<table>
<thead>
<tr>
<th>Nursing Schools</th>
<th>Respiratory Schools</th>
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<tbody>
<tr>
<td>Aliscia Ramsey (<a href="mailto:aliscia.ramsey@med.usc.edu">aliscia.ramsey@med.usc.edu</a>)</td>
<td>Julie Mata (<a href="mailto:Julie.Mata@med.usc.edu">Julie.Mata@med.usc.edu</a>)</td>
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<td>American University of Health Sciences</td>
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Last updated 8/1/2017
### School Placement Coordinators

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KECK HOSPITAL OF USC
USC NORRIS CANCER HOSPITAL

OUR MISSION
We are the Keck Medical Center of USC.
We strive to be the trusted leader in quality in health care that is personalized, compassionate and innovative.

- We stand for empowerment, integrity, respect, collegiality and vitality.
- We commit to authenticity.
- We commit to excellence in clinical care, teaching and research.

You can count on us to be fully present in the delivery of uncompromising health care.

SERVICE CREDO
We are the USC Family, working together to serve the lives entrusted to us.

KNOWN SERVICE STANDARDS

- Kind Greeting
- Notice Needs
- Own it
- Wow Them
- Next Steps

OUR VALUES

1. I deliver quality health care through uncompromised service excellence.
2. I show compassion while building positive relationships with my colleagues, our patients and their families.
3. I contribute to innovation through collegial collaboration.
4. I am empowered to improve the performance of the organization.
5. I have integrity and I am accountable to the highest professional standards.
6. I demonstrate respect for our environment by my demeanor, actions and personal appearance.
7. I demonstrate vitality by being fully present and engaging others.
8. I am responsible for authentic communication with my colleagues, out patients and their families.
9. I provide a private, safe and secure environment.
10. I commit to personalizing the “KNOWN” Service Standards.
Affiliated Schools - Student Placement Process

Valid Contract on File

Point of Contact: Larry Santiago Lawrence.Santiago@med.usc.edu

Submit a CCPS Request for Placement

Accepted

Unit Placements are subject to change

Proceed to Document Link to obtain all Student and Instructor Required Documents

Email all required documents to Alicia Ramsey. (Please ensure instructions are followed to prevent delays in processing)

Documents are approved and submitted to Keck IT Dept. for processing. Remember to use the updated link for all Parking permits.

Unit Managers are emailed to secure placement approval.

Instructor, Students, Unit Manager and Preceptors are emailed that students are cleared to start
School Coordinator Checklist

Ensure that all documents are complete

☐ Course Profile *(One per program, signed and dated)*
☐ Syllabus *(Must be attached)*
☐ Clinical Roster *(Must be completed in its entirety)*
☐ Copy of Faculty and Students current BLS card *(Front and back of both cards)*
☐ Exhibit A Responsibility Statement Form *(per student/instructor, signed and witnessed)*
☐ Exhibit B Confidentiality Statement Form *(per student/instructor, signed and witnessed)*
☐ Exhibit C Health & Background Screening Attestation *(per cohort, signed by, name and title)*
☐ Compliance Test *(per student, MUST BE GRADED BY SCHOOL, passing 100%)*
  
  If less than 100%, please take corrective actions to remediate with test to passing status.

☐ Safety Test *(per student, MUST BE GRADED BY SCHOOL, passing 100%)*
  
  If less than 100%, please take corrective actions to remediate with test to passing status.

☐ IT Access Forms: 1, 2, 21 *(per student/instructor, complete HIGHLIGHTED AREAS ONLY)*
☐ ID Badge Request Form *(per student/instructor)*
☐ Parking Form *(REFER to the New Parking Link on the Facility Information Sheet)*

Items to return at the end of the Clinical Rotation:

☐ Faculty Evaluation of Clinical Agency
☐ Student Evaluations of Clinical Agency *(one eval per student)*
☐ Student and Faculty Badges: to Nursing Administration, ATTN: ALISCIA
Dear Visiting Instructor,

Welcome to Keck Medical Center of USC to assure that your experience is pleasurable, please take a moment to review the information below and share appropriate information with your class.

**CLINICAL EDUCATION LIAISON, NURSING EDUCATION DEPARTMENT**
Lawrence Santiago, reachable at Lawrence.Santiago@med.usc.edu

**PLACEMENT COORDINATOR, NURSING EDUCATION DEPARTMENT**
Aliscia R. Ramsey, reachable at Aliscia.Ramsey@med.usc.edu

**BY APPOINTMENT ONLY. I ADVISE AGAINST WALKING IN, AS I AM TYPICALLY NOT AVAILABLE DUE TO OTHER RESPONSIBILITIES THAT TAKE ME AWAY FROM THE OFFICE.**

**PARKING**
323-442-8630
As of June 2017, a new process for permit registration has been implemented at the Keck Parking Office. The new process is online and alleviates the need to print out and scan over the applications to the parking office. Please have all students navigate to the link below to register for their parking. Once the parking office receives the online registration, a permit will be assigned and a notification will be sent advising when and where the permit will be available. If you have any questions or concerns, please reach out to the Parking Office Team at the provided number. The office hours are 9am to 4pm.

**NEW PARKING REGISTRATION LINK:**
http://keckmed.usc.edu/kecktransportation/parkingapplication.aspx

**SECURITY DEPARTMENT**
323-442-8571

**EMERGENCY NUMBER**
Dial “77”

**EMERGENCY EVACUATION ROUTES**
Review posted evacuation route maps located in major hallways.

**SMOKE-FREE FACILITY**
We are a smoke-free environment no smoking facility. All Hospital inpatients, outpatients, staff and visitors are to observe the smoke-free policy and supporting regulations of the facilities.

**CELL PHONES**
Cell phone use is not allowed anywhere within the facility. Use of camera phones to photograph patient information is prohibited and is a violation of the patients right to privacy.

**FOOD SERVICE**
The cafeteria is opened for 24 hours
FACILITY INFORMATION SHEET

Dear Visiting Instructor,

Welcome to Keck Medical Center of USC to assure that your experience is pleasurable, please take a moment to review the information below and share appropriate information with your class.

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FOOD SERVICE
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8/1/2017 12:32:26 PM
1. HIPAA states we can only use and share patient protected health information (PHI) when the law either requires or permits us to do so. PHI includes:
   a. Basic health data dx, tx
   b. Medical records
   c. Demographic information – name, address & social security number
   d. Patient description or picture
   e. All of the above

2. When may we use or share protected health information (PHI)?
   a. Treatment of patient
   b. To update neighbor of patient’s condition
   c. To publish in hospital newspaper
   d. None of the above

3. In case of emergency within the hospitals what number will you dial?
   a. 77
   b. 911
   c. 411
   d. None of the above

4. Two (2) patient identifiers to be used before administering medications obtaining blood samples/specimens or providing care or treatment are.
   a. Name and social security number
   b. Name and DOB
   c. Medical Record Number and Account number
   d. All of the above

5. Employees who can place a patient in restraints include:
   a. Competency validated RNs
   b. Security Personnel
   c. Patient Care Technicians
   d. None of the above

6. Personal Protective Equipment (PPE) includes which of the following:
   a. Goggles/eye shield
   b. Gown
   c. Gloves
   d. Mask
   e. All of the above
Keck Medical Center of USC
Safety Test

Name:________________________________

7. A reportable occurrence includes which of the following?
   a. Patient/visitor falls
   b. A hazardous condition
   c. Medication error
   d. All of the above

8. Who can initiate an occurrence report?
   a. Hospital employees
   b. Volunteers
   c. Agency staff
   d. All of the above

9. The occurrence report should be completed in its entirety and submitted to Risk Management within what time frame?
   a. 24 hours
   b. 48 hours
   c. 72 hours
   d. None of the above

10. Occurrence reports can be completed only on-line.
    a. True
    b. False

11. An injury has to occur in order to complete an SRM.
    a. True
    b. False

12. Which are considered forms of restraint?
    a. Medications
    b. Holding the patient
    c. All four side rails up
    d. Seclusion
    e. All of the above

13. It is okay not to check “eight rights” when you have had the same patient all day.
    a. True
    b. False

14. All patients must wear an ID band at all times.
    a. True
    b. False
Keck Medical Center of USC
Safety Test
Name:________________________________

15. As a student providing patient care it is okay to have artificial nails so long as they are clean, well maintained and without chipped nail polish.
   a. True
   b. False

16. Nails should be no longer then ¼ inch length.
   a. True
   b. False

17. Evacuation routes are posted and located in major hallways.
   a. True
   b. False

18. Which transmission based isolation precaution should be used for Clostridium Difficile?
   a. Airborne (pink)
   b. Contact (green)
   c. Droplet (orange)
   d. No precautions/all of the above

19. Hand washing is the single best way to reduce the spread of infection.
   a. True
   b. False

20. Who can you report a HIPAA issue to?
   a. Your supervisor
   b. Management team
   c. The hospital compliance officer
   d. The ethics action line
   e. All of the above

21. What could happen if we violate a patient’s privacy?
   a. Fines and penalties
   b. Joint commission deficiencies
   c. Patient lawsuit for invasion of privacy
   d. All of the above

22. Unwashed hands play a major role in the transmission of hospital acquired infections.
   a. True
   b. False
23. Hand hygiene or washing will be performed before and after contact with each patient and after glove removal.
   a. True
   b. False

24. Needles/sharps should not be bent, broken or recapped.
   a. True
   b. False

25. Which transmission based isolation precaution should be used for TB?
   a. Contact
   b. Airborne
   c. Droplet
   d. All of the above

26. Patients with MRSA are placed on what type of isolation precautions?
   a. Contact
   b. Airborne
   c. Droplet
   d. All of the above

27. The proper sequence to putting out a fire is RACDEE (Rescue, Alarm, Contain, Dial, Extinguish, Evacuate)
   a. True
   b. False

28. What number will you call to obtain a MSDS sheet?
   a. 1-(323)-555-0891
   b. 77
   c. 911
   d. 1 (800) 451-8346

29. Patients are not allowed to smoke in their rooms even if supplemental oxygen is off.
   a. True
   b. False
Keck Medical Center of USC
Safety Test

Name:________________________________________

30. When moving a bed from one area to another you should ask for assistance and push rather than pull the bed.
   a. True
   b. False

31. If a co-student from another unit asks to see your patient’s record to “look up something” you can give the entire record to him/her.
   a. True
   b. False

32. Family members can be used as interpreters to provide medical information.
   a. True
   b. False

33. Cultural diversity includes:
   a. Language
   b. Physical size
   c. Gender
   d. Sexual orientation
   e. All of the above

34. Respiratory therapy must be contacted to shut off the oxygen valves in the event of an emergency.
   a. True
   b. False

35. Standard precautions mean that we should treat all body and fluids as if they were infectious.
   a. True
   b. False

36. When lifting a heavy object you should lift the object over your head and stretch your back and arm muscles.
   a. True
   b. False
Keck Medical Center of USC
Safety Test

Name:________________________________

37. Match the emergency code to the correct definition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
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<tbody>
<tr>
<td>a. __Assist</td>
<td>1. Patient Elopement</td>
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<tr>
<td>b. __blue</td>
<td>2. Fire</td>
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<tr>
<td>c. __gray</td>
<td>3. Disaster within the facilities</td>
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<td>d. __green</td>
<td>4. Person with a weapon and/or hostage situation</td>
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<td>e. __orange</td>
<td>5. Bomb Threat</td>
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<td>f. __pink</td>
<td>6. Lifting/transporting a patient</td>
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<td>g. __red</td>
<td>7. Security incident assaultive behavior</td>
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<td>h. __silver</td>
<td>8. Hazardous material spill/release</td>
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<td>i. __triage internal</td>
<td>9. Medical Emergency/Cardiac or respiratory arrest</td>
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<tr>
<td>j. __triage external</td>
<td>10. Infant child abduction</td>
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<td>k. __yellow</td>
<td>11. Disaster within the community</td>
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</table>

38. Match the following Center for Disease Control (CDC) transmission based isolation categories with the appropriate personal protective equipment (PPE)

a. A mask is required within 3 feet
b. Gown and gloves when dealing with body fluids
c. The N-95 mask is required when entering a patients room

__Contact (wound, drainage, cdiff, MRSA)
__Droplet (pneumonia, influenza, meningitis)
__Airborne (TB, Chicken Pox, Measles)

39. SBAR is an acronym for handoff communication. SBAR stands for:
   S: _________________________
   B: _________________________
   A: _________________________
   R: _________________________

40. If a patient is wearing a Yellow arm band or booties, this indicates the patient is Level II or III fall risk.
   a. True
   b. False

41. If the patient is wearing a Seafoam Green arm band, this indicates the patient has chosen to NOT ACCEPT any blood products and is part of our Transfusion Free Program.
   a. True
   b. False
Prior to student clinical rotation, complete this form in its entirety and submit with the required documents to the Nursing Education Department.

School Name: _________________________________   Course#___________________________

Instructor: ____________________________________        Phone#: ___________________________

Requested Unit(s): ___________________________________________________________________

Start Date: _________ End Date: _________ Day(s)/Shift: __________ # of Hours to Complete:____

Days:____________________ Nights ____________________ Weekends: _____________________

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<th>Student Name</th>
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Nursing will send this document to the following departments:
- Parking Office
- Department Manager
Course Profile

Submit to clinical facility 3 weeks prior to clinical rotation start date.
Complete the information below in its entirety for each clinical rotation and submit to:
Aliscia Ramsey.

☑ All boxes must be checked to ensure that each student and instructor has met all clearance requirements prior to rotation start.

- Attach the syllabus.
- Paperwork will not be cleared to start without an identified Instructor.
- Students must wear their school picture ID and Hospital picture ID at all times when in the facility.

School _____________________________ School Office # ____________________________

Coordinator Name _____________________ Coordinator School Email ____________________________
email address cannot be personal

Instructor’s Name _____________________ Instructor’s School Email ____________________________
email address cannot be personal

Course#: ____________  Req’d Hours: ________ Start: ____________ End: ____________ Day(s): ________ Shift

Program Type: BSN  MSN  Other (please name) ____________________________________________

Student Group Type:   RN   NP   LVN   RT   CST ____________________________________________

I certify that the students and the instructor in this rotation have completed the following requirements and that supporting documentation for verification purposes is maintained at this academic institution.

Required for all
☐ TB Screening  ☐ Malpractice Insurance:
☐ MMR  ☐ Exhibit A, B and C
☐ Varicella  ☐ Background Check
☐ Tetanus  ☐ Negative 9 Panel Drug Screen
☐ Hepatitis B  ☐ Clinical Roster
☐ Fit Test  ☐ Safety Test
☐ H&P Clearance  ☐ Compliance Training
☐ BLS Cards (front & back)  ☐ Keck IT Forms: 1, 2 and 21
☐ Flu Vaccine or Declination form  ☐ Badge Request Form
  (September thru March)  ☐ Parking Request – Refer to Link

Refer to the “Explanation of requirements” Guidelines for Clarification

Signature of Instructor or Designee _______________________________ Date ____________

2/2/2018 5:11:09 PM
STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of Keck Hospital of USC, Inc., a California corporation doing business as Keck Hospital of USC (“Hospital”), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the Program operated by ______________________________________ (“School”) at Hospital unless such injury or loss arises solely out of Hospital’s gross negligence or willful misconduct.

Dated this ____ day of ______________, 20__.

________________________________________

Program Participant

________________________________________

Witness (Signed by School Instructor/Coordinator)
CONFIDENTIALITY STATEMENT

The undersigned hereby acknowledges his/her responsibility under applicable federal law and the Agreement between ________________________________ (“School”) and Keck Hospital of USC, Inc., a California corporation doing business as Keck Hospital of USC (“Hospital”), to keep confidential any information regarding Hospital patients and proprietary information of Hospital. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Hospital, except as required by law or as authorized by Hospital. The undersigned agrees to comply with any patient information privacy policies and procedures of the School and Hospital. The undersigned further acknowledges that he or she has viewed a videotape regarding Hospital’s patient information privacy practices in its entirety and has had an opportunity to ask questions regarding Hospital’s and School’s privacy policies and procedures and privacy practices.

Dated this ____ day of ____________, 20__.

Program Participant

Witness (Signed by School Instructor/Coordinator)
Please circle the letter that indicates the best response to each question below.

1. The primary goal of USC's healthcare compliance program is to:
   a. Find people do not follow laws and regulations
   b. Monitor high risk areas to prevent violations
   c. Provide education on compliance risks
   d. Both b and c

2. Privacy can best be described as:
   a. Rules that prevent the release of information to the patient
   b. Rules that prevent the release of information to the patient's family
   c. Rules that guide how a patient can control his or her health information
   d. Rules that prevent the sharing of information for treatment purposes

3. The minimum necessary rule means:
   a. I should share as little information as possible with the patient’s physician
   b. I should access only the health care information necessary to do my job
   c. I should restrict what information I give to the patient
   d. I should limit my discussions in the elevator to the patient’s name and diagnosis

4. You come over to a shared computer to look up information on a newly admitted patient. You find that your patient’s medical record is open on the screen. You:
   a. Log out of the computer, then log back in with your own user ID and password
   b. Begin updating the record to save time
   c. Take a break until the person who was using the computer returns
   d. Go to a different computer
   e. Answers a. or d.

5. When creating a password for your account, you should:
   a. Use your birthdate and Social Security number
   b. Use a close relative's name and his or her birthdate
   c. Use the same password that you use for your other accounts
   d. Use a password that mixes words, numbers, and symbols
6. If you have a concern about something you have been asked to do, you should:
   a. Talk with your supervisor or manager
   b. Call the Help & Hotline number
   c. Keep quiet and do the best you can
   d. Response a or b

7. Clinical documentation should be:
   a. Current and timely
   b. Copied and pasted to save time
   c. Factual and accurate
   d. Both a and c

8. To prevent unauthorized access to protected health information, you are responsible for protecting:
   a. Your User ID
   b. Your password
   c. Logging off programs and applications
   d. Ensuring no protected health information is left out and visible to the public
   e. All of the above.

9. As a Keck Medicine workforce member you are allowed to access your own medical records and those of your immediate family members through the EMR.
   a. True
   b. False

10. If you become aware of a breach of protected health information, you are required to report the breach immediately to the Office of Compliance or to the USC Help & Hotline.
   a. True
   b. False
EXHIBIT C
HEALTH AND BACKGROUND SCREENING ATTESTATION
SCHOOL NAME: ____________________________________________

HEALTH OF PROGRAM PARTICIPANTS. School affirms the Program Participant(s) listed below have completed the following health screenings or documented health status as follows:

1. Tuberculin skin test within the past 12 months or documentation as a previous positive reactor or a chest x-ray taken within 12 months; and
2. Proof of Rubella and Rubeola immunity by positive antibody titers or 2 doses of MMR; and
3. Varicella immunity, by positive history of chickenpox or proof of Varicella immunization; and
4. Proof of Hepatitis B immunization or completion of a certification of declination of vaccine, if patient contact is anticipated.
5. Negative drug screen resulting from a nine (9)-panel drug screen.

BACKGROUND CHECKS. School has informed Program Participants of the requirement to obtain and have delivered to Hospital a retrospective background check prior to their participation in clinical activities. The background check included the following:

1. Social Security number verification.
2. Criminal Search (7 years)
3. Violent Sexual Offender & Predator registry
4. HHS/OIG/GSA
Other: _______________________

ATTENDING STUDENTS:
1. _______________________
2. _______________________
3. _______________________
4. _______________________
5. _______________________
6. _______________________
7. _______________________
8. _______________________
9. _______________________
10. _______________________ 

STAFF:
1. _______________________
2. _______________________
School acknowledges this information will be available to all USC affiliates as reasonably necessary.

Signature: ____________________________________________

Name: ________________________________________________

Title: __________________________________________________

14
C:\Documents and Settings\armijo\Desktop\USCUH-Affiliation.Agreement
Just What You Need to Know: Overview of Compliance, Privacy and Social Media Risks
What you will learn about

Compliance
- Code of Ethics
- Laws and Regulations
- Clinical Documentation Integrity
- Reporting Concerns and Asking for Guidance
- Non-Retaliation

Privacy and Information Security Risks
- Patient Information
- Rules of the Road
- Safeguards

Social Media
- What’s Different in Healthcare

Wrap Up: Test Your Knowledge
The principles in the USC Code of Ethics support our Mission and Values.

Key principles for all workforce members include legal and ethical behavior, respect for others, stewardship for our resources, and fairness and honesty.

These principles are also the foundation for our Compliance and Privacy programs.

Demonstrate your commitment to doing the right thing by keeping these principles in the forefront of everything you do.

When in doubt, always ask!
LAWS, REGULATIONS AND REPORTING CONCERNS
Law and Regulations

- Healthcare is one of the most regulated industries in the country.

- The quality of healthcare touches everyone and involves matters of life and death.

- Healthcare laws and regulations protect the quality and integrity of healthcare and ensure payment for medically necessary healthcare services.

- The USC compliance program is designed to prevent and detect potential violations through education, monitoring of high-risk areas, and through corrective actions when necessary.
Law and Regulations

- Complete all required training
- Understand the scope of your services on behalf of Keck Medical Center
- Read and follow all policies that apply to your clinical department and job duties
- Follow our clinical documentation standards
- Understand and follow privacy and security rules regarding access to patients and patient health information
- If you are ever unsure about what to do, don’t guess! Ask for assistance!
Clinical Documentation Integrity

Clinical Professionalism extends to the documentation of your services. When healthcare professionals enter information into the medical record and sign their notes, they take full responsibility for its content.

The medical record serves first and foremost as the primary documentation of the care provided to patients. It is also a legal document and the official record used to:

- Establish the medical necessity for the services provided
- Support quality reporting measures
- Support claims for reimbursement from federal government and other third party payers
Clinical Documentation Integrity

Nursing documentation must provide an accurate and honest account of what happened and when events occurred, as well as identify who provided the care. Good documentation is:

- Factual
- Accurate
- Complete
- Current (timely)
- Organized
- Compliant with standards

Documentation should reflect the nursing process for planning patient care and all nursing actions within the nursing scope of practice. These core principles of nursing documentation apply to every type of documentation in every practice setting.
Clinical Documentation Integrity

- Documentation must be specific to a patient’s condition at the time of his/her encounter and accurately represent the services rendered to the patient on the specific date of service.
- Templates must be based on clinically appropriate standards of practice.
- Macros, auto texts and pre-completed notes must be edited/updated or confirmed to reflect current findings.
- Pre-completed notes should never contain patient specific information.
- Documentation must reflect a positive or active choice when making entries into the medical record. For example:
  - Positive choices include checking a box, selecting documentation templates, typing free text or selecting from a drop down menu.
  - Patient specific unique entries for all procedures must be documented within the templates.
Clinical Documentation Integrity

Never share a password or chart in a medical record opened under someone else’s password. Charting in a medical record opened under someone else’s password is the equivalent to creating false documentation. This standard applies to all documentation including, but not limited to:

- PowerNotes
- Dynamic Documentation
- Dictation
- Nursing and Technician Notes
- Clinical Orders

Ensure that the entries you make are your own – it is never permissible to copy documentation from another author without attribution.

When leaving the medical record, always use the “change user”, “suspend”, or log out function.
Questions and Concerns

USC’s Compliance Program offers all workforce members a confidential means to report concerns, or simply to ask for guidance on policies and practices that you are unsure about.

You also can take concerns and questions to your supervisor.

USC Compliance Help & Hotline (213) 740-2500
- Available 24/7
- Calls are confidential and you can report anonymously if you want to

Examples of when to use the USC Compliance Help and Hotline:
- Are there hospital policies or resources that I should know to help me do my job?
- Have I been asked to perform an activity that violates a hospital policy or simply feels wrong?
- Have I raised concerns that I feel have not been addressed?
- I believe that there has been a violation of law.
Non-Retaliation Policy

- USC has a Non-Retaliation policy that protects any person who brings forward a concern in good faith.

- “Good faith” reporting means you have a reasonable basis to believe that something wrong or improper is occurring or has occurred.

- The Non-Retaliation policy does not protect the reporting of malicious, false or frivolous information without regard for the truth.

- Most people who bring concerns forward do so because they want to do the right thing and protect the integrity of the organization where they work.
Privacy and Security of Health Information

What is Privacy?

- Rules for the use and disclosure of individually identifiable health information—often called protected health information—or PHI and ePHI.
- Right of an individual to control how his or her PHI is collected, used and disclosed.

What is Security?

- Rules, processes, and technology used to maintaining the confidentiality, integrity, and availability of protected health information.
- Use of administrative (training and education, policies and procedures, reporting violations), technical (user IDs and passwords, firewalls) and physical controls (locked offices, name badges, encryption) to safeguard ePHI on information systems, mobile devices, smartphones, and similar technologies.
How do I know if information is PHI?

Any information in a healthcare record that can be used to identify a person and is connected to a healthcare diagnosis or treatment is considered PHI. PHI can be in any format—written, spoken or electronic (ePHI).

**Obvious identifiers...**
- Names
- Street, City, County, Precinct, Zip (except for first 3 digits)
- Dates: birth, admission, discharge, death
- Social Security numbers
- Phone and fax numbers
- Email addresses
- Medical record numbers
- Health plan number (insurer)
- Account numbers
- Full face photographic images (or image of unique identifier)

**And, the not so obvious...**
- Certificate and license numbers
- Vehicle identifiers and serial numbers, including license plates
- Device identifiers and serial numbers
- Web Universal Resource locaters (URLs)
- Internet Protocol (IP) numbers
- Biometric identifiers like fingerprints and voiceprints
- Any other unique identifying number, characteristic or code
Unique Identifier

Azira volunteers at several area hospitals. When she gets to work one day, she says, “Guess who I saw coming into the emergency department last week – that actor who crashed his plane. You know, the guy in the Indiana Jones movies? Wow, he was really bashed up.” Azira doesn’t disclose the name of the patient, so is this ok?

NO! While she doesn’t use the patient’s name, Azira discloses unique identifiers that could allow another person to determine the identity of the patient.

It doesn’t matter if an event is publicly reported. You can’t discuss patient information learned through your healthcare role with others who don’t have a need to know.
Minimum Necessary Rule

The general rule for disclosing PHI is the “minimum necessary” rule. If you have access to PHI, you may only access or disclose the minimal amount of information necessary (minimum necessary) to perform your hospital duties.

The minimum necessary rule does not apply to treatment, disclosures to the patient or authorized by the patient, and to disclosures for health oversight activities or that are required by law.

TIPS FOR MEETING THE MINIMUM NECESSARY STANDARD . . .

- Only access and use health information when you need it to do your job and only access and use that health information which is necessary.

- Only discuss health information when you need to in order to do your job and only discuss it in private. Be conscientious about where you talk about health information.

- Be conscientious about how you handle health information. Keep track of where and how health information is kept in your workplace.

- Review your department’s practices regarding the communication of health or personal information via phone, email and fax.
When PHI May Be Disclosed

- A patient’s PHI may be disclosed to a spouse, family members, friends or other persons if the patient agrees or does not object. If a patient agrees to sharing health information with those people who are close to him or her, it is best practice to document this in the patient’s medical record.

- Examples (if no objection):
  - You may discuss a patient’s condition over the phone with the patient’s family member.
  - You may speak with a patient’s sister about how frequently dressings need to be changed and signs of infection.

- However, you may not disclose PHI to a person if the patient tells you not to share this information, e.g. if the patient asks you not to share with a family member, you may not share the patient’s health information.

- Hospitals can disclose patient names and other directory information to anyone asking for the patient by name or to the clergy unless the patient opts out and asks not to be listed.
Rules of the Road for PHI

- PHI is confidential information. The “minimum necessary” standard requires you access only the minimum amount you need to know based on your role.

- PHI should never be disclosed to or discussed with any person who does not have a need to know the information.
  - Do not look-up the PHI of family members, friends, supervisors, or your own medical record
  - No “concern-related” or “personal curiosity” exceptions

- Do not discuss PHI in public places and do not leave PHI unattended at your desk or on a workstation.

- Do not remove PHI from the hospital/clinic areas.

- Do not take photos or videos of patients or PHI on personal devices, including cell phones.

- Dispose of PHI properly in a secure shredding bin—never throw this information into a trash can or wastebasket.
Liability for Privacy Violations

If you intentionally access medical records for reasons beyond your duties at USC’s hospitals, you can be held personally liable. The hospital may also be fined.

- Fines range from $100 to $50,000 per violation up to a maximum of $1.5 million based on the facts and circumstances
- Criminal penalties for selling, transferring, or using health information for commercial advantage, personal gain or malicious harm (fines and imprisonment)
- Termination from position or contract at the hospital/clinic

Straight from the Headlines...

- In 2012, a registered nurse in a cardiology department was fired after she was found to have accessed her mother’s and sister’s charts on numerous occasions. The nurse explained her mother and sister had serious medical conditions so she did not believe it was wrong.

- In 2013, Cedars-Sinai fired six individuals for inappropriately accessing patient medical records during the week of June 18-24. Fourteen medical records were accessed, but five people looked at the records of one patient, Kim Kardashian. Those fired were employees of physicians with staff privileges at Cedars-Sinai, an unpaid student research assistant, and a medical assistant employed in an outpatient department.

- Enloe Medical Center in Chico paid a $130,000 fine after the facility failed to prevent the unauthorized access of medical records by seven employees.
Information Security

YOUR DATA IS SAFE WITH ME
Security Risk Areas

- Writing down or sharing passwords
- Not securing a computer workstation so PHI can be viewed by others (you are responsible for actions under your logon)
- Emailing or faxing documents with PHI to the wrong person and/or office
- Attaching a file containing PHI to an email that is not encrypted
- Sending PHI to a personal email account
- Losing or leaving a laptop or other mobile device in an unsecured location
- Posting or sharing PHI on a social media site
- Sending pictures of patients using Snapchat and other applications
- Failing to follow USC information security policies
How You Can Reduce These Risks

- Do not write your password down and leave it near your computer, under the keyboard or in another place where it is easily discovered.

- **Never ever** share your passwords or logons with others or use another person’s logon or password.

- If you can’t remember your password, call the IT Help Desk for assistance.

- Always log off or lock your computer screen if it will be left unattended.

- Use an approved USC coversheet and always double-check names and fax numbers before sending a document.

- Remember our tips on Social Media and Social Engineering!
Breaches

- A breach occurs when protected health information that is unsecured is disclosed to a person not authorized to have this information.
- Information is unsecured when it is not encrypted.
- Unsecured protected information can include information in any form or medium, including electronic, paper or oral form.
- USC must report breaches of protected health information to the State of California and the federal Department of Health and Human Services.
- Breaches are serious matters. If you become aware of a breach of protected health information, you are required to report the breach immediately to the Office of Compliance at (213) 740-8258 or to the USC Help & Hotline at (213) 740-2500.
Passwords

Password Creation Don’ts:

- Don’t use easily guessed passwords
- Don’t use details like your birthdate, Social Security number, phone number, and names of family members or pets
- Don’t use dictionary words
- Don’t use the same password for all sites

Password Creation Do’s:

- Create unique passwords using words, numbers, symbols and upper- and lowercase letters
- Use a sentence or pass phrase like: “My favorite team is the 2004 Red Sox!” = Mftm04BoSks!
- Make your password at least 8-10 characters in length
- Create new pass phrases each time you change your password

How do I remember all those passwords?

https://www.youtube.com/watch?v=Srh_TV_J144
Have You Been Socially Engineered?

**Social Engineering** is the art of manipulating people for the purpose of gaining confidential information like passwords or bank account information. Social engineers (cyber criminals, hackers) use a variety of tricks to prey on our:

- Tendency to Trust
- Desire to be helpful
- Obedience to authority

The healthcare workforce is particularly susceptible to social engineering attacks because people in healthcare tend to be helpful and trusting.
Tricks of the Social Engineer

Social Engineering techniques are used not only to disrupt or gain information from an organization. These techniques also used to gather your personal information which can be used for identity theft. Beware of the following:

- A person pretending they are from the Help Desk who asks for your password
- A person pretending to be someone in authority who calls and asks questions about how your department or the hospital works (auditor, etc.)
- A person who shoulder-surfs to get an access code or password/PIN
- A person who tailgates to gain access into a restrictive, sensitive or non-public work area
- Phishing emails that appear to come from a legitimate organization, but ask you to click on links or attachments that may contain viruses, spyware or other malware (when in doubt, delete the message)
- Sites that ask you for personal information (surveys, contests, personality tests, etc.)
An Australian radio station donated A$500,000 (£278,000) to the family of a nurse in the UK who killed herself after putting through its prank phone call to the hospital room of the Duchess of Cambridge during her first pregnancy.

The 46-year-old nurse who took the call was found dead just days afterwards. The hoax call was made by the radio station in December 2012 during the Duchess of Cambridge’s first pregnancy, when persons from the radio station pretended to be the Queen and Prince Charles.

Through the call, the persons learned the details of the Duchess’s treatment for morning sickness which they then revealed to the public.

Protect against Social Engineering

- Do not share or give out your passwords.
- Do not click on attachments or links in emails unless you are sure about the sender and are expecting the information.
- Beware of messages containing links from persons who send you jokes or send you to other "interesting" sites... They could be sending you links containing a virus or other malware but don’t realize it.
- If someone asks a lot of questions about the hospital and its operations, be cautious in your responses. If something doesn’t seem right, it probably isn’t.
- Avoid logging into social media sites while at the hospital, and use caution when providing personal information on these sites at home.
- If someone tries to tailgate you into a building or a place in the hospital where they shouldn’t be, escort them to the information desk or call security.
SOCIAL MEDIA: RISKS IN HEALTHCARE
Rising Use of Social Media

- One-third of consumers use social media sites such as Facebook, Twitter, YouTube and other online forums for health-related matters

- >80% of those aged 18-24 said they would share their health information via social media compared to about 45% of those aged 45-64

- Even if you are willing to share your own health information, as a hospital workforce member you cannot share the health information of others

- HIPAA Privacy Rules apply to postings on social media sites by all members of the healthcare workforce, including volunteers and contracted staff.

What not to post...

An emergency department physician in Rhode Island was fired, lost her hospital medical staff privileges and was reprimanded by the Rhode Island Board of Medical Licensure and Discipline for posting information about a trauma patient on her personal Facebook page. According to the Rhode Island Board of Medical Licensure and Discipline, “[The physician] did not use patient names and had no intention [of revealing] any confidential patient information.

However, ... the nature of one person’s injury was such that the patient was identified by unauthorized third parties. As soon as it was brought to [her] attention that this had occurred, [the physician] deleted her Facebook account.” Despite the physician omitting what she thought was identifiable information about the patient from her post, she did not omit enough information.

http://www.boston.com/lifestyle/health/articles/2011/04/20/for_doctors_social_media_a_tricky_case/
Social Media Rules of the Road

- Never share patient information gained through your clinical role
- Always maintain patient privacy—don’t think you can “mask” a patient’s identity
- Don’t take or post pictures or videos of patients
- Don’t comment on a patient’s post
- Don’t “friend” a patient
- Don’t allow social media to interfere with your nursing activities
- Maintain your professionalism at all times
- Report breaches of confidentiality or privacy
Concerned Friends

Consider this…

**Scenario:**
Susan, a long-time neighbor, is in the hospital. During a weekend barbecue at your home, several guests ask about her condition and when she will be coming home.

**Question:**
How will you handle this situation?
Concerned Friends Response

Your friends know you work in the hospital, but may not understand how the privacy rules apply to you. They are also concerned about Susan’s health and well-being.

You may or may not know anything about Susan’s condition or status. If you do have information, you cannot share that information. If you don’t have the information, you can’t look it up and get back to your friends.

Possible responses:

- “I don’t know. I am as concerned as you are.”
- “I haven’t heard anything.”
- “I do work in the hospital, but cannot share any information about patients, even Susan.”
- “Have you asked someone in the family? They might be able to tell you.”
Review: Sharing PHI

- Generally, you may not share a patient’s PHI for other than treatment, payment or healthcare operations without the patient’s authorization.
- There are no exceptions based on family or friend relationships and there are no personal curiosity exceptions and no excuses:
  - “I thought I could learn more about that condition.”
  - “This case will help me in my MSN studies.”
  - “Those are my son’s records.”
  - “My mother is sick and she asked me to check on her labs.”
  - “I only looked at my co-worker’s record this one time.”
Patient Photos

Consider this…

Scenario:
A woman is detained and ordered to turn over her cell phone at a hospital for taking photos of her son during a doctor’s appointment. She uses the images on a site to raise money for her son’s expensive hearing aids as he is going deaf. The physician informed her she was in violation of privacy laws.

Question:
Is this a violation of privacy laws?
Patient Photos Response

No, the physician made a mistake. The privacy rules cover the healthcare workforce and do not apply to actions by the patient, or in this case, the patient’s legal guardian, his mother.

As a member of the healthcare workforce, you cannot take photos of a patient (there may be certain exceptions for treatment purposes) and post them to a website or otherwise distribute them.
Consider this…

**Scenario:**
You walk into a patient’s room and notice that an IV bag that is labeled with a patient’s health information has been thrown into the trash bin.

**Question:**
What should you do?
Just Laying Around Response

Because the label is still attached to the IV bag and contains a patient’s health information, you should see to it that the label is disposed of properly. It should not have been discarded in a trash bin located in the patient’s room.

Make sure the label is removed and placed in a shredding bin or other secured container.
Congratulations!

You have completed the Keck Medicine Compliance and Privacy course!

If you have specific questions about any of the topics covered in this module, please discuss with your supervisor or contact the USC Office of Compliance.
Keck Medicine of USC

Contract PERSONNEL INFORMATION

Please do not fill out for FTEs. Use Form 2 only

*** COMPLETE ALL FIELDS ***

**All fields are mandatory, make sure to include email address.**

<table>
<thead>
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<th>MIDDLE INITIAL</th>
<th>LAST NAME</th>
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<th>Last 4 Digits of SSN (eTenet only)</th>
<th>DEPT. NAME / NUMBER</th>
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<td>USC Care</td>
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<td>VHH</td>
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<tr>
<th>USC E-MAIL ADDRESS (If available)</th>
<th>ALTERNATE / PERSONAL E-MAIL ADDRESS</th>
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</table>

*** Has this person previously worked at Keck? ○ Yes ○ No ***

Field Glass Candidate ID  JS

Supplier Code  Candidate # (8 Digit)

USC Health Information Technology shall provide you with access to computer system(s) necessary for your employment responsibilities. The system(s) will at all times be used professionally and in compliance with approved procedures. All of the equipment/software used to provide these services are the property of USC. The information may only be accessed and used for the proper care of patients and the performance of professional functions. You are reminded that the use of systems for purposes which include, but are not limited to the following is prohibited: transmit or receive chain letters, wagers, sexually explicit material, ethnic slurs, racial epithets, or anything that may be construed as harassment or disparagement of others based upon their race, national origin, sex, sexual orientation, age, disability, religion or political beliefs. Use of these systems for any commercial or personal purpose is prohibited. USC Health Information Technology reserves the right to monitor the use of all systems and may periodically audit your use of the information in these systems, with or without notice, for a variety of purposes, including quality control and compliance with the terms of this policy. USC reserves the right to disclose your use of these systems usage to law enforcement officials and other appropriate parties as requested.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and possibly including termination of employment at USC.

By signing below I acknowledge that I understand the terms of this policy.

Employee Name

Employee Signature

Date

Manager / Supervisor Name

Manager / Supervisor Signature

Date

If you have questions related to completing this form, contact the Keck IT Service Desk at 323.442.4444. After you have completed the form and have obtained all of the required signatures please scan and e-mail form to servicedesk@med.usc.edu or fax to 323.442.8711. *Any missing information will delay your request.*
# System Request Form

**Select One:**
- Keck/Norris
- VHH
- KSOM
- USC Care

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<td>Department Number 8720</td>
<td>Dept. Name NURSING ADMINISTRATION</td>
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<tr>
<td>PIN (Last 4 Digits of SSN)</td>
<td>Office Phone</td>
<td>Job Title LVN STUDENT</td>
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<tr>
<td>USC Employee Email (if known)</td>
<td>Alternate/Personal Email</td>
<td>Start Date (date of orientation)</td>
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**Employee Type (Please Select One):**
- Employee
- Contractor (Form O1 Required)
- Vendor (Form OV Required)
- Student
- Pharmacist

**Network Resources:**
- Outlook Email & Distribution Lists:
  - DL-Hospital-All-Users
  - DL-Hospital-Drivers
  - DL-Hospital-Ops Council
  - DL-Hospital-Leadership
  - DL-VHH-Leadership
  - DL-Keck Hospital-Users
  - DL-NCH-Users
  - DL-USC-Ambulatory Services
  - Other:
- Remote Desktop Access
- Shared Drive (Include Full Path):

**Additional Applications**

Please check the appropriate application below. If additional forms are required, they will be listed under the security form column.

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<tr>
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<td>PBAR, On-Demand Web</td>
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<td>CAFÉ</td>
<td>Form 25</td>
<td>VI Web, Showcase</td>
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<td>Form 34</td>
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<td>EyemD</td>
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<td>Lawson</td>
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<td>Form 3000</td>
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<td>Imaging/Radiology - General Access</td>
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<td>Imaging/Radiology - Advanced Access</td>
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<tr>
<td>Omnicell (Materials Management)</td>
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<tr>
<td>Optilink Plus</td>
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<td>Patient Keeper</td>
<td>Form 32</td>
<td>AS400, RES-Q</td>
</tr>
<tr>
<td>Kronos* Administrative Time Keeping (Select One):</td>
<td>Pyxis-VHH</td>
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</table>

**Kronos Scheduler**

- Shift: [Day / Night]
- Shift Length: [12HR / 10HR]
- Status: [Full Time / Part Time / Per Diem]
- Position: [CN / Relief CN / Staff]
- Reporting Manager: [Other]

**Primary Job (RN, PCT etc):**
- Home Location (4N, 8E etc):
- Health Stream [QlikView (Other)]

**Supervisor Name**

**Signature**

**Date**

If you have any questions related to completing this form, please contact the Keck IT Service Desk at 323 442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to servicedesk@med.usc.edu or fax to (323) 442-8711.
### Cerner Security Request

**Requesting Access For:**

Instructions: Select only one of the listed positions. Selecting multiple positions will delay processing. Sign on page 2. If you know of a "like user" (another user with the access you'd like this user to have) please write the ID of the "like user" here: ___________

<table>
<thead>
<tr>
<th>Clinic Positions</th>
<th>Radiology</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- P1 Clinic Audio/Speech</td>
<td>- RadNet: Dept Secretary</td>
<td>- P1 RN</td>
</tr>
<tr>
<td>- P1 Clinic Audio/Speech Student</td>
<td>- RadNet: Film Librarian</td>
<td>- P1 RN Supervisor/Charge</td>
</tr>
<tr>
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<tr>
<td>- Clinic Social Worker</td>
<td>- RadNet: RadTech/Transcription</td>
<td>- P1 LVN/LPN</td>
</tr>
<tr>
<td>- P1 Clinic Manager - Clinical</td>
<td>- RadNet: Researcher</td>
<td>- P1 Student Nurse</td>
</tr>
<tr>
<td>- P1 Clinic Manager - Non Clinical</td>
<td>- RadNet: Supervisor</td>
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</tr>
<tr>
<td>- P1 Clinic Medical Student</td>
<td>- P1 RadNet: RN</td>
<td></td>
</tr>
<tr>
<td>- P1 Clinic PharmNet: Ambulatory RX</td>
<td>- P1 IP RadNet: Radiologist</td>
<td></td>
</tr>
<tr>
<td>- P1 Clinic Resident Licensed</td>
<td>- P1 IP RadNet: Resident</td>
<td></td>
</tr>
<tr>
<td>- P1 Clinic Resident Unlicensed</td>
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<tr>
<td>- P1 Clinical RN</td>
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<tr>
<td>- P1 Clinic Scheduling Clerk</td>
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<tr>
<td>- P1 Clinic Scheduling Rad Clerk</td>
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<tr>
<td>- P1 Clinic Unit Secretary</td>
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<tr>
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<tr>
<td>- Research Coordinator - Admin</td>
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<tr>
<th>Lab</th>
<th>Nursing VHH</th>
<th>Respiratory</th>
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<tr>
<td>- PathNet: All Module Assistant</td>
<td>- P2 LVN/LPN VHH</td>
<td>- P1 Respiratory Therapist</td>
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<td>- PathNet All Module Supervisor</td>
<td>- P2 RN Supervisor/Charge VHH</td>
<td>- P1 Respiratory Therapist Supervisor</td>
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<td>- PathNet: AP Supervisor</td>
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<td>- PathNet: AP Transcription</td>
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<td>- PathNet: Cytotech</td>
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<td>- PathNet: Gen Lab Medical Technologist</td>
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<td>- PathNet: General Laboratory Processing</td>
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<td>- PathNet: General Laboratory Supervisor</td>
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<td>- PathNet: Histotech</td>
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<td>- PathNet: Micro Lab Assistant</td>
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<td>- PathNet: Micro Medical Technologist</td>
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<td>- PathNet: Microbiology Supervisor</td>
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<tr>
<td>- DBA</td>
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<td>- DBC</td>
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<td>- P1 PharmNet: Pharmacy Student</td>
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<td>- DBC: PM/Scheduling</td>
<td>- P1 PharmNet: Pharmacy Technician</td>
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<td>- P1 PharmNet: Retail DBA/Pharmacist</td>
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<tr>
<td>- P2 SurgiNet: Surgical RN w/PowerChart VHH</td>
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<td>- P2 SurgiNet: Secretary VHH</td>
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<td><strong>Surgery</strong></td>
<td><strong>Emergency Department VHH</strong></td>
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<tr>
<td>○ HIM</td>
<td>○ P1 Surginet: Database Coordinator</td>
<td>○ P2 ED Medical Director</td>
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<tr>
<td>○ P1 HIM Auditor Research View and Print</td>
<td>○ P1 SurgNet: LVN/LPN</td>
<td>○ P2 ED Unit Secretary</td>
</tr>
<tr>
<td>○ P1 HIM Clinical Doc Specialist</td>
<td>○ P1 SurgNet: Case Attendee No Access</td>
<td>○ P2 ED Nurse</td>
</tr>
<tr>
<td>○ P1 HIM Coders</td>
<td>○ P1 SurgNet: Materials</td>
<td>○ P2 ED Tech</td>
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<tr>
<td>○ P1 HIM External Researcher View Only</td>
<td>○ P1 SurgNet: PC Maintenance</td>
<td>○ P2 FirstNet View Only</td>
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<tr>
<td>○ P1 HIM Manager</td>
<td>○ P1 SurgNet: Post Case Charge</td>
<td>○ P2 ED Biller</td>
</tr>
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<td>○ P1 HIM Scanners</td>
<td>○ P1 SurgNet: RN Surgical Services</td>
<td>○ P2 ED Scribe</td>
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<tr>
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<td>○ P1 SurgNet: RN Surgical Services w PC</td>
<td>○ P2 ED Physician Informatics</td>
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<td>○ P1 HIM Transcriptionist</td>
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<td>○ P1 HIM Tumor Registry</td>
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<th><strong>Maternity VHH</strong></th>
<th><strong>Limited Access Positions</strong></th>
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<td>○ P1 Occupational Therapist</td>
<td>○ P2 Perinatal RN</td>
<td>○ P1 Read Only PowerChart Clinical</td>
</tr>
<tr>
<td>○ P1 Occupational Therapy Assistant</td>
<td>○ P2 Perinatal LVN</td>
<td>○ P1 Read Only PowerChart Non Clinical</td>
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<td>○ P1 Occupational Therapy Student</td>
<td>○ P2 Perinatal C.N.A./Tech</td>
<td>○ P1 Research Coordinator</td>
</tr>
<tr>
<td>○ P1 Physical Therapist</td>
<td>○ P2 Lactation Consultant</td>
<td>○ P1 Pastor</td>
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<td>○ P1 Physical Therapist Assistant</td>
<td>○ P2 Perinatal Nurse Manager</td>
<td>○ Research Monitor External</td>
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<tr>
<td>○ P1 Physical Therapy Student</td>
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<tr>
<td>○ P1 Speech Therapist</td>
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<tr>
<td>○ P1 Speech Therapy Student</td>
<td></td>
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<td>○ P1 Rehab Aide</td>
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</tr>
<tr>
<td>○ P2 Speech Therapist VHH</td>
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<table>
<thead>
<tr>
<th><strong>Scheduling/Registration</strong></th>
<th><strong>Patient Care Tech</strong></th>
<th><strong>Environmental Services</strong></th>
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<tbody>
<tr>
<td>○ P2 PCMH Reviewer</td>
<td>○ P1 Monitor Tech/Unit Clerk</td>
<td>○ P2 EVS</td>
</tr>
<tr>
<td>○ P2 Concierge</td>
<td>○ P1 Neuro Tech</td>
<td>○ P2 EVS Supervisor</td>
</tr>
<tr>
<td>○ P2 Patient Access Representative</td>
<td>○ P1 Patient Care Technician</td>
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</tr>
<tr>
<td>○ P2 Patient Access Representative VHH</td>
<td>○ P1 Unit Clerk/PCT</td>
<td></td>
</tr>
<tr>
<td>○ P2 Master Scheduler</td>
<td>○ P1 Diagnostic Technician</td>
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</tr>
<tr>
<td></td>
<td>○ P2 PCT/CNA VHH</td>
<td></td>
</tr>
</tbody>
</table>

If you have any questions related to completing this form, please contact the IS Service Desk at 323 442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to helpdesk@med.usc.edu or fax to (323) 442-8711.
Keck Medical Center of USC

Badge Request Form

Student Name: ________________________________________________________________

Title: _LVN/NURSING STUDENT____________________________________________________

School Name: __________________________________________________________________

Instructor Name: __________________________________________________________________

BADGE VALID FROM: __________________________ TO: ____________________________

This badge is to be visibly worn at all times while on premises at Keck Hospitals. If you lose your badge the replacement fee is $10.00.

Student Signature: __________________________________________________________________

Please return your badge to Nursing Administration, Attn: Aliscia Ramsey at the end of your rotation.

Any questions regarding this badge,

Please contact:

Aliscia Ramsey
Office Coordinators
Nursing Administration Department
Keck Hospital of USC
1500 San Pablo Street
Los Angeles, CA 90033

8/1/2017 11:40:16 AM
Keck Medicine of USC

Contract PERSONNEL INFORMATION

Please do not fill out for FTEs. Use Form 2 only

*** COMPLETE ALL FIELDS ***

**All fields are mandatory, make sure to include email address.**

<table>
<thead>
<tr>
<th>FIRST NAME (FORMAL NAME)</th>
<th>MIDDLE INITIAL</th>
<th>LAST NAME</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH (eTenet only)</th>
<th>Last 4 Digits of SSN (eTenet only)</th>
<th>DEPT. NAME / NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
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<td>NURSING ADMINISTRATION/8720</td>
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<tr>
<th>OFFICE PHONE</th>
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<th>End Date</th>
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<tbody>
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<table>
<thead>
<tr>
<th>ORGANIZATION (CHECK ONE)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Keck/Norris Hospital</td>
</tr>
<tr>
<td></td>
<td>USC Care</td>
</tr>
<tr>
<td></td>
<td>VHH</td>
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<thead>
<tr>
<th>USC E-MAIL ADDRESS (if available)</th>
<th>ALTERNATE / PERSONAL E-MAIL ADDRESS</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*** Has this person previously worked at Keck?  ○ Yes  ○ No  ***

Field Glass Candidate ID

Supplier Code  JS  Candidate # (8 Digit)

USC Health Information Technology shall provide you with access to computer system(s) necessary for your employment responsibilities. The system(s) will at all times be used professionally and in compliance with approved procedures. All of the equipment/software used to provide these services are the property of USC. The information may only be accessed and used for the proper care of patients and the performance of professional functions. You are reminded that the use of systems for purposes which include, but are not limited to the following is prohibited: transmit or receive chain letters, wagers, sexually explicit material, ethnic slurs, racial epithets, or anything that may be construed as harassment or disparagement of others based upon their race, national origin, sex, sexual orientation, age, disability, religion or political beliefs. Use of these systems for any commercial or personal purpose is prohibited. USC Health Information Technology reserves the right to monitor the use of all systems and may periodically audit your use of the information in these systems, with or without notice, for a variety of purposes, including quality control and compliance with the terms of this policy. USC reserves the right to disclose your use of these systems usage to law enforcement officials and other appropriate parties as requested.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and possibly including termination of employment at USC.

By signing below I acknowledge that I understand the terms of this policy.

Employee Name

Employee Signature

Date

Manager / Supervisor Name

Manager / Supervisor Signature

Date

If you have questions related to completing this form, contact the Keck IT Service Desk at 323.442.4444. After you have completed the form and have obtained all of the required signatures please scan and e-mail form to servicedesk@med.usc.edu or fax to 323.442.8711. *Any missing information will delay your request.*
## System Request Form

### Select One:
- Keck/Norris
- VHH
- KSOM
- USC Care

### Legal First Name

### Middle Initial

### Last Name

### Date of Birth

### Department Number

### 8720

### Dept. Name

### NURSING ADMINISTRATION

### Job Title

### NP STUDENT

### Start Date (date of orientation)

### PIN (Last 4 Digits of SSN)

### Office Phone

### USC Employee Email (if known)

### Alternate/Personal Email

### Employee Type (Please Select One):
- Employee
- Contractor (Form 01 Required)
- Vendor (Form 0V Required)
- Student
- Pharmacist

### Network Resources
- Outlook Email & Distribution Lists:
  - DL-Hospital-All-Users
  - DL-Leadership
  - DL-VHH
  - DL-Keck Hospital-Users
  - DL-NCH-Users
  - DL-USC-Ambulatory Services
  - Other:

- Remote Desktop Access

- Shared Drive (Include Full Path):

### Additional Applications

**Please check the appropriate application below. If additional forms are required they will be listed under the security form column.**

**Application Name** | **Security Form Required** | **Tenet Systems**
--- | --- | ---
OLHI View (Allscripts) | Form 21 | PBAR
Cafe | Form 28 | Vi Web
Cerner | Form 35 | Showcase
Eyemid | Form 41 | Daily Productivity App
Lawson | Form 42 | Other:
Pharmacy Apps (Keck/Norris) | Form 23 | AS400
Imaging/Radiology - General Access | Form 31 | RES-Q
Imaging/Radiology - Advanced Access | Form 32 | GE PACS C-Web
Omnice (Materials Management) | Form 33 | Pyxis-VHH
Optilink Plus | Form 34 | Kronos-VHH
PCI | Form 36 | Other:
Patient Keeper | Form 24 | Other:
Kronos - Administrative Time Keeping (Select One): | | Other:
- Approval
- Editor
- Cost Center: (required)

### Kronos Scheduler

**Shift:**
- Day
- Night

**Shift Length:**
- 12HR
- 10HR

**Reporting Manager:**

**Primary Job (RN, PCT etc.):**

**Home Location (4N, 8E etc.):**

**Health Stream:**

**QlikView (Other):**

---

### Supervisor Name

### Signature

### Date

---

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# Cerner Security Request

**REQUESTING ACCESS FOR:**

Instructions: Select only **one** of the listed positions. Selecting multiple positions will delay processing. Sign on page 2. If you know of a “like user” (another user with the access you’d like this user to have) please write the ID of the “like user” here: **Give access to MY EXPERIENCE**

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<tr>
<td>P: LVN/LPN</td>
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<td>P: Student Nurse</td>
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<th>Lab</th>
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</thead>
<tbody>
<tr>
<td>PathNet: All Module Assistant</td>
</tr>
<tr>
<td>PathNet: All Module Tech</td>
</tr>
<tr>
<td>PathNet All Module Supervisor</td>
</tr>
<tr>
<td>PathNet: AP Supervisor</td>
</tr>
<tr>
<td>PathNet: AP Transcription</td>
</tr>
<tr>
<td>PathNet: Cytotech</td>
</tr>
<tr>
<td>PathNet: Gen Lab Console</td>
</tr>
<tr>
<td>PathNet: Gen Lab Medical Technologist</td>
</tr>
<tr>
<td>PathNet: General Laboratory Assistant</td>
</tr>
<tr>
<td>PathNet: General Laboratory Processing</td>
</tr>
<tr>
<td>PathNet: General Laboratory Supervisor</td>
</tr>
<tr>
<td>PathNet: Histotech</td>
</tr>
<tr>
<td>PathNet: Micro Lab Assistant</td>
</tr>
<tr>
<td>PathNet: Micro Medical Technologist</td>
</tr>
<tr>
<td>PathNet: Microbiology Supervisor</td>
</tr>
<tr>
<td>P1 IP PathNet: AP Resident</td>
</tr>
<tr>
<td>P1 IP Pathologist</td>
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<table>
<thead>
<tr>
<th>Nursing VHH</th>
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</thead>
<tbody>
<tr>
<td>P2 LVN/LPN VHH</td>
</tr>
<tr>
<td>P2 RN VHH</td>
</tr>
<tr>
<td>P2 RN Supervisor/Charge VHH</td>
</tr>
<tr>
<td>P2 Psych RN VHH</td>
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<tr>
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</tr>
<tr>
<td>P1 Respiratory Therapist Student</td>
</tr>
<tr>
<td>P1 Respiratory Therapist Supervisor</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Dietary</th>
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<tbody>
<tr>
<td>P1 Dietitian</td>
</tr>
<tr>
<td>P1 Dietitian Intern</td>
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<tr>
<td>P1 Nutrition Assistant</td>
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<table>
<thead>
<tr>
<th>Surgery VHH</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2 SurgiNet: Surgical RN VHH</td>
</tr>
<tr>
<td>P2 SurgiNet: Surgical RN w/PowerChart VHH</td>
</tr>
<tr>
<td>P2 SurgiNet: Secretary VHH</td>
</tr>
</tbody>
</table>
**Keck Medicine of USC INFORMATION SERVICES**

### Medical Records/ HIM
- HIM
- P1 HIM Auditor Research View and Print
- P1 HIM Clinical Doc Specialist
- P1 HIM Coders
- P1 HIM External Researcher View Only
- P1 HIM Manager
- P1 HIM Scanners
- P1 HIM Specialist
- P1 HIM Transcriptionist
- P1 HIM Tumor Registry

### Surgery
- P1 SurgiNet: Database Coordinator
- P1 SurgiNet: LVN/LPN
- P1 SurgiNet: Case Attendee No Access
- P1 SurgiNet: Materials
- P1 SurgiNet: PC Maintenance
- P1 SurgiNet: Post Case Charge
- P1 SurgiNet: RN Surgical Services
- P1 SurgiNet: RN Surgical Services w PC
- P1 SurgiNet: Scheduler
- P1 SurgiNet: Secretary
- P1 SurgiNet: Support Staff
- P1 SurgiNet: Tech

### Emergency Department VHH
- P2 ED Medical Director
- P2 ED Unit Secretary
- P2 ED Nurse
- P2 ED Tech
- P2 FirstNet View Only
- P2 ED Biller
- P2 ED Scribe
- P2 ED Physician Informatics
- P2 ED LVN/LPN

### Limited Access Positions
- P1 Read Only PowerChart Clinical
- P1 Read Only PowerChart Non Clinical
- P1 Research Coordinator
- P1 Pastor
- Research Monitor External

### Environmental Services
- P2 EVS
- P2 EVS Supervisor

### Patient Care Tech
- P1 Monitor Tech/Unit Clerk
- P1 Neuro Tech
- P1 Patient Care Technician
- P1 Unit Clerk/PCT
- P1 Diagnostic Technician
- P2 FCT/CNA VHH

### Scheduling/Registration
- P2 PCMH Reviewer
- P2 Concierge
- P2 Patient Access Representative
- P2 Patient Access Representative VHH
- P2 Master Scheduler

Manager/Supervisor Name (Print)  Manager/Supervisor (Signature)  Date

If you have any questions related to completing this form, please contact the IS Service Desk at 323.442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to helpdesk@med.usc.edu or fax to (323) 442-8711.
Badge Request Form

Student Name: ________________________________

Title: _NP STUDENT____________________________

School Name: ______________________________________

Instructor Name: ______________________________________

BADGE VALID FROM: __________________ TO: __________________

This badge is to be visibly worn at all times while on premises at Keck Hospitals. If you lose your badge the replacement fee is $10.00.

Student Signature: ______________________________________

Please return your badge to Nursing Administration, Attn: Aliscia Ramsey at the end of your rotation.

Any questions regarding this badge,

Please contact:
Aliscia Ramsey
Office Coordinator
Nursing Administration Department
Keck Hospital of USC
1500 San Pablo Street
Los Angeles, CA 90033
Table of Contents – Continued

Infection Control
Initial Assessment and Reassessment (Policy# NA10-101)
Materials Safety Data Sheet
Medication Reconciliation (Policy# CP 4-105)
National Patient Safety Goals (JCAHO)
Occurrence Reporting Requirements for Hospital Staff Members (Policy# 6-107) eSRM
Pain Assessment and Management (Policy# CP 1-202)
Evaluations: Faculty and Students

In order for Cohorts to start, each student’s clearance is required.

Please be on the lookout for a Documents Link to our Intranet page; which is where all documents are to be obtained. We are no longer sending documents out via email.
Keck Medicine of USC

Contract Personnel Information
Please do not fill out for FTEs. Use Form 2 only
*** COMPLETE ALL FIELDS ***
**All fields are mandatory. Make sure to include email address.**

<table>
<thead>
<tr>
<th>First Name (Formal Name)</th>
<th>Last Name</th>
<th>Date of Birth (Tenet only)</th>
<th>Last 4 Digits of SSN (Tenet only)</th>
<th>Dept. Name / Number</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td>Nursing Administration/8720</td>
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<table>
<thead>
<tr>
<th>Office Phone</th>
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<th>Start Date</th>
<th>End Date</th>
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<tr>
<td></td>
<td>RCP Instructor</td>
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<table>
<thead>
<tr>
<th>Organization (Check One)</th>
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<tbody>
<tr>
<td>Keck/Norris Hospital</td>
</tr>
<tr>
<td>USC Care</td>
</tr>
<tr>
<td>VHH</td>
</tr>
<tr>
<td>KSOM</td>
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</table>

<table>
<thead>
<tr>
<th>USC Email Address (if available)</th>
<th>Alternate / Personal Email Address</th>
</tr>
</thead>
</table>

*** Has this person previously worked at Keck?  ○ Yes  ○ No ***

Field Glass Candidate ID

JS

Supplier Code

Candidate # (8 Digit)

USC Health Information Technology shall provide you with access to computer system(s) necessary for your employment responsibilities. The system(s) will at all times be used professionally and in compliance with approved procedures. All of the equipment/software used to provide these services are the property of USC. The information may only be accessed and used for the proper care of patients and the performance of professional functions. You are reminded that the use of systems for purposes which include, but are not limited to the following is prohibited: transmit or receive chain letters, wages, sexually explicit material, ethnic slurs, racial epithets, or anything that may be construed as harassment or disparagement of others based upon their race, national origin, sex, sexual orientation, age, disability, religion or political beliefs. Use of these systems for any commercial or personal purpose is prohibited. USC Health Information Technology reserves the right to monitor the use of all systems and may periodically audit your use of the information in these systems, with or without notice, for a variety of purposes, including quality control and compliance with the terms of this policy. USC reserves the right to disclose your use of these systems usage to law enforcement officials and other appropriate parties as requested.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and possibly including termination of employment at USC.

By signing below I acknowledge that I understand the terms of this policy.

Employee Name

Employee Signature

Date

Manager / Supervisor Name

Manager / Supervisor Signature

Date

If you have questions related to completing this form, contact the Keck IT Service Desk at 323.442.4444. After you have completed the form and have obtained all of the required signatures please scan and e-mail form to servicedesk@med.usc.edu or fax to 323.442.8711. *Any missing information will delay your request.*
# Keck Medicine of USC

## INFORMATION SERVICES

### SYSTEM REQUEST FORM

<table>
<thead>
<tr>
<th>SELECT ONE:</th>
<th>KECK/NORRIS</th>
<th>VHH</th>
<th>KSOM</th>
<th>USC CARE</th>
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<table>
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<tr>
<th>Legal First Name</th>
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<th>PIN (Last 4 Digits of SSN)</th>
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</table>

<table>
<thead>
<tr>
<th>USC Employee Email (if known)</th>
<th>Alternate/Personal Email</th>
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### EMPLOYEE TYPE (PLEASE SELECT ONE)

- [ ] Employee
- [ ] Contractor (Form 01 Required)
- [ ] Vendor (Form 01 Required)
- [ ] Student
- [ ] Pharmacist

### NETWORK RESOURCES

- [ ] Outlook Email & Distribution Lists:
  - [ ] DL-Hospital-All-Users
  - [ ] DL-Hospital-Directors
  - [ ] DL-Hospitals-Ops Council
  - [ ] DL-Keck Hospital-Users
  - [ ] DL-NCH-Users
  - [ ] DL-Hospital-Leadership
  - [ ] DL-USC-Ambulatory Services
  - [ ] Other:

- [ ] Remote Desktop Access
- [ ] Shared Drive (Include Full Path):

### ADDITIONAL APPLICATIONS

Please check the appropriate application below. If additional forms are required, they will be listed under the Security Form column.

<table>
<thead>
<tr>
<th>Application Name</th>
<th>Security Form Required</th>
<th>TENET SYSTEMS</th>
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<tbody>
<tr>
<td>Qlikview (Allscripts)</td>
<td>Form 21</td>
<td>[ ] PBAR</td>
</tr>
<tr>
<td>CAFÉ</td>
<td>Form 38</td>
<td>[ ] On-Demand Web</td>
</tr>
<tr>
<td>Cerner</td>
<td>Form 25</td>
<td>[ ] VI Web</td>
</tr>
<tr>
<td>EMR</td>
<td>Form 12</td>
<td>[ ] Showcase</td>
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<tr>
<td>Lawson</td>
<td>Form 34</td>
<td>[ ] S2K</td>
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<tr>
<td>pharmacy Apps (keck/norris)</td>
<td>Form 13</td>
<td>[ ] Daily Productivity App</td>
</tr>
<tr>
<td>Imaging/Radiology – General Access</td>
<td>Form 30</td>
<td>[ ] AS400</td>
</tr>
<tr>
<td>Imaging/Radiology – Advanced Access</td>
<td>Form 12</td>
<td>[ ] RES-Q</td>
</tr>
<tr>
<td>OMNICELL (Materials Management)</td>
<td>Form 32</td>
<td>[ ] GE PACS C-Web</td>
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<tr>
<td>Optilink Plus</td>
<td>[ ] GE PACS C-Web</td>
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</tr>
<tr>
<td>PCI</td>
<td>[ ] Pyxis-VHH</td>
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<tr>
<td>Patient Keeper</td>
<td>[ ] Pyxis-VHH</td>
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<tr>
<td>Kronos* Administrative Time Keeping (Select One):</td>
<td>[ ] Approver</td>
<td></td>
</tr>
<tr>
<td>[ ] Editor</td>
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<tr>
<td>Cost Center: [ ] (Required)</td>
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</tr>
</tbody>
</table>

### Kronos Scheduler

- [ ] Day
- [ ] Night

### Primary Job (RN, PCT etc.):

- [ ] 12HR Shift Length
- [ ] 10HR Shift Length

### Reporting Manager:

- [ ] QlikView (Other)

### Supervisor Name

### Signature

### Date

---

If you have any questions related to completing this form, please contact the Keck IT Service Desk at 323 442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to servicedesk@med.usc.edu or fax to (323) 442-8711.
CERNER SECURITY REQUEST

REQUESTING ACCESS FOR:

Instructions: Select only one of the listed positions. Selecting multiple positions will delay processing. Sign on page 2. If you know of a "like user" (another user with the access you’d like this user to have) please write the ID of the "like user" here: _______________________

<table>
<thead>
<tr>
<th>Clinic Positions</th>
<th>Radiology</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ P1 Clinic Audio/Speech</td>
<td>○ RadNet: Dept Secretary</td>
<td>○ P1 RN</td>
</tr>
<tr>
<td>○ P1 Clinic Audio/Speech Student</td>
<td>○ RadNet: Film Librarian</td>
<td>○ P1 RN Supervisor/Charge</td>
</tr>
<tr>
<td>○ P1 Clinic CNA</td>
<td>○ RadNet: Mammography Technologist</td>
<td>○ P1: Nurse Management</td>
</tr>
<tr>
<td>○ P1 Clinic CNS (w/ Schedule View) P1</td>
<td>○ RadNet: Physician Office Staff</td>
<td>○ P1: Quality Department</td>
</tr>
<tr>
<td>○ Clinic LVN</td>
<td>○ RadNet: Radiology Technologist</td>
<td>○ P1: Case Manager</td>
</tr>
<tr>
<td>○ Clinic Social Worker</td>
<td>○ RadNet: RadTech/Transcription</td>
<td>○ P1: LVN/LPN</td>
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<tr>
<td>○ P1 Clinic Manager - Clinical</td>
<td>○ RadNet: Researcher</td>
<td>○ P1: Student Nurse</td>
</tr>
<tr>
<td>○ P1 Clinic Manager - Non Clinical</td>
<td>○ RadNet: Supervisor</td>
<td></td>
</tr>
<tr>
<td>○ P1 Clinic Medical Student</td>
<td>○ P1 RadNet: RN</td>
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<tr>
<td>○ P1 Clinic PharmNet: Ambulatory RX</td>
<td>○ P1 IP RadNet: Radiologist</td>
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<tr>
<td>○ P1 Clinic Resident Licensed</td>
<td>○ P1 IP RadNet: Resident</td>
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<tr>
<td>○ P1 Clinic Resident Unlicensed</td>
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<tr>
<td>○ P1 Clinic RN</td>
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<tr>
<td>○ P1 Clinic Scheduling Clerk</td>
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<tr>
<td>○ P1 Clinic Unit Secretary</td>
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<tr>
<td>○ P1 Social Worker</td>
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<tr>
<td>○ One Legacy Coordinators</td>
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<tr>
<td>○ Research Coordinator - Admin</td>
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</table>

<table>
<thead>
<tr>
<th>Lab</th>
<th>PathNet: All Module Assistant</th>
<th>PathNet: AP Supervisor</th>
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</thead>
<tbody>
<tr>
<td>○ PathNet: All Module Tech</td>
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<td>○ PathNet: AP Transcription</td>
</tr>
<tr>
<td>○ PathNet All Module Supervisor</td>
<td></td>
<td>○ PathNet: Cytotech</td>
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<tr>
<td>○ PathNet: Microbiology Supervisor</td>
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<td>○ P1 IP PathNet: AP Resident</td>
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<table>
<thead>
<tr>
<th>Surgery VHH</th>
<th>○ P2 SurgiNet: Surgical RN VHH</th>
<th>Nursing VHH</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ P2 SurgiNet: Surgical RN w/PowerChart VHH</td>
<td>○ P2 RN VHH</td>
<td></td>
</tr>
<tr>
<td>○ P2 SurgiNet: Secretary VHH</td>
<td></td>
<td>○ P2 RN Supervisor/Charge VHH</td>
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<tr>
<td></td>
<td></td>
<td>○ P2 Psych RN VHH</td>
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</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>P1 Respiratory Therapist</th>
<th>P1 Respiratory Therapist Student</th>
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</thead>
<tbody>
<tr>
<td>○ P1 Respiratory Therapist</td>
<td></td>
<td>P1 Respiratory Therapist Supervisor</td>
</tr>
</tbody>
</table>

| Dietary                  | P1 Dietitian                      |                                  |
|--------------------------|----------------------------------|                                  |
| ○ P1 Dietitian Intern    |                                  |                                  |
| ○ P1 Nutrition Assistant |                                  |                                  |

| Business                 |                                  |                                  |
|--------------------------|                                  |                                  |
| ○ P1 Business Office     |                                  |                                  |
| ○ P1 Business Office Charge Auditor |                  |                                  |
Keck Medicine of USC

Medical Records/ HIM
- HIM
- P1 HIM Auditor Research View and Print
- P1 HIM Clinical Doc Specialist
- P1 HIM Coders
- P1 HIM External Researcher View Only
- P1 HIM Manager
- P1 HIM Scanners
- P1 HIM Specialist
- P1 HIM Transcriptionist
- P1 HIM Tumor Registry

Surgery
- P1 SurgiNet: Database Coordinator
- P1 SurgiNet: LVN/LPN
- P1 SurgiNet: Case Attendee No Access
- P1 SurgiNet: Materials
- P1 SurgiNet: PC Maintenance
- P1 SurgiNet: Post Case Charge
- P1 SurgiNet: RN Surgical Services
- P1 SurgiNet: RN Surgical Services w/ PC
- P1 SurgiNet: Scheduler
- P1 SurgiNet: Secretary
- P1 SurgiNet: Support Staff
- P1 SurgiNet: Tech

Emergency Department VHH
- P2 ED Medical Director
- P2 ED Unit Secretary
- P2 ED Nurse
- P2 ED Tech
- P2 FirstNet View Only
- P2 ED Biller
- P2 ED Scribe
- P2 ED Physician Informatics
- P2 ED LVN/LPN

Rehab
- P1 Occupational Therapist
- P1 Occupational Therapy Assistant
- P1 Occupational Therapy Student
- P1 Physical Therapist
- P1 Physical Therapist Assistant
- P1 Physical Therapy Student
- P1 Speech Therapist
- P1 Speech Therapy Student
- P1 Rehab Aide
- P2 Speech Therapist VHH

Maternity VHH
- P2 Perinatal RN
- P2 Perinatal LVN
- P2 Perinatal C.N.A./Tech
- P2 Lactation Consultant
- P2 Perinatal Nurse Manager

Patient Care Tech
- P1 Monitor Tech/Unit Clerk
- P1 Neuro Tech
- P1 Patient Care Technician
- P1 Unit Clerk/PCT
- P1 Diagnostic Technician
- P2 PCT/CNA VHH

Limited Access Positions
- P1 Read Only PowerChart Clinical
- P1 Read Only PowerChart Non Clinical
- P1 Research Coordinator
- P1 Pastor
- Research Monitor External

Environmental Services
- P2 EVS
- P2 EVS Supervisor

Manager/Supervisor Name (Print)  Manager/Supervisor (Signature)  Date

If you have any questions related to completing this form, please contact the IS Service Desk at 323-442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to helpdesk@med.usc.edu or fax to (323) 442-8711.
Keck Medical Center of USC

Badge Request Form

Student Name: ________________________________
Title: _RCP INSTRUCTOR________________________
School Name: ________________________________
Instructor Name: ________________________________

BADGE VALID FROM: ________________ TO: ________________

This badge is to be visibly worn at all times while on premises at Keck Hospitals. If you lose your badge the replacement fee is $10.00.

Student Signature: ________________________________

Please return your badge to Nursing Administration, Attn: Aliscia Ramsey at the end of your rotation.

Any questions regarding this badge,

Please contact:
Aliscia Ramsey
Office Coordinator
Nursing Administration Department
Keck Hospital of USC
1500 San Pablo Street
Los Angeles, CA 90033
PURPOSE

To standardize the procedure for the administration of blood products and to provide safe care to patients receiving transfusions.

POLICY

1. Transfusion Order
   a. An order is required for the administration of all blood products.
   b. Only physicians or licensed independent providers [nurse practitioner (NP), physician assistant (PA) and CRNA under supervision of a physician] can order transfusions.

2. Transfusion Consent
   a. Except in a medical emergency, informed consent for blood or blood product transfusion must be obtained prior to transfusion.
   b. Blood consent time frames are as follows:
      i. Inpatient - Consent must be obtained for each hospital inpatient admission if transfusion might be required. The consent is valid for that inpatient admission only.
      ii. Outpatient - Consent must be obtained for each outpatient whose treatment plan requires transfusion. This outpatient consent must be renewed at least annually or whenever the patient’s physician believes there is a material change in risk of transfusion for the patient.
   c. Documentation of Informed Consent or refusal of blood transfusion must be present in the medical record. A signed copy can be obtained from the medical record as applicable.
   d. Transfusion-Free patients: In a situation happens any transfusion-free patient desires transfusion, refer to instructions outlined in the Clinical Practice policy, Transfusion-Free Medicine Program (TFMP): Enrollment Process.

3. Samples drawn for blood type and antibody screen (type and screen) and crossmatch can be drawn by an RN, LVN, phlebotomist, care-partner certified in phlebotomy, Clinical Laboratory Scientist (CLS, aka medical technologist), PA or physician.
   a. Laboratory specimens will be labeled in the presence of the patient in accordance with the Specimen Labeling Policy.

4. "ABO/Rh verification sample" is a second sample collected by a separate phlebotomy that is required for patients for whom there is no history of ABO/Rh type on file in the patient’s medical record.
a. Blood Bank laboratory will initiate the request for the verification sample if needed.

b. Patients who have not had their ABO type confirmed will receive group O red cells until their blood type is confirmed by a second sample.

5. Pre-op blood orders should be submitted to the Blood Bank with blood bank samples at least 12 hours prior to surgery. Anticipated use of platelets, plasma or cryoprecipitate in the OR should be made known well in advance of surgery so the Blood Bank can assure an adequate supply.

6. Who may administer blood/blood products:
   a. Registered Nurse (RN) – may administer all blood products as ordered.
   b. IV Certified LVN – may administer all blood products as ordered with the exception of factors concentrates (e.g. FVIIa, FVIII, F IX, FXIII, K-Centra, or fibrinogen concentrate).
   c. Anesthesiology team (to include attending and resident/fellow anesthesiologist, and CRNA) – may administer all blood products in the perioperative areas.
   d. Perfusionist – may administer all blood products in the perioperative areas, and also in the ICU for ECMO.

7. Blood products must be checked in the presence of the recipient by the qualified transfusionist who will administer the transfusion and a second licensed qualified individual using the patient name and medical record number.

8. The following staff members may obtain blood products from the blood bank lab:
   a. Any medical or nursing staff member, including unit secretary, certified nursing assistant (CNA), care partner, RN, LVN, licensed registry, OR orderly or nursing student.
   b. Valid hospital approved ID badge is required.

9. Blood product infusions will be started promptly when issued to non-OR locations. If the transfusion cannot be started promptly, the blood product should be returned to the Blood Bank within 20 minutes of pickup to avoid wastage (Exception: red cells and plasma products issued in validated blood bank coolers).

10. Red cell and plasma components will be issued to the operating room (OR) in validated blood bank coolers. The coolers are transport devices and require periodic ice changes; the Blood Bank will telephone when an ice change is needed.

   **NOTE:** Blood Bank coolers will not be provided outside of the OR unless transfusion of 2 or more units of red cell or plasma products is anticipated, or if requested by the patient’s physician that blood products be available at the bedside for a procedure. Once a blood product is removed from a cooler, the infusion must be started promptly or the blood unit returned to the cooler within twenty minutes.

11. Blood products can NEVER be placed into or stored in refrigerators outside of the Blood Bank.
12. Patients may be transferred from the OR to the critical care units or PACU with blood infusing. At the end of surgery, coolers must be returned to the Blood Bank immediately.

13. Blood transfusions of all blood products (including whole blood, red cells, plasma, platelets and cryoprecipitate) MUST be completed within four (4) hours after the unit is spiked to prevent potential sepsis, and for patients in non-OR locations within five (5) hours of pickup from the Blood Bank.

14. To obtain emergency uncross-matched blood when, due to the severity of the patient’s condition, there is no time to complete a blood type and/or antibody screen and/or crossmatch:

   i. The Blood Bank is to be notified by a direct phone call (not by computer) that emergency uncrossmatched blood is required.

   ii. If a blood product is needed in an emergency and time cannot be allowed for type and screen and/or crossmatch tests, the Blood Bank/Transfusion Service “Emergency Blood Request and Release” form will be completed and sent with the blood product(s). The form should be signed immediately by a physician that is part of the patient care team. If the physician is unable to sign the form at the time the blood is needed, notify Blood Bank as to which physician has ordered the blood. If the form is not signed the blood bank staff and/or Transfusion Medicine physician will contact the physician who placed the order (and/or the attending physician or other physician who is part of the patient care team for signature of the form) as required by California State law.

   iii. Type and screen and/or crossmatches will be subsequently completed and if the screen is positive or crossmatches incompatible, the results are phoned to the patient care provider.

15. All red blood cell and platelet products must be leukocyte-reduced if indicated.

16. Irradiated, CMV sero-negative and/or hemoglobin S negative blood products are to be used as described in Attachment D.

17. The Blood Bank must be notified at the time of a suspected transfusion reaction. The forms to report the reaction should be filled out completely.

18. Normal Saline and Plasmalyte are the only acceptable IV solutions for transfusing and flushing the IV line before and after the administration of blood products.

   a. Medications NEVER may be added to blood or blood products, or infused through the same administration set as the blood product.

19. Blood and blood components always must be administered using the appropriate filter and/or tubing (see Attachments A & B).
Equipment

- Transfusions
  - IV Pole
  - 0.9% Normal saline solution
  - Infusion pump (if applicable)
  - Component-specific filter and tubing (See Attachments A & B)
  - Gloves
  - Alcohol swabs

- Blood warmer (if applicable)
  - Level 1 Fluid Warmer
  - Level 1 D70 IV fluid Administration set – obtain from Materials Management (KHUSC);

Procedure (All Areas)

1. Prior to administration, the nurse will ask the patient to determine if they have given informed consent to the transfusion
   a. Verify documentation of Informed Consent for blood in the medical record.
   b. If patient has not given consent, notify physician prior to proceeding.

2. A Type and Screen (T&S) sample is required if T&S has not been done within the prior 3 days,
   a. Exception: Samples from START Clinic patients are usable up to thirty (30) days if the patient has NOT been transfused and/or transplanted and/or pregnant within the 90 days prior to the sample draw, and the patient has completed and signed the START questionnaire.

3. The Blood Bank will communicate with Surgery, Same Day Surgery, Day Hospital, START Clinic, or the patient’s nursing unit as appropriate, when STAT orders for blood products needed on the current day are available. When requested, Blood Bank will notify the same area(s) when Routine orders for blood products are available.

4. The Blood Bank will notify Surgery, Same Day Surgery, Day Hospital, START Clinic, the nursing unit or transplant coordinator, as appropriate, when the patient has a positive antibody screen or other situations that may cause a delay in blood availability.

5. When blood is issued from Blood Bank to any area a two person read-back is done:
a. Check and verify information on patient ID label, Transfusion Record form, and tag attached to blood bag. Elements that are checked include:
   i. Patient’s name
   ii. Date of birth
   iii. Patient’s medical record number
   iv. Patient’s blood group and Rh type
   v. Donor unit number
   vi. Donor blood group and Rh type
   vii. Blood product expiration date and time
   viii. Blood product ordered
   ix. Special attributes (i.e. CMV negative, leukocyte-reduced, irradiated, hgb S negative)
   x. The unit appearance is normal and the container is intact

b. Do not accept blood component if any of the information is missing, or the information on the blood bag label, blood bag tag and/or the Transfusion Record form does not match.

c. The Blood Bank technologist will complete the verification documentation process by entering into the computer the names of the courier and blood bank staff dispensing the blood.

**ADMINISTRATION OF BLOOD IN THE OPERATING ROOM (OR)**

1. A physician or CRNA order is required for any blood product and must specify component requested and number of units.
   a. Verbal orders are recorded by the OR RN on the OR Transfusion Order Sheet.

2. Blood will be picked up on an as-needed basis, with red cell products and thawed plasma transported via the blood cooler system. Blood coolers are sealed with tape prior to transport to the OR. Refer to Clinical Laboratory/Keck Blood Bank SOP Insulated Blood Coolers.
   a. The patient must be in the actual OR room prior to pick up and delivery of blood products.
   b. Blood product courier (or designated OR staff person) can pick up and deliver coolers and/or blue ice blocks to just one OR/one patient at a time.
   c. Couriers will use plastic bags for the transport of blue ice blocks.
   d. A Blood Pickup/Delivery slip must be completed and verified by 2 OR staff members prior to
submitting to the Blood Bank. NOTE: Verification will include patient name, MRN and OR room number.

3. If additional units are needed during surgery, the RN or designee will call the Blood Bank and indicate products needed.

4. Upon receipt of the blood products, the courier and OR RN together will:
   a. Verify the cooler tape/seal is intact for blood products delivered in coolers.
   b. Verify information on the Blood Pickup/Delivery Slip to insure the blood products and cooler are being delivered the correct OR room and patient. This is done by the RN and courier doing a verbal readback of the patient name, medical record number and OR room number.
   c. If the OR RN is not readily available, the CRNA or Attending Anesthesiologist may receive the cooler and perform the verification. Anesthesia residents may NOT do the cooler receipt and verification.

5. After completion of the Blood Pickup/Delivery Slip, the RN will remove and discard the cooler tape/seal and the blood components will be checked by the OR RN.
   a. The RN will check the blood products to confirm the patient name and medical record on the blood bag tag and Transfusion Record form matches the patient name and medical record of the patient. (This is the minimum check required. The nurse may elect to check other elements, such as matching the unit number on the blood label to the blood bag tag and Transfusion Record form.)
   b. The blood units must be checked against the Transfusion Record form one by one, not as a batch to avoid switching of paperwork.
   c. After checking each product, the RN will place their initials on the blood bag tag (do NOT initial on the Transfusion Record form)

6. Transfusion of red cell and plasma products will be started promptly after removal from the cooler, or else the blood products must be returned to the cooler within 20 minutes of removal. Close the blood cooler lid after retrieval of each blood product.

7. Immediately prior to transfusion, the transfusionist and one (1) other qualified healthcare provider trained in the process will concurrently verify the information on the donor unit, blood bag tag and the Transfusion Record form.
   a. Check item by item, the following elements:
      i. Patient’s name and medical record number (MRN) located on the patient ID band matches name and MRN on the blood product tag and the Transfusion Record.
      ii. Donor unit number matches on blood bag label, blood product tag and Transfusion Record.
      iii. ABO and Rh type of both donor and recipient.
      iv. Expiration date and time of the blood product.
v. Result of crossmatch, if performed.
vi. Special attributes (e.g. CMV negative, irradiated, hgb S negative).

b. If the patient identifiers and/or unit number do not match or information is missing, do not transfuse until the discrepancy is resolved.

8. Completion of Transfusion Record form.
   a. Once verification has been made, the transfusionist and verifier will sign and complete date/time when transfusion is started, on the Transfusion Record form.
   b. Place the completed the Transfusion Record form in chart.

9. In those cases where **massive bleeding** is anticipated, the two (2) person verification of all the elements outlined in step 7 above can be done by an anesthesia provider and one (1) other qualified provider trained in the process, before active bleeding has started.
   a. An anesthesia provider must participate in the verification of the blood products; the only exception is in dire emergency with the patient is already having active massive bleeding
      i. In those dire emergency cases with current active massive bleeding, the two-person verification as outlined in step 7 can be done by two (2) qualified healthcare providers trained in the process.
   b. After completion of the verification, the two verifiers will place their initials on the Transfusion Record form on the ‘verifier’ line.
   c. At time of transfusion the transfusionist/anesthesia provider will positively match the patient name and medical record number of the patient to the blood tag, and check the ABO type of red cell blood products.
   d. The accurate identification of the blood product to the patient is the ultimate responsibility of the transfusionist.
   e. The transfusionist must sign the Transfusion Record form to complete the medical record at the end of surgery.
   f. Place the competed Transfusion Record form in the medical record under the lab section

10. The Anesthesia provider documents vital signs, time transfusion started and completed, and amount transfused on the Anesthesia Record.

11. Anesthesia personnel document any reaction on the Transfusion Record form and patient record.

12. Blood coolers must be returned to the Blood Bank immediately after the patient leaves the OR room. It is the responsibility of the circulating nurse to ensure the blood coolers are returned.

13. When reporting to PACU RN, state number volume and type of blood product(s) patient received the patient received during surgery. Be sure that the PACU RN is aware of the potential for a transfusion reaction.
14. Transfusion reactions in the OR may be difficult to recognize because the patient's signs and symptoms may be masked by the effects of general anesthesia. Elevated temperature and unexplained dark or rusty urine are very useful signs in determining the possibility of a transfusion reaction. (See Transfusion Reactions section of the SOP.)

**ADMINISTRATION OF BLOOD IN PATIENT CARE AREAS**

1. Ordering of blood products:
   a. Obtain a provider order to include component requested, number of units and infusion information.
   b. For CPOE (computerized provider order entry) areas, the provider must enter the crossmatch (red cells) or prepare (plasma, platelets, cryoprecipitate) order(s) and specify the number of units. The provider also must enter the transfuse order(s), specifying how many units to transfuse.
   c. For non-CPOE areas such as Day Hospital, the unit secretary or qualified staff enters the appropriate orders in the computer, including blood component and number of units.

2. Obtaining blood products
   a. IV access **must** be established prior to obtaining blood product from Blood Bank.
      i. Blood should be administered through a minimum of a 20 gauge needle/catheter. If larger access cannot be obtained, a 22 gauge needle/catheter may be used.
      ii. When peripheral access is limited, a central venous catheter is an acceptable option for blood transfusion.
   b. **Prior to picking up blood from Blood Bank**
      i. Assess patient condition including vital signs.
      ii. Verify there is a provider order for transfusion
      iii. Confirm that a current consent for transfusion is available in the medical record.
   c. When ready to administer the blood, the printed blood product order is taken to the Blood Bank. One product will be issued at a time unless otherwise specified. Multiple units for the same patient may be issued as long as there are sufficient vascular access sites. Blood products for more than one patient will not be released at the same time.

3. Bedside Verification:
   a. Verify the provider order to the information on the donor unit, including special instructions (e.g. CMV negative, irradiated).
   b. The bedside check will include two licensed personnel qualified to participate in the transfusion process. The responsibilities include confirmation that the correct ID armband is on the patient, and
that the content of the armband is identical to the information on the blood bag tag attached to blood bag and the Transfusion Record form, and that the information on the donor unit tag matches the blood bag label. Item by item, check the following information:

i. Patient name and date of birth (Ask the patient to state their name and date of birth when possible). Confirm the name and date of birth match on the patient armband, the blood product tag and the Transfusion Record match.

ii. Patient’s armband medical record number (MRN) matches MRN on the blood product tag and the Transfusion Record.

iii. Donor unit number on the blood product label matches that on blood product tag and Transfusion Record form.

iv. Check ABO and Rh type of both donor and recipient.

v. Expiration date and time of the blood product.

vi. Results of crossmatch test, if performed.

vii. Special attributes (e.g. irradiated, hgb S negative).

c. DO NOT transfuse the blood if any of the above information is missing, or patient identifiers and/or unit number do not match. The blood product may NOT be administered until the discrepancy is resolved. (Blood types may not always be always identical between donor and patient. Refer to Attachment C Blood Compatibility Tables).

d. Both personnel must sign their names and titles on the Transfusion Record form to verify that the blood check is complete.

4. Initiate Transfusion:

a. Wash hands and apply gloves.

b. It is strongly preferred to transfuse one blood product at a time. In case with extreme blood loss it is acceptable to transfuse multiple units via multiple vascular access sites.

c. Prime tubing with Normal Saline and start slow infusion.

d. Hang on an IV pole; spike the blood product.

e. An infusion pump may be used to assist the flow rate of the infusion. For red cell transfusions, a manual pressure cuff may be used to increase flow rate. NOTE: Pressure cannot exceed 300 mmHg.

f. Use roller clamps to stop Normal Saline and start infusion of blood.
g. Slowly infuse 15-25 mL during the first 15 minutes and, if no reaction has occurred, the infusion rate may be adjusted.

5. Stay with the patient for approximately the first 5 minutes. Closely monitor the patient for the next 10 minutes and re-check vital signs.

6. Throughout Transfusion:
   a. The patient should be monitored for signs of reaction, i.e., fever, chills, rash, SOB, chest pain, hematuria, flushing, itching, hives and condition of infusion site. The patient should have access to a call light, and response to a call should be prompt.
   b. Vital signs will include:
      i. Temperature
      ii. Heart rate
      iii. Respiratory rate
      iv. Blood pressure
   c. Vital signs should be recorded as follows:
      i. Within 30 minutes PRIOR to transfusion
      ii. 15 minutes after initiation
      iii. Hourly and prn
      iv. Post-transfusion
      v. Before sending patient home

7. Complete Transfusion:
   a. Flush with saline
   b. Remove empty blood product bag and tubing
   c. Any physician-ordered laboratory values to determine transfusion efficacy may be drawn 30-120 minutes after the transfusion is completed.

8. Documentation:
   a. The Blood Administration section on the Transfusion Record form must be fully completed.
   b. Complete all information on Transfusion Record form. Make sure all signatures are present.
c. Document blood component infused.

d. Place the Transfusion Record form in patient’s chart under lab section.

e. All education provided regarding blood transfusion will be documented in the medical record.

9. Disposal of Blood Component and Tubing:

a. The empty blood component bag is to be disposed of as infectious waste (red bag), unless a transfusion reaction is suspected.

b. If an adverse reaction occurs, return bag and tubing to the Blood Bank.

**TRANSFUSION REACTIONS**

1. Signs and symptoms may include:

   - Fever
   - Chills
   - Rash/Hives/Itching*
   - Chest or Back Pain
   - Confusion (new onset)
   - Tachycardia
   - Hematuria
   - Hypotension
   - Hyperventilation
   - Chest or Back Pain
   - Pounding Headache
   - Convulsions
   - Apprehension (new onset)
   - Hypertension
   - Hematuria
   - Diaphoresis
   - Nausea/Vomiting
   - Rise in temperature greater than 1°Centigrade from baseline

**NOTE:** Fever is often the most sensitive indicator of hemolytic or septic transfusion reactions. Fever may develop over the course of multiple transfusions.

*Rash/hives/itching with no other symptoms does not need to be reported to Blood Bank.

2. Any licensed nurse may initiate the transfusion reaction form for suspected transfusion reactions without a physician’s order.

3. If a hemolytic reaction or anaphylactic reaction is going to occur, it usually will happen after a small volume of blood enters the patient’s circulation. A febrile reaction may occur up to four (4) hours after transfusion or pulmonary reaction, such as Transfusion Related Acute Lung Injury (TRALI) or fluid overload, may occur at any point during the transfusion or up to six (6) hours after the transfusion. Sepsis due to bacterial contamination also may have delayed onset.

4. If the patient develops signs or symptoms of a reaction:

   a. Clamp off blood, maintain IV with normal saline
b. Immediately notify the patient’s physician, the Clinical Nurse Lead or NP, as applicable, and Blood Bank.

c. Inform the physician of all objective and subjective symptoms.

d. If the physician elects to STOP TRANSFUSION
   i. Notify Blood Bank
   ii. Obtain and send a pink top blood specimen to the Blood Bank.
   iii. Also send the blood bag and blood tubing to Blood Bank with completed Report of a Transfusion Reaction form and copy of the completed Transfusion Record form.
   iv. Give medications (if ordered)
   v. Observe and record vital signs at least once an hour for three hours.

e. If the physician elects to CONTINUE TRANSFUSION
   i. Notify Blood Bank of the physician decision. A transfusion reaction investigation may be initiated by the Blood Bank as determined by Blood Bank SOP and/or consult with Transfusion Service pathologist on call.
   ii. Obtain and send a pink top blood sample to the Blood Bank if requested.
   iii. Give medications (if ordered).
   iv. Observe closely and record vital signs every 15 minutes until transfusion completed.
   v. At the completion of transfusion send the blood bag and blood tubing to Blood Bank with completed Report of a Transfusion Reaction form and copy of the completed Transfusion Record form.

5. Suspected Delayed Reaction - Notify physician, Clinical Nurse Lead or LIP (as applicable) and Blood Bank.

6. Complete a hospital occurrence report for all suspected transfusion reactions.

**REFERENCE(S)**

- Transfusion Therapy Clinical Principles and Practice, current edition

• National Patient Safety Goal 1C: Eliminating Transfusion Errors

ATTACHMENTS

• Attachment A Blood Filters

• Attachment B Blood Transfusion Chart

• Attachment C Blood Compatibility Tables

• Attachment D Table of Indications for the use of Irradiated, CMV sero-negative or hemoglobin S negative blood components

RELATED POLICIES AND PROCEDURE(S)

• Administration Manual
  o Consents: Obtaining and Verifying

• Clinical Practice Manual
  o Transfusion-Free Medicine Program (TFMP): Enrollment Process
  o Specimen Labeling Policy
**Effective/Revision Dates for Policy # CP 3-115**

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<td>Medical Executive Committee</td>
</tr>
<tr>
<td>03/28/1996</td>
<td>Professional Practice Committee</td>
</tr>
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<td>10/13/1998</td>
<td>Medical Executive Committee</td>
</tr>
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<td>06/18/2002</td>
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</table>

**Keywords:** Blood, product, component, Platelets, Blood warming, Transfusion, Factors, PRBCs
### Blood Filters

<table>
<thead>
<tr>
<th>Filter</th>
<th>Pore Size</th>
<th>Comments / Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2502, Lawson #88391</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V 2520 (gravity)</td>
<td>170 micron</td>
<td>Standard Y type blood tubing used for administration of WB, RBC’s, Plasma, Platelets, Cryoprecipitate, and washed RBC’s. Removes gross clots and large microaggregates only.</td>
</tr>
<tr>
<td>V 2584</td>
<td>180 micron</td>
<td>Standard Y type blood tubing used for administration of WB, RBC’s, Plasma, Platelets, Cryoprecipitate, and washed RBC’s. Removes gross clots and large microaggregates only. Administration of blood through an infusion pump will not destroy blood components.</td>
</tr>
<tr>
<td>V 2560-39</td>
<td>170 micron</td>
<td>Y type tubing with pump chamber for rapid administration of WB &amp; RBC’s.</td>
</tr>
<tr>
<td>Pall Microaggregate SQ40S</td>
<td>40 micron</td>
<td>Provides removal of large and smaller microaggregates from whole blood, red cells and platelets. Indicated for patients needing leuko-reduced units when pre-storage leuko-reduced units are not available. Can be used for salvaged auto blood. Filter is added in-line to standard 170 micron Y type tubing. May use for up to 10 units of blood products.</td>
</tr>
</tbody>
</table>

### VOLUME AND TIME LIMIT GUIDELINES FOR BLOOD TRANSFUSION FILTERS

Federal Regulations state that all transfusion products must be administered through an in-line filter. As the filter remains in use, material trapped in it serves as a medium for bacterial growth. In Guidelines to Transfusion Practices published by the American Association of Blood Banks, it is recommended that filters be changed AT LEAST EVERY SIX HOURS during transfusion of multiple units of blood and that a filter should only be used for the duration of the transfusion.

The following table lists the recommended MAXIMUM number of components to be issued through a single filter:

<table>
<thead>
<tr>
<th>Blood Component</th>
<th>Filter Type</th>
<th>Blood Component</th>
<th>Pall SQ40S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Blood Cells</td>
<td>4</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Washed RBC’s</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Frozen RBC’s</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Thawed Plasma</td>
<td>-</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Platelet Pheresis</td>
<td>-</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Cryoprecipitate</td>
<td>-</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Filters may need to be changed more frequently if the flow rate slows before the maximum number of components is infused.

For Blood Component Chart, see Attachment B.
Attachment B

Blood Component Chart

1. All infusions must be initiated within one hour of receipt from the Blood Bank, unless stored in an approved cooler.

2. All blood components must be infused with a filter.

3. All infusions must be completed within 4 hours of spiking the blood unit.


<table>
<thead>
<tr>
<th>Blood and Blood Components</th>
<th>Composition Approximate Volume</th>
<th>Indications</th>
<th>Tubing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Blood Cells, Leuko-reduced (RBC-LR)</td>
<td>RBC, reduced plasma and WBC, 1 unit = 285-350 mL.</td>
<td>Increase RBC mass and O₂ carrying capacity in hypovolemic or normovolemic patients with symptomatic anemia.</td>
<td>V 2520, V2560-39 or Alaris 10015415</td>
<td>One unit of packed red cells will increase hematocrit by approximately 3% and hemoglobin by 1 g/dL in an adult. Transfusion must be completed within 4 hours after unit is spiked. Leuko-reduction decreases CMV risk.</td>
</tr>
<tr>
<td>Washed Red Blood Cells</td>
<td>RBC’s, no plasma, markedly reduced WBC. 1 unit equals 180-260 mL.</td>
<td>Same as RBC. Reduced risk of allergic reaction to plasma proteins</td>
<td>V 2520, V2560-39 or Alaris 10015415</td>
<td>Must be ordered from blood supplier; allow 12 hrs for availability. Unit expires 24 hours after washing completed. Transfusion must be completed within 4 hours after unit is spiked.</td>
</tr>
<tr>
<td>Platelet Pheresis (single donor)</td>
<td>Platelet collected from one donor by apheresis procedure. 1 unit = 1 dose. Volume will vary from 200-500 mL</td>
<td>To increase platelet count in bleeding patients to &gt; 50k or prophylactically in patient with plt count &lt; 10k.</td>
<td>V 2520</td>
<td>Infusion must be completed within 4 hours after the unit is spiked. One platelet Pheresis product is equal to 4-6 units of platelet concentrates. HLA matching or crossmatch pls can be requested for refractory patients, but up to several days to obtain product.</td>
</tr>
<tr>
<td>Thawed Plasma</td>
<td>Plasma, all coagulation factors (no platelets). Frozen for storage. 1 unit = 230-320 mL</td>
<td>Replacement of coagulation factors in treatment of coagulation disorders</td>
<td>V2520</td>
<td>Infusion must be completed within 4 hours after the unit is spiked. May use same filter for up to 4 units.</td>
</tr>
<tr>
<td>Cryoprecipitate</td>
<td>Concentrated source fibrinogen; also contains FVIII, FXIII, von Willebrand factor (vWF) and fibronectin. Provided as pools of 5 donors. Average volume is 90-100 mL</td>
<td>Treatment of hypo- and dysfibrinogenemia, and for production of fibrin glue. (Deficiency of factor s VIII, XIII and vWF should be treated with factor concentrates, whenever feasible, not with cryo).</td>
<td>V2520</td>
<td>Infuse as soon as possible after receipt from the Blood Bank. Infusion must be complete within 4 hrs after the unit is spiked. May use same filter for up to 10 units (2 pools of 5 units each).</td>
</tr>
</tbody>
</table>
ATTACHMENT C: Blood Compatibility Tables

The decision of the blood type of the blood component made available to the patient will be dependent on inventory management issues and patient factors in accordance with these guidelines.

For **Red Blood Cell Transfusions:**

<table>
<thead>
<tr>
<th>If the patient is group</th>
<th>First Choice</th>
<th>Acceptable Alternative Choices</th>
<th>In Emergent/Shortage Situations, With Pathologist Approval</th>
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<tbody>
<tr>
<td>O Pos</td>
<td>O Pos</td>
<td>O Neg</td>
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<td>B Pos</td>
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<td>AB Pos</td>
<td>AB Pos</td>
<td>All blood groups are acceptable</td>
<td></td>
</tr>
<tr>
<td>O Neg</td>
<td>O Neg</td>
<td>NONE</td>
<td>O Pos</td>
</tr>
<tr>
<td>A Neg</td>
<td>A Neg</td>
<td>O Neg</td>
<td>A Pos, O Pos</td>
</tr>
<tr>
<td>B Neg</td>
<td>B Neg</td>
<td>O Neg</td>
<td>B Pos, O Pos</td>
</tr>
<tr>
<td>AB Neg</td>
<td>AB Neg</td>
<td>A Neg, B Neg, O Neg</td>
<td>AB Pos, A Pos, B Pos, O Pos</td>
</tr>
</tbody>
</table>

For **Thawed Plasma** (Rh type is not a consideration when transfusing Plasma)

<table>
<thead>
<tr>
<th>If the patient is group</th>
<th>First Choice</th>
<th>Acceptable Alternative Choices</th>
<th>In Emergent/Shortage Situations, With Pathologist Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>All blood groups are acceptable</td>
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</tr>
<tr>
<td>A</td>
<td>A</td>
<td>A, AB</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B</td>
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<td></td>
</tr>
<tr>
<td>AB</td>
<td>AB</td>
<td>None</td>
<td>A or B</td>
</tr>
</tbody>
</table>

* This is provided as general information ONLY. For solid organ or allogeneic BMT (Blood/Marrow Transplant) patients, plasma components should be compatible with the donor ABO type.

**Platelet Compatibility:**

ABO type identical platelets (i.e. the blood type of the patient matches the blood type of the platelet product) are provided based on availability, inventory and the clinical setting. Rh negative male patients and female patients over age 55 and/or S/P hysterectomy will be provided either Rh negative or Rh positive platelets, depending on inventory. Rh negative platelets are provided to Rh negative females less than age 55 who have not had a hysterectomy, unless Rh negative platelets are not readily available and the need is urgent. The urgency of need is determined by the patient’s physician.

Group O platelets have additional testing to identify those group O platelet components with potential increased hemolytic activity. Group O platelet components with higher titers of anti-A and anti-B antibodies are not provided to non-group O patients.

**Cryoprecipitate**

ABO group identical cryoprecipitate usually is provided, but based on availability and inventory non ABO group identical cryoprecipitate may be provided.
INDICATIONS FOR BLOOD COMPONENT IRRADIATION

If the situation or diagnosis is listed below, then the literature supports that blood components to be transfused should be irradiated. This list is provided for information only. It is the responsibility of the patient’s physician to request special processing, to include irradiation, of any blood component. Contact the Medical Director if assistance is needed.

1. Congenital immunodeficiency syndromes
2. Intrauterine transfusions
3. Exchange transfusions if the patient received intrauterine transfusions
4. Premature infants up to 4 months
5. All directed donations from one blood relative to another
6. Leukemia
7. Neuroblastoma
8. Multiple myeloma
9. Myelodysplastic Syndrome (MDS)
10. Waldenstrom’s macroglobulinemia
11. Lymphoproliferative Disorders
12. Lymphoma
13. Blood/marrow transplant recipients
14. Donor is selected for HLA compatibility, by typing or crossmatching
15. Patient on azathioprine (Imuran), cladribine (Leustatin), clofarabine (Clolar), deoxycoformicin (Pentostatin), fludarabine (Fludara), nelarabine (Arranon), thiocyanine (Tabloid) or other purine nucleoside analog therapy including high dose mercaptopurine (Purinethol) for chemotherapeutic induction (does not apply to oral maintenance dose mercaptopurine therapy).
16. Patient on anti-CD52 (alemtuzamab; trade names Campath and Lemtrada).
17. Patient on rabbit ATG (rabbit anti-thymocyte globulin; trade name Thymoglobulin)
18. Miscellaneous (situations not listed above should be considered on a case by case basis).
19. High grade sarcomas or sarcomas in pediatric patients
20. Kidney and kidney/pancreas transplant recipients, as these patients may be given Thymoglobulin

Irradiated blood products are NOT indicated for the following diagnosis:

Aplastic anemia unless undergoing BMT
Most solid tumors (excludes high grade sarcomas and pediatric sarcomas)
Patients with HIV infection
Sickle Cell Disease patients
INDICATIONS FOR CMV SERO-NEGATIVE LEUKOCYTE-REDUCED CELLULAR COMPONENTS

CMV negative red cells and platelets are to be given as follows:

1. Allo blood/marrow transplants:
   a. If both BMT recipient and donor are CMV neg give CMV neg when feasible. If CMV negative products are not available, leukoreduced units are considered CMV safe.
   b. If either the recipient or the donor is CMV positive, there is no requirement to give CMV negative red cells or platelets.

2. Organ transplants:
   a. Lung transplant recipients: give CMV neg products. If CMV products are not available, leukoreduced units are considered CMV safe.
   b. Heart transplant recipients:
      i. If the recipient is CMV neg or CMV unknown, give CMV neg products. If CMV negative products are not available, leukoreduced units are considered CMV safe.
      ii. If the patient is positive for antibodies to CMV, CMV neg products are not indicated.
   c. Kidney transplant recipients: Give according to the physician’s order(s). If CMV negative products are not available, leukoreduced units are considered CMV safe.
   d. Liver transplant recipients: No requirement for CMV negative blood products.

**Indications for the use of hemoglobin S negative blood components:**

When whole blood or packed red blood cell units are used to support a patient known to have Sickle Cell Disease or Sickle/Thal Disease or other abnormal hemoglobin in conjunction with Hemoglobin S (e.g., Sickle/ C disease), the units should be screened and known to be negative for Hemoglobin S.
**PURPOSE**

To administer medications and blood derivatives safely and efficiently, per the physician's order in the hospital setting.

**DEFINITION**

Blood derivatives are pooled blood products such as albumin, gamma globulin, Rh immune globulin, factor VIII, factor IX, immune globulin, and cytomegalovirus immune globulin.

**POLICY**

1. Medications and blood derivatives shall be administered only upon the order of a member of the medical staff, an authorized member of the house staff, or other individuals who have been granted privileges to prescribe or write such orders. Authorized prescribers are defined in the Medical Staff Rules and Regulations.

2. The pharmacy shall supply all medications, and all medications shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with laws and governmental rules and regulations governing such acts, and in accordance with approved medical staff rules and regulations.

3. Clinical staff administering medication shall verify the prescribing practitioner’s orders and properly prepare medications for administration. Clinical staff will identify the patient prior to medication administration and will properly record each dose of medication administered in the patient’s medical record.

4. The Bar-Code Medication Administration (BCMA) system will be used to confirm appropriate medication administration.

   a. The only exception to this is during an emergency situation. Medications administered during a Code Blue will be documented on the Code Blue flowsheet.

**PROCEDURE**

1. Medications shall be administered only by individuals who are licensed and permitted by law and regulation to do so, or by individuals who are qualified, competent, and directly under the supervision of individuals who are licensed and permitted by law or regulation to administer medication. Persons authorized to administer medications shall include:

   a. Licensed physicians who have been granted privileges to administer applicable medications.
b. Registered Nurses (RNs) who may administer all medications including investigational drugs (except those approved for administration only by a physician via routes restricted to only those certified).

c. Licensed Vocational Nurses (LVNs) may administer oral, intramuscular injections, topical or rectal medications, subcutaneous, and intradermal injections.

d. IV Certified LVNs may administer plain IV fluids, dextrose, electrolytes, vitamins, or blood and blood products.

e. Physical Therapists may administer topical medications that are within their scope of practice or as approved by Hospital policy.

f. Respiratory Care Practitioners (RCP) may administer only those medications that are within their scope of practice or as approved by Hospital policy.

g. Radiology Technicians may administer certain medications, within their scope of practice, and under proper physician supervision.

h. Nuclear Medical Technologists may inject radiopharmaceuticals upon satisfying competency criteria and upon approval by the Director of Nuclear Medicine.

i. Speech Therapists may administer oral contrast for swallow exams.

2. Clinical staff may enter food and drug allergies into the medical record.

3. Clinical staff shall check patient allergies and verify no contraindications exist.

4. Clinical staff shall verify that the medication is not expired before administration.

5. Clinical staff shall visually inspect the medication packaging to ensure that it is intact and has not been tampered.

6. Clinical staff shall visually inspect the medication for signs of loss of integrity such as particulates or discoloration.

7. Clinical staff shall read the medication label three times during administration and verify that the medication selected matches the medication order and product label:

   a. When picking up the medication

   b. Just prior to administration

   c. Just after administration

8. Clinical staff shall check the medication and dosage against the Medication Administration Record ("MAR") before administration to a patient. The pharmacist shall verify the physician order for appropriateness prior to the administration of a medication. (See policy "Pharmacist Order Verification") Before administration of any drug, the licensed practitioner should review the “eight rights:”
a. Right patient (2 patient identifiers)

b. Right drug

c. Right dose

d. Right route

e. Right time

f. Right reason

g. Right monitoring/documentation

h. Right response

9. The workflow of the administration using barcode medication:

   a. Obtain medications.

   b. Visual inspect medication.

   c. Check for right patient by asking patient for hospital approved identifiers.

   d. Barcode scan the patient id band.

   e. Barcode scan the manufactures barcode when available or the KeckCare barcode.

   f. Administer medication to patient.

10. Standard Drug Administration Times in the hospital (exception for Respiratory Therapy, see (11) below):

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Administration Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0900</td>
</tr>
<tr>
<td>Daily (Warfarin)</td>
<td>1800</td>
</tr>
<tr>
<td>BID</td>
<td>0900, 1700</td>
</tr>
<tr>
<td>TID</td>
<td>0900, 1300, 1700</td>
</tr>
<tr>
<td>QID</td>
<td>0900, 1300, 1700, 2100</td>
</tr>
<tr>
<td>Every 2 Hours</td>
<td>administer at even hours</td>
</tr>
<tr>
<td>Every 3 Hours</td>
<td>administer beginning at 0300</td>
</tr>
<tr>
<td>Every 4 Hours</td>
<td>0400, 0800, 1200, 1600, 2000, 2400</td>
</tr>
<tr>
<td>Manual:</td>
<td>Clinical Practice</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>Subject:</td>
<td>Administration of Medication</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Every 6 Hours 0600, 1200, 1800, 2400
Every 8 Hours 0600, 1400, 2200
Every 12 Hours 0900, 2100
HS 2100
AC 30 minutes before meals
PC 30 minutes after meals

11. Drug Administration Times for Respiratory Therapy Medications in the hospital (includes albuterol, ipratropium bromide, levalbuterol, mucomyst); these administration times are to accommodate Respiratory Therapy Department's hours of operation:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Administration Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>0900</td>
</tr>
<tr>
<td>BID</td>
<td>0900, 2000</td>
</tr>
<tr>
<td>TID</td>
<td>0900, 1400, 2000</td>
</tr>
<tr>
<td>QID</td>
<td>0800, 1200, 1600, 2000</td>
</tr>
<tr>
<td>Every 2 Hours</td>
<td>administer at even hours</td>
</tr>
<tr>
<td>Every 3 Hours</td>
<td>administer beginning at 0200</td>
</tr>
<tr>
<td>Every 4 Hours</td>
<td>0800, 1200, 1600, 2000, 2400, 0400</td>
</tr>
<tr>
<td>Every 6 Hours</td>
<td>0700, 1300, 1900, 0100</td>
</tr>
<tr>
<td>Every 8 Hours</td>
<td>0700, 1500, 2200</td>
</tr>
<tr>
<td>Every 12 Hours</td>
<td>0900, 2100</td>
</tr>
<tr>
<td>HS</td>
<td>2100</td>
</tr>
<tr>
<td>AC</td>
<td>30 minutes before meals</td>
</tr>
<tr>
<td>PC</td>
<td>30 minutes after meals</td>
</tr>
</tbody>
</table>

12. Unless the prescriber indicates otherwise, clinical staff shall administer drugs at standard times in the hospital. Orders started on non-standard administration times or orders that deviate from standard administration times should be brought back to standard dosing times within two (2) dosing intervals, if possible. Medications will be administered not more than 60 minutes before prescribed time and no later than 60 minutes past. In instances where drug levels are measured, no delays will be acceptable. A pharmacist shall notify nursing if a drug should be administered at other than standard times.

13. Clinical staff shall leave only those medications at the bedside or in the patient's room that are so ordered by the prescriber. Clinical staff will instruct the patient that if medication is used, the patient should inform the nursing staff. See “Bedside Medications – For Patient Administration” policy.
14. To reschedule medication administration times because the patient is unavailable (i.e.; not on the unit), clinical staff will:
   a. Document the reason in eMAR.
   b. Notify Pharmacy via med request to reschedule subsequent doses.

15. If a medication is refused or omitted, clinical staff will:
   a. Notify physician if refused or omitted.
   b. Refused Medications
      i. Destroy refused medications if contaminated or if a unit dose medication is unwrapped.
   c. Medications not given
      i. If a drug is held according to certain parameters (i.e. apical pulse below 60, or hold if systolic blood pressure below 140, or the patient is NPO), it will be indicated in eMAR and the reason selected from the drop-down list. Comments may also be entered.
      ii. If medication is wrapped and intact, return to automated dispensing system or Pharmacy Return Box.
   d. Document “Not given” on the MAR and state the reason.

16. Pre-Op Medication Procedure
   a. Clinical staff shall give and chart pre-op medication promptly at time ordered. **NOTE: If medication error occurs, notify prescribing physician immediately.**
   b. The most current pre-op orders supersede others.

17. NPO-Special Test
   a. For all patients that are NPO for any procedure, clinical staff shall verify whether patient’s medications should or should not be administered.

18. PRN Medication
   a. All PRN orders must include an indication and frequency.
   b. Assess the patient to determine if the PRN medication is appropriate.
   c. Clinical staff shall check the medication administration record to determine when the medication was last given.
   d. If the prescribed interval has elapsed and the nursing assessment determines that the medication is
required, clinical staff shall administer the medication.

e. Document the patient’s response to the medication.

f. If the PRN medication is for pain control, refer to the Pain Assessment and Management Policy.

19. Preparation of PO Medications

a. Tablets and Capsules – Clinical staff shall:
   i. Administer medications directly from unit dose packages. If a medicine cup is used, transfer of pills to the cup should be done at the patient’s bedside.
   ii. Partial pills or tablets are prepared and dispensed by pharmacy.
   iii. Check with pharmacy before crushing any pills or tablets. Crushing may increase or decrease its effectiveness.
   iv. Check with pharmacy before opening capsules.

20. Administering Medications via enteral feeding tubes – Clinical staff shall:

   a. Perform eight rights of medication administration (described above) and BCMA.
   b. Wash hands, apply gloves.
   c. Elevate head of the bed greater than 30 degrees, unless contraindicated.
   d. Stop continuous feeding, if needed.
   e. Attach syringe to the end of the tube.
   f. Check placement of nasogastric and orogastric tube per Clinical Practice Nutrition Support Policy.
   g. Clamp tube and remove syringe.
   h. Crush tablet or open capsule.

   **NOTE:** Extended release and enteric coated medications should not be crushed.
   i. Mix the crushed tablet or liquid medication with diluent. Stir well.

   **NOTE:** Ensure that the particles are small enough to pass through holes at the distal end of the feeding tube.

j. If the patient is receiving enteral feeding, flush feeding tube with at least 15 mL of water prior to administering medications.
k. Aspirate the medication into syringe. Each medication should be administered separately.

l. Reattach the syringe. Deliver the medication slowly and steadily.

m. Flush the feeding tube with at least 15 mL of water.

n. Restart enteral feeding.

NOTE: Tube feedings must be held 1 hour before and 1 hour after phenytoin administration.

21. If gastric tube is to suction, clinical staff shall restart suction in 30 to 60 minutes.

22. Clinical staff shall refer to the MAR prior to each dose administration and pay close attention to special comments on the MAR and auxiliary label (examples: Black Box warning alerts, high risk-high alert drugs).

23. Medication Administration by students
   a. Student nurses may administer medications with RN present and document in eMAR with a co-signature for validation. Either the primary nurse/charge nurse or the clinical instructor can co-sign a student nurse’s eMAR entry.

24. Usage guidelines and procedures for safe administration and monitoring are provided in the Administration of Intravenous Medications policy and in the formulary.

DOCUMENTATION

1. Clinical staff shall chart medications given in real time using the BCMA system or as soon as possible in the MAR.

2. Clinical staff shall chart medicine, dosage, route of administration and time.

3. Clinical staff shall chart site of all injections, using accepted abbreviations.

4. Clinical staff shall not chart a medication before it is given.

5. Second nurse verification of the accuracy of medication administration will occur upon the administration of those medications requiring a witness. Witness co-signatures will be documented in eMAR at the time of medication administration.

6. If a medication error occurs, clinical staff shall notify the physician and complete an Occurrence Report per “Medication Errors” policy. Clinical staff shall chart any untoward effects in nurse’s notes.

7. Clinical staff shall record all medications given by a physician on the MAR.

8. Clinical staff shall document the patient’s response to each prn medication given.

9. Ancillary units/areas of the hospital may utilize other documents to record drug administration (i.e.,
10. **Intravenous Infusions**

   a. For IV infusions each bag is documented via eMAR utilizing Begin Bag option.
   
   b. Administration of an IV bolus from a continuous infusion requires an additional documentation via eMAR.
   
   c. Initial IV rate is documented in eMAR. Subsequent IV rate changes are documented on the electronic flowsheet (IVIEW).
   
   d. Documentation of IV Titrations are recorded in IView.
   
   e. Discontinuing an IV Infusion is documented in eMAR.

11. **Take Home Medication**

   a. In rare cases where a patient is unable to obtain discharge prescription medication from an outside, retail pharmacy, the inpatient pharmacy will perform the following:
      
      i. A limited quantity of medication will be supplied to the patient until he or she is able to get the outpatient prescription filled by an outside pharmacy.
      
      ii. All take home medications must be properly re-labeled in accordance with applicable laws by a pharmacist.
      
      iii. Patients and/or families will be instructed on the use of their medications at home. The documentation is to appear in the discharge instruction form.

12. **Inter-Facility Transfer of Medications**

   a. When patients are transferred from another facility to our hospital with medications and IV's from the other facility, the following procedures will be followed:
      
      i. For any IV solution that is infusing when the patient arrives, continue with that particular IV until the IV container can be replaced by the pharmacy.
      
      ii. Any unopened IV solution or medication that has been sent with the patient will be sent to the Pharmacy to be destroyed/discarded.

13. **Intra-facility Transfer of Medications**

   a. When patients are transferred from one unit to another within the facility, clinical staff will send all medications not stocked in the automated dispensing cabinet with the patient.

14. **Obtaining Discharge Medication**
a. To assist the patient in obtaining medications and supplies ordered by physician upon discharge of patient:
   
i. The patient may elect to have USC Plaza Outpatient Pharmacy, which is open during business hours, fill outpatient prescriptions.
   
ii. The ordering provider will send an eScrip via KeckCare, if available, to the patient’s preferred pharmacy.
   
iii. Clinical staff shall route all schedule II prescriptions to a printer in the location of the patient.

15. Storage

a. All spaces and areas used for the storage of drugs will be kept locked at all times so that only authorized persons have access to drugs. Medications will be stored in accordance with applicable laws.

b. Persons authorized to access the appropriate medication rooms:

   i. Pharmacist
   
   ii. Pharmacy Technicians
   
   iii. Physicians
   
   iv. Nurse Practitioners (NPs)
   
   v. Registered Nurses
   
   vi. Licensed Vocational Nurses
   
   vii. Respiratory Care Practitioners

c. Authorized persons shall only have access to medications that are used within their scope of practice.

16. Charting by proxy is permissible under the following:

a. The clinician performing the proxy witnessed the actual medication administration.

b. The clinician performing the proxy is licensed to or allowed to administer medication as per this policy.

   c. The clinician performing the proxy performed the 8 rights of medication administration.

   d. The clinician administering the medication is unable to document.
REFERENCE(S)


- Nursing Practice Act – California Business and Professions Code sections 2725-25.2 and 2860.5

- Joint Commission MM.06.01.01


- Institute for Safe Medication Practices (ISMP), List of High Alert Medications

RELATED POLICIES AND PROCEDURES

- Administration Manual
  - Medication Errors
  - Occurrence Reporting Requirements for Hospital Staff Members

- Ambulatory Care Services Manual
  - Medication Administration in the Clinic Setting

- Clinical Practice Manual
  - Administration of Intravenous Medications
  - Bedside Medications – For Patient Administration
  - Dispensing/Administration of Medications Prior to First Dose Review
  - Nutrition Support
  - Pain Assessment and Management Policy

- Nursing Manual
  - Physician Orders

- Pharmaceutical Services Manual
Pharmacist Order Verification

AACN's Evidence-leveling System

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Meta-analysis of multiple controlled studies or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention or treatment</td>
</tr>
<tr>
<td>B</td>
<td>Well designed controlled studies, both randomized and nonrandomized, with results that consistently support a specific action, intervention, or treatment</td>
</tr>
<tr>
<td>C</td>
<td>Quality studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
</tr>
<tr>
<td>D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
</tr>
<tr>
<td>E</td>
<td>Theory-based evidence from expert opinion or multiple case reports</td>
</tr>
<tr>
<td>M</td>
<td>Manufacturers' recommendations only</td>
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</table>

Effective/Revision Dates for Policy # CP 4-133

- Effective: 05/02/1991 MEC
- Revised: 06/18/2002 Governing Board
- Revised: 06/18/2002 Professional Practice Committee
- Revised: 01/12/1999 MEC
- Revised: 04/09/1996 MEC
- Revised: 06/18/2002 Transferred from Nursing Manual
- Revised: 04/15/2003 Governing Board
- Revised: 07/22/2003 Governing Board
- Revised: 06/29/2007 Governing Board
- Revised: 07/29/2010 Governing Board (Transferred from Administration Manual # 2-173)
- Revised: 01/18/2011 Medical Executive Committee
- Revised: 06/28/2012 Governing Board
- Revised: 07/09/2013 Policy Committee
- Revised: 09/13/2016 Medical Executive Committee
- Revised: 09/13/2016 Medical Executive Committee
- Revised: 09/13/2016 Medical Executive Committee
- Revised: 09/13/2016 Medical Executive Committee
- Revised: 09/13/2016 Medical Executive Committee
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- Revised: 09/13/2016 Medical Executive Committee

Keywords: Administration, administering, medication, BCMA, 8 rights, barcode, EHR
Keck Medicine of USC

Contract PERSONNEL INFORMATION

Please do not fill out for FTEs. Use Form 2 only

*** COMPLETE ALL FIELDS ***

**All fields are mandatory, make sure to include email address.**

<table>
<thead>
<tr>
<th>First Name (Familiar Name)</th>
<th>Middle Initial</th>
<th>Last Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (eTenet only)</th>
<th>Last 4 Digits of SSN (eTenet only)</th>
<th>Dept. Name / Number</th>
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</thead>
<tbody>
<tr>
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<tr>
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<th>Title</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RCP STUDENT</td>
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<tr>
<th>Organization (Check One)</th>
<th>Keck/ Norris Hospital</th>
<th>USC Care</th>
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<table>
<thead>
<tr>
<th>USC E-mail Address (if available)</th>
<th>Alternate / Personal E-mail Address</th>
</tr>
</thead>
</table>

*** Has this person previously worked at Keck? ○ Yes ○ No ***

Field Glass Candidate ID JS

Supplier Code Candidate # (8 Digit)

USC Health Information Technology shall provide you with access to computer system(s) necessary for your employment responsibilities. The system(s) will at all times be used professionally and in compliance with approved procedures. All of the equipment/software used to provide these services are the property of USC. The information may only be accessed and used for the proper care of patients and the performance of professional functions. You are reminded that the use of systems for purposes which include, but are not limited to the following is prohibited: transmit or receive chain letters, wagers, sexually explicit material, ethnic slurs, racial epithets, or anything that may be construed as harassment or disparagement of others based upon their race, national origin, sex, sexual orientation, age, disability, religion or political beliefs. Use of these systems for any commercial or personal purpose is prohibited. USC Health Information Technology reserves the right to monitor the use of all systems and may periodically audit your use of the information in these systems, with or without notice, for a variety of purposes, including quality control and compliance with the terms of this policy. USC reserves the right to disclose your use of these systems usage to law enforcement officials and other appropriate parties as requested.

I understand that failure to comply with the above policies will result in formal disciplinary action, up to and possibly including termination of employment at USC.

By signing below I acknowledge that I understand the terms of this policy.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Manager / Supervisor Name</th>
<th>Manager / Supervisor Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

If you have questions related to completing this form, contact the Keck IT Service Desk at 323.442.4444. After you have completed the form and have obtained all of the required signatures please scan and e-mail form to servicedesk@med.usc.edu or fax to 323.442.8711. **Any missing information will delay your request.**
# System Request Form

- **Select One:**
  - Keck/Norris
  - VHH
  - KSOM
  - USC CARE

<table>
<thead>
<tr>
<th><strong>Legal First Name</strong></th>
<th><strong>Middle Initial</strong></th>
<th><strong>Last Name</strong></th>
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<th><strong>Pin (Last 4 Digits of SSN)</strong></th>
<th><strong>Office Phone</strong></th>
<th><strong>Job Title</strong></th>
<th><strong>Start Date (Date of Orientation)</strong></th>
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### Employee Type (Please Select One)
- Employee
- Contractor (Form 01 Required)
- Vendor (Form 0V Required)
- Student
- Pharmacist

### Network Resources
- Outlook Email & Distribution Lists:
  - DL-Hospital-All-Users
  - DL-Hospital-Directors
  - DL-Hospitals-Ops Council
  - DL-Keck Hospital-Users
  - DL-NCH-Users
  - DL-Hospital-Leadership
  - DL-VHH-Leadership
  - DL-VHH-Employees
  - DL-USC-Ambulatory Services
  - Other:

- Remote Desktop Access
- Shared Drive (Include Full Path):

### Additional Applications

Please check the appropriate application below. If additional forms are required they will be listed under the Security Form Column.

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<thead>
<tr>
<th><strong>Application Name</strong></th>
<th><strong>Security Form Required</strong></th>
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<td>OLIKVIEW (Allscripts)</td>
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<td>CAFE</td>
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<td>PHARMACY APPS (KECK/NORRIS)</td>
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<td>GE PACS C-WEB</td>
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<td>Pyxis-VHH</td>
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<td>Health Stream:</td>
<td>QlikView (Other)</td>
</tr>
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### Supervisor Name

**Signature**

**Date**

---

If you have any questions related to completing this form, please contact the Keck IT Service Desk at 323 442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to servicedesk@med.usc.edu or fax to (323) 442-8711.
Cerner Security Request

Instructions: Select only one of the listed positions. Selecting multiple positions will delay processing. Sign on page 2. If you know of a "like user" (another user with the access you'd like this user to have) please write the ID of the "like user" here: 

Clinic Positions
- P1 Clinic Audio/Speech
- P1 Clinic Audio/Speech Student
- P1 Clinic CNA
- P1 Clinic CNS (w/ Schedule View) P1
- Clinic LVN
- Clinic Social Worker
- P1 Clinic Manager - Clinical
- P1 Clinic Manager - Non Clinical
- P1 Clinic Medical Student
- P1 Clinic PharmNet: Ambulatory RX
- P1 Clinic Resident Licensed
- P1 Clinic Resident Unlicensed
- P1 Clinic RN
- P1 Clinic Scheduling Clerk
- P1 Clinic Scheduling Rad Clerk
- P1 Clinic Unit Secretary
- P1 Social Worker
- One Legacy Transplant Coordinators
- One Legacy Coordinators
- Research Coordinator - Admin

Radiology
- RadNet: Dept Secretary
- RadNet: Film Librarian
- RadNet: Mammography Technologist
- RadNet: Physician Office Staff
- RadNet: Radiology Technologist
- RadNet: RadTech/Transcription
- RadNet: Researcher
- RadNet: Supervisor
- P1 RadNet: RN
- P1 IP RadNet: Radiologist
- P1 IP RadNet: Resident

Nursing
- P1 RN
- P1 RN Supervisor/Charge
- P1: Nurse Management
- P1: Quality Department
- P1: Case Manager
- P1: LVN/LPN
- P1 Student Nurse

Pharmacy
- P1 PharmNet: Ambulatory Clinic Rx
- P1 PharmNet: Pharmacist
- P1 PharmNet: Pharmacy Student
- P1 PharmNet: Pharmacy Technician
- P1 PharmNet: Pharmacy Tech w/Scheduling
- P1 PharmNet: Retail DBC/Pharmacist

Lab
- PathNet: All Module Assistant
- PathNet: All Module Tech
- PathNet All Module Supervisor
- PathNet: AP Supervisor
- PathNet: AP Transcription
- PathNet: Cyotech
- PathNet: Gen Lab Console
- PathNet: Gen Lab Medical Technologist
- PathNet: General Laboratory Assistant
- PathNet: General Laboratory Processing
- PathNet: General Laboratory Supervisor
- PathNet: Histotech
- PathNet: Micro Lab Assistant
- PathNet: Micro Medical Technologist
- PathNet: Microbiology Supervisor
- P1 IP PathNet: AP Resident
- P1 IP Pathologist

Nursing VHH
- P2 LVN/LPN VHH
- P2 RN VHH
- P2 RN Supervisor/Charge VHH
- P2 Psych RN VHH

Respiratory
- P1 Respiratory Therapist
- P1 Respiratory Therapist Student
- P1 Respiratory Therapist Supervisor

Dietary
- P1 Dietitian
- P1 Dietitian Intern
- P1 Nutrition Assistant

Business
- P1 Business Office
- P1 Business Office Charge Auditor

Surgery VHH
- P2 SurgiNet: Surgical RN VHH
- P2 SurgiNet: Surgical RN w/PowerChart VHH
- P2 SurgiNet: Secretary VHH
If you have any questions related to completing this form, please contact the IS Service Desk at 323-442-4444. After you have completed this form and have obtained the required signature, please scan and email the form to helpdesk@med.usc.edu or fax to (323) 442-8711.
Keck Medical Center of USC

Badge Request Form

Student Name: 

Title: _RCP STUDENT_

School Name: 

Instructor Name: 

BADGE VALID FROM: ________________ TO: ________________

This badge is to be visibly worn at all times while on premises at Keck Hospitals. If you lose your badge the replacement fee is $10.00.

Student Signature: ____________________________________________

Please return your badge to Nursing Administration, Attn: Aliscia Ramsey at the end of your rotation.

Any questions regarding this badge, 

Please contact:

Aliscia Ramsey
Office Coordinator
Nursing Administration Department
Keck Hospital of USC
1500 San Pablo Street
Los Angeles, CA 90033
PURPOSE

To reduce the risk of healthcare-acquired infections through the presence of artificial nails worn by healthcare workers delivering direct patient care.

- Artificial nails have been linked to or may contribute to the transmission of infection.
- Healthcare workers who wear artificial nails are more likely to harbor gram-negative pathogens and yeast on their fingertips than those with natural nails both before and after hand washing or the use of alcohol-based hand rub.
- Chipped nail polish may support the growth of larger numbers of organisms on the fingernails.

DEFINITIONS

- Artificial nails: Any material applied or added to the natural nails to augment or enhance (strengthen and lengthen) the wearer’s own fingernails, including nail sculpting, wraps, acrylcs, extenders, overlays, gels, tips, and any item that is glued or pierced through the nail.

- Natural nails: Nails without artificial covering other than fresh clear nail polish.

- Nail polish: Nail polish that is not obviously chipped or worn.

- Healthcare providers and workers: A healthcare provider refers to all paid and unpaid persons working in healthcare settings who have the potential for exposure to infectious materials, including contaminated medical supplies. Healthcare providers might include but are not limited to: physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, pharmacy personnel, laboratory personnel, autopsy personnel, students and trainees, contractual staff and persons, i.e., clerical, dietary, housekeeping, maintenance and volunteers not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from the healthcare provider.

POLICY

1. This policy is a condition of employment and, therefore, violations are subject to corrective action, up to and including termination.

2. This policy prohibits the wearing of artificial nails/nail jewelry for all healthcare providers and workers engaged in patient care.

3. It is the responsibility of all direct patient care providers to maintain short (less than 6mm or a ¼ inch long) to medium-length fingernails (no longer than 3mm or the size of a cotton tip swab).
4. It is the responsibility of the manager and directors of healthcare provider and worker departments to monitor and enforce this policy.

5. If a healthcare provider or worker is noted to have artificial nails the individual will remove the artificial nails by their next scheduled working day.

6. A healthcare provider or worker will not be permitted to return to work until the artificial nails have been removed.

**PROCEDURES**

1. Upon hire the Hospital Human Resources Department will distribute the Artificial Nails fact sheet and policy.

2. The Hospital Human Resources Department will require a signed attestation declaring receipt of the policy, that the policy has been read, understood and will be followed.

3. The attestation form will be maintained in the employee’s Hospital Human Resource file.

**REFERENCE(S)**


- 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. MMWR Recommendations and Reports October 25, 2002 / 51 (RR16); 1-44 [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr556a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr556a1.htm)

PURPOSE

1. To promote the identification of potential patient problems through the use of and response to clinical alarms. For the purpose of this policy, “hospital staff” shall include hospital employees and independent contractors of the hospital.

2. All patient physiologic monitoring and patient care equipment alarms in the inpatient setting (including, but not limited to, cardiac monitor alarms, apnea alarms, cell-salvaging devices, elopement alarms, infusion pump alarms, ventilator alarms, pulse oximeters, and emergency alarms).

POLICY


   a. Alarm system safety is a Hospital priority. Hospital personnel give especially high priority to management of alarms that:
      
      i. The medical staff and clinical departments identify as highly important;
      
      ii. Pose a risk to patients if unattended or malfunctioning;
      
      iii. Are clearly needed and do not unnecessarily contribute to alarm noise and alarm fatigue;
      
      iv. May have the potential for patient harm based on internal incident history at the Hospital; or
      
      v. Are highlighted in best practices and guidelines.

   b. The Biomedical Department shall perform regular preventative maintenance and testing on all alarms on patient physiological monitoring and patient care equipment.

   c. Nurses and other licensed, direct patient care providers shall ensure that all alarms are set to activate at appropriate settings for each patient and are sufficiently audible with respect to distances and competing noise within the unit.

   d. The above general provisions shall apply regardless of whether the hospital owns, borrows, rents or leases the equipment for long term or short term use (including demonstration).

2. Medical Equipment / Device Alarms

   a. All hospital staff who use medical equipment shall check alarm settings prior to device use to ensure they are appropriate and that audible alarms will be clearly discernible relative to ambient and competing noise.
b. Hospital staff are not permitted to bypass, shut off or adjust medical equipment alarm volumes to a level that cannot be readily heard when the alarm activates.

c. The hospital staff member who detects a medical equipment alarm situation first shall immediately respond.

d. Nurses and other licensed direct patient care providers shall carefully monitor equipment and devices that enunciate locally at the bedside (i.e., infusion pump alarms) with special attention to patient care areas that are remote from a nurse’s station, isolation rooms, and other situations that require patient room doors to remain closed.

3. Alarm Malfunction or Failure and Alarm-Related Incidents

a. Clinical staff shall report to their Department Managers any equipment whose clinical alarm system they suspect to be malfunctioning or failing. Department Managers shall identify/verify alarms that are in disrepair or in need of assessment. Department Managers shall take such equipment out of service to prevent inadvertent reuse. Alarm failure includes failure to alarm in the presence of abnormal measured parameters and established set points.

b. Hospital personnel will replace equipment that is removed from service with comparable equipment.

c. Hospital personnel shall report any patient monitoring or clinical equipment alarm malfunction or failure that caused or may have caused a death, serious injury, serious illness, or a material change in the plan of care.

i. The person who discovers a medical device incident must immediately notify the appropriate Department Director (or their designee), take control of the device in question, and remain at the scene of the event pending the Director’s arrival.

ii. The person must also make a list of all persons present at the time of the event.

iii. The person must personally complete a Hospital Occurrence Report describing the event prior to leaving the Hospital.

d. Unexplained alarms are indicative of equipment failure, and the hospital staff member identifying the alarm shall report them to the Biomedical Engineering Department. Hospital staff members shall not bypass alarm functions. Hospital personnel shall report any unavoidable bypass of an alarm function on a Hospital Occurrence Report. Biomedical Engineering shall repair the medical device.

4. Alarm Maintenance and Testing

a. Biomedical Engineering shall, as part of the patient care equipment inventory, identify those devices and systems that include physiologic and patient care alarms.

b. Hospital personnel shall inspect and functionally test alarms and alarm settings during regularly scheduled preventive maintenance.
# Clinical Alarm Policy

**Effective Date:** 09/23/2004  
**Revised Date:** 09/25/2014

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## References

- 42 CFR § 482.41(c)(2)  
- The Joint Commission Accreditation Manual for Hospitals; EC.02.06.01, EC.03.01.01, NSPG06.01.01  
- The Joint Commission Sentinel Event Alert, Issue 25, 2/26/02  
- The Joint Commission Perspectives, 1/2003, National Patient Safety Goal #6  
- Standards of the American Society of Anesthesiologists: Standard for Basic Anesthesia Monitoring  
- Cal Code Regs. tit. 22, §§ 70227 70837 and 70853

## Related Policies and Procedures

- Administration Manual  
  - Control of Defective Equipment or Products – Safe Medical Device Act Reporting  
  - Occurrence Reporting Requirements for Hospital Staff Members  
  - Sentinel Event Response and Reporting Policy  
  - Patient Safety Plan  
- Biomedical Engineering Manual  
  - Repair of Patient Related Medical Equipment  
  - Reporting of Medical Device Incidents

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## Effective/Revision Dates for Policy # CP 3-104

<table>
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<th>Effective/Revised Date</th>
<th>Reason for Revision</th>
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| 04/29/2008             | Governing Board (Transferred from Administration Manual #6-137)  
| 05/03/2011             | Policy Committee  
| 09/25/2014             | Governing Board  
| 00/00/0000             |  

**Keywords:** Clinical alarm, alarm, failure, equipment
PURPOSE

The hospital upholds its commitment to teaching by providing students from various disciplines access to the facility for the purpose of acquiring observational, clinical and/or managerial learning experiences. This document provides policy and procedure guidelines related to student clinical rotations at the hospital.

POLICY

1. A contract between the hospital and the college or institution must be on file in Administration.

2. All contracts will be subject to termination in accordance with the terms of the agreement.

3. Requests for placement must be submitted a minimum of eight weeks prior to the scheduled start date. Request must include:
   a. Course objectives and content outline
   b. Student’s level of experience and training
   c. Desired location(s) for rotation(s)
   d. Number of students in the rotation (maximum based on department/clinical availability)
   e. Schedule of days, dates and times the students will be in the units/departments

4. The Department Director is responsible for approving a school’s use of the Hospital’s facilities.

5. The contact person for nursing faculty shall be the Nursing Education Department staff or designee. The contact person for non-nursing departments will be the department director or designee.

6. The Department Director will maintain files on each school affiliation to include:
   a. Program curriculum.
   b. Copy of appropriate licensure and curriculum vitae or resume of each clinical instructor.
   c. Correspondence with affiliating institution.
   d. Student clinical rotation schedule with each student’s name and telephone number.
   e. Verification and/or proof of the following:
      i. Current Cardiopulmonary Resuscitation card (CPR) if providing patient care.
**USC Norris Cancer Hospital**  
**Keck Hospital of USC**  
**Operating Policies**

<table>
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<th>Policy #: 1-146</th>
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<tr>
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<td><strong>Effective Date:</strong> 05/02/1991</td>
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<td><strong>Revised Date:</strong> 11/24/2015</td>
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- ii. Student health clearance, including verification of negative tuberculosis test or chest x-ray, negative drug screening, physical examination, evidence of immunity from rubella, measles and chicken pox.


- iv. Criminal background check.

- v. OIG/GSA screen.

7. All faculty and students are required to sign a Statement of Responsibility and Confidentiality Statement.

8. All faculty and students are required to complete Introduction to Privacy and Information Security including the post-test with a score of 80% or better.

9. All student experiences are to be supervised. If a faculty member other than the regularly assigned instructor is to assume responsibility of the group of students, the appropriate Department Director is to be notified.

10. Students may (under the supervision of the faculty member or appropriate staff member) perform procedures in accordance with the hospital policy and procedures and which are part of the job description for which the student is preparing.

11. Responsibility for patient care and/or related duties is retained by the hospital department/service when students and outside personnel are providing care.

12. It is the responsibility of the school faculty or Department Director to ensure that the following information has been provided to the student prior to the first clinical rotation:

   - a. Infection control, including prevention of exposure to blood borne pathogens
   - b. Patient safety, rights
   - c. Environment of care
   - d. Emergency preparedness including fire and life safety
   - e. Role and Responsibilities
   - f. Security
   - g. Body mechanics
   - h. National Patient Safety Goals
   - i. The hospital policies and procedures relevant to the clinical or other experience.
PROCEDURE

1. All faculty and students must complete an orientation to the hospital and appropriate department/unit.
   a. Faculty must make an appointment or other arrangements with Education (nursing) or designated department representative prior to the clinical experience to plan the learning experience, submit paperwork, complete orientation to the facility and unit/department as needed.
   b. A completed roster of faculty and student signatures is to be submitted to the Nursing Education Department or designated department as evidence that orientation was received on the student’s first day at the hospital.
   c. The faculty member is responsible for providing and assuring students have completed orientation.

2. Any change in the student’s schedule is to be communicated to the Department Director or designee.

3. If a student is ill and unable to reach the faculty member, the student will notify the department and leave message.

4. Department Director will receive, on the first clinical assignment date, names and phone numbers of faculty and students.

5. Student Communication and Expectations
   a. The student and/or faculty must communicate with the hospital staff regarding the patient’s status throughout the shift and must provide hand off communication to the hospital staff before leaving the unit/department.
   b. If a staff member is concerned about the quality of care being provided by the student, the instructor will be notified immediately and the incident related to him/her. In addition, the area Director or designee will be notified to determine if further action is necessary.

6. Faculty and students will complete the “Facility Evaluation” tool and submit to the appropriate department.

7. Education programs are available for student participation. If the number of people in a particular program is too many for the facility planned, the students will be asked to make room for the hospital employees.

8. The Medical Library is available for student use. Materials cannot be checked out; they are for reference use only.

9. The medical record of a patient to whom the student has provided care is available to that student for the purpose of obtaining data for a student assignment. The student must bring a note from the instructor and on school letterhead to Medical Records. The patient record is to be reviewed in the Medical Record’s Department.

10. All charting done by the student must be reviewed for accuracy and completeness by the instructor and the staff responsible for the care of the patient. The student’s narrative note is timed to the real time the
patient is receiving care. A student’s charting is countersigned by the staff person assigned to the patient.

11. Any student member who witnesses, discovers, or has the best direct knowledge of a reportable occurrence shall complete an Occurrence Report. Occurrence reports shall be completed as soon as possible following discovery or gaining knowledge of the reportable occurrence. All occurrence reports are confidential and no photocopies of the completed report are to be made at any time. (Refer to Administration Policy, Occurrence Report Requirements for Hospital Staff Members for additional information.)

12. If a student is injured on hospital premises:
   a. It is to be reported to the faculty member and Department Director.
   b. The School and/or program participant will be responsible for arranging medical care and/or treatment, if necessary, including transportation in the case of illness or injury while participating in the education rotation.
   c. An Employee Incident Report will be completed and forwarded to Employee Health. For data collection purposes the student is to check the Contract Employee box and enter school as contractor.

13. The instructor is to obtain parking permit forms from Parking Operations prior to the clinical experience.
PURPOSE

To ensure the patient’s rights and expectations that those personal facts or conditions pertaining to his life which he communicates to members of the Admitting Department for definite purposes related to the service he is requesting or receiving from the hospital will be respected and safeguarded by all personnel.

POLICY

Any information concerning patient’s condition, treatment, personal affairs or records shall be kept confidential. Personal information will be shared with other professionals only to the extent necessary to arrange for needed services. Such information may be release by specifically designated hospital staff only with the approval of the patient, or when compelled to do so by law.

PROCEDURE

1. Information pertinent to the patient’s hospital stay will be documented in the medical record.

2. Requests for information from persons uninvolved with services arranged for the patient will be referred to the patient.

3. Any requests for information received after the patient’s discharge will be routed to Medical Records.

4. Requests for information from law enforcement or county protective agencies will be released in accordance with state law by Medical Records.

EMPLOYEE RESPONSIBILITY

Employees must be constantly reminded of their responsibility for protecting patient information. They must be made aware that even casual conversations with other employees may be overheard, thereby violating the patient’s right to privacy. Not only is the release of patient information (deliberate or accidental unethical, but it also could subject the employee and the facility to legal charges.

Managers and supervisors must also advise their employees that their failure to comply with this policy could subject them to disciplinary action up to and including discharge.

Effective/Revision Dates for Policy # ADM-102

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Keywords: Confidentiality, patient, confidential, information
PURPOSE
To outline responsibilities of hospital personnel in the event of code blue and emergency situations.

POLICY

1. A Code Blue will be called when an adult patient is in cardiac or respiratory arrest unless there is specific physician’s order not to do so. (See Administration Policy, “Foregoing Life Sustaining Treatment/Do Not Resuscitate.”)

2. A Pediatric Code Blue will be called when a pediatric patient (1 year to puberty) is in cardiac or respiratory arrest unless there is a specific physician’s order not to do so. (See Administration Policy, “Foregoing Life Sustaining Treatment/Do Not Resuscitate.”)

3. Pediatric Code Blue patients will be transferred to a local Pediatric Intensive Care Unit once stabilized.

4. A Code Blue or Pediatric Code Blue can be called when a patient has had a significant change and a cardiac or respiratory arrest is anticipated/suspected.

Examples of significant changes:

a. Significant decreases in level of consciousness
b. Hypotension – lack of audible/palpable B/P
c. Dyspnea or apnea
d. Tachypnea
e. Uncontrolled hemorrhage

5. A designated team will respond to each Code Blue as designated below. Members of the Code Blue Team are:

<table>
<thead>
<tr>
<th>Keck Hospital of USC</th>
<th>USC Norris Cancer Hospital</th>
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<tbody>
<tr>
<td>a. Medicine Resident on-call</td>
<td>a. Critical Care Service Team Member</td>
</tr>
<tr>
<td>b. Anesthesia Resident on-call</td>
<td>b. Clinical Administrative Supervisor (CAS)</td>
</tr>
<tr>
<td>c. Clinical Administrative Supervisor (CAS)</td>
<td>c. Charge Nurse or designee RN from each patient care unit</td>
</tr>
</tbody>
</table>
d. ICU RN from each ICU  
ed. Pediatric Advanced Cardiac Life Support (PALS) trained Registered Nurse from perioperative services will respond to a Pediatric Code Blue  
en. The PALS trained Registered Nurse will be the lead RN on the code.  
f. RCP (2)  
g. Pharmacist  
h. Phlebotomist  
i. Security  
d. Pediatric Advanced Cardiac Life Support (PALS) trained Registered Nurse from Clinical Trials Unit  
e. RCP  
f. Pharmacist  
g. Phlebotomist  
h. Security

6. All RNs, Physicians and Pharmacists members of the Code Blue Team will be Advanced Cardiac Life Support (ACLS) trained.

7. All patient emergencies will be immediately reported to the appropriate Clinical Administrative Supervisor and Attending Physician. As appropriate the family will also be notified and/or requested to come to the hospital.

8. Select family members will be provided the opportunity to be present during the resuscitation and designated staff within the team will respond to their questions and offer comfort which may enhance the emotional support provided to the family during cardiac arrest and after termination of a resuscitation attempt.

9. The crash cart is restocked by Supply Distribution and Pharmacy. (See Clinical Practice Policy, “Crash Cart, Testing and Maintenance.”) Two stocked carts (without drug box) will be available at all times in Supply Distribution.

10. Each Code Blue is evaluated to determine if code procedures were consistent with ACLS/PALS Guidelines. Results are reported to the Critical Care Committee and Patient Care Evaluation. Individual cases may be referred for peer review.

**EQUIPMENT**

- Crash Cart
  - Biphasic defibrillator with transcutaneous pacing capabilities
  - Portable suction equipment
  - Portable O₂ tank
PROCEDURE

1. Initiation of Code Blue

2. Initial Responders
   a. First Person
      i. Determine unresponsiveness
      ii. Call for help
         (1) Critical care units will push button at head of bed
      iii. Initiate BLS (Basic Life Support). CPR should be performed immediately on any person who has become unconscious and is found to be pulseless
      iv. Restore airway and oxygenation
         (1) Hook up O₂ set up
         (2) Insert oral airway and bag with 100% O₂
   b. Second Person
      i. Call Code number “77” if not already done. Inform operator of Code Blue and exact location. The operator will page the Code Blue to the specific unit.
      ii. Obtain the crash cart.
      iii. Place backboard under patient
      iv. Place defibrillator pads on patient. Select the automated external defibrillator (AED) function follow instructions until the Code Blue Team arrives or place on monitor mode.
      v. Begin two-person CPR
   c. Third Person (any nurses or other staff who arrive, help share the 2nd person responsibilities)
      i. Assemble suction equipment
      ii. Continue CPR switching providers every 2 minutes to maintain effective CPR
   d. Place ECG leads on patient (if not already in place) to monitor heart rhythm and rate.
      i. Telemetry
Patients should have telemetry left on, in addition to having portable monitor/defibrillator attached.

e. Secure IV line with Normal saline or D5W to TKO with largest gauge angiocath possible.

f. Prepare to give emergency medications as ordered.

g. Immediately begin documenting on Code Blue Record.

i. Complete initial assessment i.e. events leading up to code, IV solutions hanging, neurological status.

ii. Vital signs and outcome of procedures/treatments at least every two minutes.

iii. Drug dosage and route documentation should be listed in correct form i.e., mg, mEq, or mL.

iv. CPR and response to CPR should be documented initially and throughout code.

v. Post-resuscitation assessment should be written to include neurological status, respiratory effort and assistance with ventilation, vital signs and rhythm.

h. Respiratory Care Practitioners (RCP)

i. If unable to establish patent airway via bag valve mask ventilation,

ii. Prepare to intubate

iii. Ensure suction setup

iv. Remove headboard

v. Provide ventilation as needed

i. Provide privacy.

(1) Close drapes or doors to other patient rooms.

(2) Escort significant others from the immediate area.

(3) Educate and prepare patients’ families for what the families would experience in a code:

(a) Who is the patient’s decision maker? Who determines this? Who should be present? Who is the person who will approach the decision maker? (CAS, Physician, MSN or NM?). Need to consider off shift; weigh in and participate on mock codes?

3. **Delineation of Duties While Code in Progress**
## Code Blue Support Team

<table>
<thead>
<tr>
<th>Designated Duties</th>
<th>(could be delegated to another)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>An appropriately credentialed fellow or member of the medical staff.</strong></td>
<td>Director of Code</td>
</tr>
<tr>
<td></td>
<td>Communicates with Attending Physician regarding patient’s progress.</td>
</tr>
<tr>
<td></td>
<td>Performs line insertion as needed.</td>
</tr>
<tr>
<td><strong>Anesthesia Resident on-call or appropriate designee. (in-house 24 hours at Keck Hospital of USC)</strong></td>
<td>Intubates patient.</td>
</tr>
<tr>
<td><strong>Nurse #1: Documentation</strong></td>
<td>Ensures that crash cart is in the room</td>
</tr>
<tr>
<td></td>
<td>Ensures patient monitored on defibrillator</td>
</tr>
<tr>
<td></td>
<td>Monitors rhythm – defibrillates immediately if indicated</td>
</tr>
<tr>
<td></td>
<td>Records in an ongoing sequential fashion all events during the Code Blue. Completes all areas of Code Blue Record</td>
</tr>
<tr>
<td></td>
<td>Utilizes the time on the defibrillator.</td>
</tr>
</tbody>
</table>
| | Secures - signatures of code director and names below at end of code:  
  ✔ Physician  
  ✔ Recorder |
| | Critiques Code and completes Code Blue Evaluation |
| **Nurse #2: Medication** | Defibrillates/ cardioverts |
| | Maintains patient IV site |
| | Prepares and administers medications |
| **Nurse #3: Lead Nurse** | Initiates the ACLS protocol and delineates code team rolls. Oversees code until a qualified physician arrives, the nurse may return to the unit. |
| | Identifies director of code. |
| **Nurse #4: Order Placement** | Will place orders into KeckCare |
| **Nurse #5: Procedure Nurse** | Assists with central line insertion |
| | Obtains iSTAT |
| **Clinical Administrative Supervisor** | Directs personnel (limits staff as needed). |
| | Arranges for patient transfer or assists with details in case of patient death (see Death of a Patient policy and procedure). |
| | Crowd control inside the patient room |
### Code Blue Response

#### EFFECTIVE DATE: 05/02/1999

#### REVISED DATE: 05/29/2014

#### CP 3-123

<table>
<thead>
<tr>
<th>MANUAL:</th>
<th>Clinical Practice</th>
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<tr>
<td>PAGE 6 OF 9</td>
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</tbody>
</table>

#### Respiratory Therapy
- Ventilations
- Suctioning
- Blood gases
- Assists with intubation
- 12 lead ECG and continuous rhythm strip if needed.
- Set up intubation tray

#### Pharmacist
- Assists with drug calculations, compatibilities, administrations and admixtures.
- Obtains additional drugs as needed.

#### Security Officer
- Directs traffic, assists with crowd control outside the room.

#### Other Personnel Involved
**Designated Duties** *(could be delegated to another)*

- **Primary Care Nurse** *(responsible for patient before Code)*
  - Will stay with patient during Code Blue
  - Identifies self. Reports patient history and precode status to physician. Stays at bedside.
  - Monitors vital signs and continuous assessment of patient.
  - Coordinates room set-up (i.e., suction, O₂, Crash Cart, etc.). Given initial medications under supervision of physician or ACLS RN.
  - Gives report to Critical Care RN.
  - Accompanies patient during transfer if needed.

- **Charge Nurse**
  - Communicates patient progress to significant others.
  - Notifies social worker and/or clergy as appropriate.
  - Ensures notification of patient’s attending physician and resident/fellow.
  - Redirects patient care assignments temporarily.
  - Obtains other equipment as needed.
  - Crowd control inside the patient room

### 4. Procedure for Code Blue in Non-Patient Care Areas

**a.** The person who finds the situation will:
**Code Blue Response**

**EFFECTIVE DATE:** 05/02/1999  
**REVISED DATE:** 05/29/2014

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- Call 77; inform of Code Blue including exact location.
- If qualified, start CPR.
- Call 911 for all non inpatients (visitors, employees, outpatients)

b. At Keck Hospital of USC, a designated ICU nurse responds to any Code Blue called on the first floor and will bring the crash cart from ETC and initiate procedure as described in Section 1.

c. At USC Norris Cancer Hospital, a designated nurse responds to any Code Blue called on the first floor will bring the crash cart from the Breast Center and initiate procedure as described in Section 1.

d. Since KHUSC/NCH are not a full service or trauma hospital, the Code Blue physician and the nursing director/nursing administrative supervisor will assess availability of resources to determine appropriate transfer guidelines.

5. Procedures for Code Blue Situation in Departments that Are Hospital-Licensed, But Not Physically Located in the Main Building

a. Outpatient Surgery Center will call 77 to initiate the Code Blue and obtain assistance. The Code Blue Team will respond. See procedure section 3.c.

b. For all other outpatient departments, call 911, and/or Rapid Response. See Rapid Response policy.

6. Post Code Procedures

a. The following are the responsibility of the Clinical Coordinator or designee as soon as possible after code:
   - **Code Blue Record** should be separated (white copy to chart, other copies to Nursing Administration with **Code Blue Evaluation** attached). Place code summary strips in sequential order and white copy of **Code Blue Record** in Nurses Notes section of chart.
   - Assure that Supply Distribution delivers exchange crash cart.
   - Clean monitor/defibrillator, cables, and wires with approved disinfectant.
   - When new crash cart arrives, transfer monitor/defibrillator, and Code Blue binder to new cart.
   - Record new lock numbers on log sheet.
   - Soiled intubation trays shall be taken to the nearest soiled utility room.
   - Send old cart to Supply Distribution with charge card.

b. Pharmacist attending Code will return tray with any remaining medications to Pharmacy. Soiled **EMPTY** drug trays shall be taken to the nearest soiled utility room.
c. Restocking and Exchange of Crash Cart and Routine Checks (See Clinical Practice Policy, Crash Cart, Testing and Maintenance.)

7. If needed, the Code Blue Support Team will facilitate a brief post code debriefing with staff as soon as possible to share critical judgments by explaining and analyzing the event information for improving performance in similar situations. Debriefing is an information-sharing and event-processing session conducted as a conversation between code blue members. It is used to identify best practices unique to Keck Hospital of USC and USC Norris Cancer Hospital.

8. Quality Control
   a. Critique of Code Blue
      i. Critical Care Nurse obtains input from Code Blue Team members for completion of Code Blue Evaluation.
      ii. Designated nurse director or designee, reviews Code Blue Evaluation and Code Blue Record.
      iii. Resuscitation Committee to review Code Blue.
      iv. Completed code records are entered into the American Heart Association Resuscitation “Get with the Guidelines” database by Nursing Quality Manager or designee.

REFERENCES


RELATED POLICIES AND PROCEDURES

- Administration Manual
  o Foregoing Life Sustaining Treatment/ Do Not Resuscitate

- Clinical Practice Manual
  o Crash Cart, Testing and Maintenance
  o Rapid Response Team
…

- Nursing Manual
  - Standardized Procedure for Emergency Care and Arrhythmia Treatment

**Effective/Revision Dates for Policy # CP 3-123**

- Effective: 04/20/1999
- Revised: 07/20/1999
- Revised: 04/16/2002
- Revised: 07/20/2004
- Revised: 04/26/2005
- Revised: 07/29/2010 Governing Board (Transferred from Administration Manual # 2-156)
- Revised: 02/28/2013 Governing Board
- Revised: 05/29/2014 Governing Board
- Revised: 00/00/0000

**Keywords:** Emergency, cardiac, respiratory, arrest, crash cart
PURPOSE

To provide a safe environment for patients admitted to the hospitals.

POLICY

1. Patient safety during hospitalization is a primary concern for each staff member.

2. All personnel are responsible for implementing safety measures.

3. On admission and continuously thereafter, each nurse assesses his/her patient with regard to safety risks. The individualized interdisciplinary plan of care will address safety needs and reflect ongoing assessment and interventions.

PROCEDURE

1. All patients admitted to the hospitals are considered at risk for potential injury due to acuity of illness, medications and unfamiliar environment. Therefore, the patient will be assessed for safety risks on admission and throughout his stay, and the care plan will incorporate ongoing goals and interventions to provide an optimally safe environment for the patient.

2. General Patient Safety

   a. All admitted patients will wear an identification band at all times. In addition to the band, staff should verify patient’s name and date of birth (See Patient Identification Policy).

   b. All patients and their families will be oriented to their surroundings on the unit and in their rooms upon admission and on transfer to another.

   c. The call light will be within the patient's reach at all times. Nursing staff will instruct patient and family in its use.

   d. Side rails will be available for both sides of the bed. The top two rails will be in a raised position whenever the patient is in bed and nurse/physician determines that the patient is at risk for falls. In the event the patient refuses to have the side rails up, the patient must be assessed and counseled regarding the need for side rails. If the patient still refuses the side rails, the patient must sign a Release of Side Rails - Multiple Release Form. If the patient must have the side rails up for safety and the patient is refusing, the rails are considered a form of restraint. (See the Restraint and Seclusion policy)

      i. At all times four side rails will be considered a restraint and the Restraint and Seclusion policy must be followed.

   e. All patient-occupied beds are to be left in lowest position when staff is not in attendance.
f. Wheels on beds, stretchers, wheelchairs, bedside commodes, and other rolling equipment are locked when transferring a patient from one to the other.

g. Postural safety support may be used in a manner that does not restrict movement to prevent patients from falling or injuring themselves. Refer to Use of Safety Straps for Patient Safety During Interventional and Diagnostic Procedures policy.

h. Any patient placed on an examination table should be instructed regarding the narrowness and height of table and cautioned not to turn. The patient should be secured with medical immobilization devices and/or observed continuously if his condition warrants.

i. Stretchers will be equipped with side rails and/or straps, which should be used when transporting patients. The patient's extremities should not extend beyond sides of stretcher. Acutely ill, restless or confused patients waiting for treatment should be observed continuously.

j. Patients with communicable diseases will be placed in isolation as appropriate. Isolation precautions will not prevent the patient from receiving the same quality of care as provided to all other patients throughout the hospital. Standard Precautions will be used in the delivery of care to all patients. (See Hospital Epidemiology & Infection Prevention Manual)

k. Smoking is not permitted in any area of the hospital. (See Smoke-free policy)

3. Documentation:

a. The patient's medical record will reflect the planning and providing of safe patient care, including but not limited to: Side rail positions, need for restraints, bed height.

b. Patient and family education will be documented, including but not limited to: Orientation to unit environment, utilization of equipment, need for side rails, restraints.

c. History of falls prior to or during hospitalization will be documented. The patient will be assessed for further fall risk. Appropriate fall precautions will be initiated and documented. (See the Fall Prevention Program policy)

d. Individual safety considerations will be documented on the IntraFacility Transfer Summary in KeckCare, when the patient is transferred to another unit.

RELATED POLICIES AND PROCEDURES

- Administration Manual
  - Smoke-free

- Clinical Practice Manual
  - Fall Prevention Program
  - Patient Identification
Restraint and Seclusion

Use of Safety Straps for Patient Safety During Interventional and Diagnostic Procedures

Hospital Epidemiology & Infection Prevention Manual
PURPOSE

The purpose of the fire safety management plan is to assure that all facilities are designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. The safety of occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire is provided by appropriate arrangement of facilities; adequately trained staff; and development of operating and maintenance procedures composed of the following:

1. Design, construction, and compartmentation
2. Provision for detection, alarm, and extinguishment
3. Fire prevention with planning, training, and drilling programs including the isolation of fire, transfer of occupants to areas of safe refuge, or evacuation of the building

SCOPE

The hospital’s have established and maintain an effective Fire Prevention Management Plan to provide a fire-safe environment of care, for the patients, staff, and visitors. The program is applied to the following facilities and locations:

1. Keck Hospital of USC
2. USC Norris Cancer Hospital
3. All Keck Hospital of USC 1206d Clinics
4. All USC Norris Cancer Hospital 1206d Clinics
5. All grounds associated with the hospitals and 1206d hospital clinic sites

ORGANIZATION AND RESPONSIBILITIES

1. The Chief Executive Officer appoints a Safety Officer who is responsible for developing, implementing, monitoring, administering and directing an ongoing, organization-wide process to collect information about opportunities for improvement in the hospital’s Fire Safety management program. Leadership through experience, education and credentials determines the qualifications of the Safety Officer. The Safety Officer has the authority and duty to take immediate and appropriate action in the event that a hazardous condition exists, which poses threat of life, personal injury/illness, or the threat of damage of property.

2. To ensure safety and health issues are analyzed and addressed in a timely manner, a multidisciplinary process has been established. The Environment of Care Committee; composed of representatives of administration, facilities management, medical staff, quality and risk management, clinical services,
support services, infection prevention, Radiation Safety Officer, and the Hospital’s Safety Officer examines and addresses all safety and health issues.

3. The Environment of Care Committee reports the activities of the Fire Safety Management Program. The Performance Improvement Committee (PIC)/Leadership Council review the reports and, as appropriate communicate concerns about identified issues and regulatory compliance. PIC/Leadership Council provides support to facilitate the ongoing activities of the Fire Safety Program.

4. The Joint Commission places the responsibility for ensuring a safe environment on Senior Management. For this, the CEO receives regular reports of the activities of the Fire Safety Program. The CEO reviews reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Safety Officer and other appropriate staff. The CEO collaborates with the Chairperson of the Environment of Care Committee to establish operating, and capital budgets for the Fire Safety Management Program.

5. The CEO may delegate these functions to another member of the Senior Management team. The designee shall report to the CEO on all Fire safety issues.

6. The Safety Officer in conjunction with the Administrative Director of Facilities Management advises the Environment of Care Committee regarding Fire safety issues, which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

**Objectives**

1. The objective’s for the Fire Safety Management Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of previous year’s program activities, including performance measures, and environmental tours of areas for improvement or to reduce identified risks or concerns. The objective’s for this plan are to:

   a. Conduct an annual evaluation of all areas of the hospital buildings to determine the level of Life Safety Code compliance.

   b. Develop Plans For Improvement (PFI) for any code deficiencies identified and not correctable within 30 days.

   c. Determine the need for Interim Life Safety Measures (ILSM) for Code deficiencies, or during construction, renovation or building improvement projects.

   d. Update the Statement of Conditions as necessary.

   e. Maintain the fire alarm system, detection and extinguishing systems.

   f. Conduct fire drills at least quarterly on all shifts and in the hospital. Conduct fire drills at least annually for business occupancy buildings.

   g. Train all staff, including physicians, licensed independent practitioners, volunteers and students in their appropriate fire response activities to promote fire safety awareness and proper response.
h. Establish a Fire Department liaison to coordinate fire inspections, fire responses and approval of building plans as required.

i. Use performance information to identify key problems, failures and user errors, which require attention and action.

j. Measure performance using relevant standards and report findings to the Environment of Care Committee.

k. Identify opportunities to improve building designs, preventive maintenance activities, emergency response and staff training.

l. Maintain current drawings, plans, or diagrams for life safety assemblies, components or systems.

m. Conduct an annual evaluation of the objectives, scope, performance and effectiveness of the Life Safety Program and report the findings to the Environment of Care Committee.

n. Provide an environment that is free from fire hazards.

**PLAN**

**Fire Plan Elements**

The roles of all employees, medical staff, volunteers and students at and near the point of fire origin are defined. The basic plan in the Hospital is based on the six principles of life safety.

- Rescue
- Contain
- Alarm
- Dial #77 or 911, as appropriate to the location
- Extinguish
  - Pull pin
  - Aim at the Fire
  - Squeeze trigger
  - Sweep from side to side
- Evacuate

1. The roles of all employees, medical staff, volunteers and students are to stay away from the point of fire origin, close the doors, and then evaluate the situation. If the fire is in horizontally adjacent area staff should focus on where to transfer patients vertically or to another adjacent smoke compartment. In other zones, the plans should be reviewed, fire response equipment discussed and checked, the oxygen valves checked for access, and the responsibility for shutting off oxygen valves is the Respiratory Department.

2. The roles of others, such as students, physicians and volunteers vary depending on the situation.
3. If a relocation or evacuation is deemed necessary, staff should verify:

   a. Patients in the most affected areas are moved first, to adjacent zones.

   b. Patients are moved using the equipment and techniques normally used. Where practical, ambulatory patients walk, or are moved on wheelchairs. Non-ambulatory patients are moved on wheelchairs, gurneys or MedSleds as appropriate to their condition. Movement on beds is generally the last alternative, because of the additional staff necessary to move beds.

   c. Patients are moved into rooms in adjacent zones to protect them from the smoke and product of combustion that may be in the corridor.

   d. That if patients must be moved vertically, it will be under the direction of the Fire Department by either the elevators, or stairwell evacuation.

   e. That if an evacuation is deemed necessary, the Hospital Incident Command System is activated.

**PERFORMANCE STANDARDS MONITORING & MEASURES**

The Environment of Care Committee establishes annual Performance Indicators (PI) for the Fire Safety Management Plan. These indicators are derived from information gathered during routine and special risk assessment activities, annual evaluation of previous year’s program activities. These are modified as necessary based on identified needs.

**PROCESS OF THE FIRE SAFETY MANAGEMENT PLAN**

**Fire Safety Management Plan**

The hospitals have developed and maintained a written Management Plan describing the processes implemented to effectively manage the fire safety environment for patients, staff, and others. The Management Plan is evaluated annually, and modified as necessary, based on changes in conditions, regulations and standards, and identified needs.

**Evidence of Compliance:**

Fire Response Manual on file in the Engineering office and in all unit/departments and on EOC shared drive. Fire Response plan is evaluated each year by a multidisciplinary team, this evaluation includes a review of the plans’ objectives, scope, performance and effectiveness. The evaluation is submitted to the EOC committee for final review and approval.

1. **Protecting Patients Staff & Others**

   The Administrative Director of Facilities Management and the Hospital Safety Officer share responsibility for managing the program for protecting patients, personnel, visitors, and property from fire, smoke, and other products of combustion. The fire protection program includes three phases.

   The first phase is to verify that facilities designed for the hospitals are in compliance with current local, state, and national building and fire codes. The hospitals employ qualified architects and engineers to
develop building and fire protection system designs. All designs are reviewed by local or state agencies as a part of the construction and permitting process. In addition a vigorous construction monitoring and building commissioning program round out the design phase.

The Administrative Director of Facilities Management is responsible for managing the program and complying with codes and standards as well as maintaining the Statement of Conditions document.

- Compliance is maintained by ongoing inspection and preventative maintenance of key elements. Where significant deficiencies are identified, they are corrected promptly, or if the correction time will exceed 30 days a Plan For Improvement will be documented as part of the Statement of Condition's™ (SOC™). Any deficiencies identified will require an ILSM assessment to be done as outlined in section 6 below.

- As items are corrected, they will be closed in the Plan for Improvement. On an annual basis, the SOC will be reviewed and any open items evaluated to determine their status. If they will not be completed as scheduled, a determination must be made as to whether the delay will be sufficient to justify a letter to the Joint Commission notifying them of the change in plans. This determination will be made by the Administrative Director of Facilities Management, and the Hospital Safety Officer, and reviewed by the EOC Committee.

- The Plan for Improvement is reviewed bi-annually to make sure work is progressing. The Plan for Improvement is used to develop the operational budgets.

The second phase is maintenance of the current buildings. The Administrative Director of Facilities Management is responsible for setting maintenance standards based on applicable codes. The standards are applied through a process of planned maintenance and management of the work done by the hospital’s staff and contractors to verify the end product of all work maintains or improves the level of life safety in each affected area.

The third phase is an active program of fire prevention, fire safety, and fire response training. The Safety Officer manages this phase of the program.

**Evidence of Compliance:**

Contractors must complete an *ILSM Requirements Checklist* (on file in the Engineering office) prior to start of work. Compliance with fire safety requirements are assessed and noted during surveillance rounds.

2. **Fire Detection and Response System Tests and Inspections**

The Administrative Director of Facilities Management is responsible for inspection, testing, and maintenance of the Fire Detection and Response Systems, including but not limited too:

a. All supervisory signal devices

b. All valve tamper switches and water flow devices

c. All duct detectors, electromechanical releasing devices, heat detectors, manual pull stations alarm boxes and smoke detectors
d. Occupant alarm notification devices, including all audible devices, speakers, and visible devices

e. Fire pumps

f. Main drain tests

g. Fire department connections

h. Kitchen automatic fire-extinguishing systems

i. Gaseous automatic fire-extinguishing systems – Halon & Inergen

j. Portable fire extinguishers

k. Standpipe systems

l. Fire and smoke dampers

m. Automatic smoke-detection shutdown devices for air-handling equipment

n. Horizontal and vertical sliding and rolling fire doors

o. Elevator recall system

p. Annunciator panels

q. Alarm system battery power back up

3. **Evidence of Compliance:**

The Facilities Department responds to and troubleshoots fire alarm malfunction. Licensed contractors perform corrective and preventive maintenance to the fire alarm system. The assigned facilities staff or Vendor/Contractor conduct the scheduled maintenance of all components of the fire alarm and document their work with forms developed by the contractor and Hospital-generated work orders.

a. Supervisory signal devices are tested quarterly by a licensed contractor.

b. Valve tamper switches and water flow devices are tested quarterly by a licensed contractor.

c. A licensed contractor conducts tests at least annually on duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes, and smoke detectors as part of ongoing fire alarm system maintenance.

d. Occupant alarm notification and annunciator devices, including audible devices, speakers, visible devices, are tested annually by a licensed contractor, as part of ongoing fire alarm system testing, and verified by staff by exception, during fire drills.
e. Each fire pump is tested, or inspected, at least weekly under “no flow” condition to verify operations, water-bearing activity, and timeout operations by Facilities staff. A licensed contractor, in conjunction with Fire Insurance and Fire Department staff, conducts fire pump tests under full flow at least annually. Flow curves are calculated and compared with normal flow to test the pump’s continuing function.

f. A licensed contractor conducts main drain tests at least annually at all fire alarm system risers.

g. Each fire department connection is inspected quarterly by Facilities staff, as part of equipment rounds. Problems are documented by exception.

h. A licensed contractor conducts kitchen automatic fire-extinguishing systems semi-annually checks and installs date stamped tag.

i. A licensed contractor tests carbon dioxide and other gaseous automatic fire-extinguishing systems at least annually to verify proper operation.

j. Each portable fire extinguisher is clearly identified, inspected at least monthly, and maintained at least annually by a licensed contractor. In addition, extinguisher access is evaluated during ongoing environmental tours.

k. Standpipe hoses hydrostatically tested five years after installation and at least every three years thereafter; where installed, and the standpipe systems receive water-flow tests as part of the annual reg 4 testing performed by a licensed contractor.

l. Each fire and smoke damper is operated at least every six years (with fusible links removed where applicable) to verify that they fully close, where such dampers may be reached. Dampers installed in building locations that are inaccessible are maintained on the SOC and replaced by assessable dampers when renovations are done in the affected areas.

m. Each automatic smoke-detection shutdown device connected to air-handling equipment is tested (operationally activated) at least annually.

n. Each horizontal and vertical sliding or rolling fire door is tested for proper operation and full closure at least annually during ongoing maintenance activity.

o. Elevator Recall systems are checked and operation verified annually for each elevator.

- Testing reports for devices and systems with intervals indicated, are in the Fire Life Safety Systems Inspection binder and are on file in the Engineering office located in the regulatory compliance cabinet.

- A monthly Life Safety Compliance report is submitted to the EOC committee for review.


The Fire Response Plan provides clear, specific instructions for staff responding to an emergency. The procedures provide information about notifying appropriate administrative staff of the emergency and
actions to take to protect patients and staff. Each department head is responsible for maintaining copies of emergency procedures in a continuously accessible location.

The head of each department serving patients is responsible for developing and training staff about department-specific emergency fire response procedures. Each department head is responsible for providing department and area personnel with an orientation to emergency procedures related to their job. Additional department level training is provided on an annual basis as part of the continuing education program or on an as-needed basis.

Each department head is responsible for reviewing department specific Fire Safety Program emergency procedures annually.

**Evidence of Compliance:**

The Fire Response Plan is submitted for review and approval annually to LA City Fire Department Staff knowledge and response as well as accessibility of the Fire Response Plan is evaluated during weekly EOC rounds and documented in the Environmental Tour Inspection Tool.

5. **Processes to Control Flammability of New Acquisitions**

The Safety Officer, with support from the Administrative Director of Facilities Management and Director of Material Management is responsible for the identification of equipment and supplies which require purchasing control in order to ensure safety within the work place or compliance with Federal and/or State codes and regulations.

The Administrative Director of Facilities Management is responsible for assuring fire-rated products installed during construction projects meet the standards. Fire-rated products are identified for each project using standard specifications.

The Director of Material Management is responsible for purchasing only fire/flammability-rated replacement products meeting the standards defined. Department Directors who need to purchase products coordinate product evaluations with the Director of Material Management.

**Evidence of Compliance:**

**Safety Standards for Purchasing of Equipment and Supplies** policy available in the Safety Manual.

6. **Fire drills**

Fire drills are a critical tool to maintain the readiness of staff to respond to a fire emergency, to minimize the likelihood of injury to patients, visitors and staff. To evaluate staff knowledge, drill activities are observed, critiqued, and employees may be questioned about their role and activities during a fire emergency nearby and elsewhere in the building.

Fire drills are conducted throughout the Hospital, one each occupied shift each quarter, and evaluated to assure that all elements of the drill activity are exercised in occupied areas. It is the responsibility of the Administrative Director of Facilities to ensure that fire drills are conducted as required and that documentation is kept on file for review as needed by the Safety Officer, or other regulatory agencies.
Fire drills are conducted in all other areas, in which patient care takes place, at least once a year with. These drills are witnessed, documented, and evaluated to identify improvements that may be made, as appropriate. Additional drills are held as deemed necessary or when construction/renovation activities are taking place as part of the ILSM.

At least 50% of all fire drills will be unannounced, with the exception of those done as corrective training activities.

All staff in the affected areas are required to participate in the drills to the extent the fire plan describes. This includes all Hospital staff and all hospitals staff in buildings where space is shared with others.

Fire drills are observed, documented on a Formatted Data Collection Form and critiqued to identify opportunities to improve, and areas where additional training would be appropriate. In addition, fire response knowledge is evaluated, by ongoing questioning, during environmental tours. The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, equipment, and administrative compliance issues. Such improvements are included in monitoring activities, and the results used to identify the effectiveness of the activities to improve fire safety.

Staff knowledge and response is evaluated in the Environmental Tour Inspection Tool that includes:

a. How, and under what conditions, they activate the fire alarm or call a Code Red
b. When it would be necessary to call 77 or 911 to alert the Fire Department
c. Their containment of fire and smoke, where appropriate
d. How they would move patients to areas of refuge (adjacent fire zones)
e. How, and when, they would use fire extinguishers
f. Specific duties such as shut-off of oxygen valves, movement of medical records and other emergency responses
g. What they would do if a building evacuation was announced

Evidence of Compliance:


7. Interim Life Safety Measures (ILSM)

The Administrative Director of Facilities Management is responsible for managing the ILSM program. The program is applied to situations when the assessments of the life safety deficiencies identified in the existing building warrant or occur if the Pre-Construction Risk Assessment indicates the need.
An assessment tool is used to evaluate each situation to determine if the degree of deficiency warrants ILSM and what specific measures are required to minimize the effects of the deficiency. This is also part of the preconstruction risk assessment process.

The assessment evaluates the risk of non-compliance with each of the elements of the Unit Concept of the Life Safety Code (i.e. smoke and fire walls, floor separation, exiting, building construction, fire alarm system activity). During any construction or deficiency is identified, the 13 key elements of the ILSM are evaluated, and where applicable to the deficiency or construction activity, remedial activity is implemented and maintained until the deficiency is corrected.

The Administrative Director of Facilities Management is responsible for verifying that Risk Assessment findings and corresponding remedial requirements are communicated to appropriate managers, staff, contractors, and senior leaders. In addition, the Director is responsible for monitoring implementation of the ILSM and taking action when appropriate measures are not being observed.

Staff will be trained on any additional fire safety features, equipment, alternate routes of egress or other temporary measure(s) taken.

The schedule of monitoring and documentation is determined on a per project basis. The Director of Facilities Management is responsible for maintaining all ILSM documentation from the onset through elimination of the deficiencies. Regular reports of ILSM programs will be made to the Risk Manager and EOC Committee.

Evidence of Compliance:

ILSM binders are maintained by the Facilities Department and updated regularly.

_Interim Life Safety Measures_ (departmental) policy and ILSM Checklist are on file in the Engineering office.

REFERENCES

Fire Safety Management Plan utilizes several organization and regulatory standards in the formulation of departmental policies and procedures and guidelines for practice. These include:

- American Hospital Association (AHA)
- California Code of Regulations, Title 22 Social Security
- The Joint Commission
- National Fire Protection Association (NFPA)

RELATED POLICIES AND PROCEDURES/DOCUMENTS

- Emergency Operations Plan
- Facilities Management Policies and Procedures
**Subject:** Fire Safety Management Plan

**Effective Date:** 11/17/1998

**Reviewed Date:** 04/28/2016

- Materials Requiring Fire-Retardant Qualities
- Interim Life Safety Measure Policy

### Effective/Revision Dates for Policy # 6-127

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**Keywords:** Environment of Care, EOC, Fire Management Plan
The initial assessment is the foundation from which the RN develops and implements the nursing aspect of the Interdisciplinary Plan of Care as well as initiates referrals to other health care team members. Care decisions are based on the identified patient needs and priorities. The purpose of this policy is to provide guidelines for the initial assessment and reassessment of patients.

1. During the initial assessment patients are screened for nutrition status, spiritual/cultural needs, possible abuse and neglect, functional status and discharge planning.

2. The documentation of the initial assessment is to be completed by an RN within appropriate specified time frames: in-patients within 24 hours, and Same Day, OPSC and Diagnostic labs prior to sedation and/or procedure. LVNs and Patient Care Techs (PCTs) may assist in the collection of data.

   a. Initial Assessment and Screening form for all inpatients. Pre-Procedure / Surgery Assessment and Checklist form with addition of the screening tools on in-patient initial assessment form will be considered as a complete initial assessment. All initial assessments will be filed under continuum of care in the in-patient record.

   b. Pre-procedure/surgery assessment and checklist for observation/short-stay patients

3. The scope and intensity of assessments/reassessments are based on the dynamics of the patient condition, patient's response and desire for care, and unit guidelines. Unit guidelines are available on each unit for reference.

4. Each patient's physical, psychological, social status, educational needs, and learning preferences are assessed. Spiritual beliefs and cultural practices are accommodated. The patient is involved in all aspects of care.

5. Registered Nurses integrate the information from various sources to identify and assign priorities to the patient care needs. The RN is responsible for interpreting the collected data, formulating nursing diagnoses, and developing the plan of care.

6. For pediatric assessment, please refer to Clinical Practice policy, Pediatric Patients at USC Hospitals.

7. Patients who are possible victims of alleged or suspected abuse or neglect have special needs related to the admission process. For specific, objective criteria for identifying and assessing possible victims of abuse and neglect, refer to Administrative policies; Adult/Elder Abuse Reporting, Child Abuse/Neglect Reporting, and Domestic Violence.

8. The Initial Assessment serves as an assessment from which referrals to other disciplines may be initiated.
9. If any part of the Initial Assessment and Screening form is deferred, the reason must be documented and a reassessment date identified.

10. Abnormal or unexpected findings assessed on admission will be communicated to the Medical Staff or other interdisciplinary patient care providers as appropriate.

11. The scope and intensity of any further assessments are determined by the patient's diagnosis, care setting, complexity of care, duration of the care the patient is seeking, the patient's consent to treatment, and his/her response to previous care rendered.

12. Any significant change in the patient's diagnosis and/or condition necessitates an immediate reassessment with changes in the plan of care reflecting the change in diagnosis or condition.

13. Patients are reassessed after treatment, therapy or educational sessions to determine the effectiveness (extent of improvement) of the interventions undertaken by the health care team. Time frames for reassessment are dependent upon the type of treatment or therapy and/or the intensity of the educational session provided and specified in specific policy and procedure.

14. Reassessment may also occur if members of the health care team become aware of issues in the patient's social or home environment, which may impact his/her condition/treatment/care.

PROCEDURE

1. Follow directions on forms for completion.

2. Complete a head to toe assessment and document finding on the unit specific flowsheet.

3. Height and Weight: Patients are to be weighed by scale unless their physical condition restricts such activity.

4. Allergies/Intolerance: Indicate allergies and types of reactions. If patient states they have a drug allergy, question them about the symptoms they had when they took the drug and list in this section. If you have any questions as to whether or not a true drug reaction exists, consult the physician or pharmacist. Please refer to Clinical Practice policy Allergies, Intolerance, Adverse Drug Reaction.

5. Medications brought into the hospital must be sent to the Pharmacy prior to patient use. A physician’s order is required for a patient to take their own medications and for medications that are left at the bedside. Please refer to Clinical Practice policy Patient’s Own Medications.

6. Present on Admission form will be completed by the RN and signed by the physician within 24 hours of admission.

7. Assessment for Fall Potential: Complete the Risk Assessment Scoring Guide and record initial risk score. For ICU patients, institute fall protocol at minimum of Level III.

8. Assessment for Risk of Skin Breakdown: Complete the Braden Scale and record initial risk score.

9. Educational needs and learning readiness are documented on the Education Flowsheet.
MANUAL: Nursing  POLICY #: NA 10-101

SUBJECT: Initial Assessment and Reassessment

EFFECTIVE DATE: 08/28/1992
REVISED DATE: 08/02/2011

REFERENCE

- Joint Commission Comprehensive Manual for Hospitals

Effective/Revision Dates for Policy # NA 10-101

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Keywords: Assessment, Reassessment
PURPOSE

1. To establish a program for assessing inpatients for risk factors, reducing patient falls, and protecting patients from injury if a fall should occur.

2. All patients are unique and the Fall Risk Assessment Scoring Tool may not capture all patients who are at risk. If a patient does not score as a high risk for falling using the Fall Risk Assessment Scoring Tool, the nurse will use sound clinical judgment in the patient assessment and implement a fall prevention care plan.

DEFINITIONS/CLASSIFICATIONS:

Falls Rate– The rate per 1000 patient days at which a patient experiences a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface, on another person, or on an object (e.g. a trash can). If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured. All falls to the floor are reported and described by level of injury, and the circumstances (observed, assisted, or restrained at the time of the fall).

Types of fall

- **Accidental fall:** Patient is typically NOT AT RISK prior to fall, but rolls out of bed, trips or slips inambulation or transfer due to a failure of equipment or environmental hazard.

- **Unanticipated physiologic fall:** Patient experiences a physiologic event, such as syncope (fainting), a seizure, orthostatic hypotension episode, or unanticipated drug reaction or side effect in response to treatment, causing a fall that was NOT reflected in fall risk factors, thus could not have been predicted.

- **Anticipated physiologic fall:** Patient has been determined to be AT RISK for falling and cause of actual fall can be logically attributed to known fall risk factors related to weak or impaired gait; use of ambulation aid; impaired mental status; alterations in balance, strength, or mobility; or anticipated drug reaction or side effect in response to treatment.

- **Near Miss Fall:** A sudden loss of balance that does not result in a fall or other injury.

- **Assisted Fall:** A fall in which any staff member (whether a nursing service employee or not) was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent. Example: A patient who is ambulating becomes weak and the staff lowers the patient to the floor. This is considered a fall because the patient did not intend to go to the floor; it is an assisted fall because the staff eased the patient’s descent to reduce the likelihood of injury.

- **Repeat Fall:** If a patient falls more than once in a given calendar month after admission to the unit, each fall after the first fall is classified as a repeat fall.
Level of Injury

- **1= None** – Patient has no injuries (no signs or symptoms) resulting from the fall; if an x-ray, CT scan or other post fall evaluation results in a finding of no injury

- **2= Minor** – Resulted in application of ice or dressing, cleaning of a wound, limb elevation, topical medication, pain, bruise or abrasion

- **3= Moderate** – Resulted in suturing, application of steri-strips or skin glue, splinting, or muscle/joint strain

- **4= Major** – Resulted in surgery, casting, open reduction to correct fracture, dislocation or tissue injury, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration) or patients with coagulopathy who receive blood products as a result of a fall

- **5= Death** – The patient died as a result of injuries sustained from the fall (not from physiologic events causing the fall)

**Policy**

1. Within 4 hours of admission to a nursing unit, the patient will be assessed using the "Fall Risk Assessment Scoring Tool." The scoring tool must be completed by an RN.

2. The patient will have a complete assessment by an RN daily, before transfer between units, post procedure, post operatively or after any change in patient's condition using the "Fall Risk Assessment Scoring Tool" in the Electronic Health Record (EHR).

**Procedure**

**Nursing Units**

1. **Initial Assessment/Screening:**
   a. Within 4 hours of admission to the unit, an RN will complete the “Fall Risk Assessment Scoring Tool.”
   b. Level I (score less than 8 points) patients require no armbands.
   c. For **LEVEL II (8-14 points) and Level III (15 or more points)** fall risk, the appropriate level II and level III interventions will be initiated by the registered nurse.
   d. During hospitalization, the patient’s fall risk may increase to a higher level. When the score meets a new level, additional interventions on the plan of care should be added by the registered nurse to ensure the safety of the patient.
   e. All non-critical care patients assessed at Level II and III fall risk will have a physician's order obtained for Occupational and/ or Physical Therapy evaluation and treatment. Occupational and Physical Therapy will make recommendations to the patient’s plan of care as appropriate to help decrease fall risk after
evaluating the patient. All critical care patients transferring out of critical care units at Level II or III fall risk will have an order obtained for Therapy evaluation and treatment to be completed once the patient is transferred.

f. When sending the patient to another department (i.e., Radiology), notify the department using the Situation Background Assessment Recommendation (SBAR) hand-off communication, of the fall risk and interventions being utilized to prevent falls/injury.

2. **Follow up Assessment/Screening:**

a. Each patient will be reassessed for fall risk daily, before transfer, post procedure, post-operative or any change in the patient’s condition including a fall.

b. This will be documented on the “Fall Risk Assessment Scoring Tool” in the EHR and the interdisciplinary plan of care will be reviewed and updated as needed.

3. **Fall Prevention Interventions:**

a. All patients identified as a Level II or III risk for falls will have the following measures initiated:

i. A high fall risk armband will be placed on the wrist to serve as an identifier for the entire health care team.

ii. Yellow socks will be provided to the patient to be worn while out of bed.

iii. Place the high falls risk sign outside of patient’s room.

iv. The patient’s at risk status will be reported during each change of shift report and upon any transfer of the patient’s care using the SBAR hand-off communication.

v. The patient and family will be educated. Education interventions may include but are not limited to:

   (1) Using brochures, pictures, skylight video, and signage as reminders about using the call light, etc.

   (2) Enlisting family participation to support interventions and to alert the staff to any changes in the patient’s condition.

   (3) Enlisting family participation to engage the patient and remind the patient to ask for assistance if needed.

4. **Plan of Care:**

a. Strategies to prevent falls for all patients from low to high risk (Level I, II and III) may include but are not limited to:

i. Call light within patient reach, have patient return demonstrate the use of the call light.

ii. Reinforcement to patient to call for assistance.
iii. Personal items within reach.

iv. Provide non-skid footwear.

v. Provide patient and family safety education.

vi. Offer hydration and toileting with hourly rounding.


viii. Assign patient to a room that enables patient to exit the bed to his/her stronger side when possible.

ix. Involve patient in diversion activities/activities of choice.

x. Close monitoring of the effects of mind impai ring medications, including psychotropic and pain medications (see Appendix A) for a list of medications that may increase the risk of falls.

xi. Decrease noise level/stimuli.

xii. Provide psychological and emotional support.

xiii. Floors non-glare and non-slippery.

xiv. Sufficient lighting.

xv. Room free of clutter.

xvi. Encourage visitors.

xvii. Necessary assistive device available if needed (i.e., cane, walker or wheelchair). If patient needs training for a new assistive device, obtain physician order for Occupational or Physical Therapy evaluation and treatment.

xviii. Use safe patient handling mobility equipment for transferring patients when mobility or weight bearing status is unknown.

b. Strategies to prevent falls for patients at medium to high risk (Level II and III) may include but are not limited to:

i. Reorientation as needed.

ii. Provide reality orientation each contact with patient.

iii. Consider using bed and/or chair sensor alarms.

iv. Use of 2 – 3 side rails.
v. Referral to appropriate discipline for specific assessment (i.e., Occupational and/or Physical Therapy evaluation and treatment).

vi. Frequent reassessment.

vii. Toileting equipment close to patient.

viii. Watch video on patient interactive unit.

c. Strategies to prevent falls for patients at high risk (Level III) may include but are not limited to:

i. Consider placing patients close to the nurse’s station

ii. Consider one-to-one observation

iii. Multidisciplinary care conference with participation of care team

iv. Consider using bed sensor alarms

d. Post Fall Management:

i. Assess for any injury, (e.g., pain, abrasion, contusion, laceration, fracture, head injury).

ii. Assist patient back to bed; if patient cannot get up with minimal assistance activate Code Assist STAT to safely return patient back to bed using safe patient handling equipment.

iii. Obtain vital signs.

iv. As soon as possible after the patient is settled, gather all available staff and, if appropriate, the patient to conduct a Post Fall Huddle and complete the Post Fall Huddle Tool.

(1) The purpose of the Post Fall Huddle is determine what happened, how it happened, and why (such as physiological factors due to medications or medical condition).

(2) The goal of the Post Fall Huddle is to determine if appropriate interventions were in place, why the fall might have occurred, and how similar falls can be avoided.

v. Assess environment for contributing factors.

vi. Notify physician and document on the Post Fall Assessment of the EHR.

vii. Monitor patient as condition warrants.

viii. Complete the Post Fall Assessment in the EHR and document objective observations related to patient condition and the environment.
ix. Report the fall to the charge nurse and at shift reports using SBAR hand-off communication complete an Occurrence Report on the computer. Note level of fall risk prior to fall and if precautions were in place.

x. Modify the interdisciplinary plan of care and fall risk care plans as patient conditions warrants.

xi. Notify emergency contact or next of kin and document on the Post Fall Assessment in the EHR.

xii. Ask Physician for an order for Occupational Therapy and/or Physical Therapy (evaluation and treatment) if they were not already following the patient.

e. Patient/Family Education:

i. All patients will be provided skylight video for fall prevention in non-critical areas. ICU nurse will show the video in critical care setting when appropriate.

ii. Both patient and family should be informed and understand fall risk factors and agree on strategies to prevent the patient from falling. Patients and families should be educated about fall risk factors in the hospital environment and continue their active involvement in all levels of safety education throughout the continuum of care.

iii. Instruct patient and family on all activities prior to issuing assistive devices (i.e., cane or walker). If the patient was not already using an assistive device, get an order for an Occupational and/or Physical Therapy evaluation and treatment to instruct the patient.

iv. Instruct patient and family on all strategies related to vision and/or cognitive impairments. Ensure there is an order for Occupational Therapy evaluation and treatment to instruct the patient.

v. Teach patient to use grab bars while in the bathroom if indicated.

vi. Instruct patient in careful use of medications that may increase risk of falling (i.e., opioids, antihypertensives). Refer to Appendix A for a list of medications.

Interdisciplinary Team

1. When entering the patient care areas, be aware that all patients are at risk for fall. Look for high fall risk armbands, and high fall risk signage. If it appears that the patient may be in imminent danger of falling:

a. Go to the patient's bedside. Assist the patient and call for assistance from nursing staff.

b. Place the patient's call light on and ask for someone to come and help you as soon as possible. Notify the responder(s) if patient is about to fall or has fallen.

c. Stay with the patient until help arrives (the patient care staff will be responsible for assisting the patient once on scene).

d. Report to the nurse any information about what you saw and give your name and department.
2. For departments receiving patients from patient care areas, be sure to note fall risk by looking for a high fall risk armband or signage.

**REFERENCE(S)**

- California Nursing Outcomes Coalition Project; Codebook Part II: Data Capture and Submission; Acute Care Version 1/1/2007 Revision; pages 18 – 21.
- National Database of Nursing Quality Indicators® (NDNQI®); Guidelines for Data Collection and Submission On Quarterly Indicators; Version 9.2; 2/2011; pages 56 – 61.
- The Joint Commission; Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities. Issue 55, September 28, 2015; pages 2 - 3

**ATTACHMENT(S)**

- Falls Assessment Algorithm
- Appendix A – Medications That May Increase the Risk of Falls
Patient Admitted or Transferred to the Unit

Fall Risk Assessment Scoring Tool Completed within 4 hours

Basic nursing care provided. Including:
- Bed in lowest setting and locked except when performing care requiring otherwise
- Ensure patient’s necessary items are within reach.
- Assess environment
- Encourage regular toileting
- Provide safety education.
- Skylight Fall Safety Video

Low Risk of Falling
Level I

Medium Risk of Falling
Level II
(High fall risk signage & high fall risk armband)

High Risk of Falling
Level III
(High fall risk stickers & high fall risk armband)

Basic nursing care provided. (See above) Additional strategies considered:
- Re-orient confused patients
- Place the sign outside of room
- Assess patient with regard to use of 2 – 3 side rails (4 up is a restraint)

Re-assessment for Every Fall

Obtain order for Occupational and/or Physical Therapy evaluation

Arrange multidisciplinary care conference to discuss safety, precautions specific to the individual patient

Re-assessment for Every Fall

Re-assessment for Every Fall

Re-assessment for Every Fall

FALLS ASSESSMENT ALGORYTHM
### Medications That May Increase Risk for Falls

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<td>CODE</td>
<td>WHAT DOES IT MEAN</td>
<td>WHO CAN INITIATE</td>
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<tr>
<td>ASSIST</td>
<td>Lifting/Transporting a patient</td>
<td>ANYONE</td>
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<tr>
<td>BLUE</td>
<td>MEDICAL EMERGENCY: Cardiac or Respiratory Arrest</td>
<td>ANYONE</td>
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<tr>
<td>GRAY</td>
<td>SECURITY INCIDENT: Combative person</td>
<td>ANYONE</td>
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<tr>
<td>GREEN</td>
<td>Patient Elopement</td>
<td>CEO or designee</td>
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<tr>
<td>ORANGE</td>
<td>Hazardous material spill/release</td>
<td>ANYONE</td>
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<tr>
<td>RED</td>
<td>FIRE</td>
<td>ANYONE</td>
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<tr>
<td>SILVER</td>
<td>Person with a weapon and/or hostage situation</td>
<td>ANYONE</td>
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<tr>
<td>TRIAGE - EXTERNAL</td>
<td>Disaster within the community</td>
<td>CEO or designee</td>
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<tr>
<td>TRIAGE - INTERNAL</td>
<td>Disaster within the hospital facilities</td>
<td>CEO or designee</td>
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<tr>
<td>YELLOW</td>
<td>BOMB THREAT: Suspicious looking device discovered or bomb threat received from individual on the telephone.</td>
<td>CEO or designee</td>
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</tbody>
</table>
DO NOT USE ANY OF THE PROHIBITED ABBREVIATIONS

Use of PROHIBITED abbreviations may delay patient treatment until the order is CLEAR AND COMPLETE by the prescriber.

HELP PREVENT ERRORS

<table>
<thead>
<tr>
<th>PROHIBITED ABBREVIATION/DOSE DESIGNATION</th>
<th>POTENTIAL PROBLEM FOR PATIENT SAFETY</th>
<th>APPROVED ABBREVIATION/DOSE DESIGNATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>U or u</td>
<td>Mistaken as zero, 4 or cc</td>
<td>“Unit”</td>
</tr>
<tr>
<td>IU</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>“International Unit”</td>
</tr>
<tr>
<td>Q.D.</td>
<td>Mistaken for QOD or QID</td>
<td>“daily”</td>
</tr>
<tr>
<td>Q.O.D.</td>
<td>Mistaken for QD or QID</td>
<td>“every other day”</td>
</tr>
<tr>
<td><strong>Zero after decimal point (1.0)</strong></td>
<td>Decimal point is missed and mistaken for 10 mg</td>
<td>Never write zero by itself after a decimal point (X mg)</td>
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<td><em>(Prohibited only for medication-related notations)</em></td>
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<tr>
<td><strong>No zero before decimal dose (.5 mg)</strong></td>
<td>Decimal point is missed and mistaken for 5 mg</td>
<td>Always use a zero before a decimal point (0.X mg)</td>
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<tr>
<td><em>(Prohibited only for medication-related notations)</em></td>
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<tr>
<td>MS</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate</td>
<td>“morphine sulfate” or “magnesium sulfate”</td>
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<td>MSO4</td>
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<td>MgSO4</td>
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PURPOSE

1. To describe the process for enrolling patients in the Transfusion-Free Medicine Program (TFMP).

2. To identify persons who refuse blood product administration and to respect their convictions regarding non-blood management.

POLICY

1. Each patient has the right to participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.

2. The facilities respect the right of the competent adult patient to refuse blood transfusions and the administration of blood-related components and procedures.

3. Each physician and hospital employee will adhere to applicable ethical and legal principles when caring for these patients.

4. Admitting staff, nurses and physicians will encourage patients to make their wishes known in writing through an Advance Health Care Directive (ACHD) and a signed informed refusal ("Refusal to Permit Blood Transfusion" form).

5. Regarding patients with capacity to make healthcare decisions who communicate their decision not to receive blood components, and who subsequently lose their decision making capacity, the facilities and staff will honor the patient's prior expressed wishes. A surrogate decision-maker may not change the patient's expressed decisions.

6. In emergency situations, where the patient is known/believed to be a Jehovah’s Witness or is known/believed to have refused transfusion in the past, but the physician has not had the opportunity to determine the patient's wishes related to blood/blood components administration, health care providers shall use all efforts to provide treatment avoiding blood/blood components transfusion. If at any time, the physician determines that blood/blood components are required in order to save the patient's life, and the patient's wishes have not been determined - the physician will proceed in a manner that is in the best interest of the patient. In such cases, the physician will document the critical need for transfusion and the details as to why doubt exists as to the patient's wishes related to transfusion. A copy of such critical need for transfusion documentation must be sent to the Blood Bank before transfusion.

7. Minors or minor patients who are under guardianship will be treated in accordance with “Blood and Blood Component Administration/Refusal: Minor Patients” Policy.

SUPPLIES

- Green TFMP Packet containing:
**Transfusion-Free Medicine Program (TFMP): Enrollment Process**

1. **Pre-Operative Assessment and Center for Education (PACE)**
   a. If patient is seen in PACE prior to admission, the PACE staff will complete the following:
      i. Identify the patient as a person refusing blood and/or blood products.
      ii. Pull green TFMP packet.
      iii. Have patient sign the Refusal to Permit Blood Transfusion Form. This form **must** be completed to enroll the patient in the TFMP.
      iv. Flag face sheet with "Bloodless Flag" in flag section.
      v. If patient requests information regarding the TFMP, provide informational handouts. If the patient requests additional information, contact TFMP Director at x25263.
      vi. Assist patient to complete the Product/Treatment and Procedure Acceptance Form.
      vii. Fax completed Refusal to Permit Blood Transfusion Form and Product/Treatment Procedure Acceptance Form to Blood Bank at x28746.
      ix. Send chart to pre-op by 5 pm on the day prior to surgery.
2. Admitting Department or Nursing Supervisor

a. Identify the patient as a person refusing blood and/or blood products.

b. Pull green TFMP packet.

c. Flag the face sheet with "Bloodless Flag" in flag section.

d. Provide TFMP informational handouts. If the patient requests additional information, contact the TFMP Director at x25263.

e. Obtain from the patient their signed Durable Power of Attorney for Health Care or AHCD form (if available). Make a copy of this form and send it to the nursing unit with other admission paper work. If the patient does not have this form with them, the admitting clerk will notify social services.

f. Place a green armband on the patient.

3. Nursing Units

a. During the initial nursing assessment, confirm the patient’s decision to participate in the TFMP. Ensure that a green armband is in place.

b. Respect that the Jehovah's Witness WILL NOT ACCEPT:

   i. Whole Blood

   ii. Packed Red Blood Cells

   iii. Plasma (FFP)

   iv. White Blood Cells

   v. Platelets

   vi. Autologous Pre-Donation

   vii. NOTE: Some patients may accept cryoprecipitate because it is a manufactured fractionated product.

       See attached "Jehovah's Witnesses Religious and Ethical Position on Blood."

c. Pull green chart binder.

d. Have patient sign the "Refusal To Permit Blood Transfusion" form. This form must be completed to enroll the patient in the TFMP.

e. Fax completed "Refusal to Permit Blood Transfusion" form to Blood Bank at x28746 (KHUSC) or
x50216 (Norris) and document that form was faxed.

f. Ensure that the Product/Treatment and Procedure Acceptance Form is completed and fax the completed form to the Blood Bank at x28746 (KHUSC) or x50216 (Norris) and scan the form to Pharmacy.

g. Place Refusal to Permit Blood Transfusion Form and Product/Treatment and Acceptance Form under the Advance Directive tab of chart binder.

h. Document the patient’s TFMP status on the Kardex using the blood products refusal sticker (if applicable).

4. Operating Room

a. The following information must be on the patient’s medical record prior to any invasive procedure:

   i. Signed “Refusal to Permit Blood Transfusion” form;
   
   ii. Green “No Blood Products” sticker on front of chart; and
   
   iii. Signed “Product/Treatment and Procedure Acceptance” form.

b. Participation in TFMP will be determined for every patient scheduled for a surgical procedure.

c. Designate “Transfusion-Free” on the surgery schedule.

d. Post green “No Blood Products” notice on the door to the appropriate operating suite or procedure room.

5. Blood Bank

a. The Blood Bank will identify transfusion-free/blood refusal patient according to the surgery schedule and according to the faxed “Refusal to Permit Blood” form.

b. Blood Bank will enter the appropriate “transfusion-free comment” in the transfusion requirement field in the patient demographics/Blood Bank historical record.

c. If the blood bank CLS receives a request for blood for a person designated as transfusion-free, he/she will attempt to resolve or clarify the issue with the person ordering the transfusion. If the CLS is unable to resolve the issue on their own, he/she will contact the director and/or supervisor of the Blood Bank.

d. If a transfusion-free patient consents to transfusion of blood or blood components, a copy of the consent will be sent to the Blood Bank.

6. Health Care Provider Expressed Concerns

In situations where a health care provider has differing opinions such that he/she is unable to provide
care in accordance with the patient's convictions, he/she shall seek assistance from his/her immediate supervisor.

7. **Patient Experiencing Personal Conflict/Program Dis-enrollment**

   a. If a patient expresses that he/she is experiencing conflict with their own prior expressed convictions, ask Social Services and the TFMP Director to visit the patient.

   b. In any situation where a transfusion free patient desires transfusion, the physician/surgeon must obtain the patient’s informed consent and will obtain the patient's signed consent for blood/blood product transfusion. This consent may be obtained using the “Authorization for and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures.” The Blood Bank will request a copy of the consent to verify consent prior to releasing the blood.

8. If at any point the patient consents to receive blood or blood products, staff will place the medical record in a standard chart and remove the green armband.

9. Staff will notify Admitting, who will remove the “Bloodless Flag” from the face sheet.

10. The TFMP Director or designee will notify Pharmacy of change in program enrollment.

**REFERENCE(S)**


- Division of blood diseases and resources. The national heart, lung and blood institute (nhlbi). two Rockledge center, suite 10138, 6701 Rockledge drive, msc 7950, Bethesda, md 20892-7950. [http://www.nhlbi.nih.gov/about/dbdr].


**ATTACHMENT(S)**

- "Jehovah's Witnesses Religious & Ethical Position on Blood"

- TFMP Algorithm (Enrollment)
**Related Policies & Procedures**

- Clinical Practice Manual
  - Patient identification

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**Effective/Revision Dates for Policy # CP 3-116**

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**Keywords:** Blood, blood component, blood refusal, Jehovah’s Witness, transfusion, transfusion-free
**JEHOVAH'S WITNESSES RELIGIOUS & ETHICAL POSITION ON BLOOD**

### WITNESSES DO NOT ACCEPT
- Whole Blood
- Packed Red Blood Cells
- Plasma (FFP)
- White Blood Cells
- Platelets
- Autotransfusion of pre-deposited blood
- Any technique that involves blood storage

### WITNESSES DO ACCEPT

#### Surgical Devices
- Electrocautery
- Laser Surgery
- Argon Beam Coagulator
- Gamma Knife Radiosurgery
- Microwave Coagulating Scalpel
- Endoscope
- Arterial Embolization

#### Blood-Oxygen Monitoring Devices & Techniques
- Transcutaneous Pulse Oximeter
- Pulse Oximeter
- Pediatric ultra-micro-sampling equipment

#### Volume Expanders
- **Crystalloids:** Ringer’s Lactate, Normal and Hypertonic Saline
- **Colloids:** Gextran, Gelatin Hetastar

#### Operative & Anesthetic Techniques for Surgery
- Hypotensive Anesthesia
- Induced Hypotermia
- Mechanical occlusion of bleeding vessel

#### HEMOSTATIC AGENTS FOR BLEEDING/CLOTTING

**Topical**
- Avitene
- Gelfoam
- Oxygel
- Surgicel

**Injectable**
- Desmopressin (DDAVP)
- e-aminocaproic acid (Amicar)
- Tranexamic acid (Cyklokapron)
- Vitamin K

**Other Drugs**
- Vasopressin (Pitressin)
- Conjugated estrogens
- Aprotinin
- Vincristine (Oncovin)

#### THERAPEUTIC AGENTS & TECHNIQUES FOR ANEMIA
- Iron Dextran (Imferon)
- Folic Acid
- Vitamin B-12
- Perfluorocarbon solutions (Fluosol DA-20)
- Granulocyte-Colony Stimulating Factor (G-CSF)
- Hyperbaric Oxygen Therapy

### AREAS OF PERSONAL DECISION
- Albumin (minor blood fraction)
- Erythropoietin, thrombolytic enzymes (contains albumin)
- Immune Globulins (minor blood fractions)
- Topical Procoagulants (Tisseel, fibrin glue, thrombin)
- Plasma Protein Fractions (Cryoprecipitate)
- Recombinant Factor VIII, IX and VIIa (may contain human albumin)
- Dialysis and Heart-Lung equipment (non-blood primed)
- Intraoperative Blood Salvage (Cell Saver) where extracorporeal circulation is a closed circuit without blood storage
- Hemodilution (closed circuit)
- Plasmapheresis **(without fresh frozen plasma infusion, but does contain albumin)**
PURPOSE

1. To provide hospital approved guidelines for assessment, staging, interventions and documentation of patients with actual or potential skin breakdown and/or pressure ulcers.

2. To identify the patients at risk for pressure ulcers and/or skin breakdown.

3. To prevent development and promote healing of pressure ulcers and/or skin breakdown.

4. To educate the patient/family/care giver in prevention/treatment of pressure ulcers and/or skin breakdown.

DEFINITION

- Skin Breakdown – Alteration in skin integrity.

- A Pressure Ulcer – Any localized injury to the skin and/or underlying tissue as a result of pressure, or pressure in combination with shear and/or friction (NPUAP 2007). Pressure ulcers are usually located over bony prominences or under medical devices and are staged according to the degree of tissue damage observed.

POLICY

1. All patients will be assessed for pressure ulcer risk using the Braden scale. The Braden scale will be documented on admission and daily thereafter.

2. In addition, all patients will be assessed for skin integrity on admission and every shift thereafter. The initial assessment will create a baseline for further skin and/or wound care.

3. A comprehensive plan of care will be implemented to prevent or minimize tissue deterioration and improve tissue integrity. This systematic approach includes the nursing process: Assessment, Diagnosis, Planning, Intervention and Evaluation.

4. The Adult Skin Section in iView must be completed on admission or discovery, twice (Sunday and Wednesday) weekly thereafter and at resolution and/or discharge.

5. All pressure ulcers present on admission must be documented on the “Present on Admission” power form and signed by a physician within 24 hours of admission.

6. A rose placard will be placed outside of the door for all patients with a pressure ulcer or who identified with a Braden Score of 16 or less.
**PROCEDURE**

**NOTE:** For questions regarding staging contact wound care team personnel

1. **Nursing Assessment and Documentation**
   a. On admission to the hospital, the RN will:
      i. Complete the Present on Admission power form.
      ii. 2 RNs will provide a head to toe skin assessment simultaneously.
      iii. Primary RN will document, sign and forward POA to the physician.
      iv. If primary RN is a contract KMC RN, the secondary must be a KMC nurse.
   b. On admission, the RN will:
      i. Complete the Braden Scale in iView within 12 hours.
      ii. Assess and document patient’s skin/wound condition in iView within 12 hours.
      iii. Complete the Present on Admission power form.
   c. Daily, the RN will:
      i. Complete the Braden Scale
         (1) A score of 17 or above utilizing the Braden Scale indicates minimal potential for breakdown.
            (a) Continue to assess risk daily.
            (b) Implement Pressure Ulcer Prevention Care Plan **Level I** Interventions.
         (2) A score of 16 or less indicates risk of developing pressure ulcers.
            (a) The RN must address this risk in the Interdisciplinary Plan of Care.
            (b) Implement Pressure Ulcer Prevention Care Plan **Level II** Interventions.
            (c) The RN will assess the patient for appropriate placement on specialty beds using the Support Surfaces Guidelines. If the patient is placed on a support surface, this will be documented daily (Refer to Support Surfaces policy).
            (d) Place Rose placard outside of patients door to indicate risk for or current pressure ulcer.
      ii. Assess the patient’s skin condition each shift and document in iView.
iii. If skin breakdown or pressure ulcer is evident:

   (1) Notify physician

   (2) Complete a hospital occurrence report

   (3) Stage I and II: Place KeckCare order for Wound RN consult

   (4) Stage III, IV and Unstageable: Notify physician to place a PT Wound Evaluation and treat order

   (5) Initiate the Interdisciplinary Plan of Care, Pressure Ulcer Care Plan, and document assessment in iView.

   NOTE: Documentation completed by registry and traveler RNs will be verified by the Charge RN/or Designee.

2. Wound Assessment and Documentation

   a. Staging Guidelines

      i. **Stage I**: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

         (1) **Further Description**: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk)

      ii. **Stage II**: Partial thickness loss of dermis presenting as a shallow open ulcer with a red and pink wound bed, without slough. May also present as an intact or open /ruptured serum-filled blister.

         (1) **Further Description**: Presents as a shiny or dry shallow ulcer without slough or bruising. *This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Brising indicates suspected deep tissue injury

      iii. **Stage III**: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

         (1) **Further Description**: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

      iv. **Stage IV**: Full thickness tissue loss with exposed bone tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
Further Description: The depth of the stage IV pressure ulcer varies from anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

v. SDTI: Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood filled-bluister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further Description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered with this eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

vi. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed.

Further Description: Until enough slough and/or eschar is removed to expose the base of the wound, staging cannot be determined. Eschar on the heels serves as the bodies natural biological cover and should not be removed.

NOTE: If wound base is not visible, the wound cannot be staged.

vii. A pressure ulcer cannot be reverse-staged as it heals. For example: A Stage 3 pressure ulcer that no longer meets the definition of a Stage 3 pressure ulcer cannot be restaged or renamed a Stage 2 or Stage 1. The healing pressure ulcer is correctly described as a “healing Stage 3 pressure ulcer.”

b. Location: Indicate the Body Part

c. Other Wounds

i. Indicate what type of wound is assessed if not a pressure ulcer.

d. Dimensions of the Wound

i. Measure length with either the perpendicular or clock method (12:00-06:00 o’clock) and width (09:00-03:00 o’clock) of wound in centimeters.

e. Depth

i. Moisten a cotton swab with sterile water or normal saline to prevent fibers from being left in the wound bed.

ii. Insert the cotton swab into the deepest area of the wound until the cotton tip touches the wound base.
iii. Mark stick at the level of the wound opening.

iv. Remove cotton swab and measure the distance from the tip of the swab to the mark on the stick (cm).

f. **Presence or Absence of Undermining**

i. Determine if there is devitalized tissue under intact skin extending no deeper than below the level of the dermis.

g. **Drainage**

i. Indicate character (serous, serosanguinous, sanguinous, purulent), amount (none, scant, moderate, copious) and the presence and absence of odor when dressing is removed.

h. **Color of Wound**

i. Assess and document the color of the wound base (red, pink, yellow, tan, brown, or black). If necrotic tissue is present, indicate the percentage of wound surface involvement.

i. **Surrounding Skin** - Note if the surrounding skin is:

   i. **Intact**: normal, healthy
   
   ii. **Indurated**: hard swollen tissue at the margin
   
   iii. **Erythemic**: redness of skin surface
   
   iv. **Macerated**: softened, moist tissue with loss of color
   
   v. **Pale**: light pigmentation
   
   vi. **Dark Purple**: deep tissue injury

j. **Documentation**

i. Photograph and complete the wound assessment progress record for all areas of breakdown on:

   1. Admission
   
   2. Discovery
   
   3. Wednesday
   
   4. Sunday
   
   5. Resolution
6. Discharge
   ii. Label photo with only these items:
      (1) Medical Record #
      (2) Date Taken
      (3) Location of Wound
      (4) Measurements of Wound
      (5) DO NOT include the patient’s name on the photograph.
   iii. Place Pressure Ulcer Photograph Form under the skin care tab section of the chart.

k. Treatment Plan:
   i. Indicate treatment interventions
   ii. If antimicrobials are ordered enter name/type

3. Intervention
   a. For patients who are hemodynamically unstable and unable to tolerate turning every 2 hours initiate and document Gentle Pressure Relief Program every 2 hours.
      i. Gentle Pressure Relief Program
         (1) Gently tilt patient 30 degrees
         (2) Push mattress away from: occiput, scapulae, elbows, buttocks, sacral, coccyx
         (3) Elevate heels
   b. Prevention for foot drop or ankle contractures contact the physician for an order for a physical therapy consult for a needs assessment for multi podus boots.
      i. Order one boot and rotate boot every 2 hours from one foot to the other.
   c. Prevention of heel pressure injury or for vascular patients contact the physician for an order for a Roque boot order. Apply boots to both lower extremities.
   d. For prevention and treatment of pressure ulcers, see attached “Pressure Ulcer Prevention and Management Intervention Table” (Attachment A).
   e. Initiate and reinforce patient and family teaching. Document on “Interdisciplinary Patient/Family Education Record.” Update PRN.
f. Discharge Planning
   i. Physician to order for home health wound care or outpatient wound care as needed.
   ii. Written instructions for prescribed wound care will be sent with the patient. Utilize aid of Case Manager, Wound/Ostomy Nurse, or Wound Care PT services as needed.
   iii. A limited amount of medically appropriate products/supplies will be sent with the patient as medically necessary until the patient will be seen as an outpatient.

4. Evaluation
   a. Re-evaluate management plan daily and as changes occur. Enlist aid of interdisciplinary team.
   b. Revise the plan of care as necessary.

REFERENCES

ATTACHMENT
- Pressure Ulcer Prevention and Management Skin Care Interventional Table
<table>
<thead>
<tr>
<th>INTERVENTION CATEGORIES</th>
<th>Prevention</th>
<th>Stage I &amp; SDTI</th>
<th>Stage II</th>
<th>Stage III</th>
<th>Stage IV &amp; Unstageable</th>
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</thead>
<tbody>
<tr>
<td><strong>Photography</strong></td>
<td>-Consult wound/ostomy nurse PRN -Physical Therapy Mobility consult * PRN</td>
<td>-On admission or discovery</td>
<td>-On admission or discovery</td>
<td>-On admission or discovery</td>
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<tr>
<td></td>
<td>-Encourage ambulation or assisted turning q 2 hours -Add trapeze bar to assist with self turning PRN</td>
<td>-Significant deterioration or resolution</td>
<td>-Significant deterioration or resolution</td>
<td>-Significant deterioration or resolution</td>
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<tr>
<td></td>
<td>-HOB at 30 degrees or lowest degree of head elevation consistent with medical condition -Float heels, off bed</td>
<td>-Upon discharge from hospital</td>
<td>-Upon discharge from hospital</td>
<td>-Upon discharge from hospital</td>
<td></td>
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<tr>
<td><strong>Consultation</strong></td>
<td>-Consult wound/ostomy nurse PRN -Physical Therapy Mobility consult * PRN</td>
<td>-Consult wound/ostomy nurse -Physical Therapy Mobility consult * PRN</td>
<td>-Consult wound/ostomy nurse -Physical Therapy Wound Care Service*</td>
<td>-Consult wound/ostomy nurse -Physical Therapy Wound Care Service* -May consult Plastic Surgery*</td>
<td></td>
</tr>
<tr>
<td><strong>Turning, Activity</strong></td>
<td>-Encourage ambulation or assisted turning q 2 hours -Add trapeze bar to assist with self turning PRN</td>
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<td><strong>Nutrition</strong></td>
<td>-Nutrition consult</td>
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<td>-Nutrition consult</td>
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<tr>
<td><strong>Incontinence</strong></td>
<td>-Keep skin clean and dry -Use soft cloths -May use fecal management system* -Use moisture barrier cream -DO NOT USE WASHCLOTHS</td>
<td>-Keep skin clean and dry -Use soft cloths -Keep 1/16” layer of water repellent cream on effected areas at all times -May use fecal management system*</td>
<td>-Keep skin clean and dry -Use soft cloths -Keep 1/16” layer of water repellent cream on effected areas at all times -May use fecal management system*</td>
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<td><strong>Dressing Treatment</strong></td>
<td>-If appropriate, transparent film for protection from friction</td>
<td>-Transparent film to protect -Foam, hydrocolloid -Hydrogel if wound has little or no exudates with cover dressing, Absorbent dressing if mod-large exudate</td>
<td>-Minimum drainage: Hydrogel -Moderate/Heavy drainage: absorptive dressing- Calcium alginate, foam, hydrocolloid</td>
<td>-Minimum drainage: hydrogel -Moderate/Heavy drainage: absorptive dressing- Calcium alginate, foam, hydrocolloid</td>
<td></td>
</tr>
<tr>
<td><strong>Support Therapy</strong></td>
<td>ICU/Medical Surgical Units -Soft Care = High Risk or (Braden Scale ≤ 16) P 500 = May be used for the hemodynamically unstable patient in the ICU</td>
<td>ICU/Medical Surgical units -Soft care Mattress Overlay for ICU/Medical Surgical units -Hill-Rom “Sport” bed (ICU) -Strker (ICU Bed) -P-500 (ICU Bed)</td>
<td>ICU/Medical Surgical units -Soft care Mattress Overlay* for ICU/Medical Surgical units -Hill-Rom “Sport” ICU bed or Stryker (ICU Bed) -P-500 = ICU only</td>
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*Requires Physician Order
**Manual:** Clinical Practice  | **Policy #:** CP 3-305  
--- | ---  
**Subject:** Universal Protocol for Operative/Invasive Procedures  | **Effective Date:** 07/16/2002  
**Revised Date:** 10/27/2016  
**Authorized Approval:**  
--- | ---  
**Personnel Covered:** All Procedural Areas  |  
--- | ---  
**Page:** 1 OF 5

**Purpose**

To establish a standard procedure for identifying the correct patient, procedure and anatomical side/site prior to all operative and invasive procedures.

**Policy**

1. A pre-procedure verification process must be conducted.

2. The physician or physician designee performing the procedure in conjunction with the patient shall clearly mark the procedural side/site with YES to enhance the reliability of the process. Marking shall take place with the patient involved, awake and aware, if possible. To avoid confusion, the person performing the procedure shall state the side/site and point to it with the patient.

3. The physician or physician designee who is marking the site must be present for the entire procedure otherwise the new physician must perform a new “Universal Protocol or “Time Out”.

4. For patients under 18, the child may be allowed to identify the site; however, the parent or legal guardian must always verify the site, the physician or the physician designee shall mark the procedural side/site with their initials to enhance the reliability of the process.

5. For purposes of this policy, physician designee includes the following types of licensed independent practitioners (LIP): the attending surgeon, fellow, resident, physician’s assistant or nurse practitioner.

6. A time-out must be performed immediately prior to incision or starting the procedure.

7. This policy shall apply to the Medical Staff and Hospital personnel in any area where procedures, both operative and non-operative, are performed. This includes, but is not limited to, bedside procedures (including Central line insertion, PICC line insertion, cystoscopies, chest tube insertion etc.), OR, ICU, Interventional Radiology, Cardiac Catheterization lab, GI Lab, Bronch Lab etc. The Medical and Hospital Staff shall be responsible for implementing and ensuring compliance with this policy.

8. This policy applies to operative and invasive procedures involving right/left distinction (laterality), multiple structures, or levels. These sites include but are not limited to the following examples:

   a. Any procedure on an extremity

   b. Regional blocks

   c. Multiple structures (such as fingers and toes)

   d. Spinal procedures are verified in the OR before the incision by using special intraoperative radiographic techniques to verify exact vertebral level(s).
e. Unilateral procedures on the eyes, ears, sinuses, mouth, face or neck

f. Thoracotomies and thorascopscopies

g. Procedures involving the joints

h. Inguinal hernia repairs

i. Unilateral procedures involving the breast, ureters, kidneys, ovaries and testicles.

j. Chest tubes

k. Any procedure that relies on radiologic studies.

9. “Universal Protocol or “Time Out” process shall be conducted in the location where the procedure shall be done, shall involve the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who shall be participating in the procedure from the beginning and be performed immediately prior to incision or the start of the procedure.

10. While side/site marking for dental procedures is exempt, documentation of the operative tooth names(s) or marking of the operative tooth(teeth) on the dental radiographs or dental diagram is required.

11. The surgical site shall be marked for laparoscopic cases that involve operating on organs that have laterality (i.e., kidneys, ovaries).

12. Side/site marking is not required for the following procedures including those performed through or immediately adjacent to a natural body orifice:

   a. Single organ cases (i.e., Cesarean section, cardiac surgery)

   b. Cardiac Catheterization procedures (ONLY when catheter/instrument insertion site is not predetermined.)

   c. Mediastinoscopies

   d. Interventional radiological procedures, (i.e. angiographies Abdominal surgeries, i.e., Cholecystectomies, Exploratory laparotomies)

   e. Laparoscopies, Splenectomies, Ventral Hernia repairs

   f. Procedures on the larynx and trachea

   g. Tonsillectomies

   h. Transurethral procedures

   i. Anal and transanal procedures
j. GI endoscopies

k. Bronchoscopies

l. Procedures on the genitalia (excluding testicles)

13. Routine minor procedures such as venipuncture, peripheral IV line replacement, insertion of an NG tube, or Foley catheter insertion are not within the scope of this policy.

**PROCEDURE**

1. **Pre-operative**
   a. **Verification**
      i. For scheduled operative/invasive procedures, the proposed side/site must be clearly identified on the scheduling form. Illegible forms shall be rejected. The words “right” and “left” must be completely spelled out. Abbreviations shall not be accepted. In all cases, the terms “right” and “left” shall refer to the patient’s right and the patient’s left.

      ii. The physician or Licensed Independent Practitioner (LIP) shall discuss the operative/invasive procedure with the patient before anesthesia/moderate sedation. The patient shall verbalize agreement of the correct procedure and surgical site, and the discussion and patient verbalization shall be documented on the consent form.

      iii. All relevant documentation including the consent form, H&P, and diagnostic data shall be verified by the pre-procedural nurse/procedural team. If there are any discrepancies or uncertainties, the pre-procedural nurse/procedural team shall call the surgeon/physician for clarification prior to the start of the procedure.

      iv. Communication barriers (*sight and hearing impairments, a non-English-speaking patient, as well as the patient’s emotional status*) shall be addressed by all caregivers so that the patient is able to fully participate in preoperative discussions. Measures taken to address communication barriers shall be documented in the medical record.

2. **Pre-procedural**
   a. Before the patient enters the operating room or the procedure room, the pre-procedural nurse shall ask the patient to state their name and date of birth. For non-verbal patients, the pre-procedural nurse shall confirm the patient’s name and date of birth by matching the information on the patient wristband with the information in the patient’s medical record. In all cases, two patient identifiers shall be used. For patients under 18, the child may be allowed to identify the site; however, the parent or legal guardian must always verify the site. For purposes of this policy, physician designee includes the following types of licensed independent practitioners (LIP): the attending surgeon, fellow, resident, physician’s assistant or nurse practitioner.

   b. The physician or physician designee performing the procedure in conjunction with the patient shall clearly mark YES at the procedural side/site with their initials to enhance the reliability of the process.
Marking shall take place with the patient involved, awake and aware, if possible. To avoid confusion, the person performing the procedure shall state the side/site and point to it with the patient. If the patient is unable to verify the procedural side/site, the patient’s legal representative (parent, legal guardian, health care proxy) shall work with the person performing the procedure to identify the procedural side/site. If the patient’s legal representative is not available, then the person performing the procedure shall mark the procedural side/site. If the patient/legal representative refuses marking of the site, the site shall be reconfirmed verbally, and refusal and reconfirmation shall be documented in the medical record.

i. When anesthesia is performing a regional block, the site shall be marked by the anesthesiologist or LIP performing the block using the same method as described above.

ii. The surgeon or LIP performing the procedure is ultimately responsible for the verification process.

iii. To prevent confusion, the non-operative/procedure sites or sides are not to be marked, unless required for another aspect of care.

iv. The method of marking and type of mark shall be consistent throughout the organization.

v. The procedural site mark, as described in this policy, must be visible to the procedural team after the surgical prep and draping has been applied. In the case of spinal surgery with or without multiple levels, special intra-operative radiographic techniques are used for making the exact vertebral level(s).

vi. Immediately prior to performing the procedure the surgical/procedural team shall engage in the “Universal Protocol” and take a pre-procedural “time out”. “Time-Out” must be performed immediately prior to incision or starting the procedure. The “Time-Out” process shall be conducted in the location where the procedure shall be done and shall involve the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who shall be participating in the procedure from the beginning. The team shall cease all activity, face the operative area, and verbally verify the following by audibly saying “yes” that they agree. The following criteria is discussed:

1. Correct patient identity using 2 patient identifiers – patient name & date of birth
2. Correct side and site verification
3. Agreement on the procedure to be done
4. Correct patient position
5. Availability of correct implants and any special equipment or special requirements
6. Antibiotic administration & documentation 1 hour before incision when indicated/ordered
7. Any other pertinent information pertaining to the case/procedure.
(8) A Time-out can be performed multiple times, however the last time-out must be performed
immediately prior to incision or starting the procedure.

All components of the above process shall be completed and documented directly in the electronic
medical record or on a laminated universal protocol checklist before the start of the procedure which
shall be used to document the time-out in the electronic medical record.

Any discrepancies identified during the verification process and/or during the “Time Out” process
must be resolved prior to the start of the procedure.

**REFERENCE(S)**

- American College of Surgeons
- American Academy of Orthopaedic Surgeons Report of the Task Force on Wrong-Site Surgery
- Illinois State Medical Society; Wrong-Site Surgery
- Joint Commission Sentinel Event Alert: Issue 6 Lessons Learned: Wrong-Site Surgery
- American Society for Surgery of the Hand
- Joint Commission National Patient Safety Goals; FAQ’s
- Joint Commission National Patient Safety Goals
- Joint Commission Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person
  Surgery and Guidelines for Implementing the Universal Protocol

<table>
<thead>
<tr>
<th>Manual:</th>
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**Effective/Revision Dates for Policy # CP 3-305**

- Effective: 07/16/2002
- Revised: 06/17/2003
- 05/24/2005 Transferred to Administrative Manual from OR Manual
- 05/24/2005
- 06/24/2008 Governing Board (Transferred from Administration Manual #2-197)
- 10/27/2011 Governing Board
- 09/26/2013 Governing Board
- Revised: 10/27/2016 Governing Board
- 00/00/0000

Keywords: Right side, verification, time out, wrong site
# Transmission-Based Isolation Precautions Quick Guide

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<tr>
<th>Airborne</th>
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<td>N-95 Mask Required</td>
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<td>Regular Mask Required</td>
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<td><strong>Tuberculosis (TB)</strong>&lt;br&gt;(Pulmonary/Laryngeal confirmed or suspected)&lt;br&gt;<strong>To rule out TB:</strong> 3 sputums (no other source allowed) sent for AFB on different days, preferably in the morning, with an MTB PCR on the first specimen.</td>
<td>VRE infection (In any site)&lt;br&gt;[X1 yr. from last (+) result]&lt;br&gt;<strong>MDROs</strong>&lt;br&gt;(Pseudomonas MDR, Acinetobacter MDR)&lt;br&gt;ESBLs&lt;br&gt;(Klebsiella, E. coli, Serratia)&lt;br&gt;Carbapenemase producers (E. coli CRE, Klebsiella pneumoniae KPC, Enterobacter CRE)&lt;br&gt;[X1 yr. from last (+) result]</td>
<td><strong>C. difficile</strong>&lt;br&gt;[Keep in isolation X1 yr. from last (+) result]&lt;br&gt;Preemptive isolation for diarrhea of unknown cause or until (-) C. difficile result.</td>
<td><strong>Suspected or Known Neisseria meningitidis (meningitis)</strong>&lt;br&gt;Seasonal Influenza Seasonal &amp; H1N1, H5N1, H7N9&lt;br&gt;Mycoplasma pneumonia&lt;br&gt;Viral Hemorrhagic Fever&lt;br&gt;Mumps&lt;br&gt;Pertussis (Whooping Cough)&lt;br&gt;Group A Streptococcal Pneumonia&lt;br&gt;Meningococcal Pneumonia&lt;br&gt;Salmonella (with GI symptoms)&lt;br&gt;Rubella (German Measles)&lt;br&gt;Smallpox (Variola)&lt;br&gt;Scabies&lt;br&gt;Shigellosis&lt;br&gt;Any undiagnosed rash until physician has diagnosed as noninfectious</td>
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<td><strong>Measles (Rubeola)</strong></td>
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<td>For This Patient Use Soap And Water to Wash Your Hands</td>
<td></td>
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<tr>
<td>Disseminated Herpes Zoster (Shingles) And&lt;br&gt;Immunocompromised persons with localized Herpes Zoster who have not been ruled out for dissemination</td>
<td>RSV (Respiratory Syncytial Virus)</td>
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<td>Campylobacter</td>
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<td>Hepatitis A (Stool incontinent patients)</td>
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<td>Herpes Simplex (Mucocutaneous--until lesions dry &amp; crusted)</td>
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<td>Lice</td>
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<td>Chicken Pox</td>
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<td>Burkholderia cepacia (in CF patients)</td>
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*Please follow the chart above for recommended isolation guidelines. If you have any questions, please contact the Hospital Epidemiology & Infection Prevention Department at extension 29844. For more information see Policy & Procedure IC-3002 Isolation Precautions Protocols: Transmission Based Precautions on the Intranet.*

Revised: 01/2016
# Transmission-Based Isolation Precautions Quick Guide

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**Tuberculosis (TB)** (Pulmonary/Laryngeal confirmed or suspected)

To rule out TB: 3 sputums (no other source allowed) sent for AFB on different days, preferably in the morning, with an MTB PCR on the first specimen.

- VRE infection (In any site) [X1 yr. from last (+) result]
- MDROs (Pseudomonas MDR, Acinetobacter MDR)
- ESBLs (Klebsiella, E. coli, Serratia)
- Carbapenemase producers (E. coli CRE, Klebsiella pneumonia KPC, Enterobacter CRE) [X1 yr. from last (+) result]

**C. difficile** [Keep in isolation X1 yr. from last (+) result]

Preemptive isolation for diarrhea of unknown cause or until (-) C. difficile result.

**Suspected or Known Neisseria meningitidis (meningitis)**

**Seasonal Influenza Seasonal & H1N1, H5N1, H7N9**

**Mycoplasma pneumonia**

**Viral Hemorrhagic Fever**

**Mumps**

**Pertussis (Whooping Cough)**

**Group A Streptococcal Pneumonia**

**Meningococcal Pneumonia**

**Rubella (German Measles)**

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**Disseminated Herpes Zoster (Shingles)**

- RSV (Respiratory Syncytial Virus)
- Campylobacter
- Hepatitis A (Stool incontinent patients)
- Herpes Simplex (Mucocutaneous--until lesions dry & crusted)
- Lice

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**Scabies**

**Shigella**

**Any undiagnosed rash until physician has diagnosed as noninfectious**

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Revised 01/2016
USC NORRIS CANCER HOSPITAL
KECK HOSPITAL OF USC
OPERATING POLICIES

PURPOSE

1. To establish a controlled smoke-free environment. The policy is being implemented in recognition of the health, safety, and comfort benefits of a smoke-free environment, and in recognition of the Hospitals’ specific responsibility to establish and maintain an optimally healthy, safe environment for its patients, staff, and visitors.

2. The Centers for Disease Control and Prevention Office on Smoking and Health recognizes that secondhand smoke causes cancer, heart disease, and lung diseases; that cigarette smoking is the leading preventable cause of death; and that smoke-free policies are shown to improve air quality, improve health, receive public support, reduce secondhand smoke exposure, and reduce smoking.

3. Effective measures to provide protection from exposure to tobacco smoke, as envisioned by Article 8 of the World Health Organization Framework Convention, require the total elimination of smoking and tobacco smoke in a particular space or environment in order to create a 100% smoke-free environment. There is no safe level of exposure to tobacco smoke, and notions such as a threshold value for toxicity from second-hand smoke should be rejected, as they are contradicted by scientific evidence.

POLICY

It is the policy of the facilities to provide a safe, healthy, and tobacco-free environment for patients, staff, and visitors. Smoking shall not be permitted anywhere within the Keck Medical Center facilities and/or grounds.

DEFINITION

“Smoking” includes the smoke of pipe, cigar, cigarette, operating electronic cigarette or any other like substance, lighting such substance, and/or carrying a burning pipe, cigar, cigarette, or like substance of any kind.

PROCEDURE

1. All hospital inpatients, outpatients, staff, and visitors are to observe the smoke-free policy and supporting regulations of the facilities.

2. Smoking and the use of all tobacco products and/or electronic cigarettes is prohibited in all indoor and outdoor spaces operated by the Hospitals, including but not limited to buildings, grounds, ramps, plazas, and vehicles in parking lots and structures (see attached map for smoke-free environment boundaries).

3. Enforcement of the policy will be as follows:

   a. Administration and senior management, including but not limited to patients, department directors, supervisors, and managers, are expected to communicate and reinforce strict adherence to this policy.
b. Non-USC personnel are expected to comply with this policy while within the “smoke-free” environment as defined by this policy. This includes but is not limited to visitors, students, volunteers, contractors, and vendors.

c. Employees who choose to use tobacco and/or electronic cigarettes must take personal responsibility to adhere to this policy. Failure to comply will result in disciplinary action.

4. The sale of tobacco products and/or electronic cigarettes is strictly prohibited on the premises of the facilities.

5. Patients will be discouraged from smoking by appropriate healthcare professionals and provided education on the negative health effects of smoking.

6. Alternatives to smoking such as Nicotine Replacement Therapy or other means will be provided to patients with a physician’s order.

7. Resources to support smoking cessation for employees can be requested through Employee Health.

ATTACHMENT

- Geographic map of “Smoke-free Environment” enforcement boundaries

<table>
<thead>
<tr>
<th>Effective/Revision Dates for Policy # 1-109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective: 03/22/1991</td>
</tr>
<tr>
<td>Revised: 06/15/1995</td>
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<tr>
<td>06/20/1996</td>
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<tr>
<td>04/20/1999</td>
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<tr>
<td>06/18/2002</td>
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<tr>
<td>02/24/2004</td>
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<tr>
<td>03/16/2004</td>
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<tr>
<td>Revised: 04/29/2008 Governing Board</td>
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<tr>
<td>Revised: 06/24/2010 Governing Board</td>
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<tr>
<td>Revised: 06/25/2013 Policy Committee</td>
</tr>
<tr>
<td>Revised: 03/11/2014 Policy Committee</td>
</tr>
<tr>
<td>Keywords: Smoke, smoke-free, safety, environment</td>
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</tbody>
</table>
Geographic map of “Smoke-free Environment” enforcement boundaries
## Vascular Access Device Overview

<table>
<thead>
<tr>
<th>Type of Catheter/Policy</th>
<th>Flush-Capped Ports</th>
<th>Dressing Change</th>
<th>*Cap Change</th>
<th>Blood Draw</th>
<th>Line Insertion/Removal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long-term Central Venous Catheters</strong>&lt;br&gt;(Groshong, Portacath, Hickman, Cook and Broviac)&lt;br&gt;Policy #: NA 10.139.3 Policy was deleted</td>
<td>Open-ended (Hickman, Cook, Broviac): Heparin 250 units every 24 hours and after each use.&lt;br&gt;Closed-ended (Groshong): 5 mL NS every 7 days and 10 mL after blood draw</td>
<td>Mask required.&lt;br&gt;Use Sterile Central Dressing Kit with chlorhexidine sponge and chlorhexidine gluconate disc (unless contraindicated)&lt;br&gt;TOD + biopatch: every 7 days.&lt;br&gt;Gauze + tape: every 24o&lt;br&gt;Gauze + TOD: every 24o</td>
<td>Mask required&lt;br&gt;Every 7 days and after blood cultures or when visibly soiled</td>
<td>Capped: Swab*. Withdraw/discard 10mL blood. Swab*, withdraw specimen, Swab*, flush with 10mL NS.&lt;br&gt;Cont. infusion: Hold infusion; swab* withdraw/discard 10mL blood. Swab* withdraw specimen. Flush - 10mL NS and resume infusion.&lt;br&gt;Draw blood cultures from periph site unless otherwise ordered by MD. Swab* and remove cap, swab* hub and draw sample-CHANGE cap, Flush</td>
<td>Surgically placed /removed by MD.&lt;br&gt;Signed consent required</td>
<td>Infusion pump must be used on all central line infusions&lt;br&gt;Observe site every 2o&lt;br&gt;Clamp lumens when not in use</td>
</tr>
<tr>
<td><strong>Implanted Vascular Access Device: Portacath (Huber Needle)</strong>&lt;br&gt;Policy #: NA 10.136 Policy was deleted</td>
<td>Always use &gt; 3ml syringe to prevent damage.&lt;br&gt;Heparin dosing per MD order.&lt;br&gt;Flush c 10 mL NS between meds/infusions&lt;br&gt;MD order to administer meds, fluids or to draw blood</td>
<td>Mask required.&lt;br&gt;Use Sterile Central Dressing Kit with chlorhexidine sponge and chlorhexidine gluconate disc (unless contraindicated)&lt;br&gt;TOD change every 7 days</td>
<td>Mask required&lt;br&gt;Every 7 days (and after blood cultures or when soiled)</td>
<td>Requires MD order to withdraw any specimens&lt;br&gt;Access system &amp; attach ≥10mL syringe with 5mL NS to extension tubing. Flush, then withdraw &amp; discard 5mL blood. Obtain specimen. Flush c 20mL NS.&lt;br&gt;Flush port and wait at least 5 minutes prior to drawing blood if TPN was infusing</td>
<td>Accessing: Topical anesthetic if ordered. Prime needle/extension tubing c NS Prep skin w/ 2% chlorhexidine sol’n. Aspirate blood to veny placement. Flush c 20mL NS. Clamp tubing.&lt;br&gt;Only non-coring huber needles to access. Change every 7 days&lt;br&gt;Infusion pump must be used on all central line infusions&lt;br&gt;Strict sterile technique when accessing device&lt;br&gt;Clamp lumens when not in use</td>
<td></td>
</tr>
<tr>
<td><strong>Pheresis/Dialysis Catheters</strong></td>
<td>Aspirate before any flush; Brisk 10 mL Saline flush.&lt;br&gt;Heparinized Saline Lock 5000 units + volume of 0.9 NS to equal catheter vol. (after each use)</td>
<td>Mask required&lt;br&gt;Every 72’ or after each use&lt;br&gt;Use Central Dressing Kit-sterile technique.&lt;br&gt;Label lumens with amount of Heparin</td>
<td>Mask required&lt;br&gt;Q72 hours or each use</td>
<td>Requires MD order&lt;br&gt;Withdraw Heparin flush, then withdraw and discard 5ml blood. Obtain specimen, flush with 20 mL NS. Then flush with Heparin 5000 units mixed with NS to equal catheter volume.&lt;br&gt;Place new caps and label each lumen with date, time, initials, and amount of Heparin in lumen</td>
<td>Surgically placed/removed by MD.&lt;br&gt;Signed consent and universal precautions form required pre-insertion.&lt;br&gt;Dialysis catheters not for routine use. May use in ER situation with MD order&lt;br&gt;If dialysis is not performed within 72 hours, the care of the catheter is the responsibility of the primary staff nurse.</td>
<td></td>
</tr>
<tr>
<td>Type of Catheter/Policy</td>
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<tr>
<td>Peripheral IV Infusions</td>
<td>NA</td>
<td>IV bags changed every 24° Hyperal/lipid tubing change every 24° Tubing change every 96°</td>
<td>NA</td>
<td>NA</td>
<td>RN; LVN (only with IV certification) may insert/dc peripheral IV</td>
<td>Date/Time/Initial all IV labels Place ORANGE label on all IV tubing with date and initial Observe IV site every 2°</td>
</tr>
<tr>
<td>Saline Lock</td>
<td>RN or LVN</td>
<td>IV site &amp; dressing change every 96° Or PRN Use IV Stat Lock and Transparent Occlusive Dressing (TOD)</td>
<td>Every 96°</td>
<td>NA</td>
<td>RN or LVN with IV certification may insert/dc saline lock.</td>
<td>RN or LVN may convert periph. IV to saline lock. LVNs may not administer IV piggybacks Observe IV site q 2 hrs Clamped when not in use</td>
</tr>
<tr>
<td>Central Venous Catheter – Care and MaintenanceShort Term Central Line Catheter (Single, double or triple lumen catheter)</td>
<td>NS flush with 10ml every 12 hrs and after each use. Doses are recorded in eMAR</td>
<td>Mask required. Use Sterile Central Dressing Kit with chlorhexidine sponge and chlorhexidine gluconate disc (unless contraindicated) TOD + biopatch: every 7 days Gauze + tape: every 24° Gauze + TOD: ever 24°</td>
<td>Mask required Every 7 days and after blood cultures or when visibly soiled</td>
<td>Capped; Swab*: Withdraw/discard 10mL blood. Swab*, withdraw specimen, Swab*, flush with 10mL NS. Cont. infusion: Hold infusion; swab* withdraw/discard 10mL blood. Swab* withdraw specimen. Flush - 10mL NS and resume infusion. Draw blood cultures from peripheral site unless otherwise ordered by MD. Swab* and remove cap, swab* hub and draw sample-CHANGE cap, Flush</td>
<td>Inserted by MDs only. Signed consent and Universal Protocol required prior insertion. CLIP tool (insertion) May be removed by RN with MD order -except femoral lines See CVC removal policy #NA-10-111B</td>
<td>Infusion pump must be used on all central line infusions. Observe site every 2° for Necessity for central line assessed daily CXR to confirm placement (except Femoral lines) Clamp when not in use</td>
</tr>
<tr>
<td>Insertion of Peripherally Inserted Central Catheters (PICC)</td>
<td>NS flush with 10ml every 12 hrs and after each use. Record doses in eMAR Do not flush against resistance, notify PICC team for instructions</td>
<td>Mask required. Use Sterile Central Dressing Kit with chlorhexidine sponge and chlorhexidine gluconate disc (unless contraindicated) Use PICC statlock-changed with each dressing change Gauze + TOD: ever 24° Biopatch + TOD every 7 days</td>
<td>Mask required Every 7 days and after blood cultures or when visibly soiled</td>
<td>Capped; Swab*: Withdraw/discard 10mL blood. Swab*, withdraw specimen, Swab*, flush with 10-20 mL NS. Cont. infusion: Hold infusion; swab* withdraw/discard 10mL blood. Swab* withdraw specimen. Swab* Flush - 10mL NS and resume infusion. Draw blood cultures from periph site unless otherwise ordered by MD. Swab* and remove cap, swab* hub and draw sample-CHANGE cap, Flush</td>
<td>Inserted by MD or PICC qualified RNs Signed consent and Universal Protocol form required. CLIP tool May be removed by an RN with MD order See CVC removal policy #NA-10-111B</td>
<td>CXR to confirm tip placement prior to initial use Infusion pump must be used on all central line infusions Observe site every Necessity for central line assessed daily Staff RN may pull back on PICC with MD order. Order must state length (in centimeters) catheter is to be pulled back Clamp when not in use</td>
</tr>
</tbody>
</table>

*Swabbing caps= alcohol scrub for 15 seconds for EACH accession
PURPOSE

This organization’s approach to restraint is one that protects the patient’s health and safety, and preserves his or her dignity, rights, and well-being. The organization is committed to prevent, reduce, and strive to eliminate the use of restraint and seclusion. It is the intent of the organization to limit the use of restraint through the development and promotion of strategies for the prevention of behaviors that have the potential to lead to the use of restraint or seclusion. Through the establishment of guidelines the organization will limit the use of restraint to those situations with appropriate and adequate clinical justification and facilitate discontinuation of restraint or seclusion as soon as possible.

This policy does not apply to the following situations:

1. Standard practices that include limitation of mobility or temporary immobilization related to medical, diagnostic, or surgical procedures and the related post procedure care processes including but not limited to:
   a. Surgical positioning
   b. Non-surgical invasive procedures (cardiac catheterization, lumbar puncture, PICC lines, bone marrow aspirations)
   c. Non-invasive procedures (imaging services, EEG, EKG)
   d. Radiation oncology
   e. Postural support to maintain patient’s position
   f. Safety devices (helmets)
   g. Forensic restraint

DEFINITIONS

A. Physical Restraint – Any manual, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely. Examples of restraints include but are not limited to: soft restraints, mittens, vest, elbow immobilizer, hard restraints, devices such as a geri-chair or side rails, when the intent is to restrict movement and prevent removal of medical devices by the patient. If the effect of using an object fits the definition of restraint for a specific patient at a specific time, then for that patient at that time, the device is a restraint.

B. Side Rails as Restraint – When all four side rails are raised in order to prevent the patient from exiting the bed, side rails are a restraint. Raising fewer than four side rails, when the bed has more than two side rails, would not necessarily immobilize or reduce the ability of a patient to move and, therefore, is not a restraint.
It is standard practice to raise the side rails when a patient is on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of the bed. The risk presented by side rail use should be weighed against the risk presented by the patient’s behavior as determined through individualized assessment. Clinical judgment guides whether or not side rails should be considered a restraint.

C. **Holding** – Holding a patient in a manner that restricts his/her movement (this would include therapeutic holds) constitutes restraint for that patient. Holding a patient can be just as restrictive and potentially dangerous as restraining methods using devices. Physically holding a patient during a forced psychotropic (or other) medication procedure is considered physical restraint.

D. **Chemical Restraint** – The inappropriate use of a sedating psychotropic drug to manage or control the patient’s freedom of movement.

E. **Standard Treatment Medication** – A medication used within the pharmaceutical parameters approved for it by the Food and Drug Administration and the manufacturer, for the indications it is manufactured for, and labeled to address, including listed dosage parameters.
   a. The use of the medication follows national practice standards established or recognized by the appropriate medical community and/or professional medical association or organization.
   b. The use of the medication to treat a specific patient’s clinical condition is based on that patient’s target symptoms, overall clinical situation, and on the physician’s or other licensed independent practitioner (LIP) knowledge of that patient’s expected and actual response to the medication.
   c. The standard use of a psychotropic medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around him or her than would be possible without the use of the medication. **Psychotherapeutic medications are to enable, not disable.** If side effects occur the physician and the patient can address to ensure tolerability to management. Psychotherapeutic medication reduces the patient’s ability to effectively or appropriately interact with the world around him or her, then the psychotherapeutic medication is not being used as a “standard treatment” for the patient’s condition.

F. **Non-behavioral restraints** – Restraint used for healing should be considered under the non-behavioral restraint requirements. Non-behavioral behavior restraints are used to support medical healing and protect the patient from harm.

G. **Violent or self-destructive behavior restraints** – Restraints used to manage violent or self destructive behaviors and are primarily to protect the patient against injury to self or others. An emergency or crisis situation exists if the patient’s behavior becomes aggressive or violent and presents an immediate and serious danger to his/her safety or that of others and the least restrictive measure that will ensure the patient’s or other’s safety is restraint or seclusion. The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the patient and staff. **NOTE:** Non physical interventions are the first choice as an intervention, unless safety demands an immediate physical response.

H. **Seclusion** – The involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This would include, for example, a staff member standing in front of
the unlocked door of a patient’s room with the intent of not allowing the patient to leave the room. Seclusion may only be used for the management of violent or self-destructive behaviors.

I. **Time Out** – The voluntary restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to regain self control. In “timeout”, the staff and patient collaboratively determine when the patient has regained self control and is able to return to the treatment milieu.

J. **Restraint Setting** – The requirements for the use of either violent or self-destructive behavior restraints are not specific to any treatment setting, but to the behavior the restraint is being used to address. The use of violent or self-destructive behavior restraint must meet the requirements whether it occurs on an acute medical and surgical unit. The intent is to refer to a behavior rather than a setting or diagnosis.

K. **Adaptive Support** – Mechanisms intended to permit a patient to achieve normative bodily functioning would not be considered a restraint. These mechanisms include orthopedic appliances, braces, helmets, safety belts, tabletop chairs or other appliances or devices used to give postural support to the patient.

L. **Non-Restraint Limitations of Mobility** – Surgical dressings or bandages, protective helmets, or other materials or devices for the purpose of healing. Mechanisms customarily employed during medical, diagnostic or surgical procedures/tests that are considered a regular part of such procedures/tests would not be considered a restraint. These mechanisms include surgical positioning, arm board during intravenous administration, radiotherapy procedures. Voluntary mechanical support devices used during anesthesia is not a considered restraint.

M. **Forensic and Correction Restrictions** – The use of restrictive devices, such as handcuffs, applied and monitored by law enforcement officials are not governed by restraint guidelines. However, restraint use related to clinical care for individuals under forensic or correction restrictions will follow these restraint guidelines. The forensic patient is the prisoner of the law enforcement officer, but the individual is the patient of the hospital; therefore, the hospital is responsible for the provision of safe and appropriate care. Refer to the Law Enforcement Custody policy.

**POLICY**

1. Each patient has the right to be free from restraints that are not medically necessary when alternative methods are sufficient to protect the patient or others from harm.

2. Patients have the right to be free from physical or mental abuse and corporal punishment.

3. Neither restraint nor seclusion shall be used for purposes such as coercion, discipline, convenience, or retaliation by staff.

4. Each patient (and/or his or her representative) has the right to participate in the development and implementation of his or her plan of care. Patients, families, and/or significant others have the right to understand the rationales for restraints and the hospital philosophy regarding restraints.

5. Restraint may only be used when clinically necessary to improve the patient’s well being and when other less restrictive measures have been found to be ineffective to protect the patient from harm.
6. A comprehensive assessment of the patient will determine that the risks associated with the use of the restraint are outweighed by the risk of not using it.

7. Predisposing risk factors to restraint/seclusion will be assessed and considered prior to use of restraint. See Attachment A.

8. A history of falling without a current clinical basis for restraint interventions is inadequate to demonstrate the need for restraints.

9. Restraint orders must be dated and timed when signed by physician, and include:
   a. reason for restraint;
   b. type of restraint used;
   c. criteria for release;
   d. and specify duration of restraint order.

10. Restraint or seclusion shall be ended at the earliest possible time, based on release criteria.

11. Restraint orders are never written on an "as needed" basis or as PRN orders or standing orders. Trial releases are not permitted as the release of the patient is considered as discontinuation of the restraint order. Therefore, to allow the patient to again be restrained using the same order equals a PRN restraint order. **NOTE:** A temporary release that occurs for the purpose of caring for a patient's needs, i.e., toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

12. If the need for restraint is based on a significant change in the patient’s condition, the Registered Nurse (RN) must immediately notify the physician or LIP.

13. The application or initiation of seclusion or restraint respects the patient as an individual. The decision to apply restraints is based on identified individual patient needs. Consideration is given to the impact on the individual’s rights, safety, dignity and well being, which must be preserved during use of seclusion or restraint.

14. Restraint procedures are performed by competent staff following established guidelines, in accordance with safe and appropriate restraining techniques.

15. Use of restraint or seclusion may never act as a barrier to the provision of safe and appropriate care, treatments, and other interventions to meet the needs of the patient. The patient must be able to continue his/her care and participate in care processes.

16. Each patient has the right to personal privacy, modesty, comfort and respect, which includes at a minimum, that patients have privacy during personal hygiene activities (e.g., toileting, bathing, dressing) and during medical/nursing treatments. A patient's right to privacy may be limited in situations where a person must be continuously observed, such as when restrained or in seclusion when immediate and serious risk to harm self or others exists.
17. Physicians and LIPs who are credentialed to order restraints will receive training on the contents of this policy and the special considerations associated with restraints and vulnerable populations.

18. Documentation

   a. All actions taken regarding restraint and/or seclusion must be documented in the patient's medical record.

   b. Documentation in the medical record will indicate a clear progression in how techniques are implemented with less restrictive interventions attempted or considered prior to the introduction of more restrictive measures.

      i. Patient assessment prior to the implementation of restraints.

      ii. Rationale for the use of restraint or seclusion.

      iii. Behavior that met criteria for implementing or discontinuing the use of restraint is clearly documented.

      iv. Evidence that alternative least restrictive methods have failed or the patient's behavior clearly indicates alternative methods would not provide for the safety of the patient, other or staff.

      v. Type of intervention used, including assurance that method of restraint chosen is the least restrictive device according to individual needs.

      vi. Patient assessment before, during and after restrain or seclusion episode.

19. Behavioral Restraints will be located in the Nursing Supervisors Office.

**Non-behavioral Restraints**

20. Restraint is initiated only upon the order of a physician or other LIP.

21. The order is time-limited not to exceed:

   a. 24 hours for patients 18 and older.

   b. 8 hours for patient under the age of 17.

22. In emergent situations, and when a physician or LIP is not readily available, a RN competent in restraint usage may initiate restraint use based on a comprehensive assessment including physical assessment to identify medical problems that may be causing a change in the patient's behavior. An order will be obtained within one hour of application.

23. If restraint continues to be clinically justified, continued use of restraint beyond the first 24-hours must be authorized by the physician or other LIP. Restraint orders must be renewed on a daily basis not to exceed:
a. 24 hours patients 18 and older. A face-to-face physical examination by the physician at least every 24 hours determines the clinical justification for the continued use of restraints.

b. 8 hours for patients 17 and younger. A face-to-face physical examination by the physician at least every 8 hours determines the clinical justification for the continued use of restraints

24. An RN who is trained and competent assesses the patient at the initiation of restraint and at least every two hours. Every two hours this assessment includes, as appropriate to the clinical needs of the patient and the type of restraint or seclusion, the following:

a. Level of consciousness and behavior
b. Vital signs
c. Skin integrity
d. Nutrition/Hydration
e. Range of motion in the extremities
f. Hygiene and elimination
g. Safe environment
h. Restraint device

25. An LVN who is trained and competent can provide to the following needs of the patient:

a. Vital signs
b. Nutrition/Hydration
c. Range of motion in the extremities
d. Hygiene and elimination
e. Reapplication of restraints

**Seclusion or Violent or Self-destructive Behavior Restraint**

26. The maximum length of time restraint or seclusion may be utilized

(1) 4 hours for adults 18 years or older

(2) 2 hours for children and adolescents ages 9 to 17

24. In an emergency situation, the hospital authorizes a RN trained in the use of seclusion/management of violent or self-destructive-behaviors to initiate the seclusion/restraint. As soon as possible after the initiation of restraint or seclusion, an order must be secured from a physician or LIP.
25. A physician, LIP, or a RN who has been trained in accordance with hospital policy, must see and evaluate the patient in-person within one (1) hour of the initiation of seclusion or violent restraints. A telephone call is not adequate. If the patient is released from seclusion or restraint in less than one hour, the face-to-face assessment must still be performed within the one hour time frame.

If the face to face evaluation is conducted by a trained RN, a consult with the attending physician or other LIP who is responsible for the care of the patient will be conducted as soon as possible after the one hour evaluation.

If the LIP did not perform the evaluation in the first hour, a face to face evaluation must be performed within four hours. If the patient is no longer in restraint or seclusion when an original verbal order expires, the LIP will evaluate the patient in person within 24 hours of the initiation of restraint or seclusion.

30. If the seclusion or restraint is ordered by a physician other than the attending physician, that physician should consult with the attending physician as soon as possible. This will allow the attending physician to impart any information from the patient’s history that may impact the seclusion or restraint episode (i.e., the patient having a history of being physically abused where seclusion or restraint may actually escalate their behavior).

31. After the original order expires, the physician or LIP is encouraged to perform a face-to-face reassessment of the patient. However, when the order is about to expire, the RN can telephone the physician or LIP, report the results of his/her most recent assessment (i.e. that the patient is still in crisis), and request that the original order be renewed for another period of time (not to exceed the established time limits). The original order may only be renewed in accordance with these limits for up to a total of 8 hours for ages 18 and over and 4 hours for patient ages of seventeen and under.

32. A patient in restraint or seclusion is monitored through continuous (1:1), uninterrupted in-person observation by an assigned staff member who is competent and trained to do so. RNs, LVNs, or Nursing Assistants are approved by the hospital to perform uninterrupted observation of the patient in restraint/seclusion. After the first hour, a patient in seclusion (without restraint) may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient’s condition or wishes. If monitors are used, there must be a staff member assigned to constantly view the video monitors with the audio engaged.

33. If a patient is in a physical hold, a second staff member must be assigned to observe the patient.

34. An RN who is trained and competent assesses the patient at the initiation of restraint or seclusion and every 15 minutes thereafter for readiness for discontinuation. Every two hours this assessment includes, as appropriate to the clinical needs of the patient and the type of restraint or seclusion, the following:

   a. Level of consciousness and behavior
   b. Vital signs
   c. Skin integrity
   d. Nutrition/Hydration
e. Range of motion in the extremities
f. Hygiene and elimination
g. Safe environment
h. Restraint device

35. The patient and staff must participate in a debriefing about the violent or self-destructive behavior
restraint or seclusion episode as soon as possible and appropriate, but no longer than 24 hours after the
episode. The patient and, if the patient has consented, the patient’s family participate with staff members
who were involved in the episode and who are available in the debriefing about each episode of restraint
or seclusion. The debriefing is used to do the following:

a. Identify what led to the incident and what could have been handled differently
b. Ascertain that the patient’s physical well-being, psychological comfort, and right to privacy were
   addressed
c. Counsel the patient for any psychological trauma that may have resulted from the incident

Occurrence Reporting Requirements

36. In the event of patient injury or death that may be reasonably assumed to be related to restraint or
seclusion, refer to the Occurrence Reporting Requirements for Hospital Staff Members policy.

37. The hospital must report deaths associated with the use of restraint or seclusion to CMS. The following
information will be reported:

a. Each death that occurs while a patient is in restraint or seclusion
b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion

c. Each death known to the hospital that occurs within one week after restraint or seclusion where it is
   reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly
to a patient’s death. “Reasonable to assume” in this context includes, but is not limited to, deaths
related to restrictions of movement for prolonged periods of time, or deaths related to chest
compression, restriction of breathing or asphyxiation.

38. Each death meeting these criteria must be reported to CMS by telephone no later than the close of
business the next business day following knowledge of the patient’s death.

39. It must be documented in the patient’s medical record the date and time the death was reported to CMS.

PROCEDURE

A. Staff Responsibilities

1. Registered Nurse (RN)
a. Pre-Restraint Assessment
   (1) Identify potentially harmful behavior
   (2) History of behavior
   (3) Current behavior
   (4) Physical and cognitive status
   (5) Circumstances that led to consideration of restraint or seclusion use
   (6) Current risk factors associated with observed behavior
   (7) Risk of restraint use versus benefits of the restraint to the patient
   (8) Consideration of less restrictive alternatives tried and/or failed in the past, including failure of non-physical interventions (ineffective methods).

b. Receiving orders from LIP

c. Restraint initiation based on assessment of the patient if LIP is unavailable
   (1) During restraint use provide assessment, monitoring and reassessment

d. Notification of physician immediately when restraint use is initiated and with any significant change inpatient condition

e. Consultation with LIP about the patient’s physical and psychological condition

f. Development of Plan of Care

g. Discontinue use of restraints based on assessment of the patient

h. Post-Restraint Assessment
   (1) Assess patient immediately after the application of restraint to ensure safety and comfort.
   (2) Assess patient immediately after removal or discontinuation of restraint to ensure safety and well-being.

2. Licensed Vocational (LVN)
   a. Receiving orders from LIP
   b. Care and safety of the patient
   c. Patient monitoring

3. Nursing Assistants, Respiratory Care Practitioner, Physical Therapist, Occupational Therapist, Radiology Staff, Transporters
   a. Maintain the restrained patient’s safety during treatment and/or transport
   b. Patient monitoring
B. Violent or self-destructive behavior Restraints

1. Apply restraints, if indicated, according to manufacturer’s instructions.

2. Document the physician’s order for restraint on the Physician’s Order Sheet for Restraint or Seclusion following the guidelines.

3. Once the patient is under control and safe, begin documentation on the Violent or self-destructive behavior Restraint and Seclusion Flowsheet.

4. As early as feasible in the restraint or seclusion process, make the patient aware of the rationale for the intervention and the behavioral criteria for its discontinuation.

5. RN assessments are documented on the Violent or self-destructive behavior Restraint and Seclusion Flowsheet following the Observation and Monitoring guidelines.

6. Once the patient meets the criteria for release as documented in the physician’s order, the restraint or seclusion is discontinued. The decision to discontinue the intervention must include a determination that the patient’s behavior is no longer a threat to himself/herself or others.

7. Modify the patient’s plan of care to reflect seclusion or restraint implementation.

8. Document in the patient’s medical record any injuries that occur during the restraint or seclusion episode, as well as the treatment provided for those injuries.

9. The physician, LIP, or RN should:
   a. Assess the patient’s physical and psychological condition to identify any medical problems that could be causing behavioral changes
   b. Assess whether the restraint is still needed
   c. Assess the cause of the incident
   d. Assess if the restraint was appropriate to address the behavior
   e. Work with the staff on ways to help the patient regain control
   f. Revise the care plan as necessary
   g. Document his/her assessment of and plan of care for the patient

C. Documentation

1. Each episode of restraint use shall be documented in the patient’s medical record, and shall include but not be limited to:
   a. Assessment of the patient’s needs
   b. Orders for use of restraints, including least restrictive intervention, time limit, clinical justification, and type of restraint to be used.
   c. Results of patient monitoring will occur at regular intervals according to the individual’s assessed needs but not to exceed 2 hours between intervals.
d. Type of restraint and safe and appropriate techniques and placement according to facility policy and equipment guidelines.

2. Assessment and reassessment, including:
   
   a. Significant changes in the patient’s condition
   b. Patient’s response to restraint

3. Discontinuation of restraint at earliest possible time.

4. Based on the determination that the medical need for restraint is no longer present or that the patient’s needs can be met with less restrictive methods.

5. Use of restraints must be addressed in the patient’s plan of care.

6. The plan of care will not be compromised by the use of restraints and shall include provision of:
   
   a. Nutritional needs
   b. Hydration needs
   c. Elimination needs
   d. Hygiene needs
   e. Range of motion
   f. Patient safety and comfort
   g. Discuss restraint with patient and family around the time of use.

D. Monitoring and Reassessment

1. Individual patient need and health status is used to establish the frequency, nature, and extent of monitoring that is required by the patient in restraints.

2. Monitoring is accomplished by observation, direct face-to-face interaction with the patient or related direct examination of the patient by trained and competent staff.

3. Appropriate interval for re-assessment is based on the patient needs, condition, and type of restraint use.

4. Monitoring determines the following:
   
   a. Patient’s physical and emotional well-being
   b. Maintenance of patient’s rights, dignity, and safety
   c. Appropriateness of use of less restrictive methods and whether less restrictive methods are possible
   d. Changes in the patient’s behavior or clinical condition needed to initiate the removal of restraints
   e. Appropriateness of discontinuance of restraint
   f. Safety of restraint application, removal or re-application
5. Assessment and Reassessment must include, but are not limited to:

   a. Vital signs
   b. Respiration
   c. Circulation (including vascular checks such as capillary refill, temperature, and color of skin)
   d. Sensation
   e. Pain
   f. Hydration needs
   g. Level of distress and agitation
   h. Behavior
   i. Level of consciousness
   j. Cognitive functioning
   k. Skin condition and integrity
   l. Nutritional needs
   m. Exercise and range of motion
   n. Elimination needs
   o. Patient safety and comfort
   p. Other criteria based on the type of intervention used and the patient's condition.

A. Performance Improvement

The Governing Board, Medical Staff and hospital leadership are responsible and accountable for ensuring that quality and performance improvement efforts address the priority for improved care and safety. This hospital has established a priority for performance improvement activities that focuses on the high risk area of restraint and seclusion. The hospital collects data that measure the performance of potentially high-risk processes such as restraint and seclusion.

Medical Staff Roles and Responsibilities include the continuous assessment and improvement of the quality of care and treatment. LIPs participate in measuring and assessing the use of restraint and seclusion for all patients in the hospital.

1. Non-behavioral restraints

   a. Data regarding use of restraints is collected to assist the facility in measuring and assessing restraint use to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.

2. Violent or self-destructive behavior restraint or seclusion
a. Data regarding use of violent or self-destructive behavior restraint or seclusion is collected following each episode to monitor and improve its performance of processes that involve risks. Data is used to do the following:

(1) Ascertain that restraint and seclusion are used only as emergency intervention

   (a) Identify opportunities for incrementally reducing the rate and increasing the safety of restraint and seclusion use.

   (b) Identify any need to redesign care processes.

(2) Data on all violent or self-destructive behavior restraint and seclusion episodes are collected from and classified for all settings/units/locations by the following:

   (a) Patient identifier (e.g., name, record number, account number)

   (b) Shift

   (c) Staff who initiated the process

   (d) Length of each episode

   (e) Date and time each episode was initiated

   (f) Day of the week each episode was initiated

   (g) Type of restraint used

   (h) Whether injuries were sustained by the patient or staff

   (i) Age of the patient

   (j) Gender of the patient

(3) Particular attention shall be paid to the following:

   (a) Multiple instances of behavioral restraint or seclusion experienced by a patient within a 12-hour time frame

   (b) Number of episodes per patient

   (c) Instances of restraint or seclusion that extend beyond 12 consecutive hours

   (d) Use of psychoactive medications as an alternative for or to enable discontinuation of restraint or seclusion

B. Staff Training and Competency
1. Staff who have direct patient contact will have ongoing education and training in the proper and safe use of seclusion and restraint, as well as techniques and alternatives to handle the symptoms, behaviors, and situations requiring restraints.

2. All staff who have direct patient care responsibilities and who are involved with:
   a. The application of restraint
   b. Implementation of seclusion
   c. Providing care for a patient in restraint or seclusion, and/or
   d. Assessing and monitoring the condition of the restrained or secluded patient will have initial and ongoing annual education and training in the proper and safe use of non-behavioral or violent or self-destructive behavior restraint use as well as techniques and alternatives to restraint.

3. Crisis Prevention Institute
   a. The following staff are required to complete additional training in the management of aggressive behavior.
      (1) Security Guards
      (2) Clinical Administrative Supervisors
      (3) Psychiatry Social Workers
   b. This specialized training includes but is not limited to techniques to identify staff and patient behaviors, events and environmental factors that:
      (1) May trigger circumstances that require the use of restraint or seclusion.
         (a) The use of non-physical intervention skills.
         (b) Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical, or behavioral status or condition.
         (c) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress.
         (d) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
         (e) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.
(f) This specialized training will occur within 90 days of hire and annually.

4. The employee’s HR file must contain competency validation for safely applying, monitoring, and removing restraints before the employee participates in any use of restraint or seclusion. Demonstrated competence should be done initially at orientation and annually thereafter.

REFERENCES

- 42 CFR 482.13 (f)- (7)
- www.jointcommission.org
- www.hhs.com.gov
- Hospital Conditions of Participation 482.13
- www.apna.org

ATTACHMENT

- Special Considerations Associated with Vulnerable Populations

<table>
<thead>
<tr>
<th>AACN’s Evidence-leveling System</th>
<th>Effective/Revision Dates for Policy # CP 3-103</th>
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<tr>
<td>Level A</td>
<td>Meta-analysis of multiple controlled studies or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention or treatment</td>
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<tr>
<td>Level B</td>
<td>Well designed controlled studies, both randomized and nonrandomized, with results that consistently support a specific action, intervention, or treatment</td>
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<tr>
<td>Level C</td>
<td>Quality studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
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<td>04/29/2008 Governing Board</td>
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<tr>
<td>Level D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
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<td>07/17/2012 Policy Committee</td>
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<td>Level E</td>
<td>Theory-based evidence from expert opinion or multiple case reports</td>
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<td>Level M</td>
<td>Manufactures’ recommendations only</td>
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<td>Keywords: Patient restraint, seclusion</td>
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Attachment A
Special Considerations Associated with Vulnerable Populations

1. There are risks involved in any physical intervention. Therefore, the risks should always be considered when the danger presented by the patient’s behavior outweighs the risks of physical intervention.

2. The initial assessment of each patient upon admission assists in obtaining information about the patient that could help minimize the use of restraint or seclusion as well as reduce the inherent risk to the physical safety and psychological well-being of the patient.

3. Patients with pre-disposing risk factors include, but are not limited to, patients with the following:
   a. Pregnancy
   b. Asthma
   c. Smoker
   d. Head or spinal injury
   e. History of fracture
   f. History of surgery
   g. Deformity
   h. Seizure disorder
   i. Obesity
   j. Geriatric
   k. Children
   l. Abuse – physical, emotional, sexual, rape

4. Restraining a patient in a supine position may predispose the patient to aspiration.
   a. If the patient must be restrained in the supine position, ensure that the head is free to rotate to the side, and when possible, the head of the bed is elevated to minimize the risk of aspiration.
   b. Have suction equipment accessible and ready for immediate use.

5. Restraining a patient in the prone position may predispose the patient to suffocation.
   a. If the patient must be restrained in the prone position, ensure that the airway is unobstructed at all times.

6. Equipment related factors may increase the risk of injury to patient:
   a. Use of split side-rails without side-rail protectors
   b. Incorrect application of a restraining device
   c. Monitor or alarm not working or not being used when appropriate
   d. Incorrect size of equipment

7. Risk of bed-rail entrapment is increased for patients with any of the following:
   a. Confusion or other cognitive impairment
   b. Sedation
   c. Restlessness
   d. Lack of muscle control
   e. Small physical size
8. Restraint related positional asphyxia occurs when the person being restrained is placed in a position in which he/she cannot breathe properly and is not able to take in enough oxygen. Ensure there are no loose items around the patient’s head such as bed linens, towels or any type of plastic linen protection.

9. Geriatric Patients
   a. Increased risk of strangulation in vest restraints
   b. Increased risk of bed-rail entrapment.
   c. Special consideration must be given to bowel and bladder function, skin integrity, and risk of falls.

10. Pediatric Patients
    a. Ensure correct type and size of restraint is used specific to the size, weight, and developmental age of the patient.

11. Drug Overdose
    a. At risk for asphyxia due to sedation.
    b. At risk for aspiration or strangulation due to vomiting.

12. Patients with deformities, fractures, injury or physical limitations that preclude proper application of restraining devices.
    a. Assessment will include physical variances that could impact the proper application of restraint device
    b. If the physical variances do not allow for the safe application of the restraint device, other less restrictive interventions must be implemented to ensure the safety of the patient.

13. Smokers
    a. Ensure that all smoking materials are removed from patient’s access, including access from family and friends.

14. Obesity
    a. Excessive weight increases risk of asphyxiation in either the prone or supine position.

REFERENCES

- Joint Commission Sentinel Event Alert: Preventing Restraint Deaths, Nov. 18, 1998
- Joint Commission Sentinel Event Alert: Bed rail entrapment deaths, Sept. 6, 2002
PURPOSE

To enhance patient safety and provide correct medications to the patient at all transition points within the hospital, guidelines are created for obtaining, documenting, and evaluating a complete list of the patient’s current medications and comparing that with the medication(s) the hospital provides, upon the patient’s admission to the hospital and transfer to a different level of care within or outside of the facility.

POLICY

1. All medications, Over the Counter (OTC) medication and herbal supplements will be accurately and completely evaluated and reconciled across the continuum of care and at each Ambulatory visit, if applicable.

2. The Inpatient Medication Reconciliation must be completed at the time of writing initial admission medication orders.

3. The Outpatient Medication Reconciliation must be completed during each visit when seen by a physician and/or Licensed Independent Practitioner (LIP).

4. Medication reconciliation may not be completed via telephone.

DEFINITIONS

Medication Reconciliation: process for obtaining and documenting a complete list of the patient’s current medications and comparing that list against the physician’s admission, transfer, and discharge medication orders.

PROCEDURE

INPATIENT SERVICES

INITIAL ASSESSMENT:

1. The process starts upon admission when the physician or LIP takes the medication history. This information may be obtained from:
   a. History and Physical
   b. Progress notes from current or prior medical records
   c. Patient and family interview
   d. Patient’s medication list
   e. Prescription bottles
2. It is the responsibility of the admitting physician / service to review and indicate the medications which should be continued, changed or discontinued on admission. If a medication is changed (dose, route, frequency), it must be updated within the medication history list.

3. If there are any discrepancies noted, the pharmacist will evaluate the patient’s current clinical status to determine if there is sufficient evidence that the changes made are appropriate. To assist with making this determination, the pharmacist may discuss with the Medical Team and review the following:

   a. Patient’s vital signs
   b. Patient’s clinical status
   c. Laboratory findings
   d. Progress notes
   e. Consult with the nurse

4. If the pharmacist determines that changes made to the medications are potentially inappropriate, he or she will contact the prescribing physician and make him/her aware of these differences.

TRANSFER OF PATIENT TO A DIFFERENT LEVEL OF CARE:

1. The responsibility for medication reconciliation during a patient transfer to a different level of care is that of the transferring physician. Upon transferring a patient to a different level of care, the medication orders must be reviewed. The Physician will continue or discontinue each medication the patient was receiving. The pharmacist will verify the medication orders prior to drug administration.

2. If there are any discrepancies noted, the pharmacist will assess and determine if the physician needs to be contacted for clarifications. To assist with making this determination, the pharmacist may review the following data:

   a. Patient’s vital signs
   b. Patient’s clinical status
   c. Laboratory findings
   d. Progress notes
   e. Consult with the nurse
**Discharge of Patient:**

1. Upon discharge, the discharging medical team will complete the discharge section of KeckCare. The Nurse will provide a copy of the medication list to the patient upon discharge and discuss the medication(s) with the patient to reinforce the patient’s understanding of their medication regimen. In complex cases, the Nurse may ask the Pharmacist to assist with the medication education process.

2. Physicians can access the completed medication reconciliation in the electronic medical record.

**Outpatient Services**

1. Medication reconciliation requires a review of the patient’s current medication list and the comparison of this list with newly ordered medications.

2. Medication reconciliation is required for all patients at all clinic visits when seen by a physician and/or LIP.

3. The clinical staff will obtain and/or update the patient’s current medication list at each clinic visit. The primary means for obtaining the list of current medications may include:
   
   a. Patient/caregiver/family interview
   
   b. Prescription bottles
   
   c. Patient’s medication list
   
   d. Physician office records
   
   e. Pharmacy records
   
   f. Current or prior medical records

4. Medication reconciliation for new patients includes the documentation of a complete list of medication allergies and all current medications including; prescription medications, non-prescription medications, herbals and dietary supplements. This list will contain the name, dose, route, and frequency for each medication whenever possible based on the information provided by patients or caregivers. Any new medications being prescribed by the provider will be added to the list at each visit. At each follow-up visit the patient’s medication list will be reviewed and updated in the electronic medical record system.

5. The clinical staff will record the list of medications. The LIP will review the medications and acknowledge and reconcile what the patient takes at home to the current medication list in the electronic medical record in order to identify and resolve discrepancies. Discrepancies may include omissions, duplications, incomplete or unclear information, and medication changes made since the last clinic visit. A review/updated medication list will be generated by the electronic medical record at each clinic visit.

6. During visits when a medication is to be given, the licensed independent practitioner authorizing the order or the pharmacist verifying the order must review the Medication List page in the electronic medication record prior to medication administration.
7. The clinical staff will provide a copy of the medication reconciliation form to the patient and discuss the list of medications with the patient to reinforce the patient’s understanding of their medication regimen. If needed, the clinical staff may ask the pharmacist or provider to assist with the medication education process. If the patient refuses a copy of the medication reconciliation form, the clinical staff will document patient refusal in the patient electronic medical record.

REFERENCES

- Joint Commission NPSG 03.06.01
Pain Assessment and Management

PURPOSE

1. Provide guidelines for the effective control and management of acute and chronic pain for all patients using an individualized interdisciplinary multi-faceted approach to pain management.

2. Enhance patient comfort and satisfaction.

POLICY

1. Pain management will be tailored to the individual’s cognitive ability, cultural background, growth and developmental level.

2. Self report will be used as the most reliable indicator of the presence and intensity of pain (See Appendix A, Standardized Pain Assessment tools).

3. Health Care Provider will use a validated tool for the patient who is unable to provide self-report (See Appendix B).

4. Screening for pain will be done by health care providers as follows:
   a. on admission at initial assessment
   b. with unit routine vital signs and/or as needed

5. It is the responsibility of the primary physician team and of all health care providers to facilitate the pain relieving process and expedite interventions, within their scope of practice, to keep patients comfortable by reporting complaints of pain to the nursing staff and/or physician.
   a. before and within 15-60 minutes after an intervention is performed.

6. RN assessing the patient for the presence of pain will initiate and develop the Interdisciplinary Plan of Care, using the patient’s, family and significant other input.

7. The Interdisciplinary Plan of Care will be reviewed and/or revised daily, when pain is present.

8. Licensed health care providers will educate patients, family and significant others as appropriate regarding pain management plan and treatment options.

9. Health care providers will include the pain management plan as part of the discharge planning process.

10. Placebos will not be used in management of pain, except in research and controlled studies and only with informed patient consent.
DEFINITIONS

1. Pain

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

2. Acute Pain

Acute pain follows injury to the body and generally disappears when the body heals. It generally demonstrates a pattern of onset, which is usually associated with actual or potential tissue damage. It may be accompanied by autonomic activity. Acute pain is often associated with trauma or surgical treatment.

3. Chronic Pain

a. Chronic pain is characterized by prolonged episodes of pain beyond the normal healing period and adversely affects the patient’s function or well being. Chronic pain is usually not accompanied by signs of sympathetic nervous system arousal.

b. Chronic pain may be grouped into 4 sub-types based on the following characteristics:

   i. **Recurrent Acute Pain**: The pain is episodic in nature, with intervals that are virtually pain free. Recurrent acute pain has the potential for recurrence over a lifetime or over a prolonged period of time. These are self-contained episodes of pain, which may be predicted to end, but tend to recur. Examples include migraine headaches or sickle cell pain episodes.

   ii. **Ongoing Time-Limited Pain (Chronic Acute Pain)**: This pain lasts months to years, occurring daily, but has a high probability of ending. An example is burn pain.

   iii. **Chronic Non-Malignant Pain (Chronic Benign Pain)**: This is a disabling pain, occurring daily and lasting longer than 6 months. Its intensity may range from mild to very severe. It may continue throughout the life span. Examples include peripheral neuropathy, phantom limb pain, diffuse myofascial pain, vascular disease of the limbs, and low back pain from various causes.

   iv. **Chronic Intractable Pain**: Chronic non-malignant pain or chronic benign pain that is severely disabling is termed chronic intractable pain. It also occurs daily and lasts six months or longer and may continue for the person’s lifetime. An example is any type of chronic pain that prevents participation in activities of daily living.

   v. **Neuropathic Pain**: Chronic pain caused by nerve damage. The patient may describe it as burning, tingling, numbness, or shooting pain. Examples of neuropathic pain syndromes are diabetic neuropathy, low back pain with radiation components (pain going down one or both legs), postmastectomy pain, postherpetic neuralgia, and trigeminal neuralgia.

4. Chronic Malignant Pain
Chronic malignant pain has a definable etiology, usually related to tumor occurrence or treatment. Chronic malignant pain may be acute or chronic, and continuous or intermittent in nature. Chronic malignant pain is sometimes not manifested by signs of sympathetic nervous system arousal.

5. **Physical Dependence**

Physiologic response manifested by withdrawal syndrome when opioid administered is abruptly stopped, drastically reduced or opioid antagonist (Narcan) is administered.

6. **Tolerance**

Physiologic process characterized by decreasing effects of a drug at a constant dose or need for an increased dose to achieve the same effect. Tolerance is manifested first, by a decrease in duration of pain relief for a given dose followed by the inability of the dose to provide the same amount of pain relief.

7. **Opioid Addiction (Psychological Dependence)**

Psychological dependence characterized by a compulsive need to use a substance despite the risk of harm to one self.

8. **Patient Goal for Pain Relief**

Defined by the patient, the Patient Goal for Pain Relief is the acceptable level of pain as rated on a standardized scale (Appendix A).

9. **Pain Screening** is identifying the presence and intensity of pain (Non-licensed may screen).

10. **Pain Assessment** is a comprehensive assessment of pain that includes a minimum of:
   a. Location of pain
   b. Onset/pattern
   c. Intensity: For patients who are able to self-report pain, the 0-10 Numeric Pain Intensity Scale or the Wong-Baker Faces Pain Rating Scale are the preferred pain assessment scales at the hospital. For Non-English speaking patients, instructions in multiple languages for using the numeric scale or Wong-Baker Faces are available. (Appendix C).
   d. Description/quality, as expressed by the patient
   e. Radiation
   f. Alleviating/aggravating factors
   g. Effects of pain on quality of life
h. Questions about pain relief methods that have been effective or attempted in the past including non-drug therapies.

11. Licensed health care providers include the Physician, RN, LVN, Advanced Practice Nurse, PA, Pharmacist, Case Manager, Registered Dietician, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Care Practitioners.

PROCEDURE

1. Health care providers will screen for the presence of pain on admission or with first contact with the patient, using standardized assessment tool. Screening for pain will be done by health care providers as follows:
   a. On admission at initial assessment - If pain is present on admission a comprehensive pain assessment will be completed by the RN.
   b. With unit routine vital signs - When there is a new onset of pain and/or change in the character of pain, a comprehensive pain assessment will be completed by the RN.
   c. Before and within 15-60 minutes after a pain management intervention is performed, and as needed.
      i. Pain management should be pro-active, focusing on anticipation and management of pain.
      ii. It is the responsibility of all health care providers to facilitate the pain relieving process and expedite interventions, in their scope of practice, to keep patients comfortable by reporting complaints of pain to the nursing staff and/or physician.
      iii. Pain interventions that are deemed ineffective will be addressed by contacting the primary physician team, or the pain management team (epidural pain management). As a patient advocate, the health care provider has the option of utilizing the Chain of Command, up to and including the primary attending physician, CEO and Physician Chief of Staff if necessary to achieve optimal pain management. This process will be documented on the Interdisciplinary Plan of Care, Outcome Notes, or other form as appropriate.

2. RN assessing the patient for pain will initiate and document daily on the Interdisciplinary Plan of Care, Educational Record, for the relief of pain, using the patient’s, family and significant other input. The plan will include the pain relief goal as determined by the patient if possible.

3. Licensed health care providers will initiate and document interventions to relieve pain; these could be pharmacological or non-pharmacological interventions as appropriate.

4. Reassessment and documentation of pain will be done 15-60 min after pain intervention:
   a. Intravenous (IV) - 15-30 minutes
   b. Epidural bolus - 15-30 minutes
   c. Oral pain medications - within 60 minutes
d. Non-pharmacological - within 60 minutes
   i. Relaxation - deep breathing, massage, guided imagery, hypnosis, biofeedback
   ii. Distraction - music therapy, TV/Audio, visitors, humor, walking
   iii. Promote comfort - positioning, decrease noxious stimuli, heat and cold therapy.

5. Pain interventions that are deemed ineffective will be reported, addressed and alternative measures will
   be taken and documented by licensed health care providers.

6. Health care providers will educate patients, family and significant others as appropriate regarding pain
   management plan and treatment options.

7. Age Specific Considerations
   a. Pain is defined the same regardless of developmental level. Lack of pain expression does not
      necessarily mean lack of pain. The nonverbal patient of any age should be assessed for a reason to
      be having pain.
   b. The same pain rating scale should be used consistently for the same patient.
   c. The dose and/or frequency of pain medications may need to be adjusted based on age, weight, and
      general health status. Changes in metabolism of drugs may occur with various health conditions, but
      it is difficult to predict the effect on any one patient. Medications should be titrated to effect in each
      particular patient.
   d. Older patients may not use the word pain to describe their discomfort. Initiate discussions about pain,
      and do not assume that pain will automatically be reported. Be alert for other terms including
      soreness, discomfort, hurt, ache, or pressure.
   e. For patients who are able to self report over the age of 3, use the Wong-Baker Faces Scale.

   a. Patients who are comatose physically or chemically immobilized, sedated, or disoriented are at risk
      for pain and are particularly difficult to assess.
   b. Health Care Provider will use a validated tool for the patient who is unable to provide self-report (See
      Appendix B).
   c. Family member may have greater knowledge related to the patient’s expression of pain and may
      assist with pain assessment.
   d. A condition or procedure that is likely to cause pain in a cognitively intact patient is likely to cause a
      similar amount of pain in a cognitively impaired, comatose, sedated, immobilized, or demented
      person.
e. Behavioral signs may be useful as surrogate indicators for acute pain and sometimes for persistent pain. Health Care Provider will use a validated tool for the patient who is unable to provide self-report (See Appendix B).

f. Neuromuscular blockade may prevent behaviors that are indicative of pain, but does so without providing analgesia.

g. Sedation may prevent behaviors that are indicative of pain, but usually does so without providing analgesia.

h. Assessing pain in patients who cannot give self-report and who are not able to respond to pain with behaviors, use knowledge of pathology and procedures that usually cause pain. Thus, nurses should “Assume Pain is Present.”

9. Patient/Family Education

Pain management is a part of treatment. All licensed health care providers will be responsible for the education of the patient in regard to pain and pain management as appropriate. This education will be documented on the Interdisciplinary Patient/Family Educational Record or other appropriate form. Education content may include but is not limited to:

a. Definition and cause of pain.

b. Barriers to successful pain management (fear of addiction, dependence, tolerance)

c. The importance of effective pain management.

d. Importance of good communication and not letting pain escalate out of control. It is the responsibility of the patient to notify the staff members of any increase or change in the type of pain he/she experiences.

e. Type of pain scale to be used to rate pain intensity (see Appendix A).

f. Standard interventions for condition or procedure being done.

g. Safe and effective use of pain management equipment including the potential harm for patient controlled analgesia administration by other than the patient.

h. Alternative interventions or measures if the standard interventions are ineffective.

i. Follow up care, discharge instructions.

j. Pain management issues will be addressed in the discharge planning process and appropriate referrals made for a pain management consultation and/or referral for follow up post discharge.


a. Choose an appropriate route and drug, individualized to the patient.
b. Administer the drug at appropriate intervals.

c. Titrate dose to effect or side effects.

d. Use appropriate adjuvant analgesics.

e. Be aware of conversion ratios. (See Pain Management Principles, appendix D)

f. Anticipate and manage side effects. Medications to minimize drug side effects will be ordered as appropriate, such as bowel care regimens, anti-pruritic, and anti-emetics.

g. Define and understand the concept of tolerance.

i. Consider previous dosing requirements when initiating therapy in opioid-experienced patients.

ii. Opioid-experienced patient- determine baseline pain and character, and assist patient in setting realistic pain goal, and use clinical judgment in adjusting analgesia.

h. Differentiate between physical and psychological dependence. Differentiate between nociceptive pain, and pain due to psychological affective disorders such as anxiety, depression and suffering.

i. Medications (See appendix D) Opioids

   i. Non-Opioids – non-steroidal anti-inflammatory agents, acetaminophen, Adjuvant medications – used to enhance analgesic effects and to treat specific pain syndromes

      (1) Corticosteroids: anti-inflammatory, mood elevation, anti-emetic, appetite stimulant

      (2) Anticonvulsants: neuropathic pain

      (3) Antidepressants: neuropathic pain

      (4) Benzodiazepines: muscle relaxants

j. Patient Controlled Analgesia (PCA). (See Pain Management: Continuous Intravenous and/or Patient Controlled Analgesia (PCA) Opioid Infusion Policy).

k. Spinal analgesia by epidural opioid and/or local anesthetic injected intermittently or infused continuously (See Pain Management: Epidural Analgesia Policy).

l. Intermittent or continuous local neural blockade (See Pain Management: Continuous Peripheral Nerve Block Policy).

m. Local anesthetic administration (See Pain Management: Continuous Local Anesthetic Pump Policy).

11. Discharge Planning

a. Discharge Planning will consider the following:
i. Specific drugs to be taken

ii. Frequency and route of drug administration

iii. Drug side effects and their management

iv. Potential drug interactions

v. Specific precautions to follow when taking the medication

vi. Continuity of care following discharge

vii. Travel and safety precautions

b. Discharge Documentation - The continuum of care plan for pain management after discharge will be documented on the discharge instruction sheet.

**REFERENCE(S)**

- American Pain Society. [http://www.ampainsoc.org](http://www.ampainsoc.org)


- International Association for the Study of Pain


**RELATED POLICIES AND PROCEDURES**

- Clinical Practice Manual
  - Pain Management: Continuous Intravenous and/or Patient Controlled Analgesia (PCA) Opioid Infusion
  - Pain Management: Continuous Local Anesthetic Pump
  - Pain Management: Continuous Peripheral Nerve Block
  - Pain Management: Epidural Analgesia
# Pain Assessment and Management

**Effective Date:** 09/19/2000

**Revised Date:** 09/22/2015

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**Effective/Revision Dates for Policy # CP 1-202**

- **Effective:** 09/19/2000
- **Revised:** 05/31/2002
  - 05/24/2005
  - 01/27/2009  (Governing Board (Transferred from Administration #2-170))
- **Reviewed:** 09/22/2015  (Policy Committee)
- **Key Words:** Pain assessment, pain management, pain scales, CPOT tool, Wong-Baker Faces
Appendix A

KECK HOSPITAL OF USC
USC NORRIS CANCER HOSPITAL
PAIN MANAGEMENT

Relieving your pain is important to us. Keeping pain under control helps you to recover faster with fewer problems. Although it might be unrealistic to expect an absence of post surgical discomfort most pain can be managed and reduced. Our goal is to do everything possible to control your pain.

We believe you when you tell us you are in pain or hurting. We are here to help. We also believe that each person’s pain or discomfort is different. Your self-report is the best measure of the presence and intensity of pain.

It will be easier for us to manage your pain if you can rate it. We use a “0 to 10” Pain Rating Scale to describe the intensity of pain. “0” is no pain and “10” is the worst pain you can imagine. Below are some of the scales that we use to rate your pain.

PAIN RATING SCALE

As a patient at the hospital, you can expect:
- To be told when pain is to be anticipated
- A concerned staff committed to pain prevention and management.
- Health Care professionals who will respond quickly to your reports of pain
- Doctors and nurses to work with you to find the best medications to treat your pain

You can help us to manage your pain by:
- Asking questions
- Telling us when you are in pain.
- Telling us when your pain is not adequately relieved.
- Calling us before your pain feels out of control.
- Telling us how you feel after you have taken your pain medication.
  - Asking us what kind of pain you might expect to feel.
- Asking us what things can be done to relieve your pain.
  - Making sure you understand the plan to control your pain after you leave the hospital.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial Expression</strong></td>
<td>No muscular tension observed</td>
<td>Relaxed, neutral</td>
</tr>
<tr>
<td></td>
<td>Presence of frowning, brow lowering, orbit tightening, and levator contraction</td>
<td>Tense</td>
</tr>
<tr>
<td></td>
<td>All of the above facial movement plus eyelid tightly closed</td>
<td>Grimacing</td>
</tr>
<tr>
<td><strong>Body Movements</strong></td>
<td>Does not move at all (does not necessarily mean absence of pain)</td>
<td>Absence of movements</td>
</tr>
<tr>
<td></td>
<td>Slow, cautious movements, touching or or rubbing the pain site, seeking attention through movements</td>
<td>Protection</td>
</tr>
<tr>
<td></td>
<td>Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
<td>Restlessness</td>
</tr>
<tr>
<td><strong>Muscle tension Evaluation by passive flexion and extension of upper extremities</strong></td>
<td>No resistance to passive movements</td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>Resistance to passive movements</td>
<td>Tense, rigid</td>
</tr>
<tr>
<td></td>
<td>Strong resistance to passive movements inability to complete them</td>
<td>Very tense or rigid</td>
</tr>
<tr>
<td><strong>Compliance with the ventilator (intubated patients)</strong></td>
<td>Alarms not activated, easy ventilation</td>
<td>Tolerating ventilator or movement</td>
</tr>
<tr>
<td></td>
<td>Alarms stop spontaneously</td>
<td>Coughing but tolerating</td>
</tr>
<tr>
<td></td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
<td>Fighting ventilator</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Talking in a normal tone or no sound</td>
<td>Talking in normal tone or no sound</td>
</tr>
<tr>
<td><strong>Vocalization (extubated patients)</strong></td>
<td>Sighing, moaning</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td></td>
<td>Crying out, sobbing</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td><strong>Total, Range</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This is an adult validated tool that can be used for the intubated or non-intubated, cognitively impaired patient. *

*Number obtained using a pain-behavior scale is pain-behavior score, not pain-intensity rating.*

English

Please point to the number that best describes your pain.

![0-10 pain rating scale]

No pain  Terrible pain

Chinese *

請指出那個數字反映你痛的程度

Please point to the number that best describes your pain.

![0-10 pain rating scale]

無痛  劇痛

No pain  Terrible pain

French **

S'il vous plaît, indiquez le chiffre qui décrit le mieux votre douleur.

Please point to the number that best describes your pain.

![0-10 pain rating scale]

Pas de douleur  Douleur intense

No pain  Terrible pain

---


*** Translations of 0-10 pain rating scales. Most of the translations of the pain rating scales were done by volunteers. No back and forth translation has been done, so the reader is advised that errors may occur. However, these scales have been used extensively by the facilities that submitted them.

* Pain Management Committee, St. Francis Medical Center, Honolulu, HI.
** Compiled by Josephine Matsu, RN, MS, DNP, Nursing Care Manager, Pain Management Service and members of Nursing Department, Saint Vincent’s Hospital and Medical Center, New York, NY.
Tagalog ** (spoken in the Philippines)

Ituro po ninyo ang numerong nagpapaliwanag kung gaano kasakit.

Please point to the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

Walang masakit  Napakasakit
No pain  Terrible pain

Tongan ** (spoken in Tonga, an island in the south Pacific)

I he ngaahi fika koena, faakilongai mai ai e tuonga ho falangaaki.

Please point to the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

Ikai ha felangaaki  Ikai matuuki’e langa
No pain  Terrible pain

Vietnamese

Xin chỉ số mô tả đúng nhất sự đau nhức của quý vị

Please point to the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

Không đau  Dau rất nhiều
No pain  Terrible pain

---


** FIGURE 35—cont’d Translations of 0-10 pain rating scales. Most of the translations of the pain rating scales were done by volunteers. No back and forth translation has been done, so the reader is advised that errors may occur. However, these scales have been used extensively by the facilities that submitted them.

* Pain Management Committee, St. Francis Medical Center, Honolulu, HI
** Compiled by Jacqueline Hattley, RN, MS, ONC, Nursing Care Manager, Pain Management Service, and members of Nursing Department, Saint Vincents Hospital and Medical Center, New York, NY.
German **
Bitte markieren Sie die Nummer, die Ihren Schmerz am besten beschreiben.

Please point to the number that best describes your pain.

Kein Schmerz
No pain

Unerträglicher Schmerz
Terrible pain

Greek **
Παρακαλώ, δείξτε με το δάκτυλό σας τον αριθμό που δείχνει πόσο πόνο έχετε.

Please point to the number that best describes your pain.

Δεν έχω πόνο
No pain

Έχω πολύ πόνο
Terrible pain

Hawaiian *
E koho a kuhi ‘oe i ka helu pololei ma ke ‘ano o ka ‘eha i pili ia ‘oe, ina ‘ole (0) ka ‘eha ‘ole a ‘umi (10) ka ‘eha palena ‘ole.

Please point to the number that best describes your pain.

Ka ‘eha ‘ole
No pain

Ka ‘eha palena ‘ole
Terrible pain

---

* Pain Management Committee, St. Francis Medical Center, Honolulu, HI.
** Compiled by Joanneatre Wood, RN, MS, OCN, Nursing Care Manager, Pain Management Service and members of Nursing Department, St. Vincent’s Hospital and Medical Center, New York, NY.


Continued.
Hebrew **

בקרשא ת nhiên אצ主营业 על המספר ממפיס עדنشر:
שמותא לוה כמא חק הכהב

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

כמא חק
No pain

Terrible pain

Ilocano * (spoken in the Philippines)

Paki tudo ti numero nga mangipakita ti kinasakitna.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Awak sakit
No pain

Nakasaksak suhay
Terrible pain

Italian **

Segna il numero che indica il level del dolore.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Nessun dolore
No pain

Dolore insuportable
Terrible pain

---


* Pain Management Committee, St. Francis Medical Centre, Nanshika, IL

** Compiled by Josephine Wasta, RN, MS, DNP, Nursing Care Coordinator, Pain Management Service and members of Nursing Department, Saint Vincen's Hospital and Medical Centre, New York, NY.
Japanese**:

痛みの強さの度合を0～10までの階段で示して下さい。

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>ノロ</td>
<td>全く痛みがない</td>
<td>激痛を痛</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Korean:

현재 통증의 강도를 가장 잘 나타내는 번호에 표시하십시오.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>통증이 없음</td>
<td>통증이 너무 심합니다</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pakistan**:

برائے عربی اینہ درد کی شدت بیان کی لیے نیچے کی لکھ کوئی نہیں کیا ہے۔ ایک کی طرف اپنی اولی ادا کی اشارہ کریں۔

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>کوئی درد نہیں ہے</td>
<td>شدید درد ہے</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


** Figures 35—cont’d Translations of 0-10 pain rating scales. Most of the translations of the pain rating scales were done by volunteers. No back and forth translation has been done, so the reader is advised that errors may occur. However, these scales have been used extensively by the facilities that submitted them.

* Pain Management Committee, St. Francis Medical Centre, Manhattan, HI

** Compiled by Joanneke Meule, RN, MS, DNE, Nursing Care Manager, Pain Management Service and members of Nursing Department, Saint Vincent's Hospital and Medical Centre, New York, NY
Polish **

Proszę wskazać numer, który najlepiej określa jak silny jest ten ból.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nie mam bólu</td>
<td>Straszny ból</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Russian **

Выберите число, которое указывает вашу боль по десятибалльной системе.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>нет боли</td>
<td>страшная боль</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Samoan *

Fa’amolemole ta’u mai le nume a fa’amatala ai le itu-aiga tiga o loo e lagonaina.

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Le tiga</td>
<td>Tiga tele</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Spanish **

Por favor señale al numero que mejor describe su dolor. (Mas grande el numero mayor su dolor).

Please point to the number that best describes your pain.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No tiene dolor</td>
<td>Tiene un terrible dolor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No pain</td>
<td>Terrible pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FIGURE 3.5—cont’d Translations of 0-10 pain rating scales. Most of the translations of the pain rating scales were done by volunteers. No back and forth translation has been done, so the reader is advised that errors may occur. However, these scales have been used extensively by the facilities that submitted them.

* Pain Management Committee, St. Frances Medical Center, Neosho, MO.
** Compiled by Josephine Woods, RN, MS, CMC, Nursing Care Manager, Pain Management Service and members of Nursing Department, Saint Barnabas Hospital Medical Center, New York, NY.
Appendix D

Pain Management Principles

1. Base initial choice of therapy on severity and type of pain.\(^3\)
2. Consider previous dosing requirements when initiating therapy in opioid-experienced patients.\(^3\)
   (pain medication history, review old medical records)
3. Multi-drug approach—Combine opioids with non-opioids and adjuvants.
4. Opioids should be limited to agonist drugs. See Equianalgesic Chart below. Avoid the mixed agonist-antagonist opioids (e.g. Stadol, Nubain, Talwin)\(^1\) in the opioid tolerant patients.
5. **Mepidine (Demerol)** is no longer considered drug of choice for either acute or chronic pain.\(^1\)
6. Initiate bowel regimen therapy (Docusate 200 mg BID and Bisacodyl EC 5 mg daily).\(^2\) Continue to monitor for constipation.
7. Reassess pain intensity, quality, & location every 24 hours and adjust analgesia accordingly. Help patient set realistic pain goals and use clinical judgment when adjusting analgesia.
8. Breakthrough dose — 10 to 20% of total daily dose administered.\(^2\)
9. Convert PCA to PO once patient analgesic needs are stabilized.
10. When switching between opioids use Equianalgesic Chart + dose reduction of 25–33% for new approximate dose.\(^3\) Re-evaluate and adjust analgesia accordingly.
11. Patient requesting routine use of prn pain medications consider conversion to long acting preparation. **SR, long acting meds are ordered ATC not prn.**
12. Reserve **fentanyl patch, fentora, Actiq** for persistent, moderate to **severe chronic pain requiring around-the-clock analgesia that cannot be managed by other opioids.**\(^4\)
13. **Do not** use a fentanyl patch, fentora, Actiq on patients who are opioid naive, experiencing acute pain, post-operative pain, mild pain, or intermittent pain.\(^4\)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>DOSAGE FORMS/STRENGTH</th>
<th>APPROXIMATE EQUIVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IM/SC/IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ORAL</td>
</tr>
<tr>
<td>Morphine</td>
<td>Immediate Release (IR) Tablets, Short acting</td>
<td>10 mg</td>
</tr>
<tr>
<td></td>
<td>MSIR — 15, 30 mg</td>
<td>70 mg</td>
</tr>
<tr>
<td></td>
<td>Sustained Release (SR) Tablets, Long acting</td>
<td>15 mg</td>
</tr>
<tr>
<td></td>
<td>MS Cont — 15, 30, 60, 100, 200 mg</td>
<td>70 mg</td>
</tr>
<tr>
<td></td>
<td>Oramorph SR — 15, 30, 100 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td></td>
<td>Avinza — 30, 60, 90, 120 mg</td>
<td>70 mg</td>
</tr>
<tr>
<td></td>
<td>Kadian — 20, 30, 50, 60, 100 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td></td>
<td>Oral Liquid</td>
<td>2 mg/ml, 4 mg/ml</td>
</tr>
<tr>
<td></td>
<td>MSIR Oral Solution — 2 mg/ml</td>
<td>70 mg</td>
</tr>
<tr>
<td></td>
<td>Roxanol Concentrate — 20 mg/ml</td>
<td>30 mg</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>Tablets</td>
<td>1.5 mg</td>
</tr>
<tr>
<td></td>
<td>Dilaudid — 2, 4, 8 mg</td>
<td>7.5 mg</td>
</tr>
<tr>
<td></td>
<td>Liquid</td>
<td>1 mg/ml</td>
</tr>
<tr>
<td></td>
<td>Dilaudid — 1 mg/ml</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Immediate Release (IR) Tablets, Short acting</td>
<td>20 – 30 mg</td>
</tr>
<tr>
<td></td>
<td>Oxy IR — 5 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roxicodone — 5 mg, 15 mg, 30 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxycodone/Acetaminophen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percocet — 5/325, 7.5/325, 10/325 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sustained Release (SR) Tablets, Long acting</td>
<td>20 – 30 mg</td>
</tr>
<tr>
<td></td>
<td>Oxycontin — 10, 20, 40, 80 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Liquid</td>
<td>20 mg/ml</td>
</tr>
<tr>
<td></td>
<td>Roxicodone — 1 mg/ml</td>
<td></td>
</tr>
<tr>
<td>Fentanyl Transdermal</td>
<td><strong>Skin Patch</strong></td>
<td>100 mcg patch</td>
</tr>
<tr>
<td></td>
<td>Duragesic — 12.5, 25, 50, 75, 100 mcg/hr</td>
<td>every 2–3 days</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong></td>
<td>86 mg IV</td>
</tr>
<tr>
<td></td>
<td>Adjust analgesia every 3 days</td>
<td>Morphine every</td>
</tr>
<tr>
<td></td>
<td>12 hrs peak effect</td>
<td>24 hrs</td>
</tr>
<tr>
<td></td>
<td>Reserve for Opioid tolerant patients</td>
<td>2.7 – 10 mg IV</td>
</tr>
<tr>
<td></td>
<td>using dose equivalency to fentanyl patch.</td>
<td>Morphine every 1 hr</td>
</tr>
<tr>
<td>Fentanyl Transmucusa</td>
<td><strong>Oral Lozenge</strong></td>
<td>100 mcg patch</td>
</tr>
<tr>
<td></td>
<td>Actiq — 200, 400, 800, 1200 mcg/hr</td>
<td>every 2–3 days</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong></td>
<td>200 mg Oral</td>
</tr>
<tr>
<td></td>
<td>Buccal Tablet (Fentora)</td>
<td>Morphine every 24 hrs</td>
</tr>
<tr>
<td></td>
<td>2 times potency of Actiq</td>
<td>33 mg Oral Morphine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>every 2–4 hrs</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td><strong>Hydrocodone/Acetaminophen Tablets</strong></td>
<td>2 tabs</td>
</tr>
<tr>
<td></td>
<td>Vicodin — 5/500 mg</td>
<td>Hydrocodone</td>
</tr>
<tr>
<td></td>
<td>Vicodin ES — 7.5/750 mg</td>
<td>5 mg/500 mg=</td>
</tr>
<tr>
<td></td>
<td>Norco 10/325 mg</td>
<td>9 mg Oral</td>
</tr>
<tr>
<td></td>
<td>Lortab — 7.5/500 mg / 5 mL elixir</td>
<td>Morphine</td>
</tr>
</tbody>
</table>
# Initial Therapy Opioid Naive

<table>
<thead>
<tr>
<th>Pain Intensity</th>
<th>1-3 / 10</th>
<th>4-6 / 10</th>
<th>7-10 / 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Start</td>
<td>Start with simple analgesics (APAP, NSAIDS) with adjuvant analgesics as appropriate.</td>
<td>If pain does Not respond to mild analgesics and adjuvants, consider adding a pure opioid.</td>
<td>IV Opioids may be necessary for initial control.</td>
</tr>
</tbody>
</table>

**Table is suggested starting doses, printed on our PCA order form.**

**Meperidine (Demerol) is no longer considered drug of choice for either acute or chronic pain.**

## PCA Guidelines (Opioid Naive)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>PCA DOSE</th>
<th>CONT. RATE</th>
<th>HOURLY LIMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (1 mg/ml)</td>
<td>1-2 mg</td>
<td>0-0.6 mg/hr</td>
<td>6-12 mg/hr</td>
</tr>
<tr>
<td>Hydromorphone (0.2 mg/ml)</td>
<td>0.2 mg-1 mg</td>
<td>0-0.2 mg/hr</td>
<td>No upper limit</td>
</tr>
<tr>
<td>Fentanyl (10 mcg/ml)</td>
<td>25-50 mcg</td>
<td>10-25 mcg/hr</td>
<td>250 mcg/hr</td>
</tr>
</tbody>
</table>

## PCA / IV to Oral Maintenance

**Morphine**

1. Summate basal and PRN PCA use over 24 hours.
2. **1:3 IV: PO morphine (Equianalgesic Chart).**
3. Decrease calculated dose by 25–33%. When changing between opioids or route and/or to allow for breakthrough pain meds.
4. **If ATC dosing required,** round down to available doses of Morphine ER and divide every 8 or 12 hours.
5. Start oral breakthrough morphine (10–20% of total daily dose) every 2 hrs.
6. Reassess pain requirements daily and adjust SR & ATC pain management accordingly. Goal is less than 4/doses per day of breakthrough meds.

**Hydromorphone (Dilaudid)**

1. Summate basal and PRN PCA use over 24 hours.
2. Convert to IV morphine (Equianalgesic Chart).
3. Decrease calculated dose by 25–33%. When changing between opioids or route and/or to allow for breakthrough pain meds.
4. **If ATC dosing required,** round down to available doses of Morphine ER and divide every 8 or 12 hours.
5. Start oral breakthrough morphine (10–20% total daily dose) every 2 hrs.
6. Reassess pain requirements daily and adjust SR & ATC pain management accordingly. Goal is less than 4/doses per day of breakthrough meds.

*References Available upon request.*

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**USC/University Pain Management Service**

The Pain Medicine Service is a referral service to manage the care of patients requiring an epidural catheter, peripheral nerve blocks and for patients requiring acute and chronic pain management expertise.

With Attending Staff approval call Pain Medicine Consult Beeper (323) 919-2158 or page via the Hospital Operator

**USC/Norris CARE Team**

The CARE Team Service is a referral service dedicated to improve the comfort and quality of life of cancer patients by providing pain and symptom management. With Attending Staff approval call CARE Team Consult: (323) 665-3761

**USC/University Main Pharmacy**

(323) 442-8800

Call for questions about equivalency of non-formulary opioids (esp. SR, IR and/or long-acting).

**USC/Norris Main Pharmacy**

(323) 665-3604

Call for questions about equivalency of non-formulary opioids (esp. SR, IR and/or long-acting).

**Pain Management Clinical Educator:**

Questions regarding pain medicine policies and procedures or general pain management issues call: Beeper (877) 472-3752 or (323) 442-8999

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267-4040 (5-08)
2016 National Patient Safety Goals

**Goal 1: IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION**

01.01.01 – Use at least two Patient Identifiers when providing care, treatment, and services.

⇒ Use at least 2 patient identifiers (Patient’s Name and Date of Birth) when administering medications, blood transfusions, collecting specimens for clinical testing, or when providing treatments or procedures.

⇒ Label containers used for blood & other specimens in the presence of the patient.

01.03.01 – Eliminate transfusion errors related to patient misidentification

⇒ Match the blood to the order, match the patient to the blood, and use a two-person verification process or a one-person verification accompanied by automated identification technology, such as bar coding.

**Goal 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS**

02.03.01 – Report critical results of tests and diagnostic procedures on a timely basis.

⇒ Provide these results within an established time frame (per Policy) so that the patient can be promptly treated

⇒ Evaluate the timeliness of reporting

**Goal 3: IMPROVE THE SAFETY OF USING MEDICATIONS**

03.04.01 – Label all medications, medication containers, and other solutions on & off sterile field in perioperative & other procedural settings

⇒ Applies when medication or solution is not “immediately” administered and when transferred from the original packaging to another container.

⇒ Must follow Elements of Performance 1 – 8

03.05.01 – Reduce the likelihood of patient harm associated with the use of anticoagulation therapy

⇒ Use approved protocols for the initiation and maintenance of anticoagulant therapy. Patient/family education required.

03.06.01 – Maintain and communicate accurate patient medication information

⇒ Obtain information on the medications the patient is currently taking when admitted to the hospital or is seen in an outpatient setting.

⇒ Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged

**Goal 6: REDUCE THE HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS**

06.01.01 – Improve the safety of clinical alarm systems

⇒ NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.

⇒ Must - establish as a hospital priority, ID the most important alarm signals to manage, establish P&P, and educate staff and providers.

**Goal 7: REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS (HAI)**

07.01.01 – Improve compliance with Hand Hygiene Guidelines based on established goals.

07.03.01 – Implement evidence-based practices to prevent HAI due to multidrug-resistant organisms (MDRO).

07.04.01 – Implement evidence-based practices to prevent central line-associated blood stream infections (CLABSI).

07.05.01 – Implement evidence-based practices to prevent surgical site infections (SSI).

07.06.01 – Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

**Goal 15: THE HOSPITAL IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION**

15.01.01 – Identify patients at risk for suicide

**UNIVERSAL PROTOCOL – for all operative / invasive procedures, including bedside procedures**

UP.01.01.01 – Conduct a Pre-Procedure Verification Process

UP.01.02.01 – Mark the Procedure Site

UP.01.03.01 – A Time-Out is Performed (immediately before starting the invasive procedure or making the incision)

**NOTE: The specific recommendations for each goal must be followed to maintain Joint Commission Accreditation.**

Requirements of the National Patient Safety Goals (NPSGs) are monitored on an ongoing basis.

http://www.jointcommission.org/standards_information/npsgs.aspx

updt 05/24/2016
<table>
<thead>
<tr>
<th>WASTE CONTAINER TYPE</th>
<th>WASTE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Waste: Clear Bag</td>
<td>Solid Trash that is NON INFECTIOUS:</td>
</tr>
<tr>
<td></td>
<td>• Paper, Wrappers</td>
</tr>
<tr>
<td></td>
<td>• Chux</td>
</tr>
<tr>
<td>HIPAA Containers</td>
<td>• Paper with confidential patient information</td>
</tr>
<tr>
<td>Red Bag Biohazard Containers</td>
<td>• Blood Tubing/Bags/Removals/Pleurevacs with blood</td>
</tr>
<tr>
<td></td>
<td>• Soaked/Dripping Bloody Dressings</td>
</tr>
<tr>
<td></td>
<td>• Suction Liners with Bloody Fluid or OPIM</td>
</tr>
<tr>
<td></td>
<td>• Bulk Blood; bags, tubing, etc.</td>
</tr>
<tr>
<td></td>
<td>• Isolation Waste: Discarded materials contaminated with excretions or secretions from humans who are required to be isolated</td>
</tr>
<tr>
<td>Sharps Disposal Containers</td>
<td>• Any device having acute rigid corners, edges, or protuberances capable of cutting or piercing (e.g. needles, blades, scalpels, razors, pins, clips, staples, lancets)</td>
</tr>
<tr>
<td></td>
<td>• Trocars, introducers, guide wires, sharps from procedures</td>
</tr>
<tr>
<td>NON RCRA Pharmaceutical Waste Containers</td>
<td>• Needle/syringes with residual medication</td>
</tr>
<tr>
<td></td>
<td>• Glass Vials, ampules with residual medication</td>
</tr>
<tr>
<td></td>
<td>• Partially used/residual prescription or over-the-counter medication (e.g. vials, tablets, capsules, powders, liquids, creams/lotions, eye drop suppositories, 1/2 tablet)</td>
</tr>
<tr>
<td></td>
<td>• Unopened/Unused or Expired Medications: Return to Pharmacy</td>
</tr>
<tr>
<td>Pathology Waste Tubs</td>
<td>• Human Specimen Cultures from medical and pathology-laboratories</td>
</tr>
<tr>
<td></td>
<td>• Human Surgery Specimens or Tissue removed during surgery or autopsy, <em>(Pour off fixative prior to disposal)</em></td>
</tr>
<tr>
<td></td>
<td>• Suction Canisters that have been injected with solidifier materials to control liquids</td>
</tr>
<tr>
<td>Trace Chemotherapy Tubs</td>
<td>• Trace Chemo: All supplies used to make and administer chemo medication (i.e. tubing, empty bags/bottles/vials, syringes, gloves, pads, masks, gowns, wipes, etc.)</td>
</tr>
<tr>
<td></td>
<td>Return all unused Chemo to Pharmacy</td>
</tr>
<tr>
<td></td>
<td>NOTE: Pourable Chemotherapy must be disposed of as RCRA hazardous waste and must not be treated as medical waste.</td>
</tr>
<tr>
<td>RCRA Hazardous Waste</td>
<td>Hazardous R.C.R.A. Pharmaceuticals:</td>
</tr>
<tr>
<td></td>
<td>Examples: Inhalers with residual <em>(If empty - Regular trash)</em>, unused nicotine gum or patches, nitroglycerine tablets, unused/residual acetone, coumadin, cough syrup with alcohol content greater than 24%</td>
</tr>
<tr>
<td></td>
<td>Radioactive:</td>
</tr>
<tr>
<td></td>
<td>• Dispose of body-fluid soaked disposable items into radioactive trash cans only.</td>
</tr>
<tr>
<td></td>
<td>• Batteries: Dispose of all batteries in designated containers</td>
</tr>
<tr>
<td></td>
<td>* Federal Resource Conservation and Recovery Act (RCRA)</td>
</tr>
<tr>
<td>FAILURE</td>
<td>WHAT TO EXPECT</td>
</tr>
<tr>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td>COMPUTER SYSTEM</td>
<td>System down</td>
</tr>
<tr>
<td>DOMESTIC WATER</td>
<td>No hot or cold water, toilets not working</td>
</tr>
<tr>
<td>ELECTRICAL POWER</td>
<td>Normal power loss. No power from gray electrical</td>
</tr>
<tr>
<td>ELEVATORS</td>
<td>Elevator inoperable, Elevator alarm bell sounds</td>
</tr>
<tr>
<td>HAZARDOUS SPILL</td>
<td>Chemical Spills, Bio-Hazard Spills</td>
</tr>
<tr>
<td>HEATING AND AIR CONDITION</td>
<td>No ventilation, heating or cooling</td>
</tr>
<tr>
<td>MEDICAL GAS</td>
<td>Gas alarm Loss of oxygen, medical air, nitrous oxide or nitrogen</td>
</tr>
<tr>
<td>MEDICAL VACUUM</td>
<td>Vacuum alarm sounds, No Vacuum</td>
</tr>
<tr>
<td>RADIATION ALARM-LEAK</td>
<td>Nuclear release, Radiation Alarms sounds</td>
</tr>
<tr>
<td>SEWER STOPPAGE</td>
<td>Single drains backing up, toilets backing up</td>
</tr>
<tr>
<td>STEAM FAILURE</td>
<td>No building heat, No hot water, Steam sterilizer not working</td>
</tr>
<tr>
<td>TELE-COM</td>
<td>No Phone Service</td>
</tr>
</tbody>
</table>
Knowing how to access a Safety Data Sheet (SDS) is important. Safety Data Sheets provide our employees with information to help make knowledgeable decisions about chemical hazards in the workplace.

To have an SDS faxed to you:

**Contact:** 1-888-362-7416

**Account Name:**

**University of Southern California**

**24 HOURS 7-DAYS A WEEK**

The following information will be required:

- **Product Name**
- **Manufacturer Name**
- **Your Fax Number**
- **Product Code (optional)**

On-line Access is available at:

[http://hq.msdsonline.com/usc2716](http://hq.msdsonline.com/usc2716)
<table>
<thead>
<tr>
<th>FAILURE</th>
<th>WHAT TO EXPECT</th>
<th>CONTACT</th>
<th>PHONE</th>
<th>YOUR RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPUTER SYSTEM</td>
<td>System down</td>
<td>Health Information Technology</td>
<td>28440</td>
<td>Use back-up (manual) paper system</td>
</tr>
<tr>
<td>DOMESTIC WATER</td>
<td>No hot or cold water, toilets not working</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Use bottle water. Assure that faucets are turned off. Use red bags to line toilets if needed</td>
</tr>
<tr>
<td>ELECTRICAL POWER</td>
<td>Normal power loss. No power from gray electrical</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Plug all life support equipment into red outlets. Unplug all non-essential equipment. Standby for periodic reports from Nursing Supervisor</td>
</tr>
<tr>
<td>ELEVATORS</td>
<td>Elevator inoperable, Elevator alarm bell sounds</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Review evacuation plans for your areas.</td>
</tr>
<tr>
<td>HAZARDOUS SPILL</td>
<td>Chemical Spills, Bio-Hazard Spills</td>
<td>Operator EVS</td>
<td>77</td>
<td>Isolate affected area and secure. Identify spilled item if possible, get SDS if needed and avoid tracking residue. Page Safety Officer 877-323-8602</td>
</tr>
<tr>
<td>HEATING AND AIR CONDITION</td>
<td>No ventilation, heating or cooling</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Obtain blankets or fans as needed. Restrict use of odorous and/or hazardous materials.</td>
</tr>
<tr>
<td>MEDICAL EQUIPMENT</td>
<td>Failure of equipment</td>
<td>Bio-Med Operator</td>
<td>28300 Option 4 77</td>
<td>Take equipment out of service, remove from patient care area, save all attached items, notify Bio-Med.</td>
</tr>
<tr>
<td>MEDICAL GAS</td>
<td>Gas alarm Loss of oxygen, medical air, nitrous oxide or nitrogen</td>
<td>Respiratory Facilities Operator</td>
<td>28529 28300 Option 1 77</td>
<td>Respiratory Therapy or designated staff is authorized to shut-off medical oxygen. Call Respiratory Therapy to set up portable gases and equipment.</td>
</tr>
<tr>
<td>MEDICAL VACUUM</td>
<td>Vacuum alarm sounds, No Vacuum</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Call Central Supply 29300 for portable vacuum pumps.</td>
</tr>
<tr>
<td>NURSE CALL SYSTEM</td>
<td>Nurse call system not functioning</td>
<td>Bio-Med Operator</td>
<td>28300 Option 4 77</td>
<td>Request hand bells from House Supervisor. Increase patient rounds.</td>
</tr>
<tr>
<td>RADIATION ALARM-LEAK</td>
<td>Nuclear release, Radiation Alarms sounds</td>
<td>Security Operator</td>
<td>28571 77</td>
<td>Secure area, page Radiation Safety Officer 877-214-1070</td>
</tr>
<tr>
<td>SEWER STOPPAGE</td>
<td>Single drains backing up, toilets backing up</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Do not use water or flush toilets. Isolate affected area; set boards/pads to step on to avoid tracking sewage.</td>
</tr>
<tr>
<td>STEAM FAILURE</td>
<td>No building heat, No hot water, Steam sterilizer not working</td>
<td>Facilities Operator</td>
<td>28300 Option 1 77</td>
<td>Conserve sterile materials, provide extra blankets, Provide cold meals if kitchen non-operational.</td>
</tr>
<tr>
<td>TELE-COM</td>
<td>No Phone Service</td>
<td>Health Information Technology</td>
<td>28440</td>
<td>Use overhead paging, wireless medical phone, 2 way radios, cell phones and satellite phones. Send runner to PBX Office.</td>
</tr>
</tbody>
</table>
PURPOSE

The purpose of this policy is to:

1. Support a culture of shared accountability for the reporting and management of reportable occurrences that may impact the quality of care;

2. Comply with the requirements of federal and state law and the standards of applicable accrediting organizations;

3. Provide a system for promptly reporting and investigating Reportable Occurrences and integrating risk reduction strategies in the hospital’s performance improvement, peer review, credentialing and liability prevention activities;

4. Report and record information that may be necessary to support risk management activities;

5. Clarify and delineate the responsibilities of hospital employees, contractors, volunteers, and risk managers with respect to Reportable Occurrences;

6. Provide instructions and guidelines to assist hospital staff in identifying and reporting occurrences in the hospital;

DEFINITIONS

1. Reportable Occurrence

A “Reportable Occurrence” is an occurrence that is not consistent with the routine operation of the hospital or the routine care of a patient or patients. Injury does not have to occur. The potential for accident, injury, illness or property damage is sufficient for an occurrence to be considered a Reportable Occurrence. Examples of Reportable Occurrences include but are not limited to:

a. An Unanticipated Outcome (refer to Administrative Policy, “Disclosure of Unanticipated Outcome Information”).

b. A Sentinel Event (refer to Administrative Policy, “Sentinel Event Response & Reporting”)

c. A Near Miss, which is a situation that has the potential to cause injury to a patient but is averted due to the staff’s timely intervention.

d. A hazardous condition

e. An occurrence that substantially impacts or has the potential to substantially impact a patient’s plan of care
f. An occurrence that injures or places patients, Hospital Staff, members of the Medical Staff, or visitors at an substantial level of risk or accident, illness, injury or property damage

g. An unapproved deviation from hospital safety or patient care policies

h. A medical device malfunction or failure (refer to Administrative Policy, “Control of Defective Equipment or Devices – Safe Medical Devices Act Reporting”)

i. Patient or visitor falls

j. Medication administration or order errors

k. Patient complaints

l. Patient, visitor, or family member’s request for compensation or credible threat of litigation against a member of the Medical Staff, the hospital, or Hospital Staff

m. Patient’s lost belongings

n. Assault

o. Tissue and/or organ adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue and/or organ.

2. **Hospital Staff Member:** hospital employees, agency staff, contractors, and volunteers.

**POLICY**

1. In accordance with Section 70737 of Title 22, the Chief Executive Officer or his/her designee shall report to the State Department of Public Health Services either by telephone or facsimile, any unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors as soon as is reasonably practical (“Unusual Occurrence”).

2. Unusual Occurrences that require reporting include an epidemic outbreak, poisoning, fire, major accident, disaster or other catastrophic event that threatens the health, safety and welfare of patients, personnel and visitors to the hospital.

3. **No Retaliation:** No hospital employee shall intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any employee or other individual for reporting, in good faith, any Reportable Occurrence as defined under Procedure Section of this policy. (See Human Resources Policy, “No Retaliation”).

**PROCEDURE**

1. Reporting Requirements

   a. Hospital staff shall complete an Occurrence Report for every Reportable Occurrence that such staff
observes or is involved with at the hospital and at any off-site department of the hospital, whether or not the unit or department is managed by the hospital or a contractor.

b. All Occurrence Reports shall be made on the electronic form available through the hospital’s intranet.
   i. A system downtime form may be obtained from the Clinical Administrative Supervisor (CAS) / Nursing Supervisor. Hospital staff may submit downtime forms to their supervisors for entry to the occurrence reporting system.

c. All Occurrence Reports are confidential and shall not be copied.

d. If the Reportable Occurrence involves a work-related injury to an employee, the hospital shall immediately notify the injured employee’s supervisor and shall complete an Employee Injury Report (see Employee Health Policy, “Occupational Injury & Illness”).

2. Occurrence Report Form

a. All Occurrence Reports are confidential and shall be made on an approved hospital occurrence report form that complies with State statutes for reporting and protection. The Occurrence Report shall **not:**
   i. Include speculation
   ii. Assign blame
   iii. Include comments or opinions of causation or potential liability
   iv. Include opinions of any kind
   v. Be provided to a patient or their family

3. Persons Responsible for Completing an Occurrence Report

a. Any Hospital Staff member who witnesses, discovers or has direct knowledge of a Reportable Occurrence shall complete an Occurrence Report.

b. More than one individual may complete an Occurrence Report concerning the same occurrence.

c. Members of the Medical Staff may also complete Occurrence Reports or request that a Hospital Staff member with direct knowledge of the Reportable Occurrence complete a Report.

d. The Department Manager/Supervisor is responsible for:
   i. Providing leadership in all risk management functions/processes and to ensure that the staff are trained on this policy;
   ii. Assisting the Risk Manager in the investigation of the Reportable Occurrence as requested;
iii. Participating in risk-reduction analyses and action plans as requested by the Risk Manager;

iv. Promoting a non-punititive environment that focuses on improvement of systems and processes by encouraging people to report mistakes and admit problems; and

v. Reserving remedial and disciplinary action for reckless behavior and repeated errors by an individual pursuant to Human Resources Policy, "Performance Management."

e. If the Department Manager/Supervisor is involved in the Reportable Occurrence, the Risk Manager shall forward the Reportable Occurrence to the next individual in the chain of command who was not involved.

f. The hospital Risk Manager shall be responsible for reviewing, categorizing, and if appropriate, investigating Occurrence Reports and routing them as required by this policy.

4. When to Complete an Occurrence Report

a. After providing for the needs of the individuals involved, Hospital Staff Members shall complete and submit Occurrence Reports in the electronic system available on the hospital's intranet (or on a system downtime form if necessary) as soon as possible, and before leaving the hospital at the end of the work shift, and in no event longer than 24 hours after the Reportable Occurrence.

b. Occurrence Reports shall be completed as soon as possible following discovery or gaining knowledge of the Reportable Occurrence.

c. All electronic Occurrence Reports are automatically routed to the appropriate supervisors for review. If the supervisor is involved in the reportable occurrence, the Hospital Staff Member shall notify the supervisor's supervisor (i.e., the next person up the chain of command) instead of his or her immediate supervisor.

5. How to Complete an Occurrence Report

a. The Occurrence Report shall be limited to factual statements (who, what, where, and when) related to the Reportable Occurrence and any interventions taken.

b. If the individual completing the report desires to discuss potential causation, that individual shall contact the Risk Manager who may interview the individual as a part of the Risk Manager’s investigation of the Occurrence.

c. The form is completed in its entirety and submitted to the Risk Management Department within 24 hours.

d. The Occurrence Report shall accurately and legibly document who, what, when and where as follows:
   i. Date of the Reportable Occurrence
   ii. Time of Reportable Occurrence
   iii. Who was involved (including patients and their attending physicians, Hospital Staff, Medical Staff, visitors, and others)
iv. The current status of those involved

v. Where the Reportable Occurrence happened

vi. Who witnessed the Reportable Occurrence

vii. The narrative portion of the Occurrence Report should not contain opinions or conclusions, but rather, report of facts, direct observations or witnesses’ statements.

viii. Name of the preparer

ix. Date the Occurrence Report was prepared

e. The patient’s chart shall:

i. Reflect all pertinent medical facts relating to the Reportable Occurrence

ii. Be accurately, legibly, and timely completed

f. The patient’s chart shall NOT:

i. State that an Occurrence Report has been made or that an “error” or “mistake” was made

ii. Contain a copy of the Occurrence Report

iii. Include speculation

iv. Assign blame or

v. Include comments or opinions of causation or potential liability

g. Witnesses may complete separate Occurrence Reports or may attach separate sheets to one report provided that separate sheets shall comply with the requirements for completion of the Occurrence Report. Separate sheets shall be scanned into the electronic incident reporting system and attached to the corresponding Occurrence Report.

6. Incomplete Occurrence Reports

a. Staff may begin an occurrence report and save it as “Incomplete” if they are unable to complete at that time or need additional information to complete the report.

b. All Incomplete Occurrence Reports are to be completed and submitted to Risk Management within 72 hours of the onset of the event.

7. Routing of Completed Occurrence Reports

a. Occurrence reports are to be submitted directly to Risk Management Department as soon as possible
after the reportable event but **no later than 24 hours** following the Reportable Occurrence.

b. The submitter shall inform his/her Department Manager or Department Supervisor that an occurrence report has been completed, and such manager/supervisor shall initiate any follow-up and/or taken actions to prevent recurrence.

c. No photocopies of the completed report are to be made at any time.

8. Confidentiality of Occurrence Reports

   a. All Occurrence Reports are confidential and are legally privileged under state and/or federal law.

   b. All Occurrence Reports shall be directed to the Risk Management Department as required by this policy.

   c. Hospital Staff and hospital departments shall not keep copies of Occurrence Reports or otherwise compromise the confidentiality of Occurrence Reports.

   d. No patient, visitor, contract or agency employee or volunteer shall receive a copy or be informed of an Occurrence Report as doing so could adversely affect the document’s legal protections.

9. Procedures for Risk Management Department

   a. After reviewing all Occurrence Reports for legibility and completeness, the Risk Manager shall evaluate all Occurrence Reports and categorize each by direct clinical outcome to the patient.

   b. After categorization, the Risk Manager shall determine what action is required or may, given the categorization of the Reportable Occurrence, elect to take no action.

   c. The Risk Manager’s actions may include the following, as appropriate:

      i. Initiate a privileged investigation of the Reportable Occurrence. If it appears that the Reportable Occurrence involves a willfully unsafe act, a criminal act, or substance abuse, the Risk Manager shall immediately notify Administration.

      ii. Secure and document all material evidence.

      iii. Confirm that the patient/family was notified of any Unanticipated Outcomes pursuant to Administrative Policy, “Disclosure of Unanticipated Outcome Information”.

      iv. Refer the Reportable Occurrence to appropriate hospital committee(s) or department(s) for review and resolution.

      v. Refer potential Sentinel Events to the Administrative Team pursuant to Administrative Policy, “Sentinel Event Response & Reporting Policy.”

      vi. In consult with hospital administration and Hospital Counsel, determine whether the Occurrence is reportable to a state agency, the FDA, or other external agency in accordance with applicable law.
ATTACHMENTS

- Safety & Risk Management System (eSRM)
- Occurrence Reporting Criteria/Examples of Security Related Reportable Events

REFERENCES

- Medicare Conditions of Participation for Hospitals
- Joint Commission Comprehensive Accreditation Manual for Hospitals

RELATED POLICIES AND PROCEDURES

- Administration Manual
  - Sentinel Event Response and Reporting Policy
  - Disclosure of Unanticipated Outcome Information
  - Control of Defective Equipment or Devices – Safe Medical Devices Act Reporting
- Employee Health Manual
  - Occupational Injury & Illness
- Transplant Manual
  - Adverse Events – Tissue and Organ Transplant

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**Effective/Revision Dates for Policy # 6-107**

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Keywords: Occurrence, incident, equipment failure, malfunction, complaint, safety, EIR, eSRM, SRM
Safety & Risk Management System (eSRM)
Hospital Implementation

Occurrence Reporting Process

Risk Management / Administration

Incident/Occurrence Reports

Risk Management Department

Sentinel Events and Serious Events

- Notify Administration, HCO, Patient Safety Officer
- Conduct Investigation
- Conduct Root Cause Analysis (complete within 14 days)

Patient Safety Committee

Occurrence Completed

Submitted to Risk Management

Risk Management reviews Occurrence Report

Risk Management triage identification of incidents

Compliance Related-Issues

- Notify Hospital Compliance Officer
- Conduct Investigation

Risk-related Occurrence

- MD-related Occurrence
- Medication Error incidents
- Patient ID incidents
- Equipment-related Problems
- Slip/Fall
- Nursing/ Patient Safety Problems
- Lost Belongings
- Sentinel/ Serious incidents

Referral to Quality & Outcomes

- P&T/ MERT
- PIER TEAM
- FDA reportable by Risk Mgmt (as appropriate)
- Falls Committee/Nursing Quality
- Department Mgr/ CNO/Patient Safety Officer Trend Analysis

Trend/analysis reporting from Risk
EMPLOYEES:
- You have the right to notify your employer or OSHA about workplace hazards. You may ask OSHA to keep your name confidential.

- You have the right to request an OSHA inspection if you believe that there are unsafe and unhealthful conditions in your workplace. You or your representative may participate in that inspection.

- You can file a complaint with OSHA within 30 days of retaliation or discrimination by your employer for making safety and health complaints or for exercising your rights under the OSH Act.

- You have the right to see OSHA citations issued to your employer. Your employer must post the citations at or near the place of alleged violations.

- Your employer must correct workplace hazards by the date indicated on the citation and must certify that these hazards have been reduced or eliminated.

- You have the right to copies of your medical records and records of your exposures to toxic and harmful substances or conditions.

- Your employer must post this notice in your workplace.

- You must comply with all occupational safety and health standards issued under the OSH Act that apply to your own actions and conduct on the job.

EMPLOYERS:
- You must furnish your employees a place of employment free from recognized hazards.

- You must comply with the occupational safety and health standards issued under the OSH Act.