to the security department
    d. report the incident to the Chicago Police Department

An advanced practice nurse (APN) has prescribed Ativan 2mg IV for a patient, who may administer the dose to the patient?

    a. an LPN working with the APN
    b. the APN who prescribed the Ativan
    c. another RN working with the APN
    d. a medical assistant working with the APN

As a staff nurse, what are your responsibilities once you have accessed controlled substances from the Acudose machine?

    a. administer the dose, or verify the administration of the drug,
    b. waste the dose and obtain appropriate witness to the wasting
    c. record the dose given on the patient's Medication Administration Record or appropriate medical record form.
    d. all of the above

In areas that operate around the clock, what is the frequency for performing an inventory count of all controlled substances?

    a. once every 24 hours
    b. every 8 hours
    c. before and after any controlled substance is removed
    d. twice a day at 7 a.m. and 7 p.m. every day

Which of the following controlled substances **CANNOT** be signed out of the Acudose machine by a LPN?

    a. Tylenol #3 PO tablet
    b. Dilaudid PCA IV syringe
    c. Ativan 2 mg PO tablet
    d. Morphine 2 mg IM injection

Who of the following is authorized to perform the inventory count of controlled substances?

    a. one incoming shift UCH employed RN and one outgoing shift UCH employed RN or LPN
    b. any 2 UCH RNs
    c. any incoming shift nurse and any outgoing shift nurse

d. any incoming shift agency RN and any outgoing shift LPN

What must be done after the 2 nurses complete the inventory count?
      a. both nurses must check each dose for proper documentation
      b. both nurses must manually sign the narcotic reconciliation log
      c. both nurses must check for proper wastage of partial doses
      d. both nurses must notify pharmacy of narcotics below par level

If a discrepancy is created during the inventory count and cannot be resolved, what is the responsibility of the nursing staff?
      a. investigate the discrepancy further
      b. notify the ACM/PCM or temporary supervisor
      c. stay on the nursing unit until the discrepancy is resolved
      d. all of the above

MEDICATION DISPENSING CABINET (MDC) (ACUDOSE) PC97

Who is authorized to grant permanent access to the Acudose machine for UCH employed nursing staff?
      a. any RN who already has permanent access
      b. any charge nurse who has permanent access
      c. the temporary supervisor of the nursing unit
      d. the leaders of the nursing unit (care center director, PCM, ACM)

What privilege/s do nurses with permanent MDC access have?
a. Login/Witness Function
b. Access to Controlled Substances
c. System Report Access (as defined by their role)
d. all of the above

How does the agency nurse obtain temporary access to the MDC?
      a. contact the charge nurse to create temporary access
      b. contact the unit ACM/PCM or temporary supervisor
      c. contact the HOA after registering in the staffing office
      d. agency nurses receive permanent access not temporary access

How long is the temporary user access to the MDC valid?
      a. 8 hours
      b. 12 hours
      c. 16 hours
      d. 24 hours

The patient has refused a Tylenol #3 dose that was removed from the Acudose machine. The Tylenol #3 is in its unopened package. What should be done with the unopened Tylenol #3?
      a. The dose must be wasted following the proper process.
      b. The dose must be kept in the nurse server until the patient requests it.

  c. The dose must be returned to the original bin in the MDC

  d. The dose must be returned to the "Return Bin" of the MDC and witnessed by a second licensed person.

As an RN, you access the MDC to obtain Methadone 50 mg orally. Methadone is supplied in 10 mg tablets, but there are only 3 tablets remaining in the MDC. What process/es do you follow to obtain the Methadone?

  a. Text message the Pharmacy Supervisor to restock the Methadone tablets

  b. Obtain the Methadone from a sister unit by contacting the charge nurse/ACM/PCM or temporary supervisor, showing the order for the methadone, then accessing the Methadone from their MDC.

  c. Go to the pharmacy and obtain additional Methadone tablets to stock the MDC

  d. All of these options are correct.

It is 2:00 am and your patient requires Ativan 4mg IV. Unfortunately, this patient has already used the entire supply of IV Ativan, and the Acudose is empty. You obtain the dose from a sister unit, now how do you get Ativan restocked in your Acudose?

  a. Text page the Pharmacy Supervisor #8223 re: out of stock IV Ativan/nursing unit/phone number/your name

  b. Wait for pharmacy supervisor to call back and acknowledge text page

  c. Re-page pharmacy supervisor within 1 hour if the medication has not been restocked.

  d. All of these options are correct

Your patient: Manuel Garcia, MR# 12345678, has an order for Dilaudid 2mg IV push but he is not listed in the Acudose system. How do you manually add the patient to the system?

  a. Access the Acudose machine function "Add patient"

  b. Type in the patient name area: Garcia, Manuel

  c. Type in "12345678" in the field for Patient ID number

  d. All of these options are correct.

What are the responsibilities of the nurse when obtaining medication from the MDC in an emergency situation via the override function?

  a. verify the medication is appropriate for the emergency condition

  b. review the patient's allergies

  c. determine if a drug interaction exists

  d. all of the above

As an RN, you access the Acudose to obtain your patient's scheduled dose of Morphine 3 mg IV push. Morphine is supplied in 10 mg vials. What is the process for handling the partial dose of Morphine?

  a. Have another RN visually observe you access the Morphine, and observe you waste 7 mg into the sink, and immediately document the wastage of

the 7 mg dose in the MDC, prior to you administering the 3 mg dose to the patient

b. Have an LPN visually observe you access the Morphine, and observe you waste 7 mg into the sink, and immediately document the wastage of the 7 mg dose in the MDC, prior to you administering the 3mg dose to the patient.

c. Withdraw the Morphine, waste the 7 mg Morphine into the sink, administer the 3mg dose to the patient, then have another RN document the wastage at the MDC.

d. Withdraw the Morphine; administer the 3 mg Morphine to the patient and save the additional 7 mg in the patient's medication drawer to administer to the patient later in the shift.

What are the responsibilities of the nurse when finding broken seals/damaged packaging on a single dose of a controlled substance?

a. Perform chemical analysis of the contents of the damaged vial

b. Notify the ACM/PCM or temporary supervisor and waste the dose as instructed.

c. Return the entire box of controlled substances to the pharmacy

d. All of the above are correct.

Mr. Jones has an order to discontinue the PCA Morphine infusion. What is the process to follow to waste the remaining dose of Morphine?

a. Two RNs calculate the remaining amount of Morphine solution

b. Both RNs visually witness the wastage of the Morphine solution from the syringe and tubing into the sink, the empty tubing and syringe are discarded

c. Both RNs document the dose of Morphine wasted on the PCA flowsheet.

d. All of the above are correct.

Which of the following statements regarding PCA pump keys is/are correct?

a. Only one PCA pump key will be available on each nursing unit, except PACU

b. Nurses must access the PCA key under the name of the patient who is receiving PCA infusions.

c. The PCA key will be counted with the narcotics at each change of shift.

d. All of the above are correct.

Which of the following statement/s regarding narcotic lock box keys is/are correct?

a. A discrepancy report must be filed if the lock box key is missing.

b. The lock box key should not be given to an Outside Agency Nurse, Student Nurse, his/her instructor, an outside Private Duty RN, a nurse from another unit or a physician unless approved by the Care Center Director or designee.

c. The lock box key must be kept in a secure area when the unit/clinic is not operating.

d. All of the above are correct

What process should be followed if the Acudose Machine stops functioning?

a. Notify McKesson's help desk directly to resolve the issue

b. Call Pharmacy Supervisor to resolve the issue
c. **Notify the ACM/PCM or temporary supervisor, who will contact McKesson**
d. All of the above are correct

What types of audits do the ACM/PCM or temporary supervisors perform?
a. controlled substance audits by patient / medical record
b. controlled substance audits by clinician / MDC user
c. narcotic count reconciliation audit
d. **All of the above are correct**

What nursing practices are reviewed during these audits?
a. documentation of doses administered, wastage and witness
b. frequency of administration vs frequency of doses ordered
c. performance of inventory counts as per policy
d. **All of the above are correct.**

The University of Chicago Hospitals
Policy and Procedure Manual

CONTROLLED SUBSTANCES

Issue Date: June 1980 Page 1 of 8
Revised Date: June 2006 PC 109
Review Date: July 1995 Controlled Substances

PURPOSE:
1. To clarify and emphasize the responsibilities of physicians, pharmacy personnel, advanced practice nurses
registered nurses and licensed practical nurses in regard to controlled substances. (1,2,3)

2. To outline the accountability process for controlled substances. (1)

POLICY:

PRESCRIPTIVE AUTHORITY

Individuals with prescriptive authority will NOT be issued access to the medication dispensing cabinet (MDC) with two exceptions:
1. Physicians/personnel employed in anesthesia services will have access to controlled substances only when the operating room pharmacy is closed.
2. APNs who have prescriptive authority may not write, dispense and administer medications all at the same time. The APN may write the order, and another APN/RN may dispense and administer the medication.

REPORTING SUSPECTED OR WITNESSED THEFT

For suspected or witnessed theft of controlled substances:
A. Report incident to Care Center Director/designee or HOA on-call
        immediately.
B. Contact Director of Pharmacy
C. Care Center Director/Designee, Director of Pharmacy/designee in conjunction with Director of Security and Director of Human Resources will conduct an investigation and provide a written summary report of the incident.

This report is submitted to the appropriate Vice President(s) and Chief Nursing Officer. In consult with Medical Legal Affairs, the summary report may be filed with the authority agencies.

ADMINISTERING CONTROLLED SUBSTANCES

1. All orders for controlled substances must be current, not exceeding the automatic stop date, as applicable, refer to policy PC02 Automatic Stop Orders for Drug Therapy 📊
2. The nurse or physician who signs out the controlled substance is responsible for administering, or verifying the administration of the drug, to the patient and recording the dose(s) given on the patient's Medication Administration Record (MAR) or appropriate medical record form. An LPN cannot sign out a medication which he/she cannot administer. (2)

INVENTORY COUNT

1. In areas that <u>do not</u> operate around the clock, an inventory count will be performed a minimum of once every 24 hours during business operations, by two licensed personnel one of whom must be an RN employed by the University of Chicago Hospitals. When the inventory is completed, both individuals must sign the "Narcotic Count Reconciliation" log in each nursing station/clinical area.

2. In areas that operate around the clock, an inventory count will be performed twice daily at 7 am and 7 pm with one on-coming shift and one off-going shift nurse.
One of these nurses must be an RN employed by the University of Chicago Hospitals. When the inventory is completed, both nurses must sign the "Narcotic Count Reconciliation" log in each nursing station/clinical area.
3. The decision to change the frequency of Inventory Count will be made jointly between Care Center Director/Leadership Team and the Director of Pharmacy responsible for controlled substance oversight.
4. The nurse must verify the inventory count when removing any controlled substances from the MDC or narcotic lock box. If a discrepancy is found or created, please reference the "Discrepancy/Reconciliation" portion of this policy below.

CONTROLLED SUBSTANCE DISCREPANCY RECONCILIATION:

1. When the user's entered count of medication in the MDC or locked narcotic box differs from the MDC's count or the manual count for that controlled substance, a discrepancy will be created. MDC discrepancies are automatically logged and can be printed at the MDC.

2. All controlled substance discrepancies should be resolved immediately by completing the following:

A. Any controlled substance discrepancy discovered by any employee MUST be reported immediately to the PCM/ACM or Temporary Supervisor for further investigation and resolution of the discrepancy.

B. The staff should not leave the unit until the discrepancy is resolved.

C. The ACM/PCM or Temporary Supervisor completes the following investigative steps:

1. Assure that missing medications were not misplaced within the MDC unit or locked narcotic box

2. Determine all users who accessed the discrepant medication since last accurate audit was completed.

3. Interview all appropriate staff and conduct appropriate MAR and medical record audits of patients with orders for the discrepant medication.

D. When an MDC discrepancy exists, the involved users will use the "Resolve Discrepancy" function from the Procedures menu of the MDC to attach an electronic explanation for the discrepancy.

E. Once all investigative avenues have been exhausted, if the discrepancy cannot be resolved, the unit's Patient Care Manager/Care Center Director, HOA and Director of Pharmacy/designee will be informed immediately. An official Department of Pharmaceutical Services Narcotic Discrepancy 3-part form (available from the central pharmacy) must be completed by the PCM/ACM/HOA (refer to Appendix F), with one copy forwarded to the Care Center Director, one copy forwarded to the Pharmacy Director, and one copy forwarded with a patient safety report to Risk Management by the end of the shift.

F. The Pharmacy Director will review the Discrepancy Report/s for valid explanations and for discrepancies requiring further investigation.

G. If theft of controlled substances is suspected or witnessed, this must be reported immediately according to this "Controlled Substances Policy", PC 109, as described on page 1.

WASTING MEDICATIONS:

Controlled substances not in the original sealed package and not intended for patient administration must be wasted. The controlled substance must be wasted in a manner that prevents the dosage form from being recovered. Controlled substances may only be wasted by a licensed practitioner and must be witnessed by a second licensed practitioner. The individual serving as a witness must have directly observed the wasting process.

1. If a controlled substance originally taken from the MDC is being wasted, the controlled substance must be visually verified and "wasting" MUST be visually witnessed by two licensed MDC users (within the appropriate scope of practice) and <u>documented</u> at the MDC IMMEDIATELY. When the controlled substance is being used to titrate the patient to comfort, i.e. during treatments/procedures, the opened unused amount must be visually verified and visually witnessed as "wasted" by two licensed MDC users (within the appropriate scope of practice) and <u>documented</u> in the MDC immediately after the treatment/procedure is completed, or immediately upon return to home unit.

> Wasting of controlled substances removed from a lock box is accomplished in the same manner, with verification of the wastage manually documented on the narcotic sheet.

2. If the original packaging of a controlled substance is NOT intact, follow "wasting medications" as stated above following the notification of the ACM/PCM or Temporary Supervisor. Additional investigation may be necessary to rule out potential medication tampering.

3. When continuous opioid or epidural infusions are discontinued, the volume of the remaining infusion is **estimated** by two registered nurses, immediately wasted and visually witnessed by the second registered nurse. Both registered nurses must document the volume/dosage of controlled substance wasted on the intravenous administration record/epidural infusion record. The empty infusion bag/device and empty tubing is immediately discarded in a trash receptacle and visually witnessed by the second registered nurse.

4. When the PCA infusion is discontinued, the volume of the remaining infusion is **calculated** by two registered nurses, immediately wasted and visually witnessed by the second registered nurse. Both registered nurses must document the volume/dosage of opioid wasted on the PCA infusion record. The empty syringe and empty tubing is immediately discarded in a needle box and visually witnessed by the second registered nurse.

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<u>CONTROLLED SUBSTANCE AUDITS</u>

1. The Care Center Director (or his/her designee) will randomly perform the following audits, one day a week on different days:

A. Controlled Substance Audit by Patient/Medical Record (to reconcile/validate the usage of medications accessed). Complete Appendix G Attachment 1 & 2, Audit A by reconciling withdrawals from the MDC to the original order, MAR, and patient record.

B. Controlled Substance Audit by Clinician/MDC User (for trending of MDC user access). Complete Appendix G Attachment 2 Audit B by using Acudose-

Rx Station Events (By User) and Narcotic Surveillance Report,
C. Narcotic Count Reconciliation Audit (to assure that this policy is being followed). Complete Appendix G Attachment 2 Audit A, last item by using the Narcotic Reconciliation logs.
2. The attached guidelines and audit tools must be used and reported according to the policy schedule. (See Appendix G with all attachments)

3. Completed audits will be forwarded to Care Center Directors, the Acudose Administrator and the Director of Pharmacy for aggregate tracking. Pharmacy will develop a data matrix of units completing these audits. These audits will be kept on file for 18 months.
4. The Director of Pharmacy/designee will maintain records of controlled substance distribution to the medication dispensing cabinets and locked controlled substance boxes. Controlled substance audits are performed quarterly, per Pharmacy policy and forwarded to the Director of Pharmacy/designee. Refer to pharmacy policies: 06-001, 06-002, 06-003, and 06-004.

5. The Director of Pharmacy/designee will report the frequency of audits completed per policy, the unresolved discrepancies and actions to the Pharmacy and Therapeutics Committee on a quarterly basis.

OBTAINING CONTROLLED SUBSTANCES THAT ARE NOT IN THE MDC:

If a medication order is written for a controlled substance that is not available in the MDC (either it is out of stock or it is a new item that is not in the machine), the procedure to obtain the medication from pharmacy is as follows:
1. If a controlled substance must be added to stock that has not been loaded in the MDC, the medication is obtained from Pharmacy, stored in the locked controlled substance cabinet (or unit-designed "locked" area) and signed out using the manual system
2. Temporarily, the nurse may acquire the medication from a sister unit by contacting the PCM/ACM/Temporary Supervisor. If needed, the PCM/ACM/Temporary Supervisor will provide temporary access to the visiting nurse after the medical order or MAR is verified. The controlled substance will be removed from the lock box or MDC by the visiting nurse following standard procedures. Refer to Patient Care Policy 97.

3. Out of stock/non-stock controlled substances may be obtained by contacting a pharmacy narcotic technician, or by calling the main pharmacy. The registered nurse may come to the Central Pharmacy to obtain the controlled substance. Controlled substances will not be sent via pneumatic tube to any

nursing unit or clinical area.

4. No controlled drug samples will be stored or used at the University of Chicago Hospitals.

RETURNING MEDICATIONS:

1. A controlled substance removed from the MDC that is in its UNOPENED (intact original) package will be returned to the MDC Return Bin. This allows the patient to be credited for the medication. Two licensed MDC users (within the appropriate scope of practice) are required to witness the return of controlled substances to the MDC.

2. If the return is an UNOPENED controlled substance, removed from the narcotic box, it should be returned to the manual narcotic box or the unit-designated "locked" area. Two licensed personnel (within the appropriate scope of practice) are required to witness on the inventory log the return of a controlled substance to the narcotic lock box.

3. Items too large to fit in the MDC return bin or narcotic lock box must be returned to the Main Pharmacy.

4. Controlled substances not in the original sealed package must be wasted, following the process previously described in "Wasting Medications".

LOCK BOX KEYS

1. A nursing unit or clinic may have an automated MDC that holds the unit's controlled substances, and/or a controlled substances lock box. The key to the lock box should be kept in the MDC or in the possession of the charge nurse/designee during unit operations. The lock box key will be removed and returned using the same procedure as for medication removal.

2. The lock box key must be accounted for at each change of shift.

3. If the nursing unit or clinic does not have an automated MDC, the lock box key must be returned to a secure area when the nursing unit/clinic is not operating.

4 . If a nurse inadvertently takes the key to the controlled substance box home, he/she
must:

> a) Contact the unit Care Center Director/PCM/ACM/Temporary Supervisor, or in his/her absence, the RN-HOA.
> b) Return the key immediately.
> c) If a controlled substance contained in the unit's controlled substance box is needed immediately:

- Borrowing from another unit may be an option until the unit key is returned.
- Duplicate keys are not available. Lock must be removed and replaced. Call

Plant Department and notify manager.

5. If the key is unaccountable for 4 hours, the lock must be changed as soon as possible. The Care Center Director must be informed immediately.

6. The key should not be given to an Outside Agency Nurse, Student Nurse, his/her instructor, an outside Private Duty RN, or a nurse from another unit unless approved by the Care Center Director or designee. The key should not be given to a physician.

7. See UCH Pharmaceutical Services Policy 06-002, Controlled Substances Distribution and Inventory Control for Controlled Substance Boxes for all procedures related to storage and distribution of narcotics held in these secured locked boxes.

PCA PUMP KEYS:

1. Only one PCA pump key will be available on each nursing unit. The PCA pump key will be locked in the MDC. Nurses must access the PCA key under the name of the patient who is receiving PCA infusions. The PCA keys will be counted with the narcotics at each change of shift. Any alteration in count requires a discrepancy to be generated and resolved. Refer to the Discrepancy Resolution Process.

2. GOR/PACU will have seven (7) PCA keys, one for each slot/pair. All PCA keys will be kept in a dedicated drawer in the MDC. Each PCA key needs to be signed out and returned consistently with the nurse's slot/pair assignment. The drawer will contain a "dummy key", a chain without a key, which prevents the count from going down to zero (0) which would lock out the drawer.

3. If there is a need to replace a PCA pump key, the Care Center Director/designee will be notified. The Care Center Director/designee will obtain the PCA key from the pharmacy supervisor on duty. The Pharmacy Supervisor will notify the Director of Pharmacy.

Controlled Substance Access Outside of Home Unit:

1. Controlled substances may not be sent with patients to other areas within the medical complex, unless accompanied by an RN. Selected areas (Radiology/MRI, Dialysis, GI procedures, Electrophysiology Lab, Cardiac Cath Lab) have access to controlled substances available for patient treatment. Physicians and nursing staff in these areas will be provided with access to the controlled substances and will obtain medications from their stock and follow administration/monitoring guidelines established by the area.

• If a medication is needed for a patient having a procedure in an area that does not have controlled substance access, the licensed RN Hospitals Operations Administrator (HOA) is authorized to obtain the medication from selected medication dispensing cabinets and dispense the medication to the physician for direct administration of the drug to the patient.

• If a patient is accompanied by an RN to a procedure, the RN will obtain the controlled substance from the home unit's medication dispensing cabinet/lock box using the customary procedure, and keep the medication with him/her at all times during transport. If the medication is needed during the procedure, the RN will administer the medication or verify that the physician administered the medication. All doses are documented in the patient's medical record. Immediately, upon return to the home nursing unit, the opened unused controlled substance will be wasted, visually witnessed by two nurses and documented. Any unused unopened medication will be returned to the MDC/lock box.

GUIDELINES: See Patient Care Policy 97 Automated Medication Dispensing Cabinet MDC (Acudose) for the following procedures related to controlled substances:

> a. Obtaining/returning/wasting medications
> b. Stock Replenishment and inventory level changes

Revision: The Nursing Policy & Procedure Committee, the Pharmacy Department, and the Performance Improvement Council are responsible for revisions to this policy. Nursing personnel are responsible for the implementation of this policy.

References:
1. (720 ILCS 570/) Illinois Controlled Substances Act.

2. Department of Professional Regulation. Illinois Nurse Practice Act

Section 1300.44 Standards for Pharmacology/Administration of Medication Course for Practical Nurses Source: Amended at 26 Ill Reg. 17255, effective November 18, 2002. Section 1300.60 Practice of Nursing Source: Amended at 24 Ill. Reg. 1191, effective January 4, 2000.

3. Comprehensive Accreditation Manual for Hospitals: The Official Handbook, "Medication Management," Joint Commission on Accreditation of Health Organizations, January 2006.

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The University of Chicago Hospitals
Policy and Procedure Manual

MEDICATION DISPENSING CABINET (MDC) ACUDOSE

Issue Date: August 1995 Page 1 of 8
Revised Date: June 2006 PC97
Review Date: August 2005 Medication Dispensing Cabinet
(MDC) Acudose

PURPOSE:
> To describe staff responsibilities and to provide guidelines relating to the
> operation of the Medication Dispensing Cabinet

POLICY:

1. Individuals with prescriptive authority will NOT be issued access to the medication dispensing cabinet (MDC) with two exceptions:

a. physicians/personnel employed in anesthesia services will have access to controlled substances only when the operating room pharmacy is closed.

b. <u>APNs who have prescriptive authority may not write, dispense and administer medications all at the same time. The APN may write the order, and another APN/RN may dispense and administer the medication.</u>

2. Pharmacy and nursing services may use the Medication Dispensing Cabinet system (henceforth known as MDC) as a medication access and charging system for the following types of medications:

a. Controlled substances Refer to PC 109 "Controlled Substances"

b. Non-controlled medications

c. IV Fluids

3. A pharmacist must review and enter the drug order into the pharmacy computer system prior to the nurse being given access to a particular medication for a specific patient. However, if a medical emergency/sudden clinical status change is present (examples of which are included on the clinical condition list Appendices A & B) the nurse may access medications through the MDC.

ALL MEDICATION ORDERS MUST UNDERGO PROSPECTIVE

PHARMACIST REVIEW PRIOR TO MEDICATION ADMINISTRATION UNLESS A "MEDICAL EMERGENCY/SUDDEN CLINICAL STATUS CHANGE EXISTS." (3)

AUTHORIZED ACCESS FOR NON-NURSES:
The Director of Pharmacy determines and approves access privileges for pharmacists, pharmacy technicians, and physicians/personnel employed in anesthesia services. Refer to pharmacy policies 12-012 and 12-013.

AUTHORIZED PERMANENT ACCESS FOR NURSES:
1. Only nursing leadership (care center director, PCM, ACM) may request permanent access for UCH employed nurses.
2. In Comer Children's Hospital: MDC access will be granted by the PCM only. Access will not be requested or granted to any per diem agency (non-contract or non-traveler). If a pediatric patient is assigned to a per diem agency nurse, the following protocol will be followed:
• Charge nurse/designated RN will access the MDC, administer the medication to the patient, and document on the MAR or IAR according to policy.

3. The pharmacy assigns the user ID using the following format: first initial, last name up to eight characters. The pharmacy will assign a Personal Identification Number (PIN), which must be used at the time of first access to the MDC. At the time of the employee's first access of the MDC, the user will be prompted to create an individual (user specific) PIN. All PINs should be 4-8 alphanumeric characters and should not be the same as the user ID.

4. All requested employee additions, deletions, or user ID changes must be sent to the "Acudose Administrator"/Director of Pharmacy for implementation.

Upon effective date of hire, any LOA, termination or transfer of an employee, Leadership will notify the Acudose Administrator and Director of Pharmacy of the employee changes (employee name, department/nursing unit and date of hire, LOA, termination or transfer via e-mail. The Pharmacy will update the user list as appropriate.

5. Nurses with permanent MDC access have the following privileges:
Login/Witness Function
Access to Non-Controlled Medications
Access to Controlled Substances
System Report Access (as defined by their role)

AUTHORIZED TEMPORARY ACCESS FOR NURSES:

Agency nurses, contract nurses, float nurses and nursing instructors will be assigned a temporary ID and PIN by the Care Center Director, Patient Care Manager, Assistant Patient Care Manager or Temporary Supervisor. The RN HOA will be emergency back-up only. This temporary access will be valid for 12 hours.

MDC MEDICATION REMOVAL GUIDELINES:
1. Medication is removed at the MDC by selecting the profile dispense option on the main menu and following the instructions on the screen.
2. A separate entry must be made to access medications for additional patients or additional medications for the same patient. The nurse can access only medication/shown on the patient's active profile unless a medical emergency/sudden clinical status change exists. The MDC "override" function should only be used if the patient's condition meets established clinical conditions as outlined in Appendices A & B.

RETURNING MEDICATIONS:
1. A controlled substance removed from the MDC that is in its UNOPENED (intact original) package will be returned to the MDC Return Bin. This allows the patient to be credited for the medication. Two licensed MDC users (within the appropriate scope of practice) are required to witness the return of controlled substances to the MDC.

2. If the return is an UNOPENED controlled substance, removed from the narcotic box, it should be returned to the manual narcotic box or the unit-designated "locked" area. Two licensed personnel (within the appropriate scope of practice) are required to witness on the inventory log the return of a controlled substance to the narcotic lock box.

3. Items too large to fit in the MDC return bin or narcotic lock box must be returned to the Main Pharmacy.

4. Controlled substances not in the original sealed package must be wasted, following the process previously described in "Wasting Medications".

5. A non-controlled medication removed from the MDC that is in its UNOPENED (intact original) package and not administered to the patient will be returned to its original pocket or another pocket in which the medication is loaded (if loaded in more than one pocket).

STOCK REPLENISHMENT:
1. The Pharmacy will be responsible for maintaining adequate inventory of all

medications in the MDC.

2. Inventory levels will be checked every day by Pharmacy. The medications that are below the established par level will be delivered and refilled into the MDC by Pharmacy.

3. If a nurse notices that a medication is running low and the Pharmacy has already made its delivery the nurse will notify the Pharmacy. If additional controlled substances are needed during non-audit times between the hours of 7:00am -9:00pm, the nurse should page the Controlled Substance Technician who will restock the controlled substance as soon as possible at the regular delivery times. If a controlled substance is needed before the scheduled delivery times, then a registered nurse may come to the central pharmacy to obtain the medication. The controlled substance may also be accessed for the patient from an MDC on a sister unit.

4. Pharmacy personnel will periodically empty the return bin when replenishing MDC stock.

STOCK AND INVENTORY LEVEL CHANGES:
The Care Center Director/Leadership Team will request any change to the MDC stock or inventory levels in writing to **Acudose** Administrator or Pharmacy Manager.

EMPTYING THE RETURN BIN:
1. Lead Pharmacy Technicians are responsible for emptying the return bin.
2. All non-reusable controlled substance doses must be wasted with a witness and documented on the pharmacy controlled substance return form. Please follow Wasting Controlled substance procedure.

TROUBLESHOOTING/POWER OUTAGE/EMERGENCY PROCEDURES:
(Refer to Appendix H for additional trouble-shooting info)
1. If a MDC technical/mechanical problem cannot be resolved by referring to the MDC Reference guide (located on the top of the device), contact the Pharmacy during normal business hours. If necessary, the nurse may call the MDC 800-service number found on the MDC for additional assistance.
2. The MDC is plugged into the emergency power system and should remain operational in the event of power outage.
3. In an emergency event, emergency power failure or computer system malfunction the MDC will revert to battery power and "local mode" which will allow the existing patient profiled medication information to be accessible.

During operation in "local mode", new information will not be available (including new admissions and transfers to the unit, however the nurse may manually enter new or transferred patients) on the MDCs. Pharmacists will continue to review all medication orders received during that period of time.

4. If it becomes necessary to manually open the MDC for medication access, the Pharmacy Manager will be notified. The Pharmacy Manager (in the Central Pharmacy at phone 2-1387 or pager #8223) will be able to gain access to the keys and open the back of the MDC to allow the removal of medications,

5. Any controlled substances removed from the MDC during downtime will be documented on the manual controlled substance sign-out sheets. These sheets will be sent to Pharmacy after the system is back on line for the purpose of charging.

6. Nursing notifies the pharmacy of any MDC problems. If the pharmacy cannot resolve the problem, the MDC vendor will be called.

7. A nurse may decide to remove medications from another nursing unit MDC during the time that their own is not functional. To do this, the nurse may need to access a MDC on the unit designated as the "sister" unit or be given a Temporary User ID for the MDC to be used and admit patients under the dispense option. NOTE: Narcotics may be obtained only for manually admitted patients at the time of administration as required in a medical emergency/sudden clinical status change.

MEDICATION ACCESS FOR MEDICAL EMERGENCY/SUDDEN CLINICAL STATUS CHANGE (3):

Urgent (medical emergency) and/or sudden change of the patient's clinical status which demands immediate administration of medication accessed through the MDC is done so using the MDC "override" function. The pharmacist will evaluate the medication order in all situations that result in the administration of a medication acquired via the MDC "override" function.

NURSING RESPONSIBILITY FOR MEDICATION ADMINISTRATION IN MEDICAL EMERGENCY/SUDDEN CLINICAL STATUS CHANGES (3):

In an emergent condition when the patient's life, safety or well being will be jeopardized by failing to administer a medication identified as appropriate for the clinical condition, the following steps will be taken:

1. Determine if an allergy exists.

2. Review the patient chart for any other pertinent clinical information.

3. Determine if a potentially significant drug interaction exists by consulting the significant drug interaction list, (Appendices C & D) provided by Pharmacy. If a significant drug interaction exists, the nurse will seek a

pharmacist's review prior to administration of the medication.
4. The nurse is responsible for getting the medication order to Pharmacy.
5. Designated areas that DO NOT require that a pharmacist review all medication orders or prescriptions are ones where a licensed independent practitioner controls ordering preparation and administration of the drug. For example, the physician in endoscopy selects the medication from the shelf and administers it directly or the physician tells a nearby nurse to administer the drug immediately in his/her presence. (i.e., Emergency Department, GI Lab & Radiology).

PROCESS FOR EVALUATING MEDICATIONS USED IN MEDICAL EMERGENCIES/SUDDEN CLINICAL STATUS CHANGES:
The requestor must submit a completed "UCH Request for Change of Medication/s for Clinical Conditions" form (Appendix E) to the appropriate Nursing/Pharmacy Committee for evaluation. Signature by a Nursing Clinical Director is required for submission of the completed form.

The requestor identifies the medication (name, dosage form, and strength) and defines the clinical condition (or emergency situation) in which the medication would be needed. Additionally, this form will be used to request removal of a medication from the clinical condition medication list. The Nursing/Pharmacy Committees will forward requests regarding additions/deletions to the clinical conditions list to the Pharmacy and Therapeutics committee. On an annual basis, the Nursing Pharmacy Committees will review the clinical condition list and make recommendations for changes, with the Pharmacy and Therapeutics Committee having final approval.

The Pharmacy and Therapeutics Committee has authority to approve changes to the clinical conditions medication list. Only an ADM technician or pharmacy manager will be allowed to change the programming of the ADM to reflect changes to the clinical conditions medication list.

Revision:
The Nursing Policy & Procedure Committee, the Director of Pharmacy and the Performance Improvement Council is responsible for revisions to this policy. They may delegate this to a responsible person at the time of review.

ATTACHMENTS
Appendix A Pediatric Medication Override List
Appendix B Adult Medication Override List
Appendix C UCH Adult AcuDose Drug Interaction Quick Reference

Appendix D UCH Pediatric AcuDose Drug Interaction Quick Reference
Appendix E Narcotic Discrepancy Form
Appendix F Request for Change of Medications to Acudose
References:

(1) (720 ILCS 570/) Illinois Controlled Substances Act.

(2) Department of Professional Regulation Illinois Nurse Practice Act
??Section 1300.44 Standards for Pharmacology/Administration of Medication
Course for Practical Nurses Source: Amended at 26 Ill. Reg.17225, effective
November 18, 2002
??Section 1300.60 Practice of Nursing Source: Amended at 24 Ill. Reg. 1191,
effective January 4, 2000

(3) Comprehensive Accreditation Manual for Hospitals: The Official
Handbook, "Medication Management," Joint Commission on Accreditation of
Health Organizations, January 2005.

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Issue Date: August 1995 Medication Dispensing Cabinet (MDC)

Revised Date: June 2006 Page 8 of 8

Review Date: PC 97

CLINICAL CONDITION	MEDICATION/S	Restrictions
Acidosis	Sodium Bicarbonate Inj.	
Agitation/Psychosis/Anxiety	Haloperidol Inj.	
	Lorazepam Inj.	
Allergic Reaction	Epinephrine Inj.	
Allergic/Transfusion Reaction	Diphenhydramine Inj.	
	Methylprednisolone Inj.,	
Angina	Morphine Inj.	
	Nitroglycerin Inj.	
	Nitroglycerin S.L.	
Antidotes (Overdose Reversal)	Flumazenil,	
	Naloxone,	
Atrial Fibrillation	Digoxin Inj.	
Cerebral Edema, Acute Management	Dexamethasone Inj. 10mg/mL	ICU Only
Bradycardia	Atropine Inj.	
Dystonia/Extra Pyramidal Side Effects	Benztropine Inj.	
Febrile	Acetaminophen elixir	
	Acetaminophen p.o.	
	Aspirin	
	Ibuprofen	
Hydrocephalus & Neuro Changes	Mannitol Inj.	
Hyperglycemia	Insulin	
	Sodium Bicarbonate Inj.	
Hyperkalemia	Dextrose 50% Inj.	
	Sodium Bicarbonate Inj.	
Hypertension	Enalapril IV	
	Hydralazine Inj.	
	Labetolol Inj.,	
	Metoprolol Inj.	
	Nicardipine Inj.	ICU Only
	Nitroglycerin Inj.	
	Nitroprusside	
Hypoglycemia	Dextrose 50% Inj.	
	Glucagon Inj.	
	Glucose Tablets	
Hypotension	Calcium chloride Inj.	
	Calcium gluconate Inj.	
	Dobutamine	
	Dopamine	
	Epinephrine Inj.	
	Norepinephrine,	
	Phenylephrine	
	Vasopressin	ICU Only
Intubation, Acute	Hurricaine Spray	ICU Only
Pain Management, Acute	Fentanyl Inj.	
	Hydromorphone Inj.	
	Meperidine Inj.	
	Morphine Inj.	
Pre-eclampsia/Pre-term Labor	Magnesium Sulfate 40 gm/500ml bag	
Procedure Local Anesthetic	Lidocaine 1% Inj.	
	Midazolam 2mg, 5mg Inj.	
Pulmonary Edema	Furosemide	
	Milrinone	ICU Only
Rigors	Meperidine Inj.	
Sedation, Acute	Propofol	ICU Only
	Midazolam 50mg/10mL	ICU Only
Seizures (Grand Mal, Tonic-Clonic, Psychomotor)	Lorazepam Inj.	
	Phenytoin Inj.	
Tachycardia, Supraventricular	Adenosine Inj.	
Uterine Atony	Carboprost (Hemabate),	L&D
	Methergine Inj.	L&D/3NE/3NW
	Misoprostol	L&D
	Oxytocin	L&D
Vomiting	Diphenhydramine Inj.	
	Metoclopramide Inj.	

THE UNIVERSITY OF CHICAGO HOSPITALS
Appendix B - Clinical Condition Medication List (Pediatrics)

CLINICAL CONDITION	MEDICATION/S
Acidosis (Metabolic)	Sodium Bicarbonate 4.2% Inj.
	Sodium Bicarbonate 8.4% Inj.
Allergic Reaction	Acetaminophen (PO)
	Diphenhydramine Inj.
	Epinephrine Inj.
	Hydrocortisone Inj.
Anesthesia, General	Etomidate inj.
Anxiety	Lorazepam Inj.
	Midazolam Inj.
Arrhythmias	Adenosine Inj.
	Aminodarone Inj.
	Atropine Inj.
	Lidocaine Inj.
	Magnesium Sulfate
Bleeding	Vitamin K (Phytonadione Inj.)
Cardiac Arrest	Adenosine Inj.
	Albumin 5%
	Atropine Inj.
	Calcium Gluconate Inj.
	Epinephrine 1:10,000 Bristoject
	Sodium Bicarbonate 4.2% Inj.
Cerebral Edema, Acute	Dexamethasone Inj. 10mg/mL
Emergent Line Placement/ECMO	Heparin
Febrile	Acetaminophen (PO, PR)
	Ibuprofen
Heart Defect, Ductal Dependent	Alprosadil (PGE-1) Inj.
Hemodynamic Instability	Albumin 5%
	Calcium Chloride
	Dobutamine Inj.
	Dopamine Inj.
	Epinephrine 1:1,000 Inj.
	Epinephrine 1:10,000 Inj.
	Esmolol Inj.
	Hydralazine Inj.
	Milrinone
	Nifedipine (SL)
	Nitroglycerine Inj.
	Nitroprusside Inj.
	Norepinephrine
	Phenylephrine
	Vasopressin
Hyperglycemia	Insulin
	Sodium Bicarbonate Inj.
Hyperkalemia	Dextrose 50% Inj.
	Insulin
	Sodium Bicarbonate Inj.
Hypertension	Nicardipine Inj.
Hypoglycemia	Dextrose 50% Inj.
	Glucagon Inj.
Intubation, Acute	Hurricaine Spray
Intracranial Pressure, (Increased)	Mannitol
	Phenylephrine

CLINICAL CONDITION	MEDICATION/S
Newborn Medications	Under MD supervision:
	Phytonadione 1mg. Inj.
	Erythromycin Opthalmic Ointment
Pain Management	Acetaminophen (PO, PR)
	Fentanyl Inj.
	Ibuprofen
	Lidocaine 1% Inj.
	Morphine (Inj. & PCA)
	Prilocaine/Lidocaine (EMLA)
Pulmonary Edema	Furosemide Inj.
	Milrinone
Respiratory Compromise/Intubation	Atropine Inj.
	Cisatracurium Inj.
	Fentanyl Inj.
	Glycopyrolate Inj.
	Ketamine Inj.
	Midazolam Inj.
	Succinylcholine Inj.
Respiratory Distress, Newborn	Beractant (Survanta) Inj.
Reversal Agents for Overdose	Naloxone
	Flumazenil
Rigors	Meperidine Inj.
Sedation, Acute	Propofol
Seizures	Diazepam Inj.
	Fosphenytoin Inj. (May be cost prohibitive)
	Lorazepam Inj.
	Phenobarbital Inj.
	Phenytoin Inj.
Sepsis, Newborn	Ampicillin
	Gentamicin
Vomiting	Lorazepam Inj.
Withdrawal	Methadone Inj.

Restricted
ICU Only
ICU Only
ICU Only
ICU Only

Restricted
ICU Only
ICU Only

Appendix C

UCH Adult AcuDose Drug Interaction Quick Reference

The following table lists those AcuDose override medications for which potential major drug/drug interactions or therapeutic duplications exist, which are considered to be clinically significant. This list was compiled with the understanding that these AcuDose medications are given on a one time, emergent basis with subsequent orders reviewed by a pharmacist. Other potentially significant drug/drug interactions, not listed, may occur when drugs are given concurrently for an extended period of time. Note that this list is not all-inclusive and serves only as a guide to potential interactions involving University of Chicago Hospitals formulary drugs.

AcuDose Drug	Interacting Drug
Acetaminophen/Oxycodone (Percocet®), Acetaminophen/codeine (Tylenol w/Codeine®)	Butorphanol, nalbuphine, phenelzine
Aspirin	Methotrexate
Calcium Gluconate, Calcium Chloride	Digoxin
Diazepam (Valium®)	Erythromycin, clarithromycin, itraconazole, isoniazid, fentanyl
Digoxin (Lanoxin®)	Calcium
Dopamine (Intropin®)	Phenelzine, phenytoin, fosphenytoin
Epinephrine (Adrenaline®)	Propranolol, phenelzine, amitriptyline, notriptyline, desipramine, sotalol, fluphenazine, perphenazine, trifluoperazine
Fentanyl (Duragesic®, Sublimaze®)	Atenolol, esmolol, labetalol, propranolol, sotolol, metoprolol, butorphanol, nalbuphine, amlodipine, diltiazem, nicardipine, nifedipine, diazepam
Furosemide (Lasix®)	Droperidol, gentamicin, cisatracurium
Haloperidol (Haldol®)	Droperidol
Hydromorphone (Dilaudid®)	Butorphanol, nalbuphine, phenelzine
Ibuprofen (Motrin®, Advil®)	Methotrexate, ketorolac, enoxaparin, heparin, lepirudin, argatroban, warfarin, tacrolimus
Insulin	Phenelzine
Labetalol (Trandate®, Normodyne®)	Amiodarone, verapamil
Meperidine (Demerol®)	Butorphanol, nalbuphine, phenelzine, fluphenazine, perphenazine, trifluoperazine
Methadone (Dolophine®)	Butorphanol, nalbuphine
Methylergonivine (Methergine®)	Amprenavir, ritonavir, saquinavir, indinavir, efavirenz, voriconazole
Metoprolol (Lopressor®)	Verapamil, amiodarone, fentanyl
Morphine (Astramorph®, Duramorph®, Oramorph®)	Butorphanol, nalbuphine, phenelzine
Norepinephrine (Levophed®)	Phenelzine, amitriptyline, notriptyline, desipramine, fluphenazine, perphenazine, trifluoperazine
Phenylephrine (Neo-Synephrine®)	Amitriptyline, notriptyline, desipramine, phenelzine, propranolol
Phenytoin (Dilantin®)	Lidocaine, dopamine, warfarin, cisatracurium
Prochlorperazine (Compazine®)	Ibutilide, gatifloxacin, dofetilide, meperidine
Promethazine (Phenergan®)	Sotalol, gatifloxacin, dofetilide, meperidine

** If a potential interaction exists, do not administer without a pharmacist's review **

Appendix D

UCCH Pediatric AcuDose Drug Interaction Quick Reference

The following table lists those AcuDose override medications for which potential major drug/drug interactions or therapeutic duplications exist, which are considered to be clinically significant. This list was compiled with the understanding that these AcuDose medications are given on a one time, emergent basis with subsequent orders reviewed by a pharmacist. Other potentially significant drug/drug interactions, not listed, may occur when drugs are given concurrently for an extended period of time. Note that this list is not all-inclusive and serves only as a guide to potential interactions involving University of Chicago Hospitals formulary drugs.

AcuDose Drug	Interacting Drug
Alprostadil (Prostin VR Pediatric®)	Heparin, metronidazole
Amiodarone (Cordarone®)	Lidocaine, atenolol, esmolol, labetalol, propranolol, sotolol, ritonavir, ibutilide, digoxin, droperidol, ciprofloxacin, gatifloxacin, dofetilide, procainamide, warfarin, flecainide, mexiletine
Cisatracurium (Nimbex®)	Procainamide, gentamicin, tobramycin, amikacin
Diazepam (Valium®)	Erythromycin, clarithromycin, itraconazole, isoniazid, fentanyl
Dopamine (Intropin®)	Phenelzine, phenytoin, fosphenytoin, dihydroergotamine
Epinephrine (Adrenalin®)	Propranolol, phenelzine, amitriptyline, sotalol, dihydroergotamine
Esmolol (Brevibloc®)	Amiodarone, fentanyl, , morphine, diltiazem, nifedipine, nicardipine, amlodipine
Fentanyl (Duragesic®, Sublimaze®)	Atenolol, esmolol, labetalol, propranolol, sotolol, butorphanol, nalbuphine, amlodipine, diltiazem, nicardipine, nifedipine, diazepam
Furosemide (Lasix®)	Droperidol, gentamicin, cisatracurium
Gentamicin (Garamycin®)	Cisatracurium, pancuronium, rocuronium, succinylcholine, tacrolimus, cyclosporine, furosemide
Heparin	Aspirin, alteplase, dextran, alprostadil, clopidogrel, warfarin, enoxaparin, argatroban
Ibuprofen (Motrin®, Advil®)	Methotrexate, ketorolac, enoxaparin, heparin, argatroban, warfarin, tacrolimus
Insulin	Phenelzine
Mannitol (Osmitrol®)	Droperidol
Meperidine (Demerol®)	Butorphanol, nalbuphine, phenelzine
Methadone (Dolophine®)	Butorphanol, nalbuphine
Midazolam (Versed®)	Saquinavir, ritonavir, indinavir, itraconazole, nelfinavir, efavirenz
Morphine (Astramorph®, Duramorph®, Oramorph®)	Butorphanol, nalbuphine, phenelzine, esmolol
Norepinephrine (Levophed®)	Phenelzine, amitriptyline, dihydroergotamine
Phenylephrine (Neo-Synephrine®)	Amitriptyline, phenelzine, propranolol
Phenytoin (Dilantin®)	Cisatracurium, lidocaine, dopamine, warfarin

** If a potential interaction exists, do not administer without a pharmacist's review **

Appendix F

The University of Chicago Hospitals
Narcotic Discrepancy Form

Complete this form for lost or unaccountable controlled drugs.

Unit:_____   Date:_____

Check the following when complete:

____ Staff were questioned to determine if any doses had been given and not yet recorded.

____ Medication and physician order sheet of all patients receiving the drug in question were checked against the controlled drug log.

____ Totals brought forward from the previous shift were checked for correctness.

____ Arithmetic totals were double checked for the shift.

Summary of Discrepancy

_____

_____

_____

Names of All Nurses on Duty When the Discrepancy Occurred

_____

_____

_____

_____   _____
Signature of Auditing RN   Date

_____   _____
Signature of Charge Nurse   Date

printed on recycled paper

Situation #1 – Patient is not in the Acudose System

1A – Patient Meets the Clinical Condition to Perform an Acudose System Override and the Medication is Overrideable in the Acudose System

If the patient is not yet profiled in the Acudose system, complete the following:

1. Manually add the patient to the Acudose system making sure to input the following information:
   o Patient's full first and last name
      ▪ If the patient has a common name or is listed as baby boy / girl, please include the patient's bed number after his / her name. This is helpful when it comes to reconciling the patient's medications for billing.
   o Patient's Medical Record Number in the Patient ID Number field if available
   Important: Patients must be added to the system manually in order to ensure the patient is appropriately being charged for medication
2. Verify the needed medications against the patient's allergies and against the UCH drug interaction list to make sure the patient can receive the medications
   o If questions about the patient's allergies and/or interactions arise, contact Pharmacy for clarification
3. Once the patient has been added to the system and allergies have been reviewed, go into the manually added patient profile and override the desired medications
4. Prior to administering medications to the patient, verify his / her identity
5. Administer the medications and document the medications on the patient's Medication Administration Record (MAR)
6. Once medications have been administered, call Admitting at extension 26000 to see if the patient's bed has been entered into Last Word
   o If the patient's bed has not been entered, provide the patient's room and bed to Admitting
      ▪ Wait 15 minutes for the patient to be added to the system
      ▪ If the patient is still not in the system after 15 minutes, call Admitting again at extension 26000 and ask for a Supervisor or Coordinator during the week and a Charge on the weekends. Inform the Supervisor, Coordinator, or Charge of the situation and ask him / her to follow up on why the patient has still not been added to the system
   o If the patient's bed has been entered into LastWord and the patient is still not profiled in the Acudose system, ask Admitting how long ago the patient's bed was entered in the system
      ▪ If the patient was just recently entered in the system, wait 15 minutes to see if the interface is working slow
      ▪ If after the 15 minutes the patient is still not in the Acudose system, contact the Pharmacy Supervisor / Midnight Pharmacist to see if an issue with the interface has occurred
7. Once the patient's profile appears, make sure to use the official profile instead of the one that has been added to the Acudose system. Using the official profile will create less work for Pharmacy when it comes time to reconcile the manually added patients at the end of each day.

Situation #1 – Patient is not in the Acudose System (cont.)

1B – Patient Does Not Meet a Clinical Condition to Perform an Acudose System Override and/or the Medication is Not Overrideable in the Acudose System
If the patient is not yet profiled in the Acudose system, complete the following:
1. If the medication is needed emergently, take emergent action via the appropriate hospital systems (i.e. Doctor Cart, Med Team, etc.)
2. If the medication is not needed emergently, call Admitting at extension 26000 to see if the patient's bed has been entered into Last Word
    o If the patient's bed has not been entered, provide the patient's room and bed to Admitting
        ▪ Wait 15 minutes for the patient to be added to the system
        ▪ If the patient is still not in the system after 15 minutes, call Admitting again at extension 26000 and ask for a Supervisor or Coordinator during the week and a Charge on the weekends. Inform the Supervisor, Coordinator, or Charge of the situation and ask him / her to follow up on why the patient has still not been added to the system
    o If the patient's bed has been entered into LastWord and the patient is still not profiled in the Acudose system, ask Admitting how long ago the patient's bed was entered in the system
        ▪ If the patient was just recently entered in the system, wait 15 minutes to see if the interface is working slow
        ▪ If after the 15 minutes the patient is still not in the Acudose system, contact the Pharmacy Supervisor / Midnight Pharmacist to see if an issue with the interface has occurred
3. Once the patient's profile appears, make sure to use the official profile instead of the one that has been added to the Acudose system. Using the official profile will create less work for Pharmacy when it comes time to reconcile the manually added patients at the end of each day.

Nursing Acudose Trouble Shooting

Situation #2 – Medication is not Profiled in the Acudose System

2A – Patient Meets the Clinical Condition to Perform an Acudose System Override and the Medication is Overrideable in the Acudose System

If medications for the patient are not profiled in the system complete the following:

1. Verify the needed medications against the patient's allergies and against the UCH drug interaction list to make sure the patient can receive the medications
   o If questions about the patient's allergies and/or interactions arise, contact Pharmacy for clarification
2. Go into the patient's profile and override the desired medications
3. Prior to administering the medication to the patient, verify his / her identity
4. Administer the medications and document the medications in the patient's MAR
5. Once the medications have been administered, verify the order has been sent via the fax / tube as follows:

   Fax
   o If the order has been faxed, verify the order has been sent through reviewing the fax confirmation sheet
      ▪ If the fax confirmation sheet is blank or a confirmation sheet cannot be located, the fax was not received by Pharmacy and will need to be refaxed
      ▪ To refax the order complete the following:
   – Stamp "Refax" on the order sheet
      Important: Refaxed on an order sheet indicates to Pharmacy that the order is a duplicate and requires immediate attention
   – Star the medication orders that are missing. Staring the missing medication orders will indicate to Pharmacy what is still missing on the order sheet.
   – Once the order sheet is prepared, refax the order sheet to Pharmacy
   – After the order has been sent, complete the following:
   ⇨ Return the order to the chart
   ⇨ Check the fax confirmation to make sure it is not blank or unreadable. If it is blank or unreadable, send the fax again.
   ⇨ Place the fax confirmation in the fax confirmation bin

      Tube
      o If the order has been tubed, review the order sheet in the chart to see if the order was signed off and the yellow "Pharmacy Copy" of the orders has been pulled from the chart
      ▪ If the order has not been sent, transcribe the order and send it down to Pharmacy
      Important: Make sure to only send an order as STAT if the physician has written it as STAT. If an order has not been written as STAT but the clinical condition of the patient warrants immediate medication need, contact the Pharmacy Supervisor / Midnight Pharmacist to help assist with the situation.
6. If the order has been sent, determine if the appropriate time has past (30 minutes for STAT orders and 120 minutes for Non-STAT orders)
   o If the time has not pasted, wait the required amount of time

7. If the time has passed, contact Pharmacy and provide the following information:
   - Issue – Medication Not Profiled
   - Patient name
   - Medical Record number
   - Medication
   - Unit / Ext
   - Nurse's name

   Example: Jon Doe MR # 3456789 on 4NE does not have Estazolam profiled in the Acudose machine – Suzy Q

8. If unresolved, text page the Pharmacy Supervisor / Midnight Pharmacist at 8223 and provide the following information:
   - Unit
   - Nurse's name
   - Phone number

9. Continue to follow-up with the Pharmacy Supervisor / Midnight Pharmacist until the medication has been received

Situation #2 – Medication is not Profiled in the Acudose System (cont.)

2B – Patient Does Not Meet a Clinical Condition to Perform an Acudose System Override and/or the Medication is Not Overrideable in the Acudose System
1. Once the medication has been administered, verify the order has been sent via the fax / tube as follows:
     Fax
     o If the order has been faxed, verify the order has been sent through reviewing the fax confirmation sheet
         ▪ If the fax confirmation sheet is blank or a confirmation sheet cannot be located, the fax was not received by Pharmacy and will need to be refaxed
         ▪ To refax the order complete the following:
     – Stamp "Refax" on the order sheet
         Important: Refaxed on an order sheet indicates to Pharmacy that the order is a duplicate and requires immediate attention
     – Star the medication orders that are missing. Staring the missing medication orders will indicate to Pharmacy what is still missing on the order sheet.
     – Once the order sheet is prepared, refax the order sheet to Pharmacy
     – After the order has been sent, complete the following:
  ⇨ Return the order to the chart
  ⇨ Check the fax confirmation to make sure it is not blank or unreadable. If it is blank or unreadable, send the fax again.
  ⇨ Place the fax confirmation in the fax confirmation bin
     Tube
         o If the order has been tubed, review the order sheet in the chart to see if the order was signed off and the yellow "Pharmacy Copy" of the orders has been pulled from the chart
         ▪ If the order has not been sent, transcribe the order and send it down to Pharmacy
  Important: Make sure to only send an order as STAT if the physician has written it as STAT. If an order has not been written as STAT but the clinical condition of the patient warrants immediate medication need, contact the Pharmacy Supervisor / Midnight Pharmacistto help assist with the situation.
2. If the order has been sent, determine if the appropriate time has past (30 minutes for STAT orders and 120 minutes for Non-STAT orders)
     o If the time has not pasted, wait the required amount of time
3. If the time has passed, contact Pharmacy and provide the following information:
         o Issue – Medication Not Profiled
         o Patient name
         o Medical Record number
         o Medication
         o Unit / Ext
         o Nurse's name
  Example: Jon Doe MR # 3456789 on 4NE does not have Estazolam profiled in the Acudose machine – Suzy Q

4. If unresolved, text page the Pharmacy Supervisor / Midnight Pharmacist at 8223 and provide the following information:
   o Unit
   o Nurse's name
   o Phone number
5. Continue to follow-up with the Pharmacy Supervisor / Midnight Pharmacist until the medication has been received

Situation #3 – Medication is Out of Stock in the Acudose Machine
If the medication is out of stock in the Acudose Machine, complete the following:
6:30am – 11:00pm
2. The Nurse text pages the Pharmacy Supervisor / Midnight Pharmacist at 8223 making sure to indicate the following:
   o The Issue – Missing Acudose Medication
   o Medication that is missing
   o Unit the medication is missing from
   o Nurse's name
   Example: Missing Acetaminophen 325mg on 5NE – restocking required – Suzy Q
3. When the Pharmacy Supervisor / Midnight Pharmacist receives the text page, he / she will call the nurse back to acknowledge the text page and will make sure the medication is filled and delivered timely
   o If the Nurse does not hear from the Pharmacy Supervisor / Midnight Pharmacist, he / she should call the Pharmacy Supervisor / Midnight Pharmacist to make sure the information is received
4. During the delivery, the Pharmacy Tech should ask for the Nurse who requested the medication. The Pharmacy Tech should inform the Nurse that the medication has been delivered and is available for dispensing.
5. If the Nurse does not hear from a Pharmacy Tech within one hour, the Nurse should call the Pharmacy Supervisor / Midnight Pharmacist
6. Pharmacy Supervisor / Midnight Pharmacist will contact the nurse directly to resolve the issue

11:00pm – 6:30am
1. The Nurse text pages the Pharmacy Supervisor / Midnight Pharmacist at 8223 making sure to indicate the following:
   o The Issue – Missing Acudose Medication
   o Medication that is missing
   o Unit the medication is missing from
   o Nurse's name
   Example: Missing Acetaminophen 325mg on 5NE – restocking required – Suzy Q
2. When the Pharmacy Supervisor / Midnight Pharmacist receives the text page, he / she will call the nurse back to acknowledge the text page and will make sure the medication is filled
3. If the Nurse does not hear from the Pharmacy Supervisor / Midnight Pharmacist, he / she should call the Pharmacy Supervisor / Midnight Pharmacist to make sure the information is received
4. Once filled the medications will be brought to the floors as follows:
   o Non-narcotic medications will be tubed to the floors
   o Narcotic medications will be picked up by the Nurse who requested the medications from the Mitchell Pharmacy
5. If the Nurse does not receive non-narcotic medications within one hour, the Nurse should call the Pharmacy Supervisor / Midnight Pharmacist
6. Pharmacy Supervisor / Midnight Pharmacist will contact the nurse directly to resolve the issue

Situation #4 – Medications in the Acudose Machine are Expired

If medications in the Acudose Machine have expired, the following steps should be completed:

1. The Nurse text pages the Pharmacy Supervisor / Midnight Pharmacist at 8223 making sure to indicate the following:
   - Issue – Acudose Medications Expired
   - Medication that is expired
   - Quantity that has expired
   - Unit the expired medications are on

   Example: 5 doses of Acetaminophen 325mg are expired on 5NE – restocking required – Suzy Q

2. After paging the Pharmacy Supervisor / Midnight Pharmacist the Nurse should fill out an occurrence report and send it to patient safety
3. In addition, the nurse should give the expired medications to the Charge Nurse so they remain out of circulation
4. When the Supervisor / Midnight Pharmacist receives the page, he / she should document the occurrence and inform the Pharmacy Tech of the expired medications
5. Once the Pharmacy Tech arrives on the floor he / she will ask for the Charge Nurse to obtain the expire medications and will restock the Acudose machine with new medications
6. During the delivery, the Pharmacy Tech should ask for the Nurse who reported the expired medications and inform him / her that the expired medications have been replaced and new medications are available for dispensing
7. If the Nurse does not hear from a Pharmacy Tech within one hour, the Nurse should contact the Pharmacy Supervisor / Midnight Pharmacist directly to follow-up on the request

Situation #5 – Acudose Machine goes Down

If the Acudose Machine goes down, the following steps should be taken:

6:30am to 11:30pm

1. Text page the Acudose Administrator at 8360. If he / she is not available, the page will automatically be transferred to the Pharmacy Supervisor.
2. When paging the Acudose Administrator make sure to provide the following information:
   - Issue – Acudose Machine Down
   - Unit
   - Nurses Name
3. If the Acudose Administrator does not respond to the text page within 15 minutes, contact the Pharmacy Supervisor via phone
4. The Acudose Administrator or Pharmacy Supervisor will work with McKesson to trouble shoot the issue
5. While the machine is down, access medications through the unit's Back Up Acudose machine
   - If you do not know where the unit's Back Up Acudose machine is located, contact the onsite manager (Patient Care Manager (PCM), Assistant Clinical Manager (ACM), or Temporary Supervisor)

Situation #5 – Acudose Machine goes Down (cont.)
If the Acudose Machine goes down, the following steps should be taken:
11:30pm to 6:30am
1. Notify the Care Center's ACM, PCM, or Temporary Supervisor
2. When notifying the ACM, PCM, or Temporary Supervisor make sure to provide the following information:
   o Issue – Acudose Machine Down
   o Unit
   o Nurses Name
3. The ACM, PCM, or Temporary Supervisor will contact the McKesson helpdesk at 1-800-700-USER to trouble shoot the issue. When the ACM, PCM, or Temporary Supervisor contacts McKesson he / she should provide the hospital's customer code which is 1146000.
4. While the machine is down, access medications through the unit's Back Up Acudose machine
   o If you do not know where the unit's Back Up Acudose machines is located contact the onsite manager (PCM, ACM, or Temporary Supervisor)

Situation #6 – New Acudose PIN Number Needs to be Requested or Existing PIN Number Needs to be Reset
When a user has issues with his / her PIN number he / she should complete the following:
6:30am to 3:00pm
1. Contact the Acudose Administrator via the hosptial's Acudose Outlook e-mail address. The address is Acudose.
2. When the e-mail is received the Acudose Administrator will update the user's PIN number and contact the user to let him / her know his / her PIN number has been updated
3. If the user does not hear from the Acudose Administrator within 24 hours he / she should text page the Acudose Administrator at 8360. If he / she is not available, the page will automatically be transferred to the Pharmacy Supervisor.
4. If the PIN cannot be updated in the appropriate timeframe, the user should request temporary access through a PCM, ACM, Temporary Supervisor, or the HOA

3:00pm to 6:30am
1. Contact the Acudose Administrator via the hosptial's Acudose Outlook e-mail address. The address is Acudose.
2. Since the Acudose Administrator will not be available to update PIN numbers, the user should request temporary access through a PCM, ACM, Temporary Supervisor, or the HOA
3. On the next day shift the Acudose Administrator will update the users PIN number and will inform the user via e-mail

Situation #7 – New User Acudose Access is Needed
When new user access is needed the following steps should be completed:
1. PCM should contact the Acudose Administrator via the hospital's Acudose Outlook e-mail. The address is Acudose.
   Important: Only the PCM is allowed to request new user access and it must always be requested over e-mail
2. In the e-mail the PCM should include the following information:
   o Nurse's Name
   o Unit
   o Nurse's employment status (i.e., hospital hired, contract nurse, or outside agency)
     ▪ If contract nurse, please indicate the end date of his / her contract

Situation #8 – Temporary Acudose Access is Needed
When temporary user access is needed the following steps should be completed:
1. While the user is waiting for access, the PCM, ACM, Temporary Supervisor, or the Hospital Operations Administer (HOA) should provide temporary access
2. User should request temporary access from the PCM on the day shift and the ACM, Temporary Supervisor, or HOA on the night shift
   Important: Only the PCM, ACM, Temporary Supervisor, or the HOA are allowed to provide temporary user access
3. Once access is requested the PCM, ACM, Temporary Supervisor, or HOA should grant the user temporary access in the Acudose machine and provide him / her with the appropriate user name and password

DR. CART (CARDIOPULMONARY ARREST RESUSCITATION TEAM)

Policy: PC 44
Issued: June 1994
Revised: April 2007
Reviewed: April 2007

POLICY
It is the policy of the University of Chicago Medical Center (UCMC) to assure that:
1. Appropriate personnel can initiate basic life support measures,
2. A reliable and rapid method exists for summoning members of the CPR team,
3. A collaborative and organized resuscitative effort be accomplished by the members of the CPR team, and
4. All necessary supplies and equipment are rapidly available when a Dr. CART is called.

DEFINITIONS
1. Dr. CART means the UCMC Cardiopulmonary Arrest Resuscitation Team and also refers to the physician (either the cardiology resident or the PICU attending and/or fellow) carrying the Dr. CART pager who serves as the head of the CPR team.

2. Medical Center Premises are defined as the following locations: (please see attached maps for exact response locations – Appendix A)
    a. The interiors of all buildings bounded by 58th Street (north), Ellis Avenue (east), 59th Street (south), and Maryland Avenue (west)
    b. The interior of the Comer Children's Hospital building bounded by 57th Street (north), Drexel Avenue (east), 58th Street (south), and Maryland Avenue (west)
    c. The interior of the Duchossois Center for Advanced Medicine (DCAM) building bounded by 57th Street (north), Maryland Avenue (east), 58th Street (south), and Cottage Grove Avenue (west)
    d. The interior of the parking facility bounded by 58th Street (north), Maryland Avenue (east), 59th Street (south), and Cottage Grove Avenue (west) and interior of the parking facility known as the "North/DCAM" parking facility
    e. Sky bridge and tunnels connecting the DCAM, parking facility, and Mitchell Hospital
    f. Walkways to and from the normal patient entrances
    g. The Goldblatt Pavilion walkway, from the entrance door up to and including the public sidewalk
    h. The emergency room walkway, from the entrance door up to and including the public sidewalk and circular driveway
    i. The DCAM walkway, from the entrance door up to and including the public sidewalk and circular drive
    j. All of the roadway and walkway over which persons normally travel walking from the parking lot to the DCAM entrance, old Chicago Lying-in entrance and the Mitchell Hospital entrance
    k. The Medical Center's Premises also includes all other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

PROCEDURE
1. **Calling a Dr. CART**
    a. A Dr. CART is called when a patient (who does not have a written order of "Do Not Resuscitate" in accordance with Medical Center policy) is felt to have a life-threatening emergency requiring the immediate response of the entire cardiopulmonary arrest resuscitation team. This may be a respiratory or cardiopulmonary arrest or some other life-threatening disturbance in vital signs or vital functions requiring immediate resuscitation. If a response is not necessary within several minutes and if individual physicians and nurses can handle the emergency, then the appropriate physicians should be paged. If there is any uncertainty as to which level of response is most appropriate, it is preferable to call a Dr. CART.

    b. If the patient is an adult, the first responder at the scene of a cardiopulmonary arrest should establish unresponsiveness and then use the phone in the patient's room to call the Dr. CART. If the event occurs elsewhere on Medical Center Premises (see definition/ Appendix A), the first responder should leave the patient and find the nearest phone to call the Dr. CART.

    c. For a child or infant, the first responder should establish unresponsiveness, and then activate the Dr. CART response using Pediatric Advance Life Support (PALS) guidelines. In the case of a witnessed sudden collapse or suspected dysrhythmia, call Dr. CART prior to beginning CPR. If the patient is found in arrest or has a suspected asphyxial cause, provide 5 cycles or approximately 2 minutes of cardiopulmonary resuscitation before calling the Dr. CART using either the phone in the patient's room or the nearest available phone.

    d. Any Medical Center employee can call a Dr. CART by dialing 147 and stating the exact location including room and bed number, if applicable, and whether the adult or pediatric team is required. If any of this information is not volunteered, the operator should prompt the caller for missing information. However, it will be assumed that all Dr. CART calls outside of Comer Children's Hospital are for adults unless specifically called as a pediatric Dr. CART and that all Dr. CART calls within Comer Children's Hospital are for pediatric patients unless specifically called as an adult Dr. CART.

    e. The operator responding to the incoming call will summon the Dr. CART team via overhead voice paging and via the individual pagers of Dr. CART team members. Dr. CART team members will see 147 on their pagers followed by a number identifying the location of the Dr. CART followed by an alphanumeric message indicating the location. The overhead voice and radio paging will continue until the page is canceled. The responsible charge nurse or designee of the Dr. CART team cancels the page, after assuring that all Dr. CART team members are present, by dialing 147 and providing the name of Dr. CART team member authorizing the cancellation.

2. **Dr. CART response locations** - The Dr. CART team will respond to any location on the Medical Center Premises (please refer to definition/Appendix A).

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

- **Exceptions**: For cardiopulmonary arrest events occurring on Medical Cetner Premises that are not within the physical walls of a building, including cardiopulmonary arrest events occurring in the parking facility or on public sidewalks, the Chicago Fire Department (911) will be contacted in addition to Dr. CART by the first responder or designee.

3. **Members of the Dr. CART Team** The resuscitation team consists of:
   a. Dr. CART (cardiology resident on-call for adults or PICU attending and/or fellow for children)
   b. Dr. CART back-up (cardiology intern on-call and medicine resident on call (MROC) for adults or PICU resident on-call and pediatric resident on-call for children)
   c. General Surgery resident on-call
   d. Senior anesthesiology resident on-call
   e. Patient's primary nurse
   f. Critical Care nurse
   g. Unit charge nurse or designee (or ED nurses if in a non-inpatient care area)
   h. Respiratory therapist
   i. Pharmacist
   j. Chaplain
   k. Additional personnel who are paged include:
      i. Anesthesia faculty-on-call
      ii. Anesthesia resident-on-call
      iii. Nursing Directors
      iv. Critical Care on-call Patient Care Nursing Manager
      v. Hospital Operations Administrator

   l. Additional emergency response teams:
      i. Emergency Department Response Team
      ii. DCAM First Response Team

4. **Responsibilities of the Dr. CART team**
   a. **Dr. CART** - The cardiology resident on-call, or PICU attending and/or fellow are the designated leader(s) in charge of the resuscitation and assumes control of the resuscitation effort upon arrival. However, in the event the ER responders are present and both the ER responders and Dr. CART team agree that it is more appropriate for the ER responders to assume/retain control of the resuscitation effort, the ER responders will retain such control. It is his/her responsibility to first identify him/herself as Dr. CART and then direct all aspects of the medical care of the patient, in accordance with ACLS or PALS guidelines. Dr. CART shall also order that the patient's primary physician be paged and directs the charge nurse or designee to cancel the Dr. CART page once all members of the team are present. Dr. CART will also ensure that unnecessary persons are excluded from the immediate surroundings of the patient.
      i. In the case of an adult or pediatric Dr. CART, if patient care issues need to be resolved or assistance in the management of the care of the patient are required, the; cardiology attending and/or fellow on-call, or the critical care attending and/or fellow, and the PICU attending and/or fellow can be contacted and

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

becomes the team leader. If the physician members of the patient's primary team (other than the cardiology or PICU attending and/or fellow mentioned above) are present, issues will be resolved cooperatively between Dr. CART and these physicians.

    ii.   For all Dr. CARTs, the Dr. CART team member must sign the Cardiopulmonary Arrest Record (form 78.35), and write a note in the patient's medical record at the conclusion of the Dr. CART.

b. **Dr. CART backup** - For adult resuscitations, the designated cardiology intern or sub-intern on-call is responsible for bringing the monitor/ defibrillator from D5ICU to the arrest location and then hooking it up to the patient. At the end of the Dr. CART, the cardiology intern on-call is also responsible to clean the monitor/ defibrillator as per the Medical Center' Infection Control policy (see "Guidelines for Disinfection/Sterilization of Patient Care Equipment"- Infection Control Policy Section 02-05, Appendix B), and returning it to D5ICU. Upon return, this intern shall notify the D5ICU charge nurse that the monitor/ defibrillator is returned and requires restocking of any used supplies.

    i.   During the resuscitation, the cardiology intern(s) on-call and MROC or PICU and pediatric resident on-call with assistance from the general surgery resident on-call and other available team members are responsible for performing resuscitation duties, as directed by Dr. CART, which include, but are not limited to:
- Chest compressions
- Line placement
- Lab draws, including arterial blood draws (ABG's)
- Defibrillation, cardioversion, and pacing
- Administer medications as ordered by Dr. CART and call out the drug as it is given

c. **Senior Anesthesiology resident on-call** - The anesthesia resident assumes the responsibility for providing an airway for the patient.

d. **Nursing** –
    i.   Critical care nurses will respond to a Dr. CART as outlined below:
- T6ICU will respond to a Dr. CART on the 6th floor
- D5 will respond to a Dr. CART on the 5th floor
- D4 will respond to a Dr. CART on the 4th floor
- D3 will respond to a Dr. CART on the 3rd floor
- D2 will respond to a Dr. CART *on* the 2nd floor.
- DCAM recovery room will respond to a Dr. CART in the DCAM
- PICU will respond to all pediatric Dr. CARTs, regardless of location
- Emergency Department will respond to all non-inpatient care areas of the Medical Center

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

ii.   The charge nurse or designee, with the assistance of the critical care nurse, directs and coordinates the activities of the nursing staff, including the patient's primary nurse including:

- Prepare crash cart for use
- Place backboard under patient
- Assist in CPR if requested by Dr. CART
- Prepare respiratory equipment including connecting bag-valve-mask device to oxygen
- Set up suction apparatus
- Connect the monitor/defibrillator to patient ("quick-look" paddles will often be used initially by Dr. CART to identify the rhythm before electrodes are placed)
- Assign a nurse to document events on the Cardiopulmonary Arrest Record
- Administer medications as ordered by Dr. CART and call out the drug as it is given
- Cancel the Dr. CART page when authorized by Dr. CART
- Ensure the Cardiopulmonary Arrest Record is stamped with the patient's name and signed by Dr. CART
- Assist in keeping the area clear of unnecessary persons
- Assist with transport of the patient after the resuscitation if needed
- Assist family members who may wish to be present during the resuscitation. Ensure they are accompanied by either the chaplain, HOA and/or PCM

iii.   Additionally, the Charge Nurse shall:

- Obtain the pink pharmacy copy of the patient's Cardiopulmonary Arrest Record and send to pharmacy by tube station or place in the pharmacy order pick-up bin
- At the conclusion of a Dr. CART, ensure all equipment including defibrillator. backboard, and crash cart are cleaned per Infection Control Policy (see "Guidelines for Disinfection/ Sterilization of Patient Care Equipment"- Infection Control Policy Section 02-05, Appendix B)
- Confirm appropriate re-stocking of drugs and equipment

e. **Respiratory Therapist** - In the case of an adult Dr. CART or non-inpatient care areas or in the DCAM, all ICU therapists receive a page and respond to a Dr. CART. The assigned "lead technician" determines who will remain at the Dr. CART and who will return to their assigned areas. There is always a respiratory therapist in the ABG lab to analyze the ABG sample. In non-patient areas, the respiratory therapist is responsible to bring a respiratory kit with intubation equipment including, but not limited to bag-valve-mask (BVM), pulse oximetry, oxygen tank and flow meter.

    i.   In the case of a pediatric Dr. CART, the pediatric respiratory therapist responds.

    ii.   Respiratory therapy assumes responsibility for:

- Assisting with ventilation
- Hooking the patient up to a ventilator, when appropriate
- Transporting ABGs to the blood gas lab and analyzing the samples

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

   f. **Pharmacist** - Pharmacists will respond to all adult and pediatric Dr. CARTs. The pharmacist assumes primary responsibility for preparation of medications as well as to:
- i. Bringing the crash cart to non-inpatient areas
- ii. Setting up the crash cart
- iii. Calculating IV drip rates as requested by other members of the team
- iv. Providing medication information and drug interaction information as needed
- v. Tagging the old crash cart after use with a red tag; and have a new crash cart brought up to the area, and the used cart returned to the central pharmacy for restocking

   g. **Chaplain** - The chaplain is available to provide support for the family and to accompany members of the family who wish to be present at the bedside during the resuscitation effort.

   h. **Security** - Assists with crowd control in public areas under the direction of Dr. CART or a member of the Dr. CART team.

   i. **Emergency Department Resuscitation Team**- This team is composed of one designated Emergency Department nurse, resident and technician and responds to all Dr. CARTs in non-inpatient care areas. In the case of a pediatric Dr. CART in a non-inpatient care area, this team is deployed from the Pediatric Emergency Department. They bring with them a monitor/ defibrillator, airway supplies, medications etc. Emergency Department personnel will return to their responsibilities in the ED upon arrival of the Dr. CART team except for Dr. CARTs that occur in the DCAM. In this case, the Emergency Department nurse will remain throughout the CART to assist the team regardless of the admission status of the patient. If resuscitation occurs in the DCAM or involves outpatient, employee, or visitor, the Emergency Department personnel will remain and accompany the patient to the Emergency Department upon completion of the resuscitation.

   j. **DCAM First Response Team** - This team is composed of a DCAM recovery room nurse and he/she responds to all Dr. CARTs in the DCAM (adult or pediatric). The team brings with it a monitor/ defibrillator/ AED, and glucoscan. The person who initiates the Dr. CART will be responsible to bring their assigned crash cart to the scene of the Dr. CART. The DCAM First Response Team will return to their responsibilities in the DCAM recovery room upon arrival of the Dr. CART team

5. **Care of the Patient After Death** - If the patient is an inpatient, and the Dr. CART occurs in a non-inpatient area, the patient will be returned to the assigned room/unit for appropriate care. If the patient is an outpatient, visitor, employee the patient will be returned to the Mitchell ED for appropriate care (see PC 108, Care of the Patient After Death policy).

6. **Equipment and Supplies**
   a. Adult and pediatric Dr. CART crash carts are available throughout the Medical Center and clinics. Pharmacy will inspect each Dr. CART crash cart monthly for outdated

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

medications and supplies. Pharmacy is responsible for restocking the Dr. CART crash carts. An area checklist is maintained at the location where the carts (either adult or pediatric) are stored.

b. Monitor/defibrillators are available and shared between every one to two in-patient units. They are also available in the ICUs, GOR, Heart Station, UHS, EDs, Radiology, and DCAM. Additionally, there is a monitor/defibrillator located on every pediatric crash cart.

c. Upon the notification of a Dr. CART, the following personnel are responsible for assuring that the appropriate equipment and supplies are available:
     i. The designated cardiology intern on-call brings a monitor/ defibrillator (except in the DCAM where a defibrillator is located on each crash cart)
     ii. The anesthesiology resident brings anesthesia supplies
     iii. For in-patient care areas, the charge nurse or nursing designee wheels the nearest crash cart and defibrillator to the bedside
     iv. In non-inpatient care areas, pharmacy is responsible for bringing a crash cart to all areas where one is not readily available
     v. ED nurses will respond with airway and intravenous equipment, medications, a monitor/ defibrillator and a portable suction device to all non-inpatient care areas
     vi. Respiratory therapy responds with portable oxygen and airway equipment in non-inpatient care areas

INTERPRETATION, IMPLEMENTATION AND REVISION
The Chairperson of the CPR Committee is responsible for interpretation, implementation and revision of this policy. Contact The Center for Quality (2-2723).

CROSS-REFERENCES
1. Appendix A - Medical Center Premises: Map
2. Guidelines for Disinfection/Sterilization of Patient Care Equipment - Infection Control Policy Section 02-05, Appendix B
3. Emergency Care of Ill or Injured Persons, Administrative Policy A04-05
4. Care of the Patient After Death, Patient Care Policy PC 108
5. Inpatient Treatment Limitation - DNR and Withholding or Withdrawal of Treatment, Administrative Policy 03-04/Patient Care Policy 05

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

_____
David Hefner
President

_____
Jamie O'Malley, RN, MS
Chief Nursing Officer

_____
Harvey Golomb, MD
Chief Medical Officer

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J. Richard Thistlethwaite, MD
Medical Staff President

Policy: PC 44
Issued: June 1994
Revised: April 2007
Reviewed: April 2007

Patient Care Policy 44 Dr. Cart (Cardiopulmonary Arrest Resuscitation Team)

WASHINGTON PARK

E. 56TH STREET

E. 57TH STREET

E. 58TH STREET

E. 59TH STREET

E. 60TH STREET

COTTAGE GROVE AVENUE

MARYLAND AVENUE

DREXEL AVENUE

ELLIS AVENUE

UNIVERSITY AVENUE

MIDWAY PLAISANCE

MIDWAY

MIDWAY SKATING RINK H07

TENNIS COURT

REGENSTEIN LIBRARY D03

MAX PALEVSKY COMMONS (CENTRAL) C33

BARTLETT COMMONS C04

LASR B01
HIGH ENERGY PHYSICS B02
ACCELERATOR B03
ASTRONOMY AND ASTROPHYSICS B04
LOW TEMP LAB B05
RESEARCH INSTITUTES B07
BIOPSYCHOLOGY RESEARCH BUILDING B08
BSDLC B52
NRB B98

CENTER FOR INTERGRATIVE SCIENCE A86
KERSTEN PHYSICS A07
CRERAR LIBRARY A06
MINDS GEOPHYSICS A08
KOVLER CVRL A11
CUMMINGS LIFE SCIENCES CENTER A62
INGLESIDE HALL A12
BOOKSTORE A13

STAFF PARKING GARAGE
R. McDONALD HOUSE
DUCHOSSIS CENTER FOR ADVANCED MEDICINE A75
COMER CHILDRENS HOSPITAL A87
PEDS ED
AMERICAN SCHOOL A64

PARKING STRUCTURE
MITCHELL HOSPITAL A71
WYLER CHILDRENS HOSPITAL A17
ICU A10
PECK PAVILION A18
MRI A72
ABBOTT MEMORIAL HALL A15
SURGERY BRAIN RESEARCH PAVILION A14
BILLINGS HOSPITAL A23
AMOUR HOSPITAL A16
McLEAN MEMORIAL INSTITUTE A19
GILMAN SMITH HOSPITAL A25
GOLDBLATT PAVILION A26
GOLDBLATT HOSPITAL A20
BOB ROBERTS HOSPITAL A24
CHICAGO LYING-IN HOSPITAL A27
HICKS MEMORIAL HOSPITAL A21

HITCHCOCK HALL D07
ANATOMY D09
ZOOLOGY D05
MITCHELL TOWER
HUTCHINSON HALL D04
SNELL HALL D08
CULVER HALL D10
ERMAN BIOLOGY CENTER D11
MANDEL HALL D12
SEARLE CHEMISTRY LAB
KENT HALL D15
RYERSON LAB D13
ECKHART HALL D16
JONES HALL D19
ADMIN D20
COBB HALL D21
SWIFT HALL D23
ROSENWALD HALL D24
WALKER MUSEUM D25
KENT HALL D53
KLAPP HALL D44
BOND CHAPEL D22
INGRELL HALL D39
BEECHER HALL D32
GREEN HALL D33
GATES HALL D43
STUART HALL D37
KELL HALL D34
GOODSPEED D42
CLASSICS D41
WIEBOLT HALL D40
HARPER MEMORIAL LIBRARY D38
SOCIAL SCIENCE RESEARCH D36
FOSTER HALL D35

Today's topics

- The donation framework

- Opportunities for donation

- Steps in the organ donation process

- Uses for donated tissue

- Steps in the tissue donation process

- Measuring success

- Overcoming donation challenges

- Available resources

About Gift of Hope

We are the federally designated not-for-profit organ procurement organization (OPO) that coordinates organ and tissue donation in the northern three-quarters of Illinois and northwest Indiana.

Our mission: to save and enhance the lives of as many people as possible through organ and tissue donation
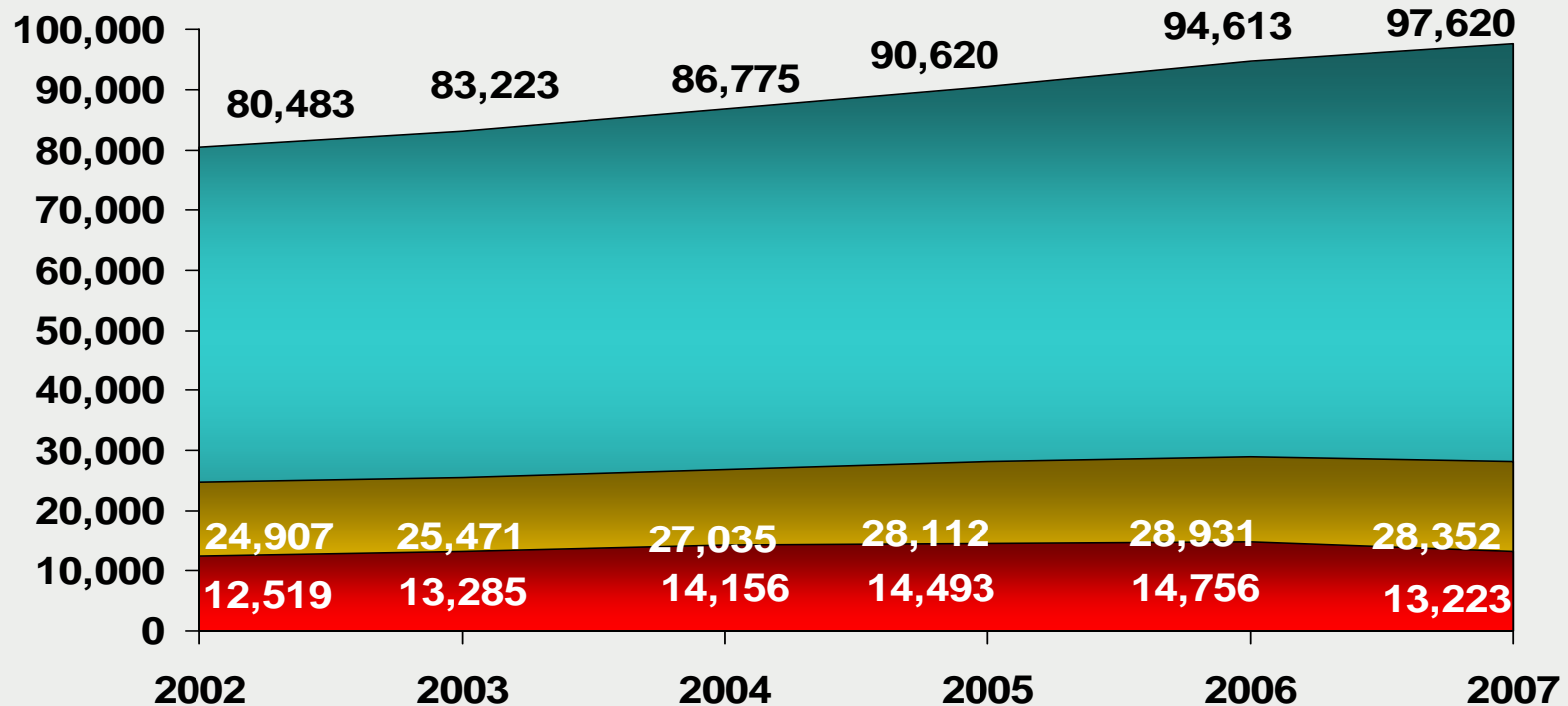
Regulatory support for donation

- Federal government requires all hospitals receiving Medicare funds to call their local OPO on every death and every imminent death to ensure that the family of every potential donor is offered the opportunity to donate

    – Hospitals must call Gift of Hope to report deaths/imminent deaths

- Gift of Hope is covered by an exemption from standard HIPAA parameters

    – Hospitals are allowed to disclose protected health information to Gift of Hope for the purpose of facilitating organ, eye or tissue donation/transplantation

- As of Jan. 1, 2006, an individual can register his/her legally binding decision to become an organ and tissue donor after death— additional witnesses, signatures or family consent are not required

    – Hospitals work with Gift of Hope and patient's family to make sure patient's wishes are honored

When is donation an opportunity?

Tissue donation

- Any patient who dies anywhere in the hospital can be a tissue donor:

  – If there is a known time and cause of death

Organ donation

- Any ventilated patient in a critical care setting can be an organ donor (can also be a tissue donor):

  – If there is a declaration of brain death

     or

  – If there is a decision to withdraw life-sustaining therapies, with the expectation that death will occur

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Organ & Tissue Donor Network

DONATE
LIFE SM

Why donated organs are needed
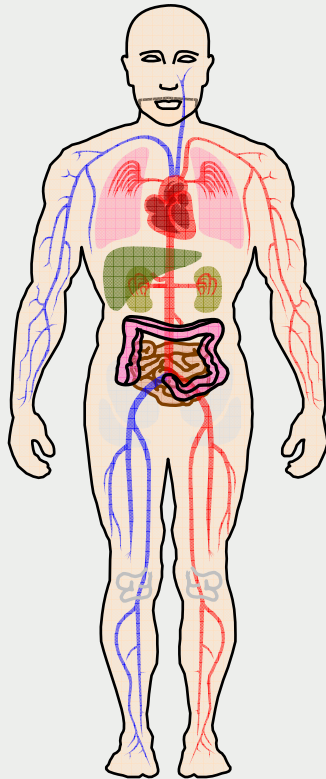
Heart: heart disease—congenital, coronary, hypertensive cardiomyopathy

Lungs: COPD, emphysema, cystic fibrosis

Liver: chronic hepatitis, liver tumors, cirrhosis

Pancreas: type 1 diabetes

Kidneys: hypertension, diabetes, polycystic kidney disease

Intestine: short bowel syndrome

Steps in the organ donation process

Maintaining donation opportunity → Referral and evaluation → Dispatch to hospital → Family discussion, consent → Donor management and organ placement → Organ recovery

How it all starts

Continue treatment

- Maintain hemodynamic stability to ensure donation remains an option

Make the referral

- When your **ventilated** patient exhibits any loss of neurological function, *or* prior to discussions with the family about change of code status to DNR or discontinuation of life-sustaining therapies, call Gift of Hope at **800/545-GIFT (4438)**

- Have patient's chart available and be prepared to provide lab results, vitals, etc.

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DONATE LIFE

Plan of care and donation consent

Dispatch to hospital

Participate in patient care conference

- Key hospital staff and Gift of Hope coordinators meet to discuss plan of care when organ donation is a viable end-of-life option

Family discussion, consent

Ensure effective request

- Gift of Hope and hospital professionals collaborate to identify the most effective approach for discussing donation with the family

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DONATE LIFE℠

Recovery and case completion

Assist Gift of Hope with donor care

- Work with Gift of Hope to evaluate organ viability/function and optimize organ function

Provide a collaborative environment

- Organ recovery takes place in donor hospital OR
- Surgical teams from accepting transplant centers arrive and complete organ recovery

How donated tissues are used
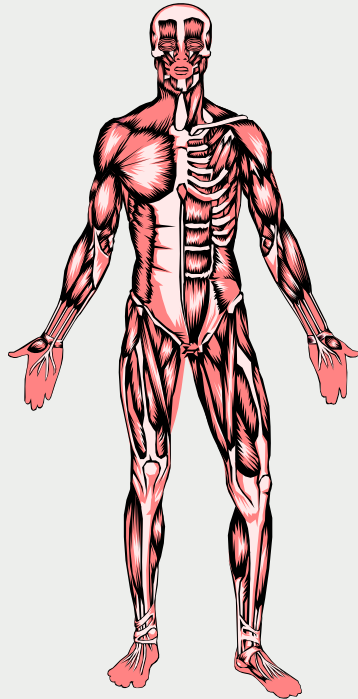
Cornea/eye: restores sight for patients with corneal damage or disease

Heart valve: replaces heart valve for patients with heart defects, infection or damage

Bone: saves limbs or replaces joints for patients with bone cancer, bone fractures or degenerative diseases

Soft tissue: repairs or restructures injured tendons and ligaments

Vein: replaces femoral or saphenous veins for patients with vascular disease or diseased/blocked arteries—limb-saving measure

Skin: grafts skin for patients with severe burns or surgical wounds—lifesaving measure

Steps in the tissue donation process

Referral and evaluation → Maintaining donation opportunity → Family discussion, consent → Tissue recovery

Patient referral and ocular care

Referral and evaluation

Make the referral

- For your **non-ventilated** patients as soon as possible after a death occurs, and prior to release of the body to a funeral home, call Gift of Hope at **800/545-GIFT (4438)**
- If patient is deemed medically eligible, give Gift of Hope tissue donation brochure to family and obtain phone number where family can be reached

Maintaining donation opportunity

Administer ocular care

- **T**ape eyes shut, **L**ift head (elevate), apply **C**old compress (TLC)

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DONATE LIFE℠

Recovery and case completion

Family discussion, consent

Tissue recovery

Await further direction

- Gift of Hope Donor Resource Center requester contacts next-of-kin via phone to discuss tissue donation

- Gift of Hope contacts hospital staff to provide update and inform how to proceed

Provide collaborative environment

- Recovery surgery can take place in donor hospital OR, Gift of Hope OR, or ME facility

- Gift of Hope staff recover tissue and coordinate transport with coroner/medical examiner (if applicable) and funeral home

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DONATE LIFE℠

How do we measure success?

Timely referral rate:
Number of potential donors referred in
time to maintain donation opportunity

Organ donation rate:
Number of eligible patients that
became organ donors

Outcomes/Performance
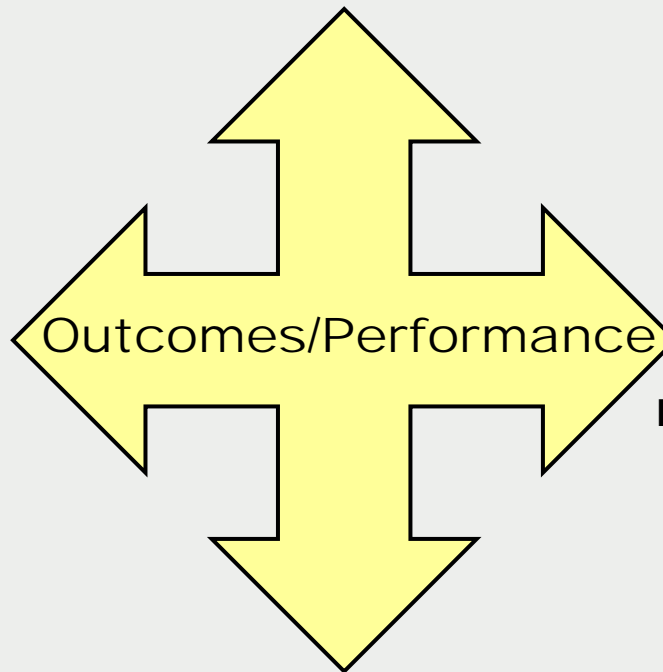
**Organs transplanted
per donor:**
Number of organs recovered for
transplant from each donor

Number of tissue donors:
Number of eligible patients that
became tissue donors

University of Chicago Medical Center Performance Outcomes

- Timely referral rate objective: **100%**
  - 2007: **97%**

- Organ donation rate objective: **75%**
  - 2007: **16%**

- Organs transplanted per donor objective: **3.75**
  - 2007: **3.00**

- Tissue donation
  - 2007: **13 donors**

Overcoming donation challenges

- Lack of identification and/or referral of potential donors

- Late referrals

- Myths and misconceptions

- Caregiver's negative attitudes, actions and beliefs

- Inappropriate physical surroundings
  (where donation conversation takes place)

- Poor communication among organ procurement
  organization, donor hospital and transplant hospital

Available resources

- Your Gift of Hope hospital liaison

  - Contact for in-services, questions, suggestions

- Education and publications

  - Attend in-services, workshops and conferences

  - Consult Gift of Hope Donor Reference Binder, newsletters, fact sheets, Web site (www.giftofhope.org)

- Your hospital

  - Get involved in your donation team—or start one!

Lifesaving partners

On behalf of all donor families and recipients, thank you for your partnership in donation.

CARE OF THE PATIENT AFTER DEATH

Policy: PC 108
Issue Date: June 1971
Revised Date: November 2008
Review Date: May 2008

<u>POLICY:</u>

This policy addresses the steps that should be followed in the event of patient **death** at the University of Chicago Medical Center. This policy applies to all patients that expire: adults, children, and infants with the exception of fetal deaths (still-births). All deaths must be reported to the Gift of Hope within two hours of a patients' **death**, or as soon as possible if **death** is imminent. (1-800-545-4438).

<u>PROCEDURE:</u>

A. Physician Duties in caring for the patient after **death**

1. A physician must pronounce a patient "dead".

2. Physician notifies relative in person or by telephone and documents this in the patient chart. The chart must be completed, including final notes by all appropriate health care practitioners. The physician will confirm whether an autopsy is required per the Medical Examiner's Criteria and/or whether the family requests an autopsy.

   3. Physicians and nurses are responsible for completing the Death-Pak forms. Do not hold Death-Pak forms on unit for signatures. Admitting office will be responsible for their completion and for obtaining signatures if not completed on unit. Death-Pak forms include: If an autopsy is requested, complete the "Authorization for Autopsy and Certificate of Removal" form. An examination of any live-born fetal demise of any gestational age or a stillborn over 20 weeks gestation requires an autopsy permit.

   4.
   a. Consent for Release of Deceased - form #36.04
   b. Authorization for Autopsy and Certificate of Removal - form #36.03
   c. Documentation of Patient **Death** - form #18.26. This includes the Gift of Hope Notification of All Deaths, - see Policy
   A03-02/PC 21 "Organ and Tissue Donation"; Risk Management Notification of Restraint and Seclusion Usage, **Death** in
   the Operating Rooms and **Death** within 24 hours of Admission; and

Disposition of the Patient.
d. State of Illinois Medical Certificate of **Death**, completed by physician in admitting office.

5. Physicians should not authorize the removal of any apparatus or precautions that were in place at the time of **death** in the following cases:
a. Cases in which an autopsy may be required or consented to by a family member.

    i. Cases warranting review by the Medical Examiner. Such cases include: Trauma deaths, violent deaths, Emergency Room deaths, deaths less than 24 hours after admission, deaths less than 12 hours after surgery, and patients not attended by a physician within 6 months. The following steps should be taken when caring for deceased patients warranting Medical Examiner review:

        1) If the **death** is related to a trauma, the Medical Examiner may dispatch personnel to pick up the body from the Emergency Department. Otherwise, the body should be left as is and transported to the morgue with ALL personal effects. (See Inpatient Valuables, Administrative Policy, 05-06).

    ii. All catheters, central lines, chest and abdominal tubes, endotracheal (ETT), nasotracheal (NT), and nasogastric (NG) tubes, tracheostomy tubes, and other prostheses should be left in place. In special circumstances, the ETT, NT, and NG tubes may be removed, but only after approval by the patient's attending physician.
    iii. Precautions should be taken to be certain that apparatus are not dislodged during preparations or transport.

B. Medical Center Staff Responsibilities in Caring for Deceased Patients
1. All deaths must be reported to the Gift of Hope within 2 hours of the **death** (1-800-545-4438).
2. Risk Management must be notified of deaths that occur while a patient is in restraint or seclusion; deaths within 24 hours after the patient has been removed from restraint or seclusion; and deaths within 1 week after restraint or seclusion was used, where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's **death**.

3. Record pertinent information regarding **death** in the medical record.

4. In the case of deaths following a Dr. Cart:

a. If the patient is an outpatient, visitor, or employee, the patient will be returned to the Mitchell ED for appropriate care.

b. If the patient is an inpatient, and the Dr. Cart occurs in a non-inpatient area, the patient will be returned to the assigned
room/unit for appropriate care.

5. General Care of body (Non-Radioactive Patients)

a. Practice Universal Precautions at all times.

b. The patient's Ident-a-band must be on the wrist.

c. Close patient's eyes.

d. Whenever possible, the patient's body should be prepared following the patient/family's cultural, spiritual and religious
customs.

e. Remove drains, catheters, tracheostomy tube, endotracheal tube and chest tubes unless otherwise instructed.

f. Cleanse body as necessary.

g. Place absorbent pads under buttocks and apply diaper loosely, if necessary, to contain fluids. Fold arms across chest.

h. Place clean bed sheet over body.

6. For care of a body isolated for Radiation (Classes I, II, III, IV) and care of body with radioactive materials, notify Radiation Protection Service, or Radiology Oncologist to remove implant. (See Care of Patients Receiving Radioactive Therapy, Patient Care Policy 126)

  a. If radioactive materials are present, indicate on the tag "contaminated materials."

7. Two (2) identification tags in Shroud-Pak must be completed.

a. All bodies are labeled using Universal Precautions.

b. Identify the presence of communicable disease on the tag.

c. If a communicable disease is present, indicate on the tag "Infection Hazard". If status is unknown, this should be indicated on tag.

d. One tag is attached to great toe, and a second tag is attached to the outside of shroud.

8. Care of Personal Possessions:

a. Release all belongings of patient to his/her family/legal guardian and obtain signature.

b. If family is not present when patient expires, nursing staff are to label belongings and attempt to contact family to retrieve
belongings.

i. Valuables - If no one is available to claim the deceased patients valuables,

contact UCMC Public Safety to collect

the items. If someone claims the valuables, the valuables remain on the nursing unit for 90 days. If the valuables are not claimed in 90 days, contact UCMC public safety to collect the items. (see Inpatient Valuables, Administrative Policy 05-06)

ii. Non-Valuables - After 7 days, nursing staff may send the deceased belongings to any Medical Center Security

Desk Security to be handled in accordance with the Lost and Found Policy (Administrative Policy 06-09).

c. For cases involving the Medical Examiner, the body should be left as is and transported to the morgue with ALL personal

effects. See Administrative policy, 05-06, Inpatient Valuables.

9. Discharge of the deceased

a. Nurses will complete "Documentation of Patient **Death**" form 18.26. Physicians and family members complete

"Authorization for Autopsy" form 36.03. Family members complete "Consent for Release of Deceased" form 36.04.

b. A discharge should be processed when the body leaves unit to make the bed available.

c. If the computer system is down, notify the following departments of the **death**:

i. Admitting Office -- 2-6233

ii. Blood Bank -- 2-6827

iii. Chaplain Office -- 2-6246 Beeper #7008 on-call 24 hours

iv. Food Services -- 2-1503

v. Environmental Services - 2-6296

vi. Pharmacy - 5-0091, 5-0093 UCCH Satellite

d. Take patient's chart (current and old) and Death-Pak forms to Mitchell Admitting office immediately after body is

transported to morgue. Note: Do not take medical record to morgue or leave any records on the cart for signature. Admitting Office will be responsible for their completion.

C. Transportation of the Deceased to the Morgue, Morgue Visitation and Funeral Arrangements

1. The morgue is open from 8:00A.M. - 5:00P.M., Monday through Friday and from 9:00A.M. to 2:00 P.M. on Saturday. At other times, the key is obtained from the Security Office, M-046.

2. The patient should be transported to the morgue as soon as possible after the family has viewed him/her.

a. The patient may remain on the unit for up to six (6) hours.

b. In a situation when the family is not present at the time the patient expires and is delayed in coming, the patient should be transferred to the morgue and the family will be allowed to view the patient in the morgue.
i. Chaplaincy, security and the HOA will facilitate morgue visitation.
ii. Nursing staff or nursing assistants from the patient's unit may be called upon to assist with preparing the body for viewing.

3. When using a cart to transport the patient, use the specially designed 'body transportation cart' should be used, except for bariatric or pediatric patients.
Note: Regular patient stretcher should not be used.
4. Call Transportation Service to bring the 'body transportation cart' to the nursing unit. Upon arriving on the nursing unit, Transportation Service will:
a. Take the body to morgue on a 'body transportation cart',
b. Transfer body to a morgue refrigerator cart, face up, and place in the refrigerated section of morgue.
c. A body is never to be left in anteroom.
d. If assistance is needed, Security may be called. In case the refrigerator is full, notify the HOA.
e. Transportation Service logs the names of all expired patients transported to and placed in the morgue. The logbook is
located in the morgue anteroom. Date, unit, time, patient's name and transporter's name for every patient brought into the morgue, regardless of age are recorded.

5. When transporting a body to the morgue, if possible, avoid using elevators in the main corridors.

6. Disposition of the deceased
a. Chaplaincy and/or social work are available to assist with funeral arrangements and the Consent for Release of Deceased.
b. In special circumstances (family requests, religious practice, suspicious deaths, etc.) a patient can be picked up by the
Funeral Home, Medical Examiner's office or other agency directly from the unit without going to the morgue as long as:
i. The body is removed from the unit within 6 hours,
ii. It is not an autopsy case, and
iii. This arrangement does not interfere with hospital patient flow/inpatient's activity/patient safety or privacy.
c. If body is being picked up by the Funeral Home directly from the unit:
i. The deceased nurse notifies Admitting of this plan and brings chart to Admitting immediately.
ii. Admitting communicates with the Funeral Home and notifies security to

open 58th and Ellis entrance.
iii. Funeral Homes remove bodies through the 58th and Ellis entrance.

Reference:
1. Smith, S, Duell, D., and Martin, B. (2008). *Clinical Nursing Skills Basic to Advanced Skills,* 7th edition, Pearson Prentice Hall.

CROSS-REFERENCES:
1. Dr. Cart (CPR), Patient Care Policy 44
2. Care of Patients Receiving Radioactive Therapy, Patient Care Policy 126
3. Inpatient Valuables, Administrative Policy 05-06
4. Organ and Tissue Donation, Administrative Policy 03-02/Patient Care Policy 21
5. Lost and Found Policy, Administrative Policy 06-09
6. Use of Restraints and Seclusion Patient Care Policy 27

Interpretation, Implementation and Revision
Nursing and Infection Control are responsible for the revision and interpretation of this policy. The nursing staff is responsible for the implementation of this policy.

_____
Jamie O'Malley, RN, MS
Chief Nursing Officer

_____
Harvey Golomb, MD
Chief Medical Officer

_____
David Hefner
President

_____
J. Richard Thistlethwaite, MD

Medical Staff Policy:

PC 108
Issue Date: June 1971
Revised Date: November 2008
Review Date: May 2008

Steps to Calling the Rapid Response Team for Adults

1. Assess your patient.

2. Provide appropriate interventions.

3. **Contact primary service.**

4. If you need immediate response, follow algorithm for decision-making.

5. For RRT, call 1-4-7 and ask operator to text page RRT and the Primary Service. Remember to give patient's room number and a call-back number.

Potential Triggers for RRT Activation

Respiratory
- Change in respiratory rate or SOB
- Decreasing O2 saturation

Cardiac
- Hypotension or uncontrolled HTN
- Change in heart rate or rhythm
- Chest pain

Neurological
- Change in mental status
- Agitation or anxiety
- Seizure activity

Fluid Balance
- Volume overload
- Decreased urine output
- Uncontrolled bleeding

General
- Fever or hypothermia
- Uncontrolled pain

Concern without clear trigger
- Nurse worried
- Patient or family worried

Patient Status Changes

RN Assesses Patient

Needs Assistance?

NO → **Continue Plan of Care**
- Contact service as needed
- Reassess patient as needed

YES → **Needs Basic Life Support ?**

YES → **Call Dr. CART**

NO ↓

YES ↓

Triggers Present and Need Immediate Response?

NO → **RN Contacts Primary Service**

YES ↓

Response Sufficient?

YES →

NO → **RN Activates RRT and Contacts Primary Service**

RRT Responsibilities
- Patient assessment
- Provide support for requesting RN
- Communication with primary service
- Communication with hospitalist, as needed
- Treatment initiation or support, as needed
- Transferring patient to higher level of care, if needed
- After patient is stabilized or transferred:
        - Completion of RRT documentation
        - Debrief call with RN and others

Points to Remember

- **Notify primary team you are calling the RRT**
- **Have RRT SBAR completed before the team arrives**
- **Dial 1-4-7 tell the operator you are calling for the Rapid Response Team**
- **Give your patient's location (Unit and Room)**
- **STAY IN YOUR PATIENTS ROOM WITH THE RRT**
- **Introduce yourself**
- **COMMUNICATE WITH SBAR**
- **Complete RRT documentation with ICU PCM**

RAPID RESPONSE TEAM
SBAR
_____

<u>SITUATION:</u>
Patient Name:_____**MRN:**_____**Room #**_____

Code status:_____**Age:**_____

I am concerned about: (Be specific.)

_____
<u>BACKGROUND:</u>
Admitting Dx:_____

Pertinent PMHX:_____

_____

Pertinent Meds:_____

Procedures/transfers within the last 24 hours:_____

Vital signs: BP_____/_____**, Pulse**_____**, Respiration**_____**, Temp**_____**, O2 Sat**_____

Supp O2:_____**Mental Status :** **A & O** <u>x</u>_____**Skin:**_____

Resp: Breath Sounds_____**Effort:**_____

Other:

_____
<u>ASSESSMENT:</u>
I think the problem is:

_____
<u>RECOMMENDATION:</u>
I think we should:

TRIGGERS for Calling A Pediatric Response

STAFF WORRIED	"The Patient Just Doesn't Look Right"
AIRWAY	If You Suspect the Airway is Unstable or At Risk
WORK of BREATHING	Breathing Becomes Labored

VITALS (Guidelines only)	Sudden Change in any ONE of the following:		
	Respiratory Rate	Heart Rate	Systolic Blood Pressure
NEONATE	<20, >75	<80, >200	<50
INFANT	<20, >70	<80, >200	<60
TODDLER	<16, >60	<65, >180	<65
PRE-SCHOOL	>50	<50, >160	<70
SCHOOL-AGE	>45	<40, >150	<75
ADOLESCENT	>40	<40, >140	<85

OXYGENATION	Pulse Oximeter Drops Below 90% DESPITE Increasing Supplemental Oxygen (Unless otherwise specified by a Physician)
LOC / Mental Status	Patient becomes somnolent, DIFFICULT TO AROUSE, AGITATED, or any sudden Decrease in Level of Consciousness
URINARY OUTPUT	Sudden Change in Urinary Output (Excessive or Inadequate)
UNCONTROLLABLE PAIN	Patient's PAIN remains UNCONTROLLED despite administration of pain medications

Don't Make the Mistake of Treating by the Numbers!

If you are concerned,
CALL the PET team by dialing 1-4-7 & asking for the
Pediatric Emergency Team.
Have someone contact the patient's primary service.

Stay with your patient!

University of Chicago Hospitals Pediatric Emergency Team (PET) Algorithm for Activating the PET

A change in patient's clinical status is identified by patient, family or staff

RN assesses patient for **Trigger Signs** of physiologic instability

Are Trigger Signs present ?

NO → **RN** notifies primary service as needed & **reassesses patient PRN**

YES

Text page sent to patient's primary service notifying of PET call

RN/Staff Activates PET calling 1-4-7

PET Actions
- PET RN/RT will assess patient status and communicate with PET MD
- Immediate treatment initiated if needed
- PET team communicates with primary team
- PET physician is decision maker if primary team not available

Does patient require transfer to higher level of care ?

NO → **PET** completes call documentation form & places original in medical record → **PET** debriefs call with floor RN, primary service, and others as needed

YES

PET transfers patient & reports to admitting service

Trouble-shooting Pediatric Triggers

AIRWAY	• Is the patient positioned appropriately? • Is the patient's tracheostomy patent? Does the tracheostomy patient have chest rise with bagging? • Can you auscultate airflow?
WORK of BREATHING	• Is there good air exchange bilaterally with respirations? • Is the patient's airway patent? • Is the patient experiencing increased work of breathing?
RESPIRATORY RATE	• Count patient's RR while auscultating for one minute to assure true rate. DO NOT rely on the monitor. • Is the patient experiencing pain? Febrile?
HEART RATE	• Is the patient febrile? • Is the patient experiencing pain? • What is the patient's blood pressure? • Is the patient experiencing respiratory distress? • How is the patient's hydration Status?
SYSTOLIC BLOOD PRESSURE	• Is the patient experiencing pain? • Does the blood pressure cuff fit appropriately? • Is the patient moving while the pressure is being read? • How is the patient's hydration Status?
OXYGENATION	• Is the oxygen source turned on and connected? • Are you using the correct pulse-ox sensor for the location and age of patient? • Is the pulse-ox sensor secured and placed appropriately? • Does the pulse-ox have a good waveform? Is it picking up the heart rate? • Is pulse-ox sensor on a cold extremity?
LOC / Mental Status	• Is the patient sleeping vs. non-responsive? • What is the patient's glucose level? • Is patient experiencing a seizure?
URINARY OUTPUT	• Is urinary catheter properly placed? • Is urinary catheter patent? • Is diaper or bedding wet? • Has patient taken PO or been receiving IV fluids at all? • Has patient received a diuretic recently?
UNCONTROLLABLE PAIN	• If meds are IV, is patient's IV patent? • Is patient absorbing PO? Is the abdomen distended? • Did the patient have emesis after receiving PO pain meds? • Is PCA time interval adequate? Has the patient been hitting the button?

Do not waste time troubleshooting if you feel you
have a clinical emergency.
CALL the PET team by dialing 1-4-7 & asking for
the Pediatric Emergency Team.
Have someone contact the patient's primary service.

Stay with your patient!

OB Alert – Rapid Response

Adopted into practice: April 17, 2006
Reviewed-updated (Jan 2009-in revision)

Purpose: To provide a mechanism for quick assessment and medical interventions in order to prevent or minimize serious morbidity and mortality in the obstetric patient population.

Definition: The OB Alert system is a procedure by which any health care professional involved with a patients care, may initiate a rapid response and consultation from the medical critical care team (MICU). The OB alert system should not be used for decompression of the obstetric unit or to expedite bed access.

A. Procedure for Calling an OB Alert:
1. **Patient Evaluation:** The patient's current clinical presentation should be thoroughly re-evaluated prior to calling an OB alert. This should include but is not limited to the following parameters:
   a. Vital signs (BP, pulse, temp, O2sat, resp) and trends
   b. Fluid balance (inputs/outputs over the past: 1hr/ 4hrs/ 8hrs/ shift)
   c. Medications
   d. Pain perception
   e. Physical exam
   f. Hospital course
   g. Medical history
   h. Laboratory tests and imaging, as indicated

2. **Review of Current Management:** A review of the current assessment and plan of care should be undertaken after the above patient evaluation. If appropriate, changes in the current management of the patient should be made. The patient's response to these changes should be closely monitored.

3. **Calling the "OB ALERT":** If after items 1&2 above have been accomplished the patients condition still warrants immediate critical care intervention then page the MICU resident at pager #6428 (#MICU) or MICU fellow at pager #7465 (#SHOK).
   a. The charge nurse for the MICU can be reached at extension 5-5738.
   b. The tower manager can be reached at _7320.
   c. Calling the OB alert will prompt an immediate bedside consult from the MICU team.
   d. If indicated, the MICU team will accept the patient to their service and she will be expeditiously transferred to the ICU.
   e. If questions arise about the continuing care of this patient the MCIU Attending physician should be called along with the L&D Attending OB, OB Anesthesia Attending, AOC, and Nursing Director for that unit the patient is currently located on.

B. Clinical Professionals Responsibilities When Calling an OB Alert:

1. **Attending Obstetrician:** If the L&D Attending physician at any time feels a patient is critically ill and needs immediate critical care intervention they may call an "OB Alert".

2. **Resident Physician:** If the resident physician feels a patient is critically ill they will, in consultation with their senior resident, do the following in order:
   a. Accomplish items one and two in procedure for calling an OB Alert
   b. Contact the L&D Attending obstetrician to help in the evaluation and management of the patient. If indicated the L&D Attending OB may call an OB alert at this time.
   c. The in-house OB Anesthesiology / critical care attending will be consulted, pager 3578
   d. If the resident physician feels the patient's condition still warrants an OB Alert then they should accomplish item A.3. above.

3. **Nursing:** If the nurse caring for a patient feels the patient is critically ill then she will accomplish the following in order:

   a. Item A.1. Review these findings with the residents caring for the patient. Together they will then determine if changes in management are needed.

   b. If the staff nurse still feels the patient needs additional care she will call the floor charge nurse and together they will reassess and reevaluate the patient according to items A.1. and A.2 above. If the charge nurse agrees that this patient is critically ill she will call the L&D Attending obstetrician to the bed side and they will discuss the case. If indicated the L&D Attending may call an OB alert at this time.

   c. The in-house OB anesthesiology / critical care attending will be consulted, pager 3578. At this point the on call nurse manager should also be called.

   d. If the charge nurse feels the patient's condition still warrants an OB Alert then they should accomplish item A.3. above.

C. Conflicting Opinions: If after the above items have been accomplished there are still conflicting opinions as to the management of any patient then the three Attending physicians (L&D Attending, Anesthesia, MICU) and the Director of Nursing for that unit will discuss the case and the most appropriate plan of care will be implemented. The AOC should also be informed of this discussion.

Debriefing: There are two types of debriefings that will take place: An informal debriefing and a formal debriefing.

1. <u>An informal debriefing</u> will take place as soon as possible following the OB Alert with the team members. The teams members will consist of the Medical Director, WCC directors, CNS, and staff that were immediately involved with the event.

2. <u>The formal debriefing</u> of any OB alert is a learning process with the major goal of better understanding of the clinical pathophysiology of the particular patient and a secondary goal of improving patient outcomes. The formal review of any OB alerts will consist of the following:

3. All OB alerts will be reviewed by the Medical Director of Labor and Delivery and the Medical Director of 3 North.
    4. All OB alerts that required anesthesia consultation will be formally reviewed
    5. All OB alerts that are initiated via items B.2.d / B.3.d will be formally reviewed.
    6. All OB alerts falling into item C. will be formally reviewed.

    7. Within 5 normal business days the case will be reviewed.
        a. This review will be chaired by Medical Director for the responsible unit.
        b. All clinical professionals involved with this OB alert will be required to attend these reviews. (i.e.: nurse, charge nurse, CNS, Attending OB, resident OB, Attending OB anesthesiologist, MICU residents and Attending & Nursing Director)
        c. Also invited to the reviews will be patient safety, risk management, Section Chief of MFM, Chief OB anesthesia, Medical Directors for both 3North and L&D, Department Chairman of OB/GYN, CNS, Chief Nursing Officer, Nursing Director.
        d. The person calling the OB alert will be asked to formally present the patient and their rational for calling the OB alert. This presentation will at a minimum include all of the information contained in items A1 and A2, along with a review of the patients post OB Alert care and clinical course.
        e. Clinical professionals involved in the care of this patient will be then asked to present and discuss the care of the patient.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
Personnel Policy Guidelines

Dress and Personal Appearance

Policy

It is important for all employees to project a professional image of the University of Chicago Medical Center (UCMC). To ensure that we consistently project this image to patients, visitors, and guests, UCMC maintains a dress code policy that applies to all personnel. Those employees who are required to wear scrubs or uniforms should also refer to the appropriate policy. Departmental policy may supersede as appropriate/reasonable for employees whose jobs do not require regular contact with patients, visitors, and guests.

Comments

At all times when employees are on UCMC premises, they are expected to wear an employee photo-identification badge, identifying themselves as employees to the public and to other UCMC personnel. As representatives of UCMC, employees are at all times expected to present a clean, neat, and professional appearance - i.e., this includes times when entering and exiting UCMC premises as well as during working time. Employees are expected to dress and groom themselves according to their position requirements and in accordance with appropriate professional standards.   In jobs that involve personal interactions with customers, patients, or visitors, a higher level of professionalism may be required as relevant to projecting an appropriate and positive image of UCMC.

Supervisors or department heads are responsible for establishing a reasonable dress code appropriate to the job their employees perform within the framework of this policy. If a supervisor determines that an employee's personal appearance is unacceptable, that employee may be asked to leave the workplace until properly dressed or groomed. If the supervisor is not aligned with the employee's department, that supervisor will notify the management of the employee's department immediately. Under such circumstances, the employee will not be compensated for his or her time away from work. Employees should consult their supervisor if they have questions as to what constitutes appropriate dress and appearance. Upon request and as appropriate, a reasonable accommodation may be made to a person with a disability.

All employees are expected to accept and follow, as a condition of employment, the standards in this policy. This is not an all-inclusive list and management reserves the right to determine appropriateness based upon relevant circumstances.

1. **General Expectations:**

   - Identification badges must be worn on the upper torso in a visible position with picture side out at all times while on UCMC premises. (See Personnel Policy Guidelines, HR Section 603.)

   - Uniform requirements: All employees will follow this policy unless the department or care center specifies that a uniform should be worn. When the department or care center requires uniforms, employees will be expected to wear the complete uniform while on duty. Uniforms supplied by the department must be worn during working hours. Uniforms should fit properly, be complete, clean, and neat. Employees are responsible for the maintenance of their uniforms unless otherwise provided under an applicable collective bargaining agreement. Sweaters may be worn either under or over the uniform when needed for warmth. For specifics on scrubs, see Administrative Policy 06-12.

   - Patient gowns and/or isolation gowns may only be worn while directly involved in the care of isolation patients, in rendering infant care, while in contact with body secretions, or as required by the IDPH regulations to cover scrub uniforms.

   - Casual attire that may be appropriate for warm weather in a non-professional setting shall not be worn under any circumstances while on UCMC premises. This includes but is not limited to the following: tank tops, "muscle shirts," tube tops, halter-tops, mid-drifts, crop-tops, beachwear, inappropriately low-cut blouses or sundresses, no shorts, no inappropriately short skirts or dresses.

   - All dress must comply with Regulatory requirements (IDPH, OSHA, etc) and with UCMC Safety and Infection Control Policies.

   - All dress must comply with UCMC Safety Policies where applicable.

   - All dress must be devoid of advertisements and slogans except for inconspicuous brand name logos.

2. **Fingernails**

All fingernails should be clean and well groomed and of a length that does not pose potential injury to patients or self or that will hinder the employee's ability to perform his or her assigned job duties.

Special infection control and safety requirements for fingernails[1] apply to following groups of employees:

- Employees who have direct contact with patients. These are employees who, as part of their job duties, may touch patients, patient supplies and/or patient care equipment; including but not limited to the following: patient transporters, environmental service workers, physicians, registered nurses, licensed practical nurses, nurse practitioners, nursing assistants, medical assistants, physician assistants, patient care managers, case managers, patient service coordinators, patient service assistants, nursing unit secretaries, and inventory specialists.

- Employees who handle sterile items used for invasive procedures.

- Employees who are directly involved in the sterilization of surgical instruments.

- Employees who are directly involved in the preparation or delivery of food.

   The above employees must comply with the following requirements for fingernails:

   ➢ All fingernails must be clean.

   ➢ Fingernails may not be longer than ¼ (one quarter) of an inch long.

   ➢ Artificial fingernails may not be worn. This includes anything affixed to the nail other than plain nail polish, including but not limited to gel or acrylic overlays and silk wraps.

   ➢ Nail polish must not be chipped.

3. Footwear Requirements

For personnel working in non-clinical areas, the following standards apply:

- Canvas or athletic type shoes are allowed; however, they must be clean and well kept with the laces tied.

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[1] Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, 2002. Note: Compliance required by Joint Commission as part of the 2006 and 2007 National Patient Safety Goals.

- Employees are expected to demonstrate appropriate judgment regarding socks, stockings or hosiery to project an image of business professionalism (e.g., no tight-fitting "fishnet" stockings).

- Open-toe and/or backless shoes projecting business professionalism may be worn during warm weather.

- All footwear is subject to the standard of what is appropriate and professional for an employee's assigned job responsibilities.

For all personnel working in clinical areas where exposure to blood of bodily fluids may occur, the following footwear requirements are in place[2]:

- Shoes that protect the foot from exposure to blood or body fluids or that are covered with a fluid resistant covering are required for all personnel working in clinical areas where exposure to blood or body fluids could occur.

- Open toe shoes (e.g., sandals), shoes with open backs, and shoes with holes (e.g., "Croc"-type) may not be worn in patient care areas. To comply with OSHA requirements, fluid resistant shoe coverings must be worn in clinical areas and must be removed prior to leaving the location where exposure to blood or body fluids could occur (e.g., patient room, procedure room, operating room, etc.) Additional footwear restrictions may be established as appropriate for respective patient care areas and operating rooms.

- Clinical personnel (e.g., nursing staff, medical/nursing assistants, and others) must wear hosiery (either white or flesh tone) or socks under the uniform.

4. Hygiene/Grooming/Fragrance /Jewelry

- Consideration of co-workers, patients, and guests is expected and all employees are to maintain appropriate cleanliness and hygiene habits at all times in the workplace.

- Perfume, cologne and after-shave should not be used in any clinical setting in consideration of patients that may have allergies or sensitivities. In a non-clinical setting, the use of scented personal products should be moderate or avoided altogether. A non-clinical department may exercise the discretion to prohibit the use of scented personal products out of consideration for employee allergies or sensitivities.

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[2] Reference for Closed or covered shoes: OSHA Question and Answers
http://www.osha.gov/pls/edata/owae_data.osha_feedback?p_id=270871 : August 24, 2006

- Hair is expected to be clean and neat. Hair should be worn in styles and colors that are appropriate for a professional business environment. Long hairstyles should be worn with hair pulled back off the face and neck to avoid interfering with job performance.

- Mustaches and beards must be clean, well-trimmed, and neat, as appropriate for a professional business environment.

- Jewelry should not be functionally restrictive, dangerous to job performance, or excessive. Facial jewelry, (e.g., eyebrow rings, nose rings, lip rings, and tongue studs), is not professionally appropriate and may not be worn during business hours.

5. "Business Casual Dress" will be permitted on Fridays, except during the specified periods when casual days will be suspended. Business casual is defined as follows:

- **Casual Shirts**
  - ➢ *Appropriate*:   All shirts with collars, including casual shirts, blouses, golf and polo shirts. (T-shirts only appropriate if pre-approved for specific events.)
  - ➢ *Inappropriate*: T-shirts, shirts with inappropriate slogans, tank tops, "muscle" shirts, and "crop tops."

- **Casual Pants**
  - ➢ *Appropriate*: Casual slacks and trousers without holes, frays, etc.
  - ➢ *Inappropriate*: Shorts, denim of any kind

- **Casual Footwear**
  - ➢ *Appropriate*: Casual business shoe that is reflective of standards appropriate for a professional business casual environment
  - ➢ *Inappropriate*: Casual sandals, "flip-flops," and other styles inappropriate for a professional business casual environment

6. Religious Accommodations: Employees may engage in appropriate religious expression in the workplace as permitted by law. Religious expression in the workplace may take the forms of certain types of dress or head covering, wearing of jewelry, discussion of religion, or the display of religious items in an employee's immediate work area. If religious items are displayed in an employee's immediate work area, such items should be placed in inconspicuous places to avoid potential offense to others who may not share the same religious beliefs. Situations shall be addressed and evaluated on a case-by-case basis as necessary.

7. **Enforcement**: UCMC management is responsible for support and implementation of this Dress and Personal Appearance Policy by:

- Personal example;

- Incorporating this policy into departmental policy;

- Reviewing and enforcing this and any department or care center policy with applicants and employees;

- Taking immediate corrective action if department or care center personnel report to work in violation of this policy;

- Progressing the corrective action process as appropriate to ensure compliance.

Interpretation, Implementation, and Revision: The Chief Human Resources Officer is responsible for the interpretation and revision of this policy. All UCMC employees are responsible for compliance with this policy.

Issued: January 1987, Dress and Personal Appearance

Revised: September, 1993, February, 1996, June, 1998, September 2001, August, 2002, April 2003, October 2004; May 2006, July 2006; January 2007; May 2007, June, 2007

Reviewed: June 1998, August 2002, October 2004, October 2005
EFFECTIVE DATE: April 2003, July 2006

_____

Darlene Lewis
Vice President and Chief Human Resources Officer, UCMCHS

Refer to Policy 00-04 Administrative Policy and Human Resources Section 201 Equal Employment Opportunity /Affirmative Action

The University of Chicago Hospitals
Policy and Procedure Manual

DOCUMENTATION OF PATIENT CARE

Policy: PC 128
Issued: February 1991
Revised: January 2009
Review Date: December 2008

PURPOSE
To review and identify documentation requirements for nursing, ancillary, students and other health care support personnel.

DEFINITIONS
Interdisciplinary Health Care Team Members: staff working in nursing, therapy services, speech therapy, nutrition services, social work, care coordination, chaplain services, respiratory therapy, pharmacy, other health care support personnel and students

POLICY
All electronic and paper patient care documentation will be maintained as a permanent part of the patient's record. The electronic documentation will reflect only those assessment elements that apply to identified problems of the patient (charting by exception). (1)

1. Charting is done using "within defined parameters" in which the clinician assessment and judgment dictates the documentation that is essential. Documentation within the Electronic Medical Record (EMR) is done in flowsheets, notes and other activities such as allergies, history, medication administration, treatment team and others. The choice of flowsheets and activities will depend upon the patient diagnosis and condition.

> 2. Assessment flowsheets are configured by the nurse. The rows that are used to document contain information about the patient's condition which is outside of (normal) defined parameters and reflect the patient's condition. Some rows may not apply to the patient and can be left blank**.** (1)
>
>> Full head to toe patient assessments are conducted by each registered nurse at the point of entry into the Medical Center, at points of transfer of care and at the beginning of each shift. Ongoing assessments are conducted by the registered nurse as patient conditions warrant. The selection "No change to Previous

Assessment" and "Change to Previous Assessment as Noted" may only be used by the same registered nurse who documented the previous abnormality as part of the patient assessment.

3. Each entry in the EMR is electronically signed by the interdisciplinary health care team member entering the data. Documentation will be completed in its entirety on site at the medical center prior to the interdisciplinary health care team member's departure.

4. Interdisciplinary health care team members should document care provided in the discipline specific flowsheet templates and ancillary notes.
5. Other health care support personnel and students (under the supervision of the appropriate licensed personnel) may document on flowsheets and notes in the EMR.

6. Whenever there is a major change in a patient's condition, a note will be written in the medical record to document the change in addition to documenting in the appropriate flowsheet templates.

7. When patients are transferred from one area to another, a report on the patient's condition must be given. The EMR patient summary reports or navigators along with other unit specific tools (SBAR) are used to give report.
8. Relevant patient data and patient care will be recorded as close to real time as possible..

9. An addendum to a patient record may be recorded by inserting a column in the flowsheet or by documenting in the EMR notes activity. The flowsheet column will specify the time of the event as well as the time that the event was recorded.
10. If an error is made in documentation, the correct data can be recorded over the old data by the same clinician. Other clinicians should not replace previous documentation but can add a column with correct/different data and include a comment about the differences. All of the information will be available to view in the patient's record including the original data (date, time, and clinician) and the changes (date, time, and clinician).
11. When charting on paper, it is illegal to erase, use white-out or to use any other method of eradication. If an error is made, draw a single line through statement, followed by date, time and initials. The original entry must remain legible. (1)

12. If information is dictated into a patient record, the transcriber and the

dictator must record their full name, title and the date/time dictation is recorded.
13. For documentation under the wrong account or encounter on an admitted patient, please contact the help desk at 2-3456.

GUIDELINES
A. PATIENT ADMISSION AND NEEDS ASSESSMENT
> 1. The patient's height, weight and dosing weight must be documented within 1 hour of arrival to the in-patient unit. The patient's allergies must be documented and/or reviewed within 1 hour of arrival to the inpatient unit.
>
> 2. The appropriate Patient Needs Assessment template will be completed by the RN within 24 hours of the patient's admission. This needs assessment will be initiated at the point of entry of the patient as an INPATIENT into the Medical Center's system. Demographic information and vital signs may be delegated to the Nursing Support Assistant/Mental Health Counselor/Nurse Extern but must be validated by the RN.
>
> 3. This assessment will include:

- physical assessment, as appropriate
- psychological assessment, as appropriate and:
1. All Patients are assessed for the risk for suicide upon admission to the hospital.
2. If patient is found to be at risk for suicide the caregiver must immediately place the patient on Suicide Precautions and a referral is immediately made to Social Work or Psychiatry (as determined by the Clinician/Physician).
- social assessment, as appropriate
- each patient's nutrition and hydration status, as appropriate
- each patient's functional status, as appropriate
- prior to admission medications
- for patients receiving end-of-life care, the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the patient, family members or significant others
- educational needs
- discharge planning
- input from the patient, family, and/or significant others

4. Quality compliance documentation will include:
- Vaccine screening and education
- Smoking cessation screening and education
    5. Referrals should be made to interdisciplinary team members or communicated to the physician via telephone or page as appropriate.
    6. Discharge Planning is initiated on admission based on findings of the needs assessment. The Care Coordinator or Social Worker in collaboration with the RN and interdisciplinary team reviews and facilitates discharge plans as needed.

B. NOTES
C. Other health care support personnel and students (under the supervision of the appropriate licensed personnel) Documentation in the EMR follows a "focus" concept: Data, Action, and Response. Data are documented in flowsheets; and actions and patient responses are documented in EMR "Notes". EMR "Notes" are problem–focused and reflect: progress toward the defined patient outcome, an exception to the expected outcome, a new patient condition, an acute change in patient condition, or a significant event in the patient's care.
1. Daily patient care and assessment of changes in the patient's condition are documented on flowsheets in EMR (Data).
2. Nurses notes must be documented at least every 24 hours and reflect the problem/s identified in the IPOC in a summary format (Problem, Action, Response).

D. INTERDISCIPLINARY PLAN OF CARE (IPOC)
1. The IPOC is documented on UCMC approved printed forms.
    2. Inpatients require an individualized, documented interdisciplinary plan of care.
    Patients temporarily located the Emergency Room or outpatient diagnostic or
    surgical procedures areas do not require Interdisciplinary Plans of Care.

    3. The Interdisciplinary Plan of Care should include the following:
- Identified patient problems
- ?Realistic and achievable expected outcomes and patient goals
- ?Interdisciplinary interventions

    4. Problems identified by the RN during the admission process will be documented on the IPOC. Only the problems applicable to the patient need to be identified and documented on the IPOC.

5. A review and update of the patient's plan of care and patient problems identified on the IPOC must be completed and documented every shift. RNs, interdisciplinary team members, and students (under the supervision of the appropriate licensed personnel) must document patient problems on the Interdisciplinary Plan of Care.

6. Patient problems must be dated and initialed when identified and when goals or outcomes are met.

7. Standardized nursing care plans/standards of practice/protocols may be used to supplement the Interdisciplinary Plan of Care.

E. PATIENT EDUCATION
1. Patient education is documented on UCMC approved printed forms.
2. Educational needs will be assessed on admission for the patient and significant others. The nurse will document his/her assessment of the learner, the barriers to learning and readiness to learn, the interventions, response to interventions and the outcomes on the Interdisciplinary Plan of Care, teaching protocol, patient education record, notes, or on the discharge form.

F. TRANSFER AND DISCHARGE
1. Refer to policies on patient transfer (PC 116, PC113, PC 10) and discharge (N1405A, WC 3.010, WC 9.07)

References:
1. Smith, S, Duell, D., and Martin, B. Clinical Nursing Skills Basic to Advanced Skills, 7th edition, Pearson Prentice Hall, 2008.
2. Comprehensive Accreditation Manual for Hospitals: The Official Handbook,
3. " Provision of Care, Treatment, and Service" Joint Commission on Accreditation of Health Organizations, January 2008.

INTERPRETATION, IMPLEMENTATION, AND REVISION:
Nursing and Patient Care Services are responsible for the review, revision and implementation of this policy.

_____
David Hefner
President

_____
Jamie O'Malley, RN, MS
Chief Nursing Officer

_____
Harvey Golomb, MD
Chief Medical Officer

_____
J. Richard Thistlethwaite, MD
Medical Staff President

Policy: PC 128
Issued: February 1991
Revised: January 2009
Review Date: December 2008

PATIENT SAFETY DEPARTMENT "PRO-ACTIVES"

CONVERSATIONS WITH PATIENTS AND FAMILIES

DOCUMENT! DOCUMENT! DOCUMENT!

The importance of recording conversations with patients and their families should never be overlooked. You may encounter someone who denies ever discussing a particular topic with you, not out of spite, but because he or she genuinely does not recall doing so.

Failure to record such information can be used to imply the health care professional was uninterested or unreceptive to the patient or family's concerns, or was not listening to new information.

"If it isn't written, it wasn't said"

- **Always chart discussions concerning risks**
 While you can't list every potential danger, you can document your major concerns along with a general inclusive statement.

- **Record patient noncompliance**
 Whether it's signing out AMA, refusing a medicine or diagnostic procedure, or refusing to listen to advice, noncompliance is a frequent cause of patient injury.

- **Omit judgmental statements**
 They often appear self-serving and can make you look unsympathetic towards the patient.

- **Record your telephone conversations with patients**
 If this information is not documented, it may be impossible later to refute allegations by the patient about what was said.

- **Always mention the patient's/family's concerns**
 Documentation is proof that such concerns were heard and taken seriously. Also any new information should be recorded.

- **Record and identify information obtained from other sources**
 If a family member expresses concern because the patient is, e.g., abusing alcohol, record that the family is worried, what was said, and who said it. Similarly, if you obtain information from an old chart, document where you found it.

YOUR BEST LEGAL DEFENSE IS TO DOCUMENT, IN A TIMELY MANNER, YOUR CONVERSATIONS WITH BOTH THE PATIENT AND THEIR FAMILIES.

ROOM G-104   The University of Chicago Hospitals/Patient Safety Department   834-0473

PATIENT SAFETY DEPARTMENT "PRO-ACTIVES"

DOCUMENTATION

DOCUMENTATION "IS" COMMUNICATION

Documentation is the primary communication medium. It is a diary of the patient's hospitalization and is evidence of the treatment provided to the patient.

It communicates:

- To peers and other care providers and aids in the planning of care
- To the Financial Department and Utilization Review Department and justifies the services provided
- To patients, patient's families, or the patient's authorized representative
- To the Legal community for insurance purposes, disability cases, workers' compensation, personal injury cases and malpractice litigation

Presumption in the law: If it was not documented, it was not done.

THE MEDICAL RECORD SHOULD BE A MAP OF THE PATIENT'S HOSPITAL ADMISSION - LIKE A STORY FROM ADMISSION TO DISCHARGE

Documentation should be:

Factual — Document objectively and factually; document what you see, hear, feel, and smell, <u>not</u> what you assume, suppose, infer or conclude

Accurate — Support subjective information with objective observation

Complete — Document the condition of the patient, assessment and/or action, results of treatment provided, and follow-up of condition

Timely — Document in a timely manner; do not wait for the patient to complain to begin appropriate documentation

COMMUNICATION THROUGH DOCUMENTATION IN THE MEDICAL RECORD RESULTS IN APPROPRIATE PATIENT CARE

Competency in Continuous Regulatory Compliance

University of Chicago

Medical Center

Department of Nursing

Professional Development

Final Verification Form 7/07

Module VII
Environment of Care

For more information refer to UCMC Internet

1. "Quality and Safety" tab

   UCMC Joint Commission Resources

   – Egress

   – Oxygen Cylinder Storage

   – Storage

2. Infection Control Policy 02-14b

   "STANDARD (UNIVERSAL) PRECAUTIONS
   INCLUDING HANDLING OF SHARPS"

Objectives: Environment of Care

At the end of the module the learner will:

- 1. Identify egress and potential barriers
- 2. Discuss the care of oxygen cylinders
- 3. Review storage standards
- 4. Describe IV tubing change and documentation and labeling of IV and tubing

Environment of Care

Egress: a place or mean of going out: an exit

- All means of egress (i.e. stairwells, designated corridors with Exit signs) are maintained to provide free and unobstructed egress from all parts of the building.

- Equipment such as:
  - isolation carts, IV poles, patient scales, clinical equipment, unattended EVS carts, supply carts, beds, gurneys, wheelchairs, food carts, etc,

    should not obstruct any egress.

Environment of Care

- The following criteria must be maintained for all means of egress:
  - inpatient units are required to have 8ft corridor clearance
  - Clinics are required to have a width of 44 inches of corridor clearance
- Doors with door closers must not be wedged or obstructed.
- Temporary wedges are allowed to move carts in and out of rooms but must not be left unattended for any amount of time

Safety Office: 5-SAFE

Environment of Care

Oxygen Cylinder Storage

- Gas cylinders must be properly secured and stored in a rack or holder

- Only 2 to 3 tanks are to be kept on the unit at all times unless the unit meets exception criteria

- Oxygen cylinders on gurney's and wheelchairs are considered in use – not in storage

- Cylinders cannot be placed on the floor at any time   Patient Care Policy PC 107

Environment of Care

Storage room

- All items should be stored in the following manner:
  - At least 8 inches from the floor
  - At least 18 inches from the ceiling and ceiling fixtures such as sprinklers
  - At least 2 inches from an outside wall
- A clear space of 18 inches or more below standard pendant sprinkler heads must be maintained
- Boxes cannot be stored on the floor and pillows should never be stored on top of the linen cart

Environment of Care

- Disposable sharp instruments such as needles, scalpels blades, disposable razors, or potential sharps such as used vacutainers or broken glass should be discarded into the sharps disposal containers. These containers should be sealed when filled to the full line or when three-quarters full if there is no "full" line.

- Eating, drinking, smoking, applying cosmetics, lip balm or handling contact lenses is prohibited in areas where exposure to blood or body fluids may occur.

Environment of Care

IV Tubing Change and Documentation

- **Documentation**
  - 1. Peripheral I.V. dressings should be labeled with date and time of insertion, gauge of catheter and inserter's initials
  - 2. The date of insertion, gauge, site of insertion and initials of person inserting I.V. must be documented in the patient progress record, along with an assessment of the site
  - 3. The RN documents the appearance of the insertion site and surrounding area daily

- **Tubing Label**
  - IV tubing should be labeled with the date and time of initiation, date and time of expiration, and the clinician's initials.
  - Do not use day of the week

    (Patient Care Policy PC118)

Final Verification

- It is the policy to perform a final verification to confirm the correct patient, procedure and surgical procedure site prior to any surgery or invasive procedure.

- At a minimum, the surgical procedure site(s) should be marked in all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (disks).

- "Right", "left", "bilateral" and level must be identified on the informed consent form, the operating room (OR) schedule, and the pre-operative checklist.

Final Verification

- Surgical procedure site must be verified with the patient or legal guardian, or in the case of a minor, with the parent or guardian prior to administering pre-operative or pre-procedure sedation.

- If the procedure involves multiple sides/sites during the same operation, each side and site must be marked.

- Patients should participate in the verbal verification of surgical site only and should not mark the operative site.

- The site is to be marked by the person doing the procedure or specified professional personnel.

Final Verification

- "Final Verification" is defined as an active form of communication among the care team members confirming that they have:
    - The correct patient identity
    - The correct side and site
    - Agreement on the procedure to be done
    - The correct patient position
    - Availability of the correct implants and any critical equipment
- "Invasive Procedure" is defined as the surgical entry into tissue, cavities or organs

Final Verification

- "Laterality" is defined as referring to the side of the body as "right", "left", "bilateral" and other potential sites including levels

- As long as the person performing the procedure identifies the patient and confirms all data including the consent, history and physical or radiographs; and is in continuous attendance, he/she may perform the procedure without marking the site.

- A final verification still must occur prior to the start of the procedure.

Patient Care Policy 38

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
5841 S. Maryland Avenue
Chicago, IL 60637

Patient Name: _____

MRN: _____

AFFIX PATIENT IDENTIFICATION LABEL HERE:

Final Verification (*Universal Protocol*) Checklist
INVASIVE PROCEDURE

INVASIVE PROCEDURE LIST
The following procedures require a Final Verification Checklist.

Select a Procedure:

- ☐ Ablation
- ☐ Cardio version
- ☐ Central Venous Line Insertion/PICC
- ☐ Chest Tube Insertion
- ☐ Circumcision
- ☐ Defibrillator Insertions
- ☐ Electrophysiology Study
- ☐ Endoscopy (e.g. bronchoscopy and upper and lower GI)
- ☐ EVD/ICP Monitor Placement
- ☐ Invasive Infertility Procedure
- ☐ Interventional Radiology Procedure

- ☐ Lumbar Puncture
- ☐ Needle Localizations In Mammography
- ☐ Pacemaker Insertion
- ☐ Paracentesis
- ☐ Peg Placement
- ☐ Peritoneal Lavage
- ☐ Therapeutic Nerve Block
- ☐ Thoracentesis
- ☐ Tracheostomy
- ☐ Transesophageal Echo
- ☐ Other: _____

Verification – Pre-Procedure

Confirm Patient Identification and Verify Correct Procedure:

- Identify Correct Patient by confirming Name and Medical Record #
- Patient/ Guardian response matches ID band and relevant documentation (if applicable)
- Verify Consent Form

Final Verification "TIME OUT"

Team Time Out:

- Correct Patient Identity
- Correct Side and Site (if applicable)
- Agreement on Procedure to be Done
- Correct Patient Position (if applicable)
- Availability of Implants and any Critical Equipment (if applicable)

Print Name: _____ **Pager/Ext.:** _____ **Date:** _____ **Time:** _____

- *Any clinician involved in the Time Out may sign the form including MD, RN, Technician, etc.*
- *If any discrepancy is noted during the final verification, the Attending describing the resolution must complete a progress note.*

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
5841 S. Maryland Avenue
Chicago, IL 60637

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☐ Lumbar Puncture
☐ Needle Localizations In Mammography
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☐ Peritoneal Lavage
☐ Therapeutic Nerve Block
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☐ Tracheostomy
☐ Transesophageal Echo
☐ Other: _____

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- *If any discrepancy is noted during the final verification, the Attending describing the resolution must complete a progress note.*

Falls Prevention

Issue Date: January 1998
Revised Date: February 2009
Review Date: February 2009

PURPOSE:
To minimize the risk of **falls** among the patient population.
To increase awareness of risk factors for **falls** among health care providers and patients.
To protect the patient's right to autonomy, dignity, and security.

DEFINITION:
A patient fall is an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient. (1) This includes **falls** as a result from physiological (fainting) or environmental reasons (slippery floor) and assisted **falls** – when a staff member attempts to minimize the impact of the fall.

POLICY:
Inpatient Adults
1. The nurse must assess and document all adult inpatient's risk factors relating to falling, daily, upon admission or transfer and whenever there is a change in the patient's condition.

2. The Morse Fall Scale will be used to assess risk factors in adult patients.

3. Universal Fall Prevention interventions will be initiated for all adult patients and documented every shift.

4. Patients identified at "high risk" for falling will have a **Falls** Prevention Plan of Care initiated, in addition to the Universal Fall Prevention interventions. Fall prevention interventions for high risk patients will be documented every shift.

5. Patients and their families are educated on the patient's risk for **falls** and the **Falls** Prevention Program. (2)

Inpatient Pediatrics
1. The nurse must assess and document risk factors for all pediatric inpatients

greater than 12 months of age, or patients able to pull to a stand, upon admission, every shift, upon transfer and whenever there is a change in patient condition.

2. The General Risk Assessment for Pediatric In-patient **falls** (GRAF-PIF) (4) will be used to assess fall risk factors in pediatric patients.

3. Patients identified at "high risk" for falling will have a **Falls** Prevention Plan of Care initiated. Once a pediatric patient is identified as "high risk" by the GRAF-PIF, he/she will remain at high risk for the remainder of hospitalization. These patients will not need future GRAF-PIF assessment; the nurse will document once per shift the patient's high risk status. Interventions will be documented every shift.

4. Pediatric patients and their families will be educated on the patient's risk for **falls** utilizing the "Children Are at Risk of Falling While Hospitalized" document in the admission packet.

Out-Patients
1. Out-patients age 65 years and over, under the care of and having an appointment with a Physician, Nurse Practitioner and/or Physicians Assistant, should be screened annually for Fall Risk.

2. The University of Chicago Medical Center's "Out-Patient Fall Risk Assessment Tool" is suggested to screen out-patients for fall risk factors.

3. Out-patients identified as "high-risk" for falling, should be provided the UCMC "Out-Patient Fall Prevention Education Guidelines".

4. Physical Therapy consultation and treatment should be considered for out-patients identified as "high risk" for falling as deemed appropriate and feasible by the patients Provider.

Guidelines for Adult Patients (3):
Patient care interventions that may reduce the risk of falling must be examined in the context of the larger goal of maximizing function and minimizing disability.

1. The following interventions (Universal Fall Precautions) should be initiated for all adult patients (as appropriate):

        a. Provide patient and family orientation to environment and routine.

b. Ensure call light is in reach, patient able to use.

c. Answer calls for assistance promptly.

d. Offer frequent toileting and other assistance.

e. Keep bed in lowest position.

f. Lock wheels of bed, wheelchair, etc.

g. Keep all assistive devices (glasses, walker, etc.) available to patients.

h. Provide adequate lighting.

i. Provide non-slip footwear.

j. Arrange furniture and objects so they are not obstacles and remove unnecessary furniture in rooms.

2. Additionally, the following interventions, should be initiated (as indicated and when possible) for adult patients at "high risk":

a. Yellow **Falls** identification bracelet applied

b. Yellow **Falls** stickers placed on patient cart and/or SBAR report sheet

c. Yellow **Falls** magnets in appropriate places as indicated

d. Yellow **Falls** sign placed on patient bulletin board or door

e. Educate patient and family when there is a risk of falling and reinforce as much as possible to call for assistance with ambulating and toileting

f. Encourage family to stay with high-risk or confused patient, where allowed

g. Consider patient's potential for orthostasis

h. Use dim light at night

i. Elimination needs assessed & assistance offered every 2 hours while awake

j. Door to room open, unless isolation or privacy required

k. Communicate to ancillary departments patient is at high risk for **falls**

l. Encourage/assist with short walks frequently to build strength and endurance

m. Request referral to Physical Therapy if patient's gait or balance is impaired

n. Frequently observe patients at high risk for **falls**

o. Review medications that can place the patient at risk for falling, and communicate concerns to physician.

Guidelines for Pediatric Patients

1. The following interventions (Universal Fall Precautions) should be initiated for all pediatric patients (as appropriate) and documented every shift:

    a. Select safest sleeping arrangement for patient. All patients under three years of age are to be placed in a crib with a climber-hood. Should a parent request a full-sized bed, the parent must sign a Patient Safety Release Form (Form 76.05) and be educated regarding risk of injury or **falls** related to bed choice.

    b. Provide patient and family orientation to environment and routine.

    c. Educate families regarding fall risk and fall prevention, and reinforce as much as possible to call for assistance with ambulating and toileting.

    d. Per unit standards and patient condition, offer patient assistance to bathroom every 2-4 hours while awake, and monitor every four hours at night; answer calls for assistance promptly.

    e. Assist with age appropriate ambulation.

    f. Ensure caregiver is able to operate crib or bed.

    g. Keep bed in lowest position.

    h. Lock wheels of beds, wheelchairs, strollers, etc.

    i. Determine safest side rail position (2-4 side rails up based upon diagnosis); ensure side rails are up and climber-hood down, as appropriate.

    j. Do not leave side of bed if side rails are in down position.

    k. Maintain direct supervision of children on elevated surfaces such as infant scales.

    l. Use safety straps on swings, infant seats, wheelchairs and PT devices.

    m. Remove objects that provide young children with climbing access to elevated areas; do not allow child to lay or play on furniture.

    n. Set behavioral activity limits; monitor patient/parents ability to comply and re-emphasize limits as needed.

    o. Ensure patient is able to reach call light, bedside table, telephone, and personal items.

    p. Keep all assistive devices available to patient.

    q. Review medications that can place the patient at risk for falling, and communicate concerns to physician.

    r. Reduce environmental hazards:

        i. Eliminate spills, wet areas, and dragging cords.

        ii. Maintain tubes and monitor wires as not to obstruct patient mobility.

iii. Arrange furniture and objects so they are not obstacles.
iv. Provide and encourage use of non-skid footwear for all patients able to ambulate or cruise.
v. Ensure clothing is appropriate for child's size and not dragging or inhibiting movement.
vi. Provide adequate lighting.

2. In addition to above universal fall risk interventions, the following interventions should be initiated (as indicated and when possible) for pediatric patients at "high risk", and documented every shift:

a. Identify patients as high risk for **falls** (ID band, door sign, sticker).

b. Include Fall Risk as element of nurse to nurse SBAR communication

c. Communicate with ancillary departments that patient is at high risk for **falls**.

d. Use a dim light at night.

e. Assess patient coordination and balance before transfer and mobility activities.

f. Instruct parents to inform RN or MD if the patient seems less coordinated, dizzy or weak.

g. Instruct parents to walk alongside of child to provide support and protection.

h. Reinforce activity limitations as appropriate.

i. Elimination needs assessed and assistance offered every two hours while awake.

j. Remain in bathroom with patient as warranted by physical activities.

k. Request referral for physical therapy if patient's gait or balance is impaired; provide assistive devices to steady gait.

l. Monitor medications for side effects that may add to the patient's risk of falling.

m. Educate patient and caregivers regarding high risk for **falls** and review fall prevention strategies.

Attachments:

1. Morse **Falls** Risk Assessment

2. General Risk Assessment for Pediatric In-patient **falls** (GRAF-PIF)

3. UCMC Outpatient Fall Risk Assessment Tool

4. Outpatient Fall Prevention and Precaution Information for patients and families

Interpretation, Implementation, and Revision:

The Department of Patient Safety/Risk Management and Department of Nursing are responsible for the interpretation, implementation and revision of this policy.

References:
1 National Quality Forum (2008).

(2) The Joint Commission's National Patient Safety Goals. (2008). *Comprehensive accreditation manual for hospitals: The official handbook.* National Patient Safety Goal 9B

(3) Lyons, S. S. & Titler, M.G. (2004). Evidence-based protocol Fall Prevention for Older Adults. The University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core.

(4) General Risk Assessment for Pediatric Inpatient **Falls** Scale (2005). Retrieved November 10, 2008 from http://www.mnhospitals.org/inc/data/tools/Safe-from-Falls-Toolkit/General Risk Assessment for Pediatric.doc

Additional Sources:
Skyol, A.D., (2007) **Falls** in the elderly: what can be done? *International Nursing Review 54,191-196.*

Stevens, J., (2005) Science Direct- Journal of Safety Research. *Falls among older adults- risk factors and prevention strategies.*

UCMC intranet, *The 14 Forces of Magnetism Chapter 6*

Ward, A.,Candela, L., Mahoney, J.,(2006) National association for health quality *JHQ 143 - Developing a Unit-Specific Falls Reduction Program*

www.health.vic.gov.au/qualitycouncil/pub/improve/**falls**.htm ((2006)The Victorian Quality Council Minimizing the risk of **falls** and **falls** injuries: *Guidelines for acute, sub acute and residential care settings*

MayoClinic.com

2008 Physician Quality Reporting Initiative (PQRI)
Coding for Quality – A Handbook for PQRI Implementation

_____

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Issue Date: January 1998
Revised Date: February 2009
Review Date: February 2009

morse falls risk assessment.bmp   GRAF PIF.doc   Out patient Fall Prevention and Precaution finalspanish.doc

Out Patient referral final.doc

GENERAL RISK ASSESSMENT FOR PEDIATIC IN-PATIENT FALLS
GRAF-PIF SCORE WORKSHEET (5 Day Version)
© 2005 Children's Memorial Hospital

1. LOS _____

Score one point for each 5 days of expected length of stay
1 to 4 days, score is 0
5 to 9 days, score is 1
10 to 14 days, score is 2
15 to 19 days, score is 3, etc.

2. NO IV/Heparin Lock. _____

If patient does not have an IV/Heparin Lock, then score one point

3. PT/OT _____

If patient has recently received or is expected or currently receiving PT/OT services either as inpatient or outpatient, then score one point.

4. Antiepileptic Medication _____

If patient is prescribed on an antiepileptic medication, regardless of reason, then score one point.

5. Ortho/Muscular/Skeletal Diagnosis _____

If patient has an acute or chronic Orthopaedic diagnosis, then score one
point. (Patient does not need to be on the orthopaedic service) Diagnoses include: skeletal, ligaments, tendons and muscle alterations.

Add up all the points. This is the GRAF-PIF score. _____

If the score is 1 or less, implement general injury prevention strategy for hospitalized children.
If the score is 2 or greater, implement high risk fall prevention strategy.
If the child has past history of falling either at home or during previous hospitalization, implement high risk fall prevention strategy regardless of current GRAF-PIF score.

Out Patient Fall Prevention and Precaution Information for Patients and Families

Who is at a higher risk for falling?
Studies have shown that the odds of falling increase each year after the age of 65. Other leading causes of falls include: surgery, added stress from illness, physical changes and multiple medications.

Five Ways to reduce your risk for falling

1) Tell the nurse or doctor:
➢ If you have fallen and injured yourself in the last 12 months
➢ Provide a complete list of pills you take at home
➢ If you feel weak, dizzy or unsteady on your feet
➢ Ask for help and ask more often. (Request a wheelchair)

2) Keep Moving (*improve your strength*)
➢ Ask about exercise programs
➢ Start Regular exercise (walking, water workouts, tai chi)

3) Wear sensible shoes
➢ Wear and buy sturdy rubber-soled, flat, nonskid, shoes or slippers
➢ Avoid high heels, floppy slippers and extra thick soles

4) Remove Hazards from home
➢ Keep your home brightly lit (use night lights and lamps)
➢ Move and or remove coffee tables, magazine racks, plant stands, boxes, newspapers, phone cords, from high traffic areas and walkways
➢ Secure or remove loose rugs, repair loose wooden floor boards
➢ Clean spilled liquids, grease and food at once.

5) Use assistive devices
➢ Use canes, walkers and crutches given to you
➢ Wear your eyeglasses

Anyone can fall, even patients that appear healthy and strong.
Help Us Help You Stay Safe

Reference:
Fall prevention: 6 ways to reduce your falling risk (2008) Retrieved from mayoclinic.com/health/fall-prevention/HQ00657 on October, 2008.

Pacientes Externos-Prevención para evitar caídas e Información para la Familia sobre medidas de Precaución

¿Quien tiene mayor riesgo de caerse?

Los estudios han demostrado que las probabilidades de caerse se incrementan cada año después de los 65 años de edad. Otras causa principales de caídas son: cirugía, tensión nerviosa por la enfermedad, cambios físicos y múltiples medicinas.

Cinco Maneras para Reducir el Riesgo de Caídas

1) Dígale a la enfermera o doctor:
  ➢ Si se ha caído y lastimado en los últimos 12 meses
  ➢ Provea una lista completa de las pastillas que usted toma en la casa.
  ➢ Si usted se siente débil, mareado o inestable al estar de pie.
  ➢ Solicite ayuda y haga preguntas más seguido. (Pida una silla de ruedas)

2) Manténgase en movimiento (mejora su fortaleza)
  ➢ Pregunte acerca de programas de ejercicios.
  ➢ Empiece con Ejercicio Regular (caminar, ejercicios en el agua, tai chi)

3) Use zapatos cómodos
  ➢ Use y compre zapatos o zapatillas de suela de hule firme, bajos, anti-resbalantes
  ➢ Evite zapatos de tacón alto, pantuflas, y zapatos de suelas muy gruesas.

4) Retire de la casa obstáculos peligrosos
  ➢ Mantenga su casa iluminada (use lámparas y luces tenues para la noche)
  ➢ Mueva y/o retire de los pasillos o de las áreas mas utilizadas las mesas de centro, porta revistas, maceteros, cajas, periódicos y cables de teléfono.
  ➢ Asegure o quite los tapetes sueltos, repare las tablas flojas del piso de madera.
  ➢ Limpie inmediatamente los líquidos derramados, grasa o comida.

5) Use aparatos de asistencia
  ➢ Use bastones, andaderas o muletas que se le hayan dado.
  ➢ Use sus anteojos.

Cualquiera puede caerse, aún los pacientes que se ven saludables y fuertes

Ayúdenos para Ayudarlo a Mantenerse Seguro

Reference:
Fall prevention: 6 ways to reduce your falling risk (2008) Retrieved from mayoclinic.com/health/fall-prevention/HQ00657 on October, 2008.

University Of Chicago Medical Center

Out Patient Fall Risk Assessment

Step 1:
If 65yrs or over ask the following questions:
☐ Y ☐ N Do you have a fear of falling?
☐ Y ☐ N Have you had 2 or more falls in the past year?
☐ Y ☐ N Have you had any fall with injury in the past year?

If answered yes to any of the above questions patient is "High Risk" please complete step 2.

Step 2:
☐ Y ☐ N Would the patient like to be referred for an evaluation of fall risk?
If no, why? _____
☐ **Patient is already being evaluated by Physical Therapy**

For all referrals please complete Step 3a and 3b then sign

Step 3a /Diagnosis:
☐ **Weakness- 780.79** /evaluate and treat for Fall Risk
☐ **Gait disturbance/abnormality- 781.2** /evaluate and treat for Fall Risk
☐ Other _____/evaluate and treat for Fall Risk

Step 3b/ Referral
Patient is being referred to Physical Therapy for evaluation and treatment
☐ Physical Evaluation / Therapy
☐ Home Evaluation/ Home Physical Therapy (Refer to Social Work)
☐ Other

_____
Physician signature   MD Print Name   Office phone

Referring service: _____
Fax order to the Physical Therapy Department Ext: 25340

Appointment Date: _____ Time: _____
Other:_____
 Location: University of Chicago Physical Therapy Department

Place this referral in the patients chart.

University Of Chicago Medical Center

THE UNIVERSITY OF CHICAGO HOSPITALS
PATIENT SAFETY REPORT
PROFESSIONAL PEER REVIEW

This material is for use in the course of internal quality control or medical study for the purpose of reducing morbidity and mortality, and improving patient care and is privileged, strictly confidential and shall be used only for medical research or the evaluation and improvement of quality care.

Please call Patient Safety/Risk Management at 702-1057 to report a serious occurrence.

PATIENT INFORMATION

Date of Admission/Appointment: _____/_____/20____   Date of Occurrence _____/_____/20____   DOB: _____/_____/_____   Sex: F____ M____

Attending Physician: _____   Unit #_____   Room No.: _____

Admitting Diagnosis: _____

Patient Condition Before Incident: _____Confused   _____Disoriented   _____Restrained   _____Sedated
_____

Time of Occurrence   Day_____   Evening _____   Night _____

Location of Occurrence: Unit/Dept _____   Specific Area/Room Number _____

Brief, Factual Description of Occurrence/Potential Occurrence:_____

_____

_____

_____

_____

_____

Injury: ☐ Yes ☐ No.   If yes, please describe injury: _____

Additional Treatment/Test Required: _____

MD Contacted / Name: _____   Patient / Family aware of occurrence: ☐ Yes   ☐ No

Personnel With Information Concerning Occurrence:

_____   _____

_____   _____

Name of Person Completing Form (**please print**): _____   Date: _____

Title: _____   Phone/Pager: _____

TO BE COMPLETED BY THE PHYSICIAN

Physician Comments / Treatment: _____

_____

_____

_____

Name of Physician Completing Form (**please print**): _____

Date: _____   Phone/Pager: _____

DO NOT WRITE BELOW THIS LINE. PATIENT SAFETY COMMITTEE USE ONLY.

Submit to Patient Safety/Risk Management within 72 hours
- **DO NOT DUPLICATE THIS FORM**
- **DO NOT PLACE THIS FORM IN THE MEDICAL RECORD**

_____

_____

_____

_____

Adult Inpatient Falls Prevention

University of Chicago
Medical Center (UCMC)
Center for Nursing Professional Practice and Research 2009

What is a fall?

- "A patient fall is an unplanned decent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient..."

(National Database of Nursing Quality Indicators [NDNQI])

Falls

- Falls may occur due to physiological reasons (fainting) or environmental reasons (slippery floor).

- A fall may be an assisted fall. An assisted fall occurs when a staff member attempts to minimize the impact of the fall.

(National Database of Nursing Quality Indicators [NDNQI])

Fall Prevention

- Keeping patients safe requires a plan
- A fall prevention process provides a safe plan of care
- Great quality of care always keeps patient safety a very high priority
- Reducing the risk of harm resulting from falls is a National Patient Safety Goal

Factors Influencing Acute Care Falls

- Advanced age, specifically if older than 75
- History of recent fall
- Specific co-morbidities: dementia, hip fracture, type II diabetes, Parkinson's disease, arthritis, and depression
- Functional disability: use of assistive device
- Alteration in level of consciousness or cognitive impairment
- Gait, balance, or visual impairment
- Use of high risk medications
- Substance Abuse

National Guideline Clearinghouse. (2008). *Preventing falls in acute care.* Retrieved December 1, 2008, from http://www.guideline.gov/summary

Factors Influencing Acute Care Falls (cont.)

- Urge urinary incontinence

- Physical restraint use

National Guideline Clearinghouse. (2008). *Preventing falls in acute care.* Retrieved December 1, 2008, from http://www.guideline.gov/summary

Morse Fall Risk Assessment Tool

- **Morse Fall Risk Assessment Tool is completed on every adult admission and daily.**

- The patient is reassessed upon transfer to another unit, or upon change in patient condition.

Falls Risk Assessment

- Risk assessment is performed on admission and transfer, daily, and upon change in patient condition.

- The UCMC uses the Morse Fall Risk assessment tool to assess fall risk.

- The tool assigns a number for each risk factor category and categories are added for a total score.

MORSE FALLS RISK ASSESSMENT

- Please assign a score for each of the indicators below.
- This is to be done every day, on every patient. In addition to the following:
  when patient initially admitted to hospital; whenever a patient is transferred
  between nursing units; and anytime the patient experiences a change in condition.

Risk factors	Indicator	DATE & TIME	
		Score	Score
History of Falls	No	0	
	Yes	25	
Secondary Diagnosis	No	0	
	Yes	15	
Ambulatory Aid	• None/Bedrest/Nurse Assistance	0	
	• Crutches/Cane/Walker	15	
	• Furniture	30	
Intravenous Therapy/Heplock	No	0	
	Yes	20	
Gait	• Normal/Bedrest/Wheechair	0	
	• Weak	10	
	• Impaired	20	
Mental Status	• Oriented to own ability	0	
	• Overestimates/Forgets Limitations	15	
Final Risk Score			

Falls Prevention

- Patients with scores less than 55 are placed on "Universal Fall Prevention"

"Universal Fall Prevention" Includes

- Orientate the patient and family to the environment (inpatient or outpatient area)
- Call light in reach (inpatient)
- Offer frequent toileting (inpatient)
- Instruct the patient how to obtain assistance and where the bathroom is located (outpatient)
- Keep bed or exam table in the lowest possible position

Universal Fall Prevention cont.

- Lock wheels of bed and/or wheelchair
- Keep all assistive devices available to the patient (walker, crutches, glasses etc.)
- Provide adequate lighting
- Provide non-slip footwear
- Arrange furniture and objects so they are not obstacles
- Remove unnecessary furniture in rooms

Universal Fall Prevention cont.

- Intravenous (IV) poles are sturdy if used during ambulation and tubing does not cause tripping
- Patient gowns/clothing do not cause tripping
- Assess floor surfaces for spills, wet areas, and unevenness.

National Guideline Clearinghouse. (2008). *Preventing falls in acute care.* Retrieved December 1, 2008, from http://www.guideline.gov/summary

"Falls Intervention (High Risk)"

- If the patient has a total score of greater than 55, or if the nurse's assessment indicates a high risk of falls regardless of Morse risk score the "Falls Intervention (High Risk)" plan of care is implemented.

Yellow ID bracelet, falls prevention sticker on chart, sign on activity board, and/or door

High Risk Falls Interventions Include

- Communicate to ancillary departments patient is at high risk for falls

- Door to patient room should be kept open, unless isolation or privacy required

- Reinforce safety instructions & to call for assistance

- Patient & family education about risk factors

High Risk Falls Interventions (cont.)

- Monitor for medication effects (dizziness, orthostatic hypotension) and communicate concerns to physician

- Identify risks for significant injury due to use of anticoagulants such as Coumadin, Plavix, or aspirin and or those with osteoporosis or risks for osteoporosis

National Guideline Clearinghouse. (2008). *Preventing falls in acute care.* Retrieved December 1, 2008, from http://www.guideline.gov/summary

High Risk Fall Interventions (cont.)

- Encourage/assist with short walks frequently

- Request physical therapy evaluation if indicated
- Encourage family to stay
- Use of dim night light
- Elimination needs assessed
- Frequent observations

The next group of slides are computer snapshots of electronic clinical documentation and examples of the appropriate Morse Risk Assessment Tool. All adult patients must have either the "Universal Fall Prevention" or "Fall Intervention (High Risk)" plan of care in place.

Home | **Coonhound, Victor** [X] Epic

Coonhound, Victor

Acct #
74000274

183 cm
95.3 kg

Allergies(9/17/08)
WOOL ALCOHOLS

MDRO
(None)

Isolation
(None)

Flag
(None

Patient Summary
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Flowsheet: Assess

Assess	☑
Patient Bands	☑
Neuro Assessment	☑
Cardiovascular Assessment	☑
Respiratory Assessment	☑
-----Lung Field Assessments	☑
Musculoskeletal Assessment	☑
Morse Fall Risk Score	☑
Abdominal Assessment	☑
Urinary	☑
Skin Assessment	☑
Braden Scale	☑
Pressure Ulcer Prevention/Int...	☑

Additional Info for Morse Fall Risk Score... [X]

History of Falling

Value Range for Row

Back   Next   Clear

0=No

25=Yes

Back   Next   Clear

Row Description

Has the patient fallen during the previous 3 months?

Last Filed Value

aily Care   ▣ I-O   ▣ WALDO   ▣ Needs Assess   ▣ IV MAR

	ent 9/7/08,	
	12/04/08	
	1700	

Morse Fall Risk Score

History of Falling		☐ 🔍
Secondary Diagnosis		
Ambulatory Aid		
IV Device		
Gait/Transferring		
Mental Status		
Morse Fall Risk Score		
▣ Choose Fall Interventions		

Abdominal Assessment

▣ Abdominal (WDP)		

Urinary

▣ Urinary (WDP)		

Skin Assessment

▣ Integumentary (WDP)		
Skin Color		
Skin Temperature		

Braden Scale

| Sensory Percentions | | |

Value	Comment	Time Taken	Time Recd	User Taken	User Recd	Show Audit

File

Patient Station Patient Lists

Print ▾ Log

Home   Coonhound, Victor ✕   Epic

Coonhound, Victor   Acct # | 183 cm   Allergies(9/17/08)   MDRO   Isolation   Flag
4002882   740002740 | 95.3 kg   **WOOL ALCOHOLS**   (None)   (None)   (None

Left panel	Doc Flowsheet		
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Additional Info for Morse Fall Risk Score... ✕

| **History of Falling** |
| **Value Range for Row** |
| **Back** **Next** **Clear** |
| 0=No |
| 25=Yes |
| **Back** **Next** **Clear** |
| **Row Description** |
| Has the patient fallen during the previous 3 months? |
| **Last Filed Value** |

Flowsheet: Assess

		Daily Care I-O WALDO Needs Assess IV MAR

Assess	☑
Patient Bands	☑
Neuro Assessment	☑
Cardiovascular Assessment	☑
Respiratory Assessment	☑
-----Lung Field Assessments	☑
Musculoskeletal Assessment	☑
Morse Fall Risk Score	☑
Abdominal Assessment	☑
Urinary	☑
Skin Assessment	
Braden Scale	☑
Pressure Ulcer Prevention/Int...	☑

ent 9/7/08,
12/04/08
1700

Morse Fall Risk Score

History of Falling		📄🔍
Secondary Diagnosis		
Ambulatory Aid		
IV Device		
Gait/Transferring		
Mental Status		
Morse Fall Risk Score		
Choose Fall Interventions		
Abdominal (WDP)	**Abdominal Assessment**
Urinary (WDP)	**Urinary**
Integumentary (WDP)	**Skin Assessment**
Skin Color	
Skin Temperature	
	Braden Scale
Sensory Perceptions	

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Value	Comment	Time Taken	Time Recd	User Taken	User Recd	Show Audit	File

Cascading groups/rows for Coonhound, Victor

The following groups/rows are suggested for:

Choose Fall Interventions

Row Info:

Choose Low Risk Fall if score less than 55. Choose High Fall Risk if score equal to or greater than 55.

Choose groups/rows to add to the flowsheet

- Suggested groups
  - ——Universal Fall Prevention
  - ——Fall Interventions (High Risk)

Groups/Rows you have chosen to add

➡ Add

⬅ Remove

[Accept] [Cancel]

Cascading groups/rows for Coonhound, Victor

The following groups/rows are suggested for:

Choose Fall Interventions

Row Info:

Choose Low Risk Fall if score less than 55. Choose High Fall Risk if score equal to or greater than 55.

Choose groups/rows to add to the flowsheet

- Suggested groups
  - ——Universal Fall Prevention
    - Orientation to Environment
    - Call Bell
    - Frequent Toileting
    - Bed in Low Position
    - Wheels Locked
    - Assistive Devices
    - Lighting
    - Non-Slip Footwear
    - Remove Obstacles
  - ——Fall Interventions (High Risk)

Groups/Rows you have chosen to add

- ——Universal Fall Prevention
  - Orientation to Environment
  - Call Bell
  - Frequent Toileting
  - Bed in Low Position
  - Wheels Locked
  - Assistive Devices
  - Lighting
  - Non-Slip Footwear
  - Remove Obstacles

➡ Add

⬅ Remove

Accept   Cancel

Cascading groups/rows for Coonhound, Victor

The following groups/rows are suggested for:

Choose Fall Interventions

Row Info:

Choose Low Risk Fall if score less than 55. Choose High Fall Risk if score equal to or greater than 55.

Choose groups/rows to add to the flowsheet

- ⊟ Suggested groups
  - ⊟ ——Universal Fall Prevention
    - Orientation to Environment
    - Call Bell
    - Frequent Toileting
    - Bed in Low Position
    - Wheels Locked
    - Assistive Devices
    - Lighting
    - Non-Slip Footwear
    - Remove Obstacles
  - ⊞ ——Fall Interventions (High Risk)

➡ **Add**

⬅ Remove

Groups/Rows you have chosen to add

- ⊟ ——Universal Fall Prevention
  - Orientation to Environment
  - Call Bell
  - Frequent Toileting
  - Bed in Low Position
  - Wheels Locked
  - Assistive Devices
  - Lighting
  - Non-Slip Footwear
  - Remove Obstacles

Accept   Cancel

Cascading groups/rows for Coonhound, Victor

The following groups/rows are suggested for:

Choose Fall Interventions

Row Info:

Choose Low Risk Fall if score less than 55. Choose High Fall Risk if score equal to or greater than 55.

Choose groups/rows to add to the flowsheet	Groups/Rows you have chosen to add
Suggested groups	——Fall Interventions (High Risk)
⊞ ——Universal Fall Prevention	Yellow Falls Identification Band
⊟ ——Fall Interventions (High Risk)	Yellow Falls Sticker
Yellow Falls Identification Band	Yellow Falls Magnets
Yellow Falls Sticker	Yellow Falls Sign
Yellow Falls Magnets	Educate Patient and Family
Yellow Falls Sign	Encourage Family to Stay
Educate Patient and Family	Potential for Orthostasis
Encourage Family to Stay	Dim Night Light
Potential for Orthostasis	Elimination Needs Assessed
Dim Night Light	Door Open
Elimination Needs Assessed	Communicate
Door Open	Short, Frequent Walks
Communicate	PT Referral
Short, Frequent Walks	Frequent Observation
PT Referral	Review Medications
Frequent Observation	
Review Medications	

→ Add

← Remove

Accept   Cancel

What do you do if a patient falls?

- Perform a physical assessment of the patient at the time of the fall, including vital signs, neurological assessment, and evaluation of head, neck spine, and/or extremity injuries.

- Report any injuries to the physician

- Fill out an "Patient Safety Report" or call the "Patient Safety Hotline" 2-5544

FORM 10.01-601-1A

THE UNIVERSITY OF CHICAGO HOSPITALS
PATIENT SAFETY REPORT
PROFESSIONAL PEER REVIEW
This material is for use in the course of internal quality control or medical study for the
purpose of reducing morbidity and mortality, and improving patient care and is privileged,
strictly confidential and shall be used only for medical research or the evaluation and
improvement of quality care.

Please call Patient Safety/Risk Management at 702-1057 to report a serious occurrence.

PATIENT INFORMATION

Date of Admission/Appointment: _____/_____/20_____   Date of Occurrence _____/_____/20_____   DOB: _____/_____/_____   Sex: F_____   M_____

Attending Physician: _____   Unit #_____   Room No.: _____

Admitting Diagnosis: _____

Patient Condition Before Incident: _____Confused   _____Disoriented   _____Restrained   _____Sedated
_____

Time of Occurrence   Day_____   Evening _____   Night _____

Location of Occurrence: Unit/Dept _____   Specific Area/Room Number _____

Brief, Factual Description of Occurrence/Potential Occurrence:_____
_____
_____
_____
_____
_____

Injury: ☐ Yes ☐ No.   If yes, please describe injury: _____

Additional Treatment/Test Required: _____

MD Contacted / Name: _____   Patient / Family aware of occurrence: ☐ Yes ☐ No

Personnel With Information Concerning Occurrence:

_____   _____
_____   _____

Name of Person Completing Form (**please print**): _____   Date: _____
                                        Title: _____   Phone/Pager: _____

TO BE COMPLETED BY THE PHYSICIAN

Physician Comments / Treatment: _____
_____
_____
_____

Name of Physician Completing Form (**please print**): _____

                        Date: _____   Phone/Pager: _____

DO NOT WRITE BELOW THIS LINE. PATIENT SAFETY COMMITTEE USE ONLY.

Submit to Patient Safety/Risk Management within 72 hours   _____
   • **DO NOT DUPLICATE THIS FORM**   _____
   • **DO NOT PLACE THIS FORM IN THE MEDICAL RECORD**   _____

Please take this 5 question short quiz.

Good Luck!

1. All adult inpatients are assessed for fall risk potential using the Morse Fall Risk Assessment Tool and scores are documented

A. Within 24 hours of admission and daily

B. Upon transfer to another nursing unit

C. Whenever a significant change in condition occurs

D. All of the above

2. Patients are considered **high risk** for falls when:

A. The Morse Fall Risk score is greater than 55

B. The nursing assessment indicates patient is at high risk for falls even if the score is less than 55

C. The patient has multiple medical diagnoses

D. A & B

3. What process must the nurse follow when a patient is assessed to be at <u>high risk</u> for falls?

A. Document the assessment and interventions in the medical record

B. Develop and document the nursing plan of care to address fall risk

C. Implement appropriate individualized interventions for the patient

D. Evaluate the interventions implemented for the patient

E. All of the above

4. Which interventions are appropriate for patients at <u>high risk</u> for falls?

A. Communicate to ancillary departments the   patient is at high risk for falls

B. Keep patient room door open, unless isolation or privacy required

C. Reinforce safety instructions & to call for assistance

D. Educate patient/family about risk factors

E. Monitor for medication effects (dizziness, orthostatic hypotension, etc) and communicate concerns to physician

F. All of the above

5. A patient was assisted to the floor without injury.

A. This incident does not need to be reported to Patient Safety and an Occurrence Report is not necessary.

B. Report this "assisted fall" to Patient Safety and/or complete an Occurrence Report.

FOOD SERVICES

Patient Meals for Mitchell 3, 4, 5, all intensive care units, L&D, W3:
Patients should contact:
Mitchell Room Service 4-3000 (7 am – 7 pm daily)
Staff should contact:
Patient Services Manager on Duty: 188-7514 (6:00 am – 9:00 pm daily)

Patient Meals for Mitchell 6 and Comer patients:
Patients should contact:
Comer Room Service, 4-FOOD (4-3663) (7:00 am – 7:00 pm daily)
Staff may contact:
Room Service Manager on Duty: 188-5619 (6:30 am – 8:00 pm daily)
.
For unresolved or non-immediate patient issues, contact:
Senior Patient Services Manager at ext. 2-1507 or pager 9238

Billings Cafeteria (Open Daily) or Café ala Carte (Open M-F):
Retail Manager on Duty: 188-6505 from 5:00 AM to 9:00 PM daily

Vending Machine Refunds (6:30 am – 8:00 pm daily)
Mitchell and Billings buildings: Billings Cafeteria cashier
Comer building: contact Room Service Manager (188-5619)

NUTRITION SERVICES

Tube Feedings/Nutritional Supplements/Infant Formulas: a small supply is kept in AOC cabinet in TC202 for access after 6 PM. A charge slip with name, room, date and product taken should be left in cabinet. If there is an emergent need from 8 AM – 6 PM page the Diet Tech at 188-8074. Some "Ready to Feed" pediatric formulas can be obtained from General Stores.

Nutrition Consults/Patient Education: page on call dietitian at 188-8406 from 9 AM – 9 PM daily.

On Call Coverage: Diet Tech – Daily 8 AM – 6 PM at 188-8074
Dietitian – Daily 9 AM – 9 PM at 188-8406
Manager – Daily 7:30 AM - 9 PM at either 188-6023

The University of Chicago Hospitals
Policy and Procedure Manual

HAND HYGIENE (INCLUDING CARE OF HANDS), ANTISEPTICS, AND SKIN PREPARATION

I. PURPOSE

This policy, which is in accordance with those issued by the Centers for Disease Control and Prevention (CDC) and regulatory agencies, is intended to provide background information about hand hygiene, antiseptics, and skin preparation for an operative site or an invasive procedure. The Committee on Infections and Epidemiology will assist individual departments in applying this policy to specific hospital areas.

II. POLICY

A. Routine Handwashing

1. In accordance with the Centers for Disease Control and Prevention, hands should be washed before and after each patient contact. However, frequent handwashing may lead to chapped hands and overgrowth of pathogens on chapped skin. Therefore, the following minimum standards have been set that permit, but do not encourage, less frequent handwashing.

a. Hands must be washed thoroughly with soap and water when visibly soiled, **or when working with stool**.

b. Personnel must wash their hands after contact with blood, body fluids, mucous membranes, non-intact skin, other potentially infectious materials, or inanimate objects that are likely to be contaminated, even if gloves were worn.

c. Hands must be washed after removing gloves.

d. Handwashing is required before and after

eating, drinking, or smoking, before handling food, and after using the toilet.

e. If a healthcare worker's hands have been washed after leaving one patient's room or after having contact with potentially infectious material, and the healthcare worker moves directly to the next patient's room without touching anything, hands need not be rewashed before contact with the second patient.

2. Routine handwashing should be performed using bar or liquid soap, warm water, and at least a **15** second vigorous wash. The use of gloves is not a substitute for good handwashing. The key to good handwashing is the use of friction and running water, rather than relying on the soap or antiseptic.

B. Handwashing with Antiseptics

1. An antiseptic handwashing agent should be used to wash hands:

a. Before caring for newborn infants, neutropenic patients or patients in the intensive care units;

b. Before performing surgical procedures or other invasive procedures, such as the placement of intravascular catheters, indwelling urinary catheters, or other invasive devices;

c. After caring for patients in isolation;

d. As a control measure to terminate outbreaks involving pathogens transmitted by direct contact.

2. Rings and watches should be removed prior to handwashing in the perinatal center, nurseries, and operating rooms.

C. Hand Antisepsis Using an Alcohol-Based Hand Rub

1. **An alcohol-based hand rub may be used in place of routine handwashing for decontamination of hands if hands are not visibly soiled or when not working with stool**.

2. When decontaminating hands with an alcohol-based

hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow manufacturer's recommendations regarding the proper procedure and volume of product to use.

3. The product currently supplied by the Hospitals for use by staff is Purell Instant Hand Sanitizer.

D. Fingernails

1. All fingernails should be clean.

2. **Special infection control and safety requirements for fingernails apply to the following groups of employees:**

a. **Employees who have direct contact with patients. These are employees who, as part of their job duties, may touch patients, patient supplies and/or patient care equipment; including but not limited to the following: patient transporters, environmental service workers, physicians, registered nurses, licensed practical nurses, nurse practitioners, nursing assistants, medical assistants, physician assistants, patient care managers, case managers, patient service coordinators, patient service assistants, nursing unit secretaries, and inventory specialists.**

b. **Employees who handle sterile items used to invasive procedures.**

c. **Employees who are directly involved in the sterilization of surgical instruments.**

d. **Employees who are directly involved in the preparation or delivery of food.**

3. **The above healthcare workers must comply with the following requirements for fingernails:**

a. **All fingernails must be clean.**

b. **Fingernails may not be longer than 1/4 (one quarter) of an inch long.**

c. **Artificial fingernails may not be worn (i.e., anything affixed to the nail other than plain nail polish). This includes but is not limited to gel or acrylic overlays and silk**

wraps. (Refer to Human Resources Policy 602: "Dress and Personal Appearance" for further information.)

        E. Antiseptics shall be used for surgical scrubs and to prepare an operative site or the site of an invasive procedure.

III. DEFINITIONS

        A. Alcohol-Based Hand Rub

An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%-95% ethanol or isopropanol.

        B. Antiseptic

An agent that prevents or arrests the growth or action of microorganisms either by inhibiting their activity or by destroying them, and is safe for use on living tissues. Antiseptics are not intended for use on inanimate objects. Antiseptics are regulated as drugs under the Federal Food, Drug, and Cosmetic Act.

IV. HANDWASHING AGENTS

        A. Routine handwashing

                1. Either bar, foam or liquid soaps should be used for routine handwashing.

                        a. Bar soaps should be kept on racks that allow water to drain.

                        b. Liquid soap should be stored in clean, closed containers. Reusable containers should be washed and thoroughly dried before refilling. Disposable containers should be discarded when empty. Refilling or topping off dispensers may result in contamination and spread of pathogens.

                2. Handwashing brushes should be single-use or sterilized in between uses.

        B. Handwashing using an antiseptic

                1. Based on the aforementioned policy, antiseptics should be available and used at UCH in the following manner:

                        a. Antiseptics should be routinely used

                                  i. in the operating rooms

                                  ii. in Labor and Delivery

                                  iii. in the care of newborn infants

          iv. in the maternity units

          v. in the hematology/oncology
          units

          vi. in the Intensive Care Units

          vii or solid organ transplant
          patients

          viii. and for patients in isolation.

b. An antiseptic handwashing agent does not need to be routinely used on other units, but since a patient may be placed on isolation precautions on any unit, all nursing units shall have antiseptics readily available.

c. Nursery, Maternity Areas

          i. Rings, bracelets, and watches must be removed before handwashing and entering the nursery.

          ii. Hands must be washed using an antiseptic before entering the nursery.

2. In most circumstances, the antiseptic of choice for handwashing is chlorhexidine gluconate (CHG). Examples include Provon 2% CHG, Hibiclens®, Foam Care® CHG (pink label). Iodophors (EZ Scrub®, Betadine®) and alcohols are acceptable alternatives.

          a. Iodine is not recommended because use on a regular basis may cause skin irritation.

          b. Hexachlorophene's effectiveness is limited to gram-positive organisms. In addition, hexachlorophene is slow acting and doesn't work well with only a single use. Therefore hexachlorophene should not be used routinely as an antiseptic. It may be used when the control of staphylococcal infection is the reason for using an antiseptic soap and the employee is prone to developing dermatitis with the use of chlorhexidine gluconate, iodophors or alcohols.

          c. PCMX (para-chloro-meta-xylenol) has good activity against gram-positive organisms, but has limited activity against

gram-negative organisms. The speed with which it acts is intermediate. It is not as good as CHG and iodophors, and therefore is usually not recommended.

d. Quaternary ammonium compounds **are disinfectants and** are unacceptable as antiseptics because they are rapidly inactivated by protein and other organic matter.

C. Hand Antisepsis Using an Alcohol-Based Hand Rub

1. An alcohol-based hand rub (62% ethyl alcohol), such as Purell®, may be used in place of routine handwashing when hands are not visibly soiled.

2. The product currently supplied by the Hospitals for use by staff is Purellâ Instant Hand Sanitizer.

a. The Purell® product is compatible with latex products and chlorhexidine gluconate.

b. Purell® is fast acting and has been shown to kill approximately 99% of most common bacteria in as little as 15 seconds.

c. Purell® alcohol-based instant hand sanitizer should not be used in situations where hands are visibly soiled.

D. Regardless of whether soaps or antiseptics are used, the hand hygiene regimen must not lead to dermatitis. Dermatitis negates the purpose of handwashing, because bacterial counts on broken, inflamed skin cannot be reduced appreciably, even with antiseptic agents. Colonization of the hands with *Staphylococcus aureus* becomes more common, and colonization with gram negative rods may occur. In addition, individuals whose hands are inflamed may tend to avoid handwashing. If antiseptic agents are causing dermatitis, careful thorough handwashing with a lotion soap may be substituted.

E. Petroleum-based lotions negate the persistent and residual antimicrobial effect of CHG antiseptics. A CHG-compatible lotion is available to staff.

V. SURGICAL SCRUB

A. Selection of Antiseptic

1. Chlorhexadine gluconate (CHG) is the preferred antiseptic for surgical scrub. Alternatively, in iodophor or tincture of iodine may be used. CHG-containing products

are available for use as a surgical scrub.

2. Hexachlorophene effectiveness is limited to gram positive organisms and in general is not recommended for use as a surgical scrub.

3. Alcohols and soaps have no residual effect and are not recommended for use as a surgical scrub.

4. Quaternary ammonium compounds are ineffective as antiseptics and should not be used for a surgical scrub.

5. PCMX has good activity against gram-positive bacteria, but limited activity against gram-negative bacteria. Therefore, it is not as effective as CHG **but may be used in certain limited circumstances as a surgical scrub** (e.g., use of chlorhexidine gluconate, iodophor and alcohol has been documented to cause dermatitis in an individual employee).

6. Staff should contact **Occupational Medicine** when they have difficulty tolerating routine (iodine and chlorhexidine gluconate) surgical scrubs.

B. Surgical scrub procedure:

1. Rings, watches, and bracelets should be removed prior to scrubbing.

2. Subungual areas should be cleaned under running water using a nail cleaner.

3. Surgical hand antisepsis may be performed using either an antimicrobial soap or an alcohol-based hand rub with persistant activity.

4. Procedure when using an antimicrobial soap.

a. Hands and forearms should be moistened with water, washed with the scrub agent, and rinsed.

b. The antiseptic should be applied using friction. Use of a sterile brush or sponge impregnated with an antiseptic will facilitate the scrubbing.

c. Hands and forearms should be rinsed, taking care not to touch anything and to hold them higher than the elbows and out from the surgical attire. This action will prevent contamination of the hands and elbows and will allow water to run from the cleanest area down the arm.

d. The most effective duration for scrubbing is thought to be between five and ten minutes.

e. The brush or sponge should be discarded or sterilized after each use.

f. The scrubbed hands and forearms should be dried using a sterile towel in the following manner:

i. A different end of the towel should be used to dry each hand and forearm.

ii. Holding one end of the towel, begin drying the fingers, then the forearm, and progress to the elbow, being careful not to let the towel touch nonsterile surfaces.

iii. Then use the other end of the towel for the other hand.

iv. Care should be taken not to re-wipe areas already wiped.

5. Procedure when using an alcohol-based hand rub with persistent activity.

a. Products available through manufacturers include both waterless and water-assisted formulations.

b. Follow manufacturer's instruction for use of each product.

VI. SKIN PREPARATION OF A PATIENTS PRIOR TO AN OPERATIVE OR INVASIVE PROCEDURE

A. Use of antiseptic skin preparation prior to an operative or other invasive procedure:

1. Prior to surgery, bathing or showering by the patient with an antiseptic soap may be desired because it reduces skin colonization. Chlorhexidine gluconate (CHG) is approved by the FDA for use as a preoperative shower soap. CHG for patient use is available in disposable, premoistened cloths as well as in liquid form.

2. Prior to surgery, the skin at the operative site must be thoroughly cleaned with an antiseptic to reduce the

numbers of resident skin flora and remove transient skin flora.

3. Refer to specific manufacturer recommendations for application instructions and ideal prep times.

4. The prepared area must be large enough to include the entire incision and an adjacent area large enough for the surgeon to work without contacting unprepared skin.

5. If laser surgery is to be performed, the operative site shall be prepared as previously outlined. Because of the hazards of fires or release of toxic fumes from residual antiseptics, any residual antiseptic shall be thoroughly removed using sterile water.

B. Selection of Perioperative Antiseptic

1. 2% chlorhexidine gluconate (CHG) with 70% isopropyl alcohol is the preferred antiseptic for surgical skin prep. Alternatively, an iodophor or tincture of iodine may be used.

   a. CHG-containing products are available for use as a surgical skin prep (e.g., Chloraprep). These preps should NOT be used before head or neck surgeries, for lumbar punctures, or in open wounds. The product should not come in contact with the meninges. Refer to manufacturer recommendations for other contraindications and use.

   b. Iodophors should have 1-2% available iodine. Since iodophors depend on the slow release of elemental iodine for their antibacterial properties, the solution should not be wiped off with alcohol.

   c. Tincture of iodine (0.5-2.0%) may be substituted for an iodophor, but because of its more irritating effect on human tissue it should be wiped off with 70% alcohol in a circular motion moving outward.

2. Hexachlorophene effectiveness is limited to gram-positive organisms and in general is not recommended for use as a skin prep.

3. PCMX has good activity against gram-positive

bacteria, but limited activity against gram-negative bacteria. Therefore, it is not as effective as CHG and it may be used in certain circumstances as a surgical scrub (e.g., use of chlorhexidine gluconate, iodophor and alcohol has been documented to cause dermatitis in an individual employee).

VII. SELECTION, STORAGE AND USE OF ANTISEPTICS

A. The selection of an antiseptic for handwashing or a surgical scrub shall be based on efficacy, toxicity, and acceptability.

B. Antiseptics should be used according to the manufacturer's specifications. Most antiseptics are sold in dilutions ready for use.

C. The expiration date on the antiseptic should be checked prior to use. Expired solutions should be discarded.

D. Antiseptics should be stored in clean, closed containers. Disposable containers should be discarded when empty. Reusable containers should be washed and thoroughly dried before refilling. Refilling or topping off dispensers may result in contamination and spread of pathogens.

E. Antiseptics should not be used as disinfectants. Because antiseptics are safe for use on living tissues, they are usually more expensive and the active ingredient is present in a lower concentration than in disinfectants.

F. Antiseptics are categorized as a patient care item and should be stored with other clean items. They should not be stored with cleaning supplies or under a sink.

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_____
Stephen G. Weber, MD, MS, Chairman
Committee on Infections and Epidemiology

HIGH ALERT MEDICATION SAFETY POLICY

Policy: PC 143
Issued: January 2008
Revised: March 2008
Reviewed: March 2008

PURPOSE:

1. Focus organizational attention on implementing best practices and assuring safety around the small number of medications responsible for the majority of preventable serious patient harm for the purpose of continually reducing and mitigating associated hazards.

2. Standardize and improve the safety of high alert medication management at all steps of the process.

3. Identify specific high alert medications categories and agents.

Definitions:

1. **High alert medications** are defined as drugs that have been implicated in the most serious and/or most frequent preventable events causing patient harm or undesirable hazards.

2. **"Double-checking"** is defined as two licensed clinicians within the scope of their practice (e.g., RN's MD, APN, R. Ph) independently performing, as appropriate, the following verifications, Medical Order Review, Drug and Solution Mix Amounts, Drug Dosage Calculations, Infusion pump settings; followed by a comparison of their results with each other.

PROCEDURE

1. The following safety guidelines will be implemented for High Alert Medications – see Appendix 1 for cross-reference to specific UCH policies –
a. Storage – Remove concentrated solutions from patient care areas.
b. Standardize drug concentrations and packing.

c. Implement medication storage safety measures/best practice that minimize or

eliminates the risk of confusing medications (e.g., high alert notations on the MAR drug label, separating Look-alike-Sound-alike (LASA) medications, and use different colors and fonts on labels on medications to minimize confusion)

2. Reduce or eliminate verbal orders for High Alert Medications. Implement double-checking measures as appropriate. Double checking procedures are as follows:

a. Required for following medication types and drug administration routes: (rules of administration may vary, please see appendix A)

i. Medication types - **chemotherapeutic agents,** with specific procedures as defined in pharmacy and patient care policies (see PC 33 Chemotherapy, Pharmacy 03-004, 03-008), **insulin (regardless of route), parenteral nutrition, narcotic infusions and anticoagulant infusions.**

ii. Routes of Administration - The following routes: intrathecal, epidural, intravenous, and intramuscular as specified in appendix 1 of this policy.

b. Double checking at the time of administration will be documented by two licensed personnel within their scope of practice. At minimum the nurses are to sign their initials on the medication administration record or designated flow sheet.

c. Double-checking will occur with each: Drug initiation, rate or program change, change order, infusion bag and unit-to-unit transfer.

d. During emergency, when deemed inappropriate to conduct double check, person-administering drug WITHOUT double check will announce all drug therapy to another provider(s) immediately before administration.

INTERPRETATION, IMPLEMENTATION, AND REVISION:
The Departments of Nursing, Pharmacy, Medical Staff Office, and the Pharmacy and Therapeutics Committee are responsible for the interpretation, implementation and revision of this policy.

REFERENCE: Comprehensive Accreditation Manual for Hospitals: The Official Handbook, "Medication Management, MM7.10," Joint Commission on Accreditation of Health Organizations, January 2007.

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Appendix - I

The University of Chicago Hospitals
High Alert Medication List

High Risk Medication	Hazard	Risk Control	UCH Policy Reference
Chemotherapeutic Agents	▪ Highly toxic drugs with narrow toxic/therapeutic ratio	▪ Chemo policy defines multidisciplinary review process for prescribing, dispensing, and administration ▪ CPIT notes approved for >350 order sets ▪ Annual lectures for oncology fellows	▪ Pharmacy 03-004, 03-008 ▪ PC 33
Epidural administration	▪ Wrong dose, wrong drug given via epidural route ▪ Similarity of	▪ Yellow striped tubing used for epidurals ▪ Brightly colored	▪ Pharmacy 04-011 ▪ PC 99

	epidural connectors to other connectors	labels affixed to standard epidural infusion bags ▪ Epidurals must be double checked by two nurses per the Continuous and Patient Controlled Epidural Analgesia Policy	
Esmolol	▪ Availability of vials (100mg/10 ml) and ampules (2.5 g/10 ml)	▪ Premixed bags and small vials only in ICUs, ER, OR, and PACU ▪ Vials only stocked when premixed is unavailable	▪ Refer to drug monograph Nursing Policy/Procedure for Administration of Intravenous Medications in UCH Formulary ▪ Pharmacy 07-013

Heparin and Direct Thrombin Inhibitors (i.e., lepirudin, argatroban)▪ Ordered in units; abbreviated as "U," can cause errors
▪ Many vial sizes, concentrations
▪ Heparin syringes can be confused with similar looking syringes
▪ May be mixed up with insulin because both are ordered as units
▪ Heparin-induced thrombocytopenia (HIT) introduce additional contraindications, complexity
▪ Lovenox (enoxaparin) should not be given with heparin or to HIT positive patients▪ "U" is on Do Not Use Abbreviation Policy
▪ Standard infusion concentration of heparin 25,000 units/500mL
▪ Pharmacy computer system prevents co-administration of heparin and enoxaparin
▪ Heparin allergy indicated MAR for HIT positive patients
▪ Double checking required for intravenous anticoagulants

▪ Administrative 02-32, 03-17
▪ PC 81, 55
▪ Pharmacy 07-012, 07-013

Hypertonic	▪ Administration may	▪ Hypertonic saline	▪ Pharmacy 07-008

Saline	cause rapid changes in serum sodium. ▪ Should not be stored as floor stock ▪ Should not be used by dialysis centers to increase blood volumes and reduce cramping	is not stocked outside of the pharmacy per Concentrated Electrolyte Policy ▪ Not used by dialysis	
Insulin	▪ Potential: order as "U" for Units ▪ Mix ups may occur with heparin (both are ordered as units) ▪ New insulins have similar sounding names, creating the potential for mix-ups.	▪ "U" is on Do Not Use Abbreviation Policy ▪ Insulin must be double checked by two licensed personnel per Insulin Policy	▪ PC 111, 81 ▪ Administrative 02-32 ▪ Pharmacy 07-012, 07-13

Intrathecal administration	▪ Inappropriate intrathecal administration of medications which should be given IV can be fatal (e.g. Vincristine)	▪ CPIT approved intrathecal administration sticker affixed to intrathecal doses per policy ▪ Vincristine and vinblastine syringe must be placed in plastic intrathecal warning sleeve provided by manufacturer per policy	▪ Pharmacy 03-002, 03-005 ▪ Nursing 1415C
IV Calcium Salts	▪ Prescribers fail to specify the salt when ordering IV calcium; amount of elemental calcium can vary by 3 fold. ▪ Salt potencies confused	▪ Salt must be specified when placing order ▪ Special instruction in pharmacy computer system alerting to calcium chloride potency	▪ Pharmacy 07-013
IV Magnesium	▪ Mix-ups with	▪ "MSO4" and	▪ Administrative

	morphine may occur if abbreviated MgSO4.	"MGSO4" are included in Do Not Use Abbreviation Policy	02-32 ▪ PC 81 ▪ Pharmacy 07-012, 07-13
Lidocaine	▪ Lidocaine mix-ups have occurred when lidocaine and heparin are obtained from the same manufacturer because of similar labeling. ▪ Multi-dose vials of lidocaine can result in contamination as a result of poor technique	▪ Lidocaine and heparin are purchased from the same manufacturer (Baxter), but premixed lidocaine is only stocked in 250mL bags, and heparin in 500mL bags ▪ Pharmacy purchases smallest vial size of lidocaine, and P&T has approved "use once and then discard" for all lidocaine	

Narcotics ▪ Presence of narcotics as floor stock means no double check are performed
▪ Narcotics are commonly drugs to which patients report allergies. Floor stock presence and need to have acutely for pain control can avoid pharmacist check for allergies
▪ PCA pumps can be miscalibrated
▪ Mix-up of morphine and hydromorphone ▪ Two nurse check of PCA order, drug, and programming defined in PCA Policy
▪ Narcotic infusions must be double checked by two nurses per Narcotic/Opioid Continuous Infusion Policy
▪ PC 95, 117

Neuromuscular Blockers (NMB)	▪ Outside of OR s, NMB s have been inadvertently given to un-intubated patients ▪ Mix-ups have occurred when NMBs	▪ NMB storage and use limited to OR, ICU, and ER per the NMB Policy ▪ Approved areas store NMBs in	▪ Pharmacy 07-009 ▪ Refer to individual drug monograph's Nursing

	were confused with other drugs in refrigerators and administered in error.	Paralytic tackle box per NMB Policy • Paralytic warning label will be affixed to all vials, drips, and syringes dispensed from the pharmacy per NMB Policy	Policy/Procedure for Administration of Intravenous Medications in UCH Formulary
Phosphate salts - sodium, potassium	• Prescribers need to consider amount of K and PO4 being ordered with each order • Phosphate salts need to be ordered as millimoles, not mEq • Rate of administration over 4-6 hours, depending on amount • Always dilute in NS or D5W. Use of concentrated form can lead to cardiac arrest.	• Storage of concentrated phosphate salt vials limited to pharmacy as defined in the Concentrated Electrolyte Policy • Phosphate repletion administered as IV piggyback • Infusion rate is indicated on bag label • Phosphate dosing cards available and distributed annually to new residents	• Pharmacy 07-008
Potassium chloride (KCL)	• KCL should always be mixed in NS or D5W and never given as a concentrated form. This can cause cardiac arrest • KCL, if injected faster than a rate of 10 mEq/hour can cause cardiac arrest	• Storage of concentrated KCL vials limited to pharmacy, with exception for OR perfusionist use as defined in Concentrated Electrolyte Policy • Infusion rate of 10 mEq/hr indicated on bag label • Infusion rate may increase to 20 mEq/hr for central line administration	• Pharmacy 07-008, 16-010, 16-011

Warfarin	• Many food-drug interactions • Need to closely monitor INR to maintain within narrow therapeutic range • Patient education is important	• Anticoagulation consult service available for patient teaching • Food-drug interaction teaching by nurse or pharmacist	• PC 100 • Pharmacy 04-010
Vasoactive Drugs	• Extravasation from a peripheral vein can cause severe tissue damage.	• Administer via central line	• Refer to drug monograph's Nursing Policy/Procedure for Administration of Intravenous Medications in UCH Formulary

INSULIN STORAGE AND ADMINISTRATION

Issue Date: February 1999 Page 1 of 4
Revised Date: August 2004 MSO Patient Care Policy 111
Review Date: May 1995 Insulin Storage and Administration

PURPOSE:

    1. To clarify the responsibilities for the storage and administration of subcutaneous (SubQ), intramuscular (IM) and intravenous (IV) **Insulin**

    2. To standardize use and administration of **Insulin** Drips

POLICY:

    1. Registered Nurses and Licensed Practical Nurses may administer (SubQ/IM) **insulin**. Only Registered nurses may administer IV **insulin**.

    2. **Insulin** dose must be double checked by two licensed personnel.

    3. **Insulin** drips should only be initiated in the emergency room, labor & delivery, step-down or a critical care area because of the level of patient care required.

    4. Patients should be stabilized in the emergency room, labor & delivery, step-down or critical care areas for at least two (2) hours before being transferred to a general care area. Blood sugar monitoring should NOT be required more often than every two hours in the general care area. The drip can be maintained, titrated down and discontinued in the general care area, but cannot be increased.

    5. The exact time of administration of any **insulin** must be documented in the medical record.

    6. All unopened **insulin** vials must be refrigerated. Unopened refrigerated **insulin** vials expire according to the manufacturer's expiration date.

7. **Insulin** vials must be initialed and dated at the time of opening. All opened insulin vials must be refrigerated and expire 28 days after opening.

GUIDELINES FOR INSULIN ADMINISTRATION:

1. Standing orders for regularly scheduled **insulin** may be written. The word "Units" must be written. Refer to Prohibited Abbreviations policy

2. The appropriate setting for the use of sliding scale **insulin** orders is in patients on diabetic therapy whose glycemic control is less than optimal.

a. Only rapid and short-acting insulins will be administered by sliding scale **insulin** orders.

b. No sliding scale orders will be accepted for glucoses < 100 mg/dL or > 350 mg/dL as the threat of hypoglycemia or severe uncontrolled diabetes requires re-evaluation of basal **insulin** therapy.

c. Patients with sliding scale **insulin** orders should have glucose monitoring performed at least four (4) times a day (q6 hours or qid, ac and hs). Sliding scale **insulin** should be administered before meals or during continuous enteral or parenteral feedings. It should be noted that significant risk of hypoglycemia exists for patients who receive supplemental **insulin** at bedtime or while fasting.

d. If significant amounts of supplemental **insulin** are provided by sliding scale, the nurse will notify the physician so that the basal **insulin** dose can be reconsidered every twelve (12) to forty-eight (48) hours to prevent recurrent hyperglycemia, and to reconsider the continued need for sliding scale supplementation.

e. Routine glucose monitoring will not be performed during night shifts (between 11 pm and 6:30 am) unless specifically ordered. Each nursing unit should determine standard times for glucose monitoring designed to obtain glucose results approximately thirty minutes before the arrival of meal trays. This is aimed to provide the most useful glucose monitoring results for designing therapy.

GUIDELINES FOR INSULIN DRIP:

1. Only regular **insulin** is used when continuous intravenous **insulin** administration is necessary. Intermediate and long acting insulins are not suitable for intravenous administration.

2. **Insulin** drips are generally administered for less than a twenty-four (24)
hour period and the administration must be through an Infusion Pump.

3. A standard concentration of 100 Units of Regular Human **Insulin** in 100cc
of 0.9% Normal Saline (1 unit per mL) will be used to facilitate the
maintenance
of the IV line and the adjustment of **Insulin** doses.

4. Pharmacy prepares **insulin** drips. A RN may only prepare an **insulin** drip in
a
medical emergency. When prepared by an RN, the **insulin** dose is double
checked by two licensed personnel. The **insulin** infusion bag must be labeled
with the patient's name, location, **insulin** dose, volume of diluent, date and
time
prepared, expiration date, and preparer's initials. All prepared **insulin** infusions
expire in 24 hours.

5. Rapid and short-acting **insulin** may be administered IM or SubQ if IV access
is
not available or if a long delay is anticipated in starting the **insulin** drip.
If **insulin** is required prior to the availability of the **insulin** drip, regular **insulin**
should be administered by IV push injection.

6. After receiving the **insulin** drip solution, the new administration set should
be
attached to the IV container and the line should be flushed with the **insulin**
solution. Wait 30 minutes, and then flush the line again with the **insulin**
solution
prior to initiating the infusion. If new tubing is not needed, wait a minimum of
30 minutes between the preparation of the solution and initiation of the
infusion.

7. Because of absorption, the actual amount of **insulin** being administered
could be
substantially less than the apparent amount (100 units/100mL, yield 1 unit per
mL).
Therefore, adjustment of **insulin** drip rate should be based on effect and not on
the
apparent **insulin** dose. Furthermore, the apparent dose should not be used as the
basis for determining the subsequent **insulin** dose upon discontinuing the
insulin drip.

8. Nurses should monitor patients on **insulin** infusions for signs and symptoms of
hypoglycemia by checking capillary glucose every two (2) hours, and PRN until
stable, or as per physician orders. Serum glucose and serum ketones should be
checked as per medical orders. Nurses should document glucose values on the
Diabetic/Metabolic Flow Record, or another appropriate flow sheet, and inform
physician per parameters specified.

9. Generally, **insulin** infusions should continue infusing for thirty (30) minutes after
administration of subcutaneous **insulin** therapy to prevent rebound
hyperglycemia.

References: UCH Formulary
Lexi-Comp On-line http://online.lexi.com/crlonline

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Issue Date: February 1999 Page 4 of 4
Revised Date: August 2004 MSO Patient Care Policy 111
Review Date: May 1995 **Insulin** Storage and Administration

July 13, 2007

To: All Directors of Adult Nursing Care Centers
Patient Care Managers of Adult Nursing Units
Staff Nurses of Adult Inpatient Nursing Units
Mitchell Emergency Department

From: Jamie O'Malley, R.N., MS
Vice President & Chief Nursing Officer

Re: Additional Changes to Insulin Administration Procedure

In our ongoing review of insulin management and administration, there have been some additional practice recommendations made that will further tighten controls and enhance patient safety.

Therefore, I am requesting that these additional measures be put into practice immediately.

1. Staff RNs are to consistently withdraw insulin from the AcuDose Medication Dispensing Cabinet (MDC) with a witnessing RN **at the MDC machine only**. As indicated in the previous 6/25/07 memo, the RN should document the reason for the override i.e**.**, "hyperglycemia", and now include the **type and amount of insulin removed**.   The multi-dose vial must be returned to the locked AcuDose pocket during the initial transaction (i.e., do not remove insulin vial from immediate MDC area, do not close drawer without replacing insulin vial.)

2. We also need to begin a separate insulin vial count every shift along with the shift narcotic count. A manual count will be done on each individual vial and type of insulin. If there are two or more vials of the same type of insulin, they will be documented separately. This will be recorded on the Manual Inventory Control Log for Insulin Tracking (see attached) to be kept in the insulin drawer or with the Manual Narcotic Log. To access the insulin drawer, go to Med. Mgt and then select "custom inventory". Then select the generic button and type in the insulin.

3. Empty insulin vials should be left in the MDC. If the insulin supply runs low, please call Pharmacy to restock the insulin in the MDC. Over the next week, we will begin meeting with Local Practice Council Chairpersons to discuss reallocation of AcuDose inventory and other options that may further enhance our practice.

I appreciate your patience and understanding in implementing these practice changes.

Thank you

Cc: Krista Curell, JD, RN, Director Patient Safety Risk Management
Dave Hicks, RPh, MBA, Interim Chief Pharmacy Officer
Judy Brown-Scott, Manager Pharmacy

Look-alike and sound-alike (LASA) medications

Policy: PC 142
Issued: October 2007
Revised: December 2008
Reviewed: November 2008

Policy:
The University of Chicago Medical Center, (UCMC) will maintain a list of Look-alike and sound-alike (LASA) medications and take steps to reduce occurrences involving the interchange of these medications.

Purpose:
1. Focus individual and organizational attention on LASA medications.

2. Identify problem-prone medications, and review annually.

3. Describe procedures to reduce risk of medication errors with the identified medications.

Procedure: (see Appendix I for cross reference):
1. STORAGE/DISPENSING PROCEDURES:
a. Tall-man lettering will be used on pharmacy shelf labels, on automated dispensing cabinet product selection screens and within the online formulary.
b. Bright yellow and red "**look** alike - sound alike" stickers will be affixed to the front/face of the LASA medication bin in pharmacy dispensing areas and the corresponding storage/dispensing bins of the decentralized medication dispensing cabinets on patient care units as appropriate.

c. Bright yellow and red "**look** alike – sound alike" alert stickers will be affixed to the labels of all designated LASA medications.

d. LASA medications will be physically separated in automated dispensing machines, where applicable.

e. Maximum dose warnings are established in the pharmacy order entry system, where appropriate.

f. The possibility of name confusion will be considered when drugs are reviewed for formulary inclusion.

2. PRESCRIBING PROCEDURES:
a. The medication order should include the drug name, dosage form, medication strength, route, and complete administration directions.

b. Verbal or telephone orders will be given only when truly necessary. Staff must read back all orders and state its indication.

3. ADMINISTRATION PROCEDURES:
a. Verbal Orders - Staff must document verbal orders in the medical record and read back all verbal or telephone orders for verification. (See PC 125, Medical Orders)
b. Authentication of verbal orders must occur before the medical staff member leaves the area.

c. Authentication of telephone orders - A member of the care team must co-sign the telephone order as soon as practicable, but no later than 48 hours after the order is taken

d. Staff must use the Five Rights when verifying and administering medications at the UCMC (Right Patient, Right Drug, Right Dose, Right Route, Right Time).

INTERPRETATION, IMPLEMENTATION AND REVISION:
The departments of Nursing and Pharmacy are responsible for the interpretation, implementation and revision of this policy.

REFERNCES:
1. Joint Commission (2006), The 2007 National Patient Safety Goals - Goal 3C
2. Joint Commission (2007) **Implementation Expectations for the 2007 NPSGs**
Retrieved from http://www.jcipatientsafety.org/fpdf/icps/2007NPSGsIE.pdf.

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Policy: PC 142
Issued: New Policy
Revised: New Policy
Reviewed: New Policy

APPENDIX I: UCMC LOOK-ALIKE, SOUND-ALIKE MEDICATION LIST

GENERAL LIST

Potential Problematic Drug Names	Brand Name(s) (uppercase) and Generic (lowercase)	Potential Errors and Consequences	Specific Safety Strategies *
Acetohexamide and Acetazolamide	(acetohexamide) DIAMOX (acetazolamide)	The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance

		dispensed as both medications could appear close to each other on computer screen and on shelf.	and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Avandia and Coumadin	AVANDIA (rosiglitazone) COUMADIN (warfarin)	Poorly handwritten orders for Avandia (used for type II diabetes) have been misread as Coumadin (used to prevent blood clot formation), leading to potentially serious adverse events. Mix-ups originally occurred due to unfamiliarity with Avandia – staff read the order as the more familiar Coumadin. However, mix-ups between these two products continue to occur. Neither medication is safe without appropriate monitoring that is specific to the drug.	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Bupropion and Buspirone	WELLBUTRIN, ZYBAN (bupropion) BUSPAR (buspirone)	The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or dispensed as both	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product

| | | medications could appear close to each other on computer screen and on shelf. | names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication

administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different. |
|---|---|---|---|
| Celebrex and Celexa and Cerebyx | CELEBREX (celecoxib)

CELEXA (citalopram hydrobromide)

CEREBYX (fosphenytoin) | Patients affected by a mix-up between these three drugs may experience a decline in mental status, lack of pain or seizure control, or other serious adverse events. | Clearly specify the dosage form, drug strength, and complete directions when prescribing.

Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different. |
| Chloropropamide and Chlorpromazine | DIABINESE (chloropropamide)

THORAZINE (Chlorpromazine) | The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication | Clearly specify the dosage form, drug strength, and complete directions when prescribing.

Change the appearance |

		could be selected and/or dispensed as both medications could appear close to each other on computer screen and on shelf.	and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Clonidine and Clonazepam	CATAPRES (clonidine) KLONOPIN (clonazepam)	The generic name for clonidine can easily be confused as the trade or generic name for clonazepam.	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Cyclosporine and Cycloserine	SANDIMMUNE, NEORAL (cyclosporine) SEROMYCIN (cycloserine)	The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or dispensed as both	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product

		medications could appear close to each other on computer screen and on shelf.	names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Ephedrine and Epinephrine	ADRENALIN (epinephrine) (ephedrine)	The names of these two medications **look** very similar, and their clinical uses make storage near each other likely, especially in obstetrical areas. Both products are available in similar packaging (1ml amber ampuls and vials).	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Fentanyl and Sufentanil	SUBLIMAZE (fentanyl) SUFENTA (sufentanil)	The products are not interchangeable. Confusion has resulted in episodes of respiratory arrest due to potency differences between these drugs. Some errors occurred when using sufentanil during drug	Do not stock sufentanil in patient care units outside OR/PACU settings. Do not store these agents near one another if both products are available (e.g., pharmacy, anesthesia supplies).

		shortages of fentanyl.	
Hydromorphone injection and Morphine injection	DILAUDID (hydromorphone) ASTRAMORPH, DURAMORPH, INFUMORPH (morphine)	Some health care providers have mistakenly believed that hydromorphone is the generic equivalent of morphine. However, these products are not interchangeable. Fatal errors have occurred when hydromorphone was confused with morphine. Based on equianalgesic dose conversion, this may represent significant overdose, leading to serious adverse events. Storage of the two medications in close proximity to one another and in similar concentrations may contribute to such errors. Confusion has resulted in episodes of respiratory arrest due to potency differences between these drugs.	Stock specific strengths for each product that is dissimilar. For example, stock units with hydromorphone 1mg unit dose cartridges, and morphine in 2mg unit dose cartridges. Ensure that health care providers are aware that these two products are not interchangeable.
Hydralazine and Hydroxyzine	APRESOLINE (hydralazine) ATARAX, VISTARIL (hydroxyzine)	The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or dispensed as both medications could appear close to each other on computer screen and on shelf.	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication

			administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Insulin products: Lantus and Lente Humalog and Humulin Novolog and Novolin Humulin and Novolin Humalog and Novolog Novolin 70/30 and Novolog Mix 70/30	LANTUS (insulin glargine) LENTE (insulin zinc susp) HUMULIN (human insulin products) HUMALOG (insulin lispro) NOVOLIN (human insulin products) NOVOLOG (human insulin aspart)	Similar names, strengths and concentration ratios of some products (e.g., 70/30) have contributed to medication errors. Mix-ups have also occurred between the 100 units/ml and 500 units/ml insulin concentrations.	Limit the use of insulin analog 70/30 mixtures to just a single product. Limit the variety of insulin products stored in patient care units, and remove patient-specific insulin vials from stock upon patient discharge. For drug selection screens, emphasize the word "mixture" or "mix" along with the name of the insulin product mixtures. Consider auxiliary labels for newer products to differentiate them from the established products. Also apply bold labels on atypical insulin concentrations.
Lamisil and Lamictal	LAMISIL (terbinifine hydrochloride) LAMICTAL (lamotrigine)	Patients with epilepsy who do not receive Lamictal due to an error would be inadequately treated and could experience serious consequences. Conversely, patients erroneously receiving Lamictal would be unnecessarily subjected to a risk of potential side effects (including serious rash) and would miss important antifungal therapy.	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through

			bold face, color, and/or tall man letters, the part of the names that are different.
Lipid-based amphotericin products vs. conventional forms of amphotericin (Lipid-based amphotericin products vs. conventional forms of amphotericin - Continued)	**Lipid-based**: AMBISOME (amphotericin B liposomal) ABELCET (amphotericin B lipid complex) AMPNOTEC (amphotericin B. cholesteryl sulfate complex for injection: **Conventional**: AMPHOCIN, FUNGIZONE INTRAVENOUS (amphotericin B desoxycholate)	Many drugs now come in liposomal formulation indicated for special patient populations. Confusion may occur between the liposomal and the conventional formulations because of name similarity. The products are not interchangeable. Lipid-based formulation dosing guidelines differ significantly from conventional dosing. Conventional amphotericin B desoxycholate doses should not exceed 1.5mg/kg/day. Doses of the lipid-based products are higher, but vary from product to product. If conventional amphotericin B is given at a dose appropriate for a lipid-based product, a severe adverse event is likely. Confusion between these products has resulted in episodes of respiratory arrest and other dangerous, sometimes fatal outcomes due to potency differences between these drugs.	Staff involved in handling these products should be aware of the differences between conventional and lipid-based formulations of these drugs. Encourage staff to refer to the lipid-based products by their brand names and not just their generic names. Stop and verify that the correct drug is being used if staff, patients or family members notice a change in the solution's appearance from previous infusions. Lipid-based products may be seen as cloudy rather than a clear solution. Storage of lipid-based product in patient care areas and automated dispensing cabinets is highly discouraged. To reduce potential for confusion, consider limiting lipid-based amphotericin B products to one specific brand.

CHEMO LIST

Potential	Generic	Potential Errors and	Specific Safety

Problematic Drug Names	(lowercase) and Brand Name(s) (uppercase)	Consequences	Strategies *
Cisplatin and Carboplatin	PLATINOL (cisplatin) PARAPLATIN (carboplatin)	Similarity in names can lead to confusion between these two products. Doses appropriate for carboplatin usually exceed the maximum safe dose of cisplatin. Severe toxicity and death has been associated with accidental cisplatin overdoses.	Install maximum dose warnings in computer systems. A boxed warning notes that cisplatin doses greater than 100mg/m² once every 3 to 4 weeks are rarely used and that the package insert should be consulted for further information. Use safe handling recommendations and safety stickers for cisplatin as provided by manufacturer. Do not store these agents next to each other. Use generic names when prescribing and not chemical names or abbreviations.
Cladribine and Clofarabine	cladribine (LEUSTATIN) clofarabine (CLOLAR)	The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or dispensed as both medications could appear close to each other on computer screen and on shelf.	Clearly specify the dosage form, drug strength, and complete directions when prescribing. Change the appearance and look-alike product names on computer screens, pharmacy and nursing units' shelf labels and bins (including automated dispensing cabinets), pharmacy product labels and medication administration records by highlighting, through bold face, color, and/or tall man letters, the part of the names that are different.
Lipid-based daunorubicin and doxorubicin products vs.	Lipid-based: DOXIN (doxorubicin	Many drugs now come in liposomal formulations indicated for special patient population.	Staff involved in handling these products should be aware of the differences between conventional and

| conventional forms of daunorubicin and doxorubicin.

(Lipid-based daunorubicin and doxorubicin products vs. conventional forms of daunorubicin and doxorubicin – Continued) | liposomal)

DAUNOXOME (daunorubicin citrate liposomal)

Conventional:

CERUBIDINE (daunorubicin, conventional)
ADRIAMYCIN, RUBEX (doxorubicin, conventional) | Confusion may occur between the liposomal and the conventional formulation because of name similarity. The products are not interchangeable. Lipid-based formulation dosing guidelines differ significantly from conventional dosing.

Accidental administration of the liposomal form instead of the conventional form has resulted in severe side effects and death. | lipid-based formulations of these drugs. Encourage staff to refer to the lipid-based products by their brand names and not just their generic names. Stop and verify that the correct drug is being used if staff, patents or family members notice a change in the solution's appearance from previous infusions. Lipid-based products may be seen as cloudy rather than a clear solution. Storage of lipid-based products in patient care areas and automated dispensing cabinets is highly discouraged. Include specific method of administration for these products. |
|---|---|---|---|
| Taxol and Taxotere | TAXOL (paclitaxel)

TAXOTERE (docetaxel) | The generic names for both medications can easily be confused with poorly handwritten orders or transcriptions errors. Wrong medication could be selected and/or dispensed as both medications could appear close to each other on computer screen and on shelf. | Install maximum dose warnings in computer systems to alert staff to name mix-ups during order entry. Do not store these agents near one another. |
| Vinblastine and Vincristine | VELBAN (vinblastine)
Oncovin (vincristine) | Fatal errors have occurred, often due to name similarity, when patients were erroneously given vincristine intravenously, but at the higher vinblastine dose. A typical vincristine dose is usually capped at around 1.4mg/m² weekly. The | Install maximum dose warnings in computer systems to alert staff to name mix-ups during order entry. Do not store these agents near one another. Staff involved in handling these products should be aware of the differences. Use brand names or brand |

		vinblastine dose is variable but, for most adults, the weekly dosage range is 5.5 to 7.4mg/m².	and generic names when prescribing and do not use abbreviations for these drug names

The University of Chicago Medical Center
Office of Medical Center Compliance
Summary of
The HIPAA Privacy & Security Rules

HIPAA PRIVACY RULE OVERVIEW

The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 became effective on April 14, 2003. The federal government said that every employee working in health care in any job must be taught about the Privacy Rule. The Privacy Rule tells us how we are to use and share health information about patients. A major goal of the Rule is to assure patients that their health information will be protected.

The Privacy Rule applies to all members of the workforce of The University of Chicago Medical Center (UCMC) and includes all physicians, residents, medical students, nurses, nursing students, and permanent as well as temporary staff. This summary is being given to you to help you understand the Rule and how important it is to the patients and the UCMC.

PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is anything that might reveal something about the medical or emotional condition of a patient. It is also information that might tell us who the patient is. Many different pieces of information can identify a patient or tell us something about their medical condition. Examples of items or information that might identify a patient or tell us something about their condition include a social security number, driver's license, state ID, fingerprints, name, address, and photographs, medical record number, labels, ID bands, and any reports or x-rays.

USE AND DISCLOSURE

An organization, such as the UCMC, can use and disclose or share patient information without a patient's specific authorization if it is for treatment, payment, and health care operations.

Treatment is anything we may do to care for the patient, for example talking about or to the patient, asking another doctor's opinion, and sending the patient for tests or to therapy.

Payment is sharing information in order to be paid for the services we have given to the patient.

Health Care Operations covers any activity that might be done for or with the patient to help them get better such as setting up home care, arranging transportation, obtaining a wheelchair. It also includes quality control, credentialing, and educating medical students, nurses, and other allied health professionals.

Sometimes we are required by law to disclose a patient's health information to a government agency. Child abuse, communicable disease, and medical examiner reporting are a few examples of disclosures to government agencies. It is important that we keep track of the places where we disclose or send information about the patient. If the patient wants to know where we have sent information about them, we have to be able to provide a list. If the unit that you will be working in makes these kinds of disclosures, your supervisor will train you on how to keep track of them.

One way that we try to safeguard the privacy of our patients is by making sure that the person asking for any information about a patient has a right to get that information. So we must always make certain we identify the caller or visitor as someone the patient wants us to speak to. At the UCMC we have a password system in place to protect our patients and their information. You will learn more about the password system from your supervisor.

INCIDENTAL USE AND DISCLOSURE
It is very important that we try to limit the patient information that other people (such as visitors) might hear while we are doing our jobs. We should speak in quieter voices when in public places and never discuss a patient or their condition in the elevators or cafeteria. We should always pull curtains in patient rooms, and ask visitors to step out while we finish our work or speak with the patient. We should make sure our workspace is clean and does not have patient information lying around for others to see. All written information about patients that is no longer needed and is not part of the medical record, such as report sheets, notes, labels, and post-its, should be placed in the shredding boxes and not thrown in the garbage.

AUTHORIZATIONS
For anything outside of treatment, payment, or health care operations, we need to get the patient's consent to share their health information or we are risking the patient's privacy. The law also tells us to share only the information that is absolutely needed. Only the patient can ask for and get a copy of his own medical information.

NOTICE OF PRIVACY PRACTICE
The law tells us that we must explain to our patients what we will do with the information about them. Every patient has the right to know this. We give them the information in the Notice of Privacy Practice that is given to all of our patients when they come to the Medical Center. This Notice tells them they may:
- Inspect and get a copy of their medical record documentation
- Get a list of places and people who asked for and received information about them
- Be kept out of the hospital directory

For patients who have complaints or want to ask questions about the Privacy Rule, they may call the HIPAA Program Office at 773-834-9716.

ENFORCEMENT AND PENALTIES FOR NON-COMPLIANCE
The Office for Civil Rights enforces the Privacy Rule.

Civil penalties for not obeying the Privacy Rule are:
- $100 for each failure to comply
- $25,000 per year for multiple violations of the same requirement

Criminal penalties for a person who knowingly violates HIPAA are as follows:
- $50,000 and a one year prison term
- $100,000 and up to 5 years in prison for wrongful conduct involving false pretenses

$250,000 and up to 10 years in prison for wrongful conduct with intent to sell, transfer, or use individually identified health information personal gain or malicious harm.

HIPAA SECURITY RULE OVERVIEW

The HIPAA Security Rule became effective on April 20, 2005. The Security Rule standards define how we are to ensure the integrity, confidentiality, and availability of our patients' electronic protected health information (ePHI). The Security Rule requires that we have administrative, physical, and technical safeguards for protecting ePHI. Some examples of each are:

Administrative Safeguards: Administrative functions that should be implemented to meet the security requirements.
1) Assigning or delegating security responsibility to an individual – Chief Security Officer.
2) Training workforce members on security principles and organizational policies/procedures.
3) Terminating workforce members' access to information systems.
4) Reporting and responding to security incidents.

Physical Safeguards: Mechanisms to protect electronic systems, equipment, and the data they hold, from threats, environmental hazards and unauthorized intrusion.
1) Limiting physical access to information systems containing ePHI (i.e. server rooms).
2) Preventing inappropriate viewing of ePHI on computers.
3) Properly removing ePHI from computers before disposing or reusing them.
4) Backing up and storing ePHI .

Technical Safeguards: Automated processes used to protect data and control access to data.

1) Providing all designated users with unique identifiers for accessing ePHI.
2) Accessing ePHI during an emergency.
3) Encrypting ePHI during transmission.
4) Automatically logging off users after a determined time period.

PRIVACY/SECURITY AND TECHNOLOGY

As we use technology to improve patient care, we are faced with additional challenges to protect patient information from unauthorized use and disclosure. It is important to understand the form of technology being used and the precautions we must take to safeguard patient information.

CONCLUSION

Our patients entrust us with their health information; therefore we must protect it against deliberate or inadvertent misuse or disclosure. The consequences of not complying with HIPAA are too great. We do not want to see the University of Chicago Medical Center's name in the newspaper associated with a systems attack or theft of patient information. So, it is imperative that we all follow our privacy and information security policies, and do the right thing . . . protect our patients' privacy and confidentiality of their health information.

The following page is a list of HIPAA tips on protecting our patients' privacy, and information and security of their health information. In addition, please feel free to go to the HIPAA Program Office website at http://HIPAA.bsd.uchicago.edu for additional information and resources.

THE UNIVERSITY OF CHICAGO
HIPAA Program Office

GUIDANCE	January 2007

A to Z: HIPAA TIPS for PROTECTING PRIVACY AND SECURITY

A. Contact Security Services if you see suspicious individuals in patient care or restricted areas.

B. Wear your ID badge at all times.

C. Discard documents containing patient information only in a shredding container.

D. Discard floppy disks or CD-ROMs containing patient information only in shredding containers

E. Use private areas to discuss PHI.   Do not discuss patient information in cafeterias, elevators, or other public places.

F. Lower voices when having conversations concerning patients in non-private areas.

G. Report any suspicious activity appearing on your computer to the IS Help Desk.

H. Do not leave messages concerning a patient's condition or test results on answering machines.   Do not leave messages containing highly confidential patient information (i.e. mental health, substance abuse, HIV/AIDS, genetic testing, etc.) on answering machines.

I. Do not open unknown email attachments or unrecognizable emails.

J. Do not access protected health information unless it is necessary to perform your job duties, including that of your friends, family members, and colleagues.

K. Use private areas to discuss patient information with patient, family, or visitors.

L. Access only electronic information that you "need to know" to perform your job.

M. Log-off your computer when away from your workstation.

N. Turn computer monitors so they cannot be viewed by unauthorized persons.

O. Verify caller's identity or applicable code before releasing patient information by phone.

P. Lock laptop computers and other portable devices in secure location when not in use.

Q. Store passwords in secure areas - not accessible by others.

R. Remove patient information from copy machines, fax machines, printers, or conference rooms.

S. Obtain patient verbal permission before discussing information in front of family and friends.

T. Do not share your computer user ID or password with anyone.

U. Do not access your PHI or PHI of family members, friends, or other individuals for personal or other non-work related purposes even if written or verbal authorization has been obtained.

V. Medical records should not be taken away from the UCMC campus or off-site property.

W. Clinic schedules, surgery schedules, and procedure schedules that contain PHI should not be left out in view of others. When no longer needed, schedules should be placed in shredding bins, not regular trash cans.

X. If you do not need PHI to do your job, do not seek it out.

Y. If you overhear a conversation concerning a patient, keep it to yourself.

Z. Report suspected privacy violations to the HIPAA Program Office by calling (773) 834-9716.

The University of Chicago Medical Center
Policy and Procedures Manual

HOLD ORDERS

Policy: PC 136
Issued: March 2007
Revised: NEW POLICY
Reviewed: NEW POLICY

PURPOSE
To describe how hold orders will be processed at the University of Chicago Medical Center.

POLICY
1. No unspecified hold orders are permitted.

2. Orders to hold a single dose of a medication are permitted

3. Orders to hold a medication for more than a single dose will be handled as an order to discontinue the medication.

4. If a medication is administered by continuous infusion, the hold orders are permitted based on specific time parameters, clinical parameters, or planned procedures/activities.

PROCEDURE
1. Orders to hold a medication will be written on an approved order form and signed by the ordering physician according to Medical Center policy.

2. Orders to hold a single dose of medication should be written as "Hold next scheduled dose of XXXXXX" or "Hold 9am dose of XXXXX".

3. If the prescriber desires to hold a medication for more than one scheduled dose, the medication should be discontinued.

4. If the prescriber writes a hold order not allowed by the policy, the prescriber will be contacted to clarify the intent of the order.

5. Orders to hold a medication administered by a continuous infusion should be written with the parameters specified in the order. (e.g. "Hold XXXXXX infusion for six hours")

6. Orders to hold a medication based on specific clinical parameters are permitted (e.g. "Hold for SBP < 100")

7. Prior to the re-initiation of therapy, the patient may be re-assessed to assure therapy is still warranted.

INTERPRETATION, IMPLEMENTATION, AND REVISION:
Patient Care Policy 136 Hold Orders

The Pharmacy and Therapeutics Sub-Committee is responsible for the interpretation, implementation and revision of this policy.

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Chief Medical Officer

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Medical Staff President

Policy: PC 136
Issued: March 2007
Revised:
Reviewed:

Patient Care Policy 136 Hold Orders

The University of Chicago Hospitals
Policy and Procedure Manual

Isolation Policy: Appendix B
ISOLATION PLACARDS

STRICT ISOLATION (sign is yellow)

VISITORS-REPORT TO NURSES' STATION BEFORE ENTERING ROOM

Ideally, persons susceptible to chickenpox should not enter the room.

1. PRIVATE ROOM *required*; **patients must be assigned to a containment isolation room (room with a ventilation system that has negative pressure relative to the corridor or positive pressure anteroom). Door(s) must be kept closed.**

2. GLOVES must be worn by all persons entering room.

3. GOWNS must be worn by all persons entering room.

4. MASKS must be worn by all persons susceptible to chickenpox entering room, if room entry is necessary. Persons immune to chickenpox do not need to wear a mask.

5. HANDS must be washed on leaving the room.

6. ARTICLES Disposable items contaminated with infective material must be placed in a red bag for isolation trash. Linen must be placed in an impervious linen bag and labeled "ISOLATION." When possible, articles such as scissors, stethoscopes, or tourniquets should be designated for use by this patient only and should be left in the patient's room. Reusable equipment should be decontaminated before being removed from the isolation room.

7. TRANSPORT For transportation, a clean blanket or sheet should be wrapped around the patient and the patient should wear a mask. The door(s) to the patient's room should remain closed for at least 45 minutes after the patient leaves the room.

8. SPECIAL INSTRUCTIONS

DROPLET PRECAUTIONS (sign is red)

VISITORS - REPORT TO NURSES' STATION BEFORE ENTERING ROOM

1. PRIVATE ROOM *required;* door must be kept completely closed. See isolation policy for when patients should be assigned to a containment isolation room (room with a ventilation system that has negative pressure relative to the corridor or positive pressure anteroom).

2. GLOVES not required except if coming in contact with respiratory secretions or other potentially infective material.

3. GOWNS not required .

4. MASKS must be worn by any person who is susceptible to the disease and enters the patient's room.

5. HANDS must be washed upon leaving the room.

6. ARTICLES contaminated with respiratory secretions must be decontaminated or discarded in a red bag for isolation trash. Linen must be placed in an impervious linen bag and labeled "ISOLATION."

7. TRANSPORT for transportation, the patient should wear a mask when outside his/her room. The door(s) to the patient's room should remain closed for at least 45 minutes after the patient leaves the room.

8. SPECIAL INSTRUCTIONS

AIRBORNE PRECAUTIONS (sign is orange)

VISITORS-REPORT TO NURSES' STATION BEFORE ENTERING ROOM

1. PRIVATE ROOM *required*; patients must be assigned to a containment isolation room (room with a ventilation system that has negative pressure relative to the corridor or positive pressure anteroom). Door(s) must be kept closed.

2. GLOVES not required.

3. GOWNS not required.

4. RESPIRATORS required. **NO ADMITTANCE WITHOUT WEARING A TYPE N95 PARTICULATE RESPIRATORS (PRS) OR A MORE PROTECTIVE RESPIRATOR.** The wearer must be trained before using respirators. Personnel must be fit tested for respirator use.

5. HANDS must be washed before and after touching the patient or after contact with potentially contaminated articles.

6. ARTICLES Waste contaminated with infective material should be placed in a red bag. Linen should be placed in an impervious linen bag and labeled "ISOLATION."

7. TRANSPORT Patient should not leave the room unless absolutely necessary. When leaving the room, the patient should wear a surgical mask, and the door to the patient's room should remain closed for at least 45 minutes after the patient leaves their room.

8. SPECIAL INSTRUCTIONS

CONTACT PRECAUTIONS
(sign is green)
VISITORS - REPORT TO NURSES' STATION BEFORE ENTERING ROOM

1. PRIVATE ROOM *required*, except as noted in Isolation Policy.

2. GLOVES **must be worn by all persons entering the patient's room or cubicle.**

3. GOWNS **must be worn by all persons entering the patient's room or cubicle.**

4. MASKS not required except during procedures which may generate aerosols of infective material (i.e., dressing changes) and if splattering is anticipated.

5. HANDS **must be washed or sanitized upon leaving the room or cubicle.**

6. ARTICLES Waste contaminated with infective material should be placed in a red bag. Linen should be placed in an impervious linen bag and labeled "ISOLATION." When possible, articles such as scissors, stethoscopes, or tourniquets should be designated for use by this patient only and should be left in this patient's room. **Reusable equipment should be disinfected with a germicidal wipe or spray before being removed from the isolation room or cubicle.**

7. SPECIAL INSTRUCTIONS

PROTECTIVE ISOLATION
(sign is blue)

1. PRIVATE ROOM *required.* When possible, patients should be assigned to isolation rooms with a ventilation system that has positive pressure relative to the corridor or a room with a positive pressure anteroom. It is preferable to keep doors closed.

2. GLOVES not required unless coming in contact with blood or other potentially infectious material.

3. GOWNS not required.

4. MASKS not required except for individuals with suspected upper respiratory tract infections who *must* enter the room. The patient should wear a mask when outside the room.

5. HANDS Strict handwashing should be performed before and after contact with the patient.

6. ARTICLES (e.g., stethoscopes, otoscopes) - should be wiped with alcohol before with patient.

7. SPECIAL INSTRUCTIONS

FORM 56.49 R 7/98	

SPECIAL HANDLING PRECAUTIONS (sign is pink)

VISITORS - REPORT TO NURSES' STATION BEFORE ENTERING ROOM

1. PRIVATE ROOM required only for patients with draining cerebrospinal fluid or bleeding problems.

2. GLOVES must be worn by all persons having contact with the patient's cerebrospinal fluid or blood.

3. GOWNS must be worn by all persons having contact with the patient's cerebrospinal fluid or blood.

4. MASK/EYEWEAR not required except if splattering of cerebrospinal fluid or blood is anticipated.

5. HANDS must be washed after contact with the patient or if contaminated by cerebrospinal fluid or blood, even if gloves are worn.

6. ARTICLES require special precautions if contaminated with CSF or blood. Use disposables whenever possible, and discard in red bags or, if sharps, in sharps disposal container. If reusable critical (enters normally sterile tissue or area through which blood flows) or semi-critical (comes in contact with mucous membranes) items become contaminated with CSF or blood, they must be sealed in a **clear** bag or rigid container, if sharp, labeled with a copy of this placard, and sent to the decontamination area of Central Sterile Processing for sterilization. Non-critical items (come in contact with intact skin and not mucous membranes) and surfaces such as countertops and floors can be decontaminated using household bleach (unduiluted or diluted 1:10) or 1N sodium hydroxide. (refer to general infection control policy "disinfection and Sterilization for further information.) Linen soiled with CSF or blood should be disposed of in a red "biohazard" biohazardous waste container.

7. LABORATORY SPECIMENS specimens containing cerebrospinal fluid, tissue, or blood must be labeled with a pink label specifying "special handling precautions" or using NAPCO label # 56.54 (refer to the Isolation Policy), and placed in a plastic ziplock bag.

8. SPECIAL INSTRUCTIONS

FORM 56.53	Rev. 04/01

USE OF DEMISTIFIER UNITS

Policy: PC 130
Issued: August 1995
Revised Date: September 2006
Review Date: June 2001

PURPOSE
To provide guidelines for the appropriate use of demistifier units.(1)

POLICY
1. Demistifier units should be used for any patient requiring negative pressure isolation when a negative pressure isolation room is not immediately available.

2. All personnel must follow precautions for airborne isolation while patients are using demistifier units.

3. GUIDELINES FOR DEMISTIFIER UNITS (2): Refer to attached flowchart

   a. The nurse will call patient transportation to obtain the demistifier unit and canopy.
   b. The demistifier canopy is attached to the unit and is a one time patient use item.
   c. The demistifier canopy will be placed around the patient and bed/cart and connected to the demistifier unit. The unit must continue to operate until the patient is moved to a negative pressure isolation room or until the infectious condition is ruled out.
   d. The patient will be transported to a negative pressure isolation room with the demistifier unit operating in place over the patient and the bed/cart.
   e. After patient use, patient transportation personnel will return the demistifier unit to the patient transportation area for cleaning.
   f. The demistifier canopy is discarded into regular trash.

3. **AIRFLOW IN NEGATIVE PRESSURE ROOMS The direction of airflow in the patient room must be checked and documented as follows. Refer to N1604.**

   a. at the time the need for isolation is recognized and the unit is placed in the room,
   b. prior to admitting the patient to the room, and
   c. daily while the patient is on isolation.

INTERPRETATION, IMPLEMENTATION AND REVISION

Nursing and Infection control are responsible for the interpretation, implementation and revision of this policy

Patient Care Policy 130 Use of Demistifier Units

REFERENCES:

1. <u>Centers for Disease Control and Prevention.</u> Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005 MMWR 2005;54(No. RR-17) pp 61-62.

2. Demistifier Units: http://www.peacemedical.com/ProductsIndex.htm

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Patient Care Policy 130 Use of Demistifier Units

The University of Chicago Hospitals
Policy and Procedure Manual

ISOLATION

I. PURPOSE

This policy is to ensure proper implementation of precautions and **isolation** techniques in order to prevent the spread of healthcare associated infections to patients, personnel, and visitors. General policies referred to herein may be found on the UCMC intranet within policies and procedures.

II. **INDICATION FOR ISOLATION**

A. If it is known prior to admission that a patient requires **isolation** precautions, the Admitting Department and Bed Access should be notified by the admitting physician so that **isolation** can be instituted as quickly as possible after the patient enters the hospital. The physician should also tell the Admitting Department if the **isolation** precautions require a private room or a room with special ventilation. The Admitting Department should notify the nursing unit when such a reservation is made, so the necessary equipment can be obtained prior to the patient's arrival. Refer to "Infection Control Guidelines for Bed Assignments" in infection control policy IC03-01, "Patient Access Center".

B. The need for **isolation** precautions may also be indicated by a prompt on a report from the Clinical Microbiology Laboratory. The prompt states, "Your patient may require **isolation**. Please consult the **Isolation** Policy located in the Infection Control Manual." If **isolation** is indicated, **isolation** precautions should be initiated as outlined below.

C. An M, V or O will appear in the IFD (infectious disease field) in the patient record in Last Word, OR greaseboards, or other electronic record that has the IFD included within the records. This is an indication of a previously positive culture with a resistant organism and need for contact **isolation** to be initiated.

III. SELECTION OF A ROOM

A. Shared Room

          1. Generally, infected or colonized patients should not share a room with a patient who is likely to become infected or in whom the consequences of infection are likely to be severe.

          2. If two patients are infected with or exposed to the same agent (e.g., chickenpox) and space does not permit assignment to private rooms, contact the Infection Control Program for recommendations. Refer to "Infection Control Guidelines for Bed Assignments" in infection control policy IC03-01, "Patient Access Center".

B. Private Rooms

          1. In rooms without a special ventilation system, the exhausted air is recirculated. Patients with infections highly transmissible by the airborne route should not be assigned to these rooms.

          2. A private room without special ventilation is needed if:

                    a. The patient requires Droplet Precautions for an infection spread by droplets over short distances through the air.

                    b. The patient is on Contact Precautions (see Appendix A). If the patient on Contact **Isolation** is in the Intensive Care Nursery, Comer Cardiac Intensive Care Unit, or in a Recovery Room, the need for a private room will be evaluated on a case-by-case basis.

                    c. A patient who is not known to be infected or colonized with an agent which is spread by direct contact, but is likely to contaminate his/her environment because of a bleeding problem, diarrhea, projectile emesis, impaired mental status, or poor hygiene should also be given a private room.

C. Negative Pressure (Containment) **Isolation** Rooms

          1. Containment of infections transmitted by the airborne route via droplet nuclei requires **isolation** rooms with: (a) negative pressure in the patient room relative to the anteroom or corridor; and (b) direct exhaust of air to the outside (Reference A). Rooms with these features are listed in Appendix C.

          2. Patients requiring negative pressure **isolation** have

priority over other patients for use of the negative pressure **isolation** rooms. If a patient has a condition requiring airborne/strict **isolation** and the room is occupied by a patient who does not require airborne/strict **isolation**, the patient who does not require airborne/strict **isolation** must be transferred to another room. (Refer to the Administrative Policy and Procedure Manual)

3. When the patient leaves the negatie presssure **isolation** room or is discharged, the doors to the room should remain closed for at least 45 minutes.

4. An isolette is at positive pressure, and therefore, is not a substitute for a containment **isolation** room.

5. A room with a portable HEPA filter is not a substitute for a containment **isolation** room.

6. The airflow in the negative pressure room **isolation** rooms must be checked by nursing or nursing care personnel before admitting a patients on negative pressure **isolation** to the room and at least daily when occupied by a patient on **isolation** precautions. If the airflow is not appropriate, the Plant Department (x2-6295) should be notified immediately. (Refer to the Nursing Policiy and Procedure Manual).

D. Positive Pressure **Isolation** Rooms for Neutropenic Patients

1. Private rooms with positive pressure ventilation (see Appendix C) have been constructed on 6NW to protect neutropenic (neutrophil counts below 500/mm^3 patients from infections that may be transmissible via air. Air in positive pressure rooms flows from the patient's room into the corridor. In order for the ventilation system to function properly, all of the doors to the anteroom (one to each of two patient rooms and one to the hall) must be kept completely closed and the door to the bathroom must be kept open.

2. If a patient in the positive pressure room develops an infection transmitted by the airborne route, the patient must be transferred out of that room and evaluated for placement in a negative pressure **isolation** room.

IV. **ISOLATION** CATEGORIES (Reference A)

A. Contact Precautions

1. These precautions are designed to prevent transmission of organisms by direct or indirect contact with secretions or excretions from an infected or colonized body site.

2. Patient care items

        a. When possible, disposable items (e.g., thermometers) should be assigned to the patient and discarded when not needed or upon discharge. Dedicate non-critical medical items to patients with multi-drug resistant organisms (MDROs) if possible (reference J).

        b. Reusable items (e.g., IV poles, ventilators, x-ray machines, EKG machines, toys) should be decontaminated before they are removed from the patient's room. Any equipment which cannot be adequately decontaminated should be bagged in a clear bag, labeled as equipment from an **isolation** room, and sent for decontamination or sterilization.

3. Patients who should be placed on contact precautions include those with:

        a. Suspected or confirmed gastrointestinal pathogens (*C. difficile* toxin positive, *Salmonella, Shigella, Rotavirus*). This includes any child admitted to the University of Chicago Comer Children's Hospital with vomiting and/or diarrhea and any adult with acute diarrhea.

        b. Organisms with high antibiotic resistance including MRDOs:

                i. Enteric gram-negative bacilli or *Pseudomonas aeruginosa* resistant to at least two aminoglycosides (gentamicin, tobramycin, amikacin) or ceftazidime;

                ii. Cystic fibrosis patients colonized or infected with *Burkholderia cepacia*;

                iii. Vancomycin-resistant *Enterococci* (VRE). Contact precautions may be discontinued

if three sets of cultures obtained at least 1 week apart arenegative for VRE on a final culture report. Cultures should be obtained from any previously positive site (if still obtainable) AND stool or rectal culture. VRE culture should be specified on the laboratory requisition.

iv. Methicillin-resistant *S. aureus* (MRSA). Contact Precautions may be discontinued if two sets of cultures obtained at least 2 days apart and at least two days after the completion of appropriate antibiotic therapy are negative for MRSA on a final culture report. Surveillance cultures should be obtained from both anterior nares, axilla and groin using one moist swab and, using a second swab, from any other site which was previously positive. MRSA culture should be specified on the requisition. The specimen and requisition should be sent to the Clinical Microbiology Laboratory.

v. *Enterobacteriacea* (i.e., *Klebsiella sps.* and *E. coli*) resistant to ceftazidime (a marker for extended spectrum beta lactamase [ESBL] producers).

c. *Adenovirus* conjunctivitis

d. Children or immunocompromised adults with suspected or confirmed respiratory syncytial virus (RSV). Any patient less than five years of age who has a specimen sent for RSV testing should be placed on Contact Precautions. This includes any child under the

age of 5 with upper respiratory symptoms, pneumonia, bronchiolitis, difficulty breathing, or asthma exacerbation.

4. *PPE is required prior to entry into patient's room or cubicle.*

B. Droplet Precautions

1. This **isolation** category is designed to prevent the transmission of infectious diseases that are spread primarily over short distances through the air (droplet transmission). Examples of such diseases include: meningococcal disease, pertussis, diphtheria, mumps.

2. The door to the patient's room should be kept completely closed. If the patient is in Mitchell Hospital, the door to the patient's bathroom should be kept open to allow air to exhaust from the room. Private rooms with sliding walls between rooms should not be used for these patients.

3. If the patient leaves the room or is discharged, the door to the room should remain closed for at least 45 minutes. Patients may or may not need to be placed in a negative pressure **isolation** room (refer to Appendix A).

C. Airborne Precautions

This **isolation** category is designed to prevent the spread of tuberculosis.

1. Criteria for Initiation of Airborne Precautions:

Patients who should be placed on Airborne Precautions include:

a. Patients with suspected or confirmed pulmonary or laryngeal tuberculosis.

b. Patients with HIV who have cough or any unexplained infiltrate on chest radiograph.

c. Patients receiving treatment for proven tuberculosis who still may have active infection as evidenced by persistent cough, persistent constitutional symptoms, recent positive sputum culture during treatment, or no decrease in the number of mycobacteria seen on smear.

d. Patients who have active tuberculosis and who are receiving an inadequate treatment regimen.

e. Patients with proven or suspected active extrapulmonary tuberculosis draining externally through the skin.

f. Patients with multidrug-resistant (MDR) tuberculosis who have not been receiving supervised therapy.

g. Children or adults with proven or suspected communicable tuberculosis.

2. Criteria for Discontinuing Airborne Precautions:

Isolation precautions should be discontinued as soon as there is substantial evidence that a patient does not have, or no longer has, infective tuberculosis. Criteria for discontinuing **isolation** precautions include:

a. Three smear-negative sputum specimens from patients with cavitary pulmonary disease or three smear-negative specimens from patients with extrapulmonary lesions draining externally through skin.

b. Three negative smears obtained from gastric aspirates (for pediatric patients).

c. Three negative sputum smears and establishment of a diagnosis other than tuberculosis in patients with pulmonary infiltrates suggestive of tuberculosis or HIV patients with cough.

d. The Adult or Pediatric Infectious Diseases consultation service in conjunction with the Infection Control Program determine **isolation** may be discontinued.

D. Strict **Isolation**

This **isolation** category is designed to prevent transmission of highly contagious or virulent organisms, such as chickenpox, that may be spread by both the airborne and contact routes. Patients place on Strict **Isolation** are to be placed in a containment **isolation** room (negative pressure room or room with positive pressure anteroom). Appendix A, "**Isolation** Requirements by Infection/Condition" indicates the diseases the require use of containment **isolation** rooms.

E. Code Bio or Outbreak **Isolation**

In the event that an outbreak or Code Bio is occurring and an **isolation** cohort is necessary, **isolation** may be modified with approval of the Infection Control Program (See Appendices E.1-6)

F. Special Handling Precautions

This **isolation** category describes the necessary precautions for patients with suspected or confirmed Creutzfeldt-Jakob Disease (CJD), a progressive, fatal neurologic disease caused by a particle called a prion which is found in the brain, spinal cord, cerebrospinal fluid (CSF), and leukocytes (blood). Precautions should be taken when handling tissue, CSF, or blood (Reference E, F). This prion is unusually resistant. Specimens for patients with known or suspected CJD must be labeled with a special pink sticker that says "Creutzfeldt-Jakob". These labels may be obtained from Graphics and Technology (Label 5654). Reusable instruments or equipment contaminated with blood or spinal fluid must be sealed in a bag, labeled, and sent to the decontamination area of materials management for sterilization. Refer to the general infection control policy IC02-05, "Disinfection and Sterilization" for methods of inactivation.

G. Protective **Isolation**

This **isolation** category may be used for immunocompromised patients, especially when their neutrophil counts fall below 500/mm^3. Patients should be assigned to rooms with positive pressure anteroom, positive pressure room, or a private room. If neutropenic patients develop a communicable disease (e.g., chickenpox, disseminated herpes zoster) which requires containment **isolation**, they should be assigned, when possible, to a containment **isolation** room with a positive pressure anteroom.

V. PROCEDURES FOR **ISOLATION** PRECAUTION

A. Initiation of **Isolation** Precautions

1. **Isolation** precautions (refer to Appendix A, "**Isolation** Requirements by Infection/Condition") may be initiated by a physician, a nurse, or an infection control practitioner. **Isolation** precautions may be initiated in one of the following ways:

a. A written order from the physician.
b. A note written in the progress notes by the physician, nurse, infection control practitioner, or other clinical staff member indicating the reason for requiring **isolation** precautions.
c. Patient Access Center assesses need for **isolation** upon admission.

2. Initiation of **isolation** precautions is documented on the patient's medical record.

3. The physician or nurse initiating **isolation** precautions for his/her patient is responsible for explaining to the patient and his/her family, when appropriate, the reasons for **isolation** precautions and the procedures to follow.

B. Maintaining **Isolation**

1. All personnel

a. Every hospital employee is responsible for maintaining **Isolation** precautions. Personnel caring for any patient should check for an aqua identification band and an **isolation** placard on the front of the patient's chart and on the door of the patient's room.
b. If a patient is to be transported to another floor, department, or operating room, personnel in the area to which the patient is to be taken should be notified beforehand that the patient is on **isolation** precautions.
c. If a patient is continuously non-compliant with the **isolation** policy, staff should enlist the help of Risk Management and Security to assist them.

2. The charge nurse or the nurse assigned to the isolated patient is responsible for ensuring that:

a. A preprinted **isolation** sign is placed on the door or door frame to the patient's room and on the cover of the patient's medical record (maroon and gray binder, if both are used). Any necessary special instructions should be written in the designated space on the placard.
b. An aqua identification band is placed on the patient unless circumstances prevent such

placement (e.g., premature neonate) in which case the band may be affixed to the bed/crib. The **isolation** category should be written on the band.

c. The necessary **isolation** equipment such as gloves, gowns, masks, and **isolation** labels for soiled linen are obtained.

d. Ancillary departments are notified, when necessary.

3. Nurse's responsibility

a. Nursing personnel caring for isolated inpatients and outpatients are responsible for maintaining an adequate and appropriate supply of **isolation** equipment (e.g., masks, gowns, gloves, red bags, **isolation** labels for linen bags), instructing visitors about **isolation** procedures, notifying ancillary departments (e.g., Physical Therapy, Food Services, Radiology, etc.) of the need for **isolation**, and documenting maintenance of **isolation** precautions.

b. If a patient on **Isolation** precautions has a cardiopulmonary arrest ("Dr. Cart"), it is the responsibility of nursing personnel on the unit to inform the physicians and other support staff responding to the "cart" that the patient is on **isolation** and the reason for **isolation**.

4. Physician's responsibility

If the patient requires a special procedure such as an operation, cardiac catheterization, or cholangiogram, it is the responsibility of the physician making the reservation for the procedure to indicate that the patient is on **isolation** precautions, and what type of **isolation** has been ordered.

5. Discharge planner's responsibility

Nurses, social workers, home care personnel, and others involved in discharge planning are responsible for notifying post-discharge caregivers of necessary **isolation** precautions.

C. Patient Restrictions

1. Patients on **isolation** should remain in their room and should not walk the halls or visit with other patients. When possible, tests should be performed in their rooms. The only "routine" exception to ambulation in the hallway is as follows.

    a. If a formal evaluation by THERAPY SERVICES (physical or occupational) determines that ambulation in the hall is the only means by which to effectively rehabilitate a patient. The following criteria must be met in order to modify the Contact Precautions.

        i. A patient evaluation checklist must be completed by PHYSICAL THERAPY/ OCCUPATIONAL THERAPY prior to ambulation.

            a. A patient who is on Airborne, Strict, or Droplet Precautions may NOT ambulate in the hallway

            b. A patient with active diarrhea may NOT ambulate in the hallway.

        ii. A patient on Contact Precautions can only leave the room to walk the hallway of the unit under the direct supervision/assistance of a physical/occupational therapist.

            a. The physical/occupational therapist must wear an **isolation** gown (yellow) and gloves while in the patient's room and while assisting the

patient in the hallway.

b. The patient must wear an **isolation** gown and gloves while ambulating in the hall.

c. If the patient is physically unable to don gown and gloves, then the patient may walk without these items.

d. It is the responsibility of the physical/occupational therapist to clean any surfaces that the patient touches with an EPA registered disinfectant immediately following ambulation.

e. Once patient has been returned to his/her room the physical/occupational therapist should clean any reusable equipment that was used (walker, gait belt, etc.) that will be removed from the room, remove the gown and gloves in normal fashion and dispose of the PPE in the

patients room, and then perform hand hygiene when leaving the room.

2. Children on **isolation** precautions are not permitted to participate in play group or playroom sessions. Activities should be restricted to the bedside or Infection Control should be contacted for evaluation of activities planned outside of the patient's room (e.g., one-to-one sessions in the playroom).

3. If an isolated patient needs to leave their room for a procedure or other test, appropriate barriers (mask, impervious dressing, etc.) should be worn by the patient. When a patient on Strict, Airborne, or Droplet Precautions leaves their room, the door(s) to that room should remain closed for at least 45 minutes.

4. Exceptions to patient restrictions, not already specified above, must be approved by the Infection Control Program (pager 7025).

D. Pregnant Healthcare Workers

Pregnant healthcare workers are at no higher risk of acquiring an infection when appropriate infection control practices are followed.

E. Visitors

It is the responsibility of nursing personnel to instruct visitors on the proper procedures for handwashing, gloving, gowning and masking, and other necessary precautions before entering and after leaving the patient's room. Visitors should be reminded to wash their hands upon leaving the patient's room.

NOTE: If a family member or significant other is "rooming-in" with the patient, that person is not considered a visitor. See "Rooming-in" below.

F. Rooming-in

Rooming-in occurs when a family member or significant other is participating in the care of the patient as part of the patient care team and is living in the patient's room (using the patient's bathroom, sleeping on a cot, eating their meals in the patient's room, etc.). **Rooming-in DOES NOT apply in the ADULT ICU setting because visitors**

MUST leave the room to eat, bathe, and use restroom facilities. Visitors to the ICU should continue to wear **isolation** garb, even if they are allowed to sleep in a chair at the bedside table. If a person is rooming-in with the patient, that person is not considered a visitor and may choose not to wear the **isolation** garb. If they choose not to wear **isolation** garb while in the patient's room, then they must follow the same restrictions as the patient (must wash their hands and leave the unit, cannot sit in common areas, or use the nutrition room, etc.). (See Appendices F.1-2 for instructions for Comer visitors).

G. Soiled linen (Refer to the general infection control policy IC02-12, "Linen: Distribution, Storage, and Handling")

Soiled linen should be handled with gloved hands and with a minimum of agitation to prevent microbial contamination of air. A gown should be worn to protect clothing that may come in contact with soiled linen. Linen from **isolation** patients should be placed in a plastic linen bag and labeled "**Isolation**" (Reference H. 1.). If linen is contaminated with the blood or CSF from a patient on Special Handling precautions, the linen should be placed into a red bag and discarded.

H. Dishes

Either nondisposable or disposable food trays, dishes, and utensils may be used for patients on **Isolation** precautions (Ref. A). Disposable trays should be discarded in the trash receptacle in the patient's room. Nondisposable trays, dishes, and utensils require no special precautions if they are removed from the patient's room and placed directly onto the soiled tray cart. If the tray must be removed from the patient's room and must be placed in a location other than the soiled tray cart, it must be placed in a clear bag at the time of removal. Used trays, dishes, and utensils should be handled with gloves and put through the routine dishwashing process.

I. Patient's medical record

The patient's medical record should never be taken into an **isolation** room and should not be in contact with blood, body fluids, or potentially infectious materials. During

transport, a patient's chart can be wrapped in a clean sheet, blue "chuck", pillowcase, or other material to minimize contamination.

J. Flowers

Patients on Protective **Isolation** may not have fresh or dried flowers or potted plants. Fresh or dried flowers or potted plants are not allowed in patient care areas where there are immunocompromised patients (i.e., hem/onc and transplant units, ICUs, radiation/oncology, IV infusion, and transplant and hem/onc clinics).

K. Waste (Refer to general infection control policy IC02-03, "Biohazardous (Potentially Infectious) Waste").

All dressings, paper tissues, and other disposable items grossly contaminated with blood or other potentially infective material (see Appendix A) should be placed in a biohazardous waste container (Ref. A). Waste not grossly contaminated with potentially infectious material may be placed in a nonbiohazardous waste container.

L. Housekeeping (Refer to the general infection control policy IC02-09, "Housekeeping")

1. **Isolation** rooms should be cleaned in the same manner as regular patient rooms (Reference A). Equipment used to clean the rooms should be decontaminated or discarded after use (e.g., dirty water should be discarded, wiping cloths and mop heads should be laundered and thoroughly dried, and buckets should disinfected before being refilled). Protective **Isolation** rooms should be cleaned before regular patient rooms, when this is not possible, clean equipment should be used to clean these rooms. Other types of **isolation** rooms should be cleaned after non-**isolation** rooms.
2. Personnel performing the cleaning procedures should wear the protective apparel listed on the **isolation** precaution placard. If the patient was on Strict, **Droplet**, or Airborne Precautions, the door should be kept closed for at least 45 minutes after the patient has been discharged. Personnel working in the room should remain masked during that time period.

VI. DISCONTINUATION OF **ISOLATION** PRECAUTIONS

Criteria for discontinuing **isolation** can be found in Appendix A.

VII. EXPOSURE OR INFECTION WITH A COMMUNICABLE DISEASE
Refer to the general infection control policy IC02-15a, "Personnel Health: General Policy" when an exposure or infection occurs.

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The University of Chicago Medical Center
Policy and Procedure Manual

INTRAVENOUS THERAPY AND VASCULAR ACCESS

Policy: PC 118
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Revised: July 2008
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PURPOSE:
A. To provide guidelines for insertion and care of peripheral intravenous (IVs), central venous catheters, arterial catheters, implanted ports, and peripherally inserted central catheters (PICC) lines.
B. To provide guidelines for maintenance of tubing, dressings, and equipment attached to vascular access devices.

POLICY:
I. Peripheral IVs
A. Insertion and/or access
1. RN's and other clinically competent personnel may insert peripheral IV catheters and scalp vein needles with a medical order.
2. RN's can initiate saline or heparin flush or fluids. LPNs can initiate and perform a saline flush under the supervision of a RN. Patient Care Technicians (PCTs), Phlebotomists, Nursing Support Assistants (NSAs), and Nurse Externs cannot push flush solutions, initiate or maintain flow of IV fluids. Technicians and paramedics will function within the practice standards for the State of Illinois.
3. In adults, use an upper-instead of a lower-extremity site for catheter insertion. Replace a catheter inserted in a lower-extremity to an upper-extremity as soon as possible. (5) The physician/APN should be consulted prior to placing a peripheral IV on the same extremity as an AV access site for hemodialysis, or in the leg or foot of an adult patient.
4. A medical order is required prior to using topical analgesic cream or intradermal injections of anesthesia before cannula insertion.(1)
5. Preparation of IV site: Refer to Infection Control Policy 2-10b section VIII.
6. Emergency Insertion of Peripheral IVs: Refer to Infection Control Policy 2-10b section IX.

7. Blood draws should not be routinely performed from a peripheral IV catheter except upon initial insertion (1,2).

B. Solutions

1. Nurses may not mix IV solutions outside of laminar flow hoods unless an emergency situation occurs. Refer to Pharmacy policy PH16-001

2. All ready-to-mix IV solutions must have a "do not use after" date noted. If not, return to pharmacy. Ready-to-mix IV solutions must note the date and time the solution was mixed the pharmacy, and be dated, timed and initialed by the nurse when administered.

3. All pharmacy prepared admixtures must have an expiration date noted. If these dates are not noted, return IV to pharmacy.

4. All IV fluids must note the date and time when the fluids were spiked, and the nurse's initials.

5. All IV fluids MUST be infused via infusion pump, for pediatric and neonatal patients. Infusion pumps should also be used for all IV fluids in adult patients, unless an emergency situation occurs, or the patient is in the operating room. The medication library on the infusion pump should be used for all infusions.

6. Do not administer any bag unless it is clear of precipitate and the seal is intact (5).

7. Do not administer any IV additive or IV push simultaneously with blood through the same infusion set (2).

8. Commercially or pharmacy prepared intravenous solutions expire 96 hours after wrapper is removed, and should be changed at least every 96 hours, or at the pharmacy expiration date, if sooner. Solutions prepared emergently outside of a laminar flow hood should be changed at least every 24 hours. Do not remove wrapper until ready to use (5).

9. Do not use bags of IV solution as a common source supply for multiple patients.

C. Maintenance

1. Maintenance of Peripheral Intravenous Catheters: Also refer to Infection Control Policy 2-10b

2. Sites: Peripheral IV sites should be changed every 96 hours (1, 2 5,7) for adults unless extenuating circumstances exist, are documented and a medical order is obtained to maintain existing IV site. PEDIATRICS: Peripheral IV catheters should remain in place in children until IV therapy is completed unless complications occur (5).

3. Flushes: Flush locked peripheral IV catheters with 0.5 –5ml sterile saline at least every 8 hours, depending on catheter size and patient size (9).

4. Dressings: Sterile semi-permeable transparent dressings are the preferred dressings for peripheral IV sites as they allow for visual inspection of the insertion site. Peripheral transparent dressings are changed every 96 hours. Sterile gauze and tape are changed daily if bulky dressing prevents palpation or direct visualization (5).

Replace dressing if the patient is diaphoretic or the dressing becomes moist, soiled, or loose. PEDIATRICS: In neonates, infants, and children, the sterile semi-permeable transparent dressing or gauze dressing should remain intact for the duration of the therapy, unless the integrity of the dressing is compromised or the patient has local tenderness or other possible signs of catheter related infection.

5. Tubing: All IV tubing (including add-on devices, filters, CLAVE® connectors, etc) connected to peripheral IV catheters and central venous catheters should be changed every 96 hours, unless catheter-related infection is suspected or documented. All IV tubing should be changed immediately when contamination is suspected or when product integrity is compromised . (1,5) IV tubing should be labeled with the date of expiration, and the clinician's initials. (1)

a. Blood administration sets must be used with filter for transfusion of blood products. If blood is administered continuously, regardless of add-on devices, change the set at the end of 4 hours. If a single unit of blood is administered intermittently, regardless of add-on devices, change the set after each unit. (1)

b. Tubing into which fat emulsion is infused must be changed at least every 24 hours down to the catheter hub (1,5,9). Tubing used to administer propofol should be changed every 6 or 12 hours, depending on its use, per the manufacturer's recommendation (5). Follow manufacturer's recommendations regarding frequency of tubing changes for unstable drugs.

c. Access ports of the tubing should be wiped with alcohol or iodophor prior to accessing and accessed with only sterile devices (5).

d. Dead end caps must be changed with each entry (1,5).

e. Stopcocks must be capped when not in use (5).

D. Assessment of the Peripheral IV site.

1. In adults, assess the IV access site for catheter placement, catheter patency, and signs of infiltration or extravasation every 1 to 4 hours and as needed, (2) depending on infusate, and document in the medical record.

2. In pediatrics, assess the IV access site for catheter placement, catheter patency, and signs of infiltration or extravasation at least every 2 hours and as needed, depending on infusate, and document in the medical record.

E. Documentation:

1. Peripheral IV dressings should be labeled with date and time of insertion, gauge of catheter and inserter's initials (1,9).

2. The date of IV tubing change, insertion date, gauge, site of insertion and initials of person inserting IV must be documented in the patient medical record.

F. Removal of Peripheral IVs: Refer to Infection Control Policy 2-10b section XIII.

II. Central Venous Catheters/ Peripherally Inserted Central Catheters (PICC

Lines)
A. Consent, Insertion, and Access
1. Informed consent must be obtained prior to the insertion of any central venous catheter (3, 10).
2. Advanced practice nurses and physician assistants may insert the following if outlined in their collaborative agreement
a. Pulmonary artery catheter
b. Multi-lumen catheters
c. Pheresis catheters
d. Dialysis catheters
e. Large bore introducers (Cordis)
f. Implanted subcutaneous infusion port devices
g. Tunneled central venous access devices
h. PICC lines
3. PICC lines may also be inserted by clinically competent staff nurses
4. Only clinically competent personnel may access a Pheresis/Dialysis catheter (7).
5. Large bore introducer lines are used in the critical care areas only, including the operating rooms.
6. Fluids and hemodialysis may not be initiated until placement of the central venous catheter into the superior vena cava has been verified by fluoroscopy or chest x-ray, unless the patient is in the Operating Room or emergency placement is performed. (2,6,7,9) In such cases, a medical order shall be in place prior to usage of the central line and radiographic verification should be obtained as soon as possible thereafter.

B. Solutions
1. RNs perform assessments and flush all central venous catheters and initiate flush bags/transducers. LPNs who are clinically competent, under RN supervision may flush multi-lumen catheters with normal saline. Technicians who are clinically validated may flush dialysis or pheresis catheters with normal saline. RNs, LPNs, and technicians who are clinically competent may perform dressing changes RNs and clinically validated technicians in the role of ECMO, dialysis and apheresis technicians may draw blood from central lines.
2. Dedicated hemodialysis catheters should be used only for hemodialysis unless emergency circumstances exist, and are documented in the medical record (5)
3. RNs who are clinically competent may remove large bore introducers, triple lumen catheters, PICC lines, pulmonary artery catheters and arterial lines (2).
C. Maintenance of Central Venous Catheters Dressings (Refer to Infection Control Policy 2-10a section XII):
1. Use aseptic technique and observe standard precautions when accessing the port/line/lumen or performing dressing changes (5). 2% Chlorhexidene is the preferred antiseptic to clean the insertion site. (5).

2. Sterile semi-permeable transparent dressings are the preferred dressing, as they allow for visual inspection of the insertion site. Replace the catheter-site dressing when it becomes damp, loosened, soiled or when inspection of the site is necessary. Replace dressings used on short-term central venous catheters every 2 days for gauze dressings and at least every 7 days for transparent dressings, except in those pediatric patients in which the risk for dislodging the catheter outweighs the benefit of changing the dressing. **(5) The Chlorhexidene sponge dressing (Biopatch®), should be placed (grid/light blue side up) over the insertion site of non-tunneled catheters in adult patients, and covered with a sterile semi-permeable dressing (5). Do not use Biopatch® dressings in neonates (5) as the safety and effectiveness of Biopatch® antimicrobial dressing has not been established in children under 16 years of age.**

3. The dialysis staff change dressings on hemodialysis catheter sites on days when the patient is dialyzed. (6).

4. Nurses on the nursing units will change dressings on tunneled or implanted hemodialysis catheter sites when the catheter site dressing becomes damp, loosened, soiled or when inspection of the site is necessary and at least every 7 days (5) if the patient is not receiving dialysis.

5. Transducers, components to transducer, and flush bags (a closed-flush system) should be replaced at 96 hour intervals (1). LPNs who are clinically validated, under RN supervision may flush multi-lumen catheters with normal saline.

6. Dead-end caps must be changed with each entry. (1)

7. Stopcocks must be capped when not in use (5).

D. Replacing catheters - In adult and adolescent patients, catheters should be replaced and the site changed NO MORE FREQUENTLY than every 4 days to prevent phlebitis and catheter colonization. Do not routinely replace catheters to prevent catheter-related infections (5).

E. Assessment of the Central Venous IV site. The site should be assessed for signs of complications at least every 2 hours in adults, and every 1 hour in pediatrics and documented in the medical record.

F. Documentation
1. Dressings should be labeled with date and time of dressing change, and personnel's initials (9).
2. The date of IV tubing change, insertion date, gauge, site of insertion and initials of person inserting IV must be documented in the patient medical record.

III. Arterial lines (Refer to Infection Control Policy 2-10d.)
A. Insertion and Access
1. APNs may insert arterial lines if outlined in their collaborative agreement.

2. RNs perform assessments, initiate flush bags/transducers, and flush all arterial lines. RNs, may perform dressing changes and draw blood. Arterial lines are used in the critical care and step-down units only.

B. Solutions

1. Flush bags containing 0.9%NS, 0.45%NS or sodium acetate (10) should be replaced every 96 hours (1).

2. Do not use solutions with dextrose (2).

C. Maintenance

1. Change transparent semi-permeable dressings every 3 to 7 days. (1) If a semi-permeable transparent dressing is applied over sterile gauze, it is considered a gauze dressing. The site should be assessed at least daily by gentle palpation through the intact gauze dressing for catheter related complications and dressing changed every 48 hours (5).

2. Transducers and components to transducer (a closed-flush system) should be replaced at 96-hour intervals, or immediately upon suspected contamination or when the integrity of the product is compromised. (1).

D. Replacing catheters - Do not routinely replace arterial catheters to prevent catheter-related infections (5).

IV. Implanted Ports

A. Needle Insertion

1. Registered nurses who have clinical competence may access a port-a-cath and remove the needle (2)

2. Use sterile technique when accessing the port (2,5,7,9).

3. Only a Huber needle may be used to access a port-a-cath thus preventing coring of the septum of the port.

4. Clinically competent RNs and dialysis technicians may access specially designated dialysis ports with a vendor-approved needle and remove the needle once dialysis is completed.

B. Maintenance

1. RNs who have clinical competence may perform other procedures: IV line connection, dressing change, heparinization, and cap change (2).

2. Use aseptic technique and observe standard precautions when accessing the tubing and performing dressing changes (5).

3. Change the Huber needle at least every 7 days using sterile technique (9).

4. Sterile semi-permeable transparent dressings are the preferred dressing for accessed subcutaneous implanted ports, as they allow for visual inspection of the insertion site. If using a sterile semi-permeable transparent dressing, the dressing should be changed at least every 7 days, or when the dressings is moist, soiled, or loose (9).

5. If sterile gauze covers the insertion site, then the dressing must be changed every 48 hours. The site should be assessed at least daily for catheter related complications (5).

The site should be visually inspected at least every 48 hours. Implanted port dressings should be labeled with date and time of dressing change, needle gauge, and nurse's initials (2,9).

C. Documentation - Date of needle insertion, needle gauge, nurse's initials, and assessment of site are documented in the patient medical record at least every shift. (2,7).

INTERPRETATION, IMPLEMENTATION AND REVISION:
The Nursing Department is responsible for the interpretation and revision of this policy.

REFERENCES:

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Policy: PC 118
Issued: August 1986
Revised: July 2008
Reviewed: July 2008

The University of Chicago Hospitals
Policy and Procedure Manual

The University of Chicago Medical Center
Policy and Procedures Manual

Policy: PC 137 Labeling of Specimens
Issued: May 2007
Revised: November 2008
Reviewed: July 2008

POLICY
1. It is the policy of the University of Chicago Hospitals that all persons providing care to UCH inpatient or outpatients shall not
collect a specimen from a patient without first identifying the patient. This includes but not limited to: physicians, nurses,
technicians, phlebotomists.
a. Two identifiers must be used to determine the patient's identity.
b. The two identifiers must be person-specific and verified against each label.
i. Outpatients and Emergency Department Patients – (Requires active patient participation in the identification
process.) Acceptable identifiers may be the individual's name, an assigned identification number, date of birth, or other person-specific identifiers.
ii. Inpatients – Acceptable identifiers are only the patient's name and medical history number and when possible
requires patient participation in the matching process.

iii. All patients - The patient's room number bed number, or physical location is never used as patient identifier.
2. All specimens must be immediately labeled in the presence of the patient after the collection, and **before** leaving the patient's
bedside, room, cubicle, or surgical suite.
a. The University of Chicago Hospitals prohibits hand off of this labeling process to another member of the healthcare team.
i. The only exception to this process is during a procedure to maintain sterile technique.
b. Type and Screen specimens must also be labeled with the barcode label from the Type and Screen requisition.
3. The healthcare worker collecting the specimen shall verify each labeled specimen against the patient's two identifiers.

INTERPRETATION, IMPLEMENTATION, AND REVISION
Quality & Risk Management, Phlebotomy, Laboratory and Nursing are responsible for the revision, implementation and interpretation of this policy.

ATTACHEMENT:
Properly Positioned Specimen Labels.

REFERENCES :
1. Patient Identification, Patient Care Policy 29
2. Specimen Submission to Surgical Pathology. Patient Care Policy 47/Administrative Policy A03-16
3. Universal Protocol: Verifying Patient Identification and Surgical Site Prior to Surgery and Invasive Procedures, Patient Care Policy 38/Administrative Policy A02-19.
4. Properly labeled specimens attachment
5. Online Lab Handbook, UCH Intranet quick-link.
6. Blood Products, Procurement and Administration, Patient Care Policy 83.

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Policy: PC 137
Issued: May 2007
Revised: November 2008
Reviewed: July 2008

PROPERLY POSITIONED SPECIMEN LABELS

Example of barcode label with four attachments, all on original paper backing

Each label must be verified against the patient's two identifiers. All specimens must be labeled immediately after the collection. Each labeled specimen must be verified against the patient's two identifiers.
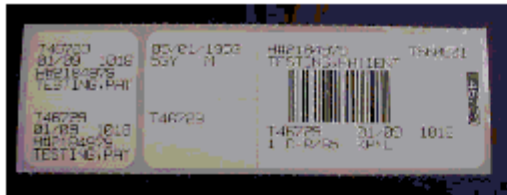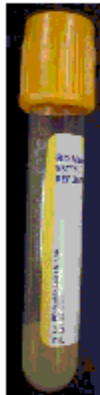
Blank label on unused BD Vacutainer® tube with color-coded sidebar (over which a barcode label or tear tag will be placed)

A properly positioned barcode label with patient ID and barcode, that leaves the colored sidebar exposed and leaves a clear window to the specimen.

(The colored sidebar allows for tube-type verification after the stopper has been removed.)

A properly positioned tear tag from an accompanying requisition that leaves the colored sidebar exposed and leaves a clear window to the specimen.

A Blood Bank requisition for Type & Screen requests with additionally required attached barcodes (one per specimen)

A properly positioned EPIC/LastWord label with patient ID on Type & Screen specimen and additionally required barcode label from requisition order that leaves the colored sidebar exposed and leaves a clear window to the specimen.

PROPERLY POSITIONED SPECIMEN LABELS (MICROTAINER TUBES AND TWO MILLILITER MONOJECT TUBES)

Example of barcode label with four attachments, all on original paper backing

A properly positioned label and properly submitted microtainer tube: the microtainer tube is labeled with one of the two left-most labels. The barcode label is left intact on the original paper backing and submitted in the ziplock bag with the specimen. (If multiple barcodes for one specimen, label specimen with one label, but enclose all barcode labels in the ziplock bag.)

In the laboratory...the barcode label is placed on the carrier tube into which the microtainer tube is placed. An aliquot cup is labeled with the other of the left-most labels and is placed in the carrier tube above the microtainer tube.

IMPROPERLY POSITIONED LABELS – DO NOT POSITION LABEL AS SHOWN:

Too many labels on tube - can't fit on instrument

Barcode unreadable

Horizontal barcode unreadable

No window to view specimen

Upside down barcode off tube bottom - unreadable

Barcode unreadable

One barcode on multiple tubes - unreadable

Medication Labeling On and Off the Sterile Field

Policy: PC 147
Issued: September 2008
Revised:
Reviewed: June 2008

PURPOSE

To provide a process for labeling medications and/or solutions prepared outside of the Pharmacy Department for the purpose of promoting patient safety and reducing medication errors.

II. POLICY

1. Any time one or more medications are prepared but not administered immediately, or anytime the person preparing the medication is not the person administering the medication, the medication container or syringe must be appropriately labeled.
2. All medication, solution containers and packages must be labeled even if there is only one medication being used, except those which are drawn for use and used immediately by the person who prepared the medication.

III. DEFINITIONS

1. Medications include any prescription medications; herbal remedies; vitamins; nutriceuticals; medical foods, over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; pharmacy-dispensed blood derivatives; intravenous solutions, and any product designated by the Food and Drug Administration (FDA) as a drug.
2. Henceforth items listed in III.A. above will be referred to as "medications".

IV. PROCEDURE

1. Any time one or more medications or solutions are drawn up or prepared but not administered immediately (e.g., without leaving the area or moving to another function prior to administration) the container or package (syringe, bottle, basin, bag, etc.) must be appropriately labeled.

The syringe or container must be labeled if :

- The medication is prepared and slowly administered over the course of a procedure;
- The medication is prepared by a staff member other than the administering provider;
- The medication is prepared in bulk for the day's cases; or
- The provider preparing the medication participates in another function prior to administration.

2. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

3. Labeling of the container must occur at the time a medication or solution is transferred from the original packaging to another container

4. Appropriate labeling consists of:

- Name and concentration (strength) of the medication or solution
- Volume/amount (if not apparent from the container)
- Expiration date (if it is not to be used within 24 hours or is not an IV admixture)
- Time of expiration (if it is less than twenty-four hours)
- Date prepared and diluent for all compounded IV admixtures

5. The labels are verified both verbally and visually by two individuals (at least one must be a licensed or certified professional) when the person preparing the medication is not the person administering it to the patient.

6. No more than one medication or solution is labeled at one time.

7. Any medications or solutions found unlabeled are immediately discarded.

8. All original containers from medications or solutions need to remain available for reference until the conclusion of the procedure.

▪ Exception: Cut glass vials should be disposed of in the sharps container immediately after opening to ensure the safety of staff.

9. At shift change or break, all medications and solutions and their labels are reviewed by entering and exiting personnel.

10. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

INTERPRETATION, IMPLEMENTATION, AND REVISION:

The Departments of Nursing and Patient Safety & Risk Management are responsible for the interpretation, implementation and revision of this policy.

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