Procedure: ZOLL Defibrillator (R Series Plus) (MUNSON)
Checklist: ZOLL Defibillator (R Series Plus) Basics (MUNSON)
Evaluator's Name: _____ **Examinee's Name:** _____
Evaluator's ID: _____ **Examinee's ID:** _____
Evaluator's Dept: _____ **Examinee's Dept:** _____
Date: _____ **Meets criteria/Does not meet criteria:** _____
Select Evaluation Method:
☐ Clinical Observation ☐ Documentation Review
☐ Demonstration ☐ Verbalization

ZOLL Defibillator (R Series Plus) Basics (MUNSON)

Demonstrate the use of the ZOLL defibrillator as an AED according to the Lippincott skills checklist, titled, "Zoll Defibrillator (R Series Plus) Basics".

Checklist Step	Comments
Y- Meets; N- Does not meet; I- Not Applicable	
__ If a red "X" is noted in the Code Readiness area on the front of the defibrillator, state that action is needed, and locate the troubleshooting instructions. __ State that daily testing of the machine is automatic. __ Verbalize who is responsible to perform the weekly test on the unit, and when this is done. __ Check and verbalize process for changing paper. __ Connect OneStepTM pads to OneStep cable. __ State how to open package correctly. __	
Demonstrate proper pad placement for adults.	
__ Place the back pad below the left scapula first. __ Place the front pad mid sternal/mid nipple center of the sternum (where you do compressions).	
Next steps:	
__ Turn on defibrillator.	

__ Follow voice prompts and deliver shock, if indicated.

__ Perform compressions and adjust rate and depth according to the ZOLL defibrillator CPR feedback.

Pediatric Considerations

__ State pediatric indications/parameters (Under age 8 and under 25 kg [55 pounds])

__ Attach the Pediatric OneStepTM pads for connection to OneStep cable. (Pediatric pads are in the crash cart.)

__ State that when pediatric OneStep pads are attached, the only CPR feedback is a metronome.

__ State the default defibrillation energy protocol adjusts automatically when pediatric pads are used. (50-70-85 joules)

__ State the need to manually adjust joules (2-4J/kg) when adult pads are used

__ If the department has external paddles, demonstrate how to access pediatric paddles (Less than 10 kg). (Press black pedi button and slide adult plate off)

Defibrillator Data and Care

__ Locate the "Print Log" to run a report of interventions

__ Locate the "Transfer Mode" to send the code data via WIFI.

__ State the defibrillator will be cleaned after each use using one of these cleaners: 1. 90% isopropyl alcohol (except on adapters, patient cable, and Wi-Fi Data COMM Card) 2. Soap and water 3. Chlorine bleach solution of 30 ml per liter of water (except on Sync In/Marker Out connector and battery compartment pins).

__ R Series products and accessories are chemically resistant to most common cleaning soluations and

non-caustic detergents. The above cleaning solutions are approved.

State the machine should be setup for the next use:

__ Clean the defibrillator surfaces.

__ Plug the defibrillator into a red electrical outlet.

__ Attach the OneStep CPR pads to the defibrillator.

Plum 360™ with ICU Medical MedNet™ System

Quick Reference Card Software 15.11 and higher

℞ Only. Please refer to the System Operating Manual for complete operating instructions.

icumedical
human connections

Contents

Definition of Terms

ICU Medical MedNet™ Software – Enhances safety at the point of care with highly customizable drug libraries that guide users and help to protect patients by alerting to hard and soft limits, upper and lower dosing limits intended to help prevent infusion errors. These limits are based on a hospital's specific IV administration practices.

Lower Hard Limit (LHL): The lower limit that cannot be overridden.

Lower Soft Limit (LSL): The lower limit that can be overridden.

Upper Soft Limit (USL): The upper limit that can be overridden.

Upper Hard Limit (UHL): The upper limit that cannot be overridden.

Auto-Program: Auto-programming refers to the ability to receive a remotely configured therapy from ICU Medical MedNet™ software.

Definition of Operating Keys – Indicators – Display Symbols

[ON/OFF] – Infuser power on and off.

[START] – Is the first key to press to start a delivery. For safety reasons, every delivery must be confirmed by checking the programming and then pressing an additional softkey, in response to a prompt.

[STOP] – Stops delivery. If 2 lines are pumping when you press **[STOP]**, you must press one of the following softkeys: ▲ **[Stop A]**, ▲ **[Stop B]**, or ▲ **[Stop All]** in response to the prompt to specify which line(s) to stop.

[SELECT] – Moves the cursor between fields on the display. The top pair of arrows moves the cursor up or to the left.

The bottom pair of arrows moves the cursor down or to the right

[LOCK KEYPAD] – Pressing this key, followed by entering a lock passcode disables all keys on the keypad except [STOP] until a valid passcode is entered.

[AUDIO PAUSED] – Has two functions, temporarily silencing all audio output for any active alarms for two minutes or temporarily silencing keypad input sound feedback for two minutes if there is no active alarm.

[C] – Clears all values in the currently highlighted field. [C] also clears the dashes (- - -) that are displayed when an entry is invalid or a drug delivery parameter is beyond the pre-programmed hard limits.
NOTE: [C] will NOT clear an entire program.

Caution – Appears on the display to tell the clinician to use CAUTION because the specified drug has been programmed without rule sets (soft or hard limits), and may have been programmed outside of specified safety limits for that specific drug.

Upper Soft Limit Override – Appears next to the drug name when the dosage of the drug being infused is higher than the upper soft limit set for the drug in the Custom Drug Library.

Lower Soft Limit Override – Appears next to the drug name when the dosage of the drug being infused is less than the lower soft limit set for the drug in the Custom Drug Library.

Wireless Connection – Appears when the infuser is communicating with the network using a wireless connection.

ICU Medical MedNet Connection – Appears when the infuser is communicating with ICU Medical MedNet software over either a wireless or Ethernet connection.

Battery Capacity – Shows the battery charge level when a battery is installed in the infuser, or indicates that a battery is not installed.

To maintain maximum battery charge and to prolong battery life, connect the infuser to AC (mains) power whenever possible.

Set Up PlumSet™

1. Prime the set according to package instructions.
2. Push in flow regulator to close.
3. Insert primed cassette into the infuser, close door.
4. Press [ON/OFF] to turn on the infuser.

Clinical Care Area (CCA) Selection

1. Use ▲▼ to highlight the desired CCA.
2. After you select the desired CCA, press ▲ [Choose].
3. The on-screen message "New Patient" may appear – press ▲ [Yes] to clear all settings or ▲ [No] to continue.

NOTE: If no settings currently exist or all settings are 0, this screen will be bypassed.

Change CCA During Infusion

1. On the Delivery (A/B) screen, press ▲ [Settings/Vol/CCA].
2. Press ▲ [Change CCA].
   - › The current CCA is indicated by arrows before and after the CCA.
3. Use the [SELECT] ▲ or ▼ to highlight the new CCA.
4. Press ▲ [Choose].
5. Press ▲ [Previous Screen].

NOTE: New CCA is highlighted at the bottom of the screen.

NOTE: When the Delivery screen displays, the infuser will inform the user that line is delivering under a prior CCA. Until a VTBI Complete alarm occurs for the line, you can still titrate the infusion on that line under the old CCA.

Programming Line A/B with a Custom Drug Library

1. On the Delivery (A/B) screen, select a line to program. If you are programming a primary delivery, select Line A. If you are programming a secondary delivery, select Line B.
2. In the drug list, select the drug – You may use the alphanumeric keypad to search.
3. Select a clinical use (if applicable).
4. Enter Weight (if applicable), Rate and/or Dose, VTBI, and Duration as appropriate for the displayed program parameters. These values can be entered in any order.

   ⚠ CAUTION: BEFORE STARTING DELIVERY, VERIFY THE VALUES.

5. Press [START].
6. Confirm the program.
7. Press ▲ [Yes] to start the infusion.
   - If a maximum hard limit is exceeded, an alert appears. You cannot proceed until the entry is cleared. Press the C [C] key to clear the entry and enter a new value.
   - If a soft limit is exceeded, an alert appears when [START] is pressed to confirm the program.
   - When the alert displays:
     - Select ▲ [Yes] to override and continue to the confirmation screen.
       or
     - Select ▲ [No] to return to the program screen and edit the value.

When programming Line B with a non-Piggybackable drug (as defined in the Custom Drug Library), the delivery mode for Line B defaults to Concurrent and cannot be changed.

If there is a confirmed program on Line A with a drug that is non-interruptible when programming Line B, the delivery mode for Line B will default to Concurrent and cannot be changed.

If Line A is not programmed, or is programmed with a drug that is interruptible, and the drug selected on Line B is Piggybackable, select Piggyback or Concurrent as the delivery mode (the default is Piggyback).

Programming Line A/B without a Drug List

1. On the Delivery (A/B) Screen, select a line to program. If you are programming a primary delivery, select Line A. If you are programming a secondary delivery, select Line B.
2. On the Program screen, enter the Rate, VTBI and Duration. Values can be entered in any order.
   - › A Caution Symbol will appear ⚠ on the Confirm Program screen that alerts you that the infuser is being operated without rule sets.

   ⚠ CAUTION: BEFORE STARTING DELIVERY, VERIFY THE VALUES.
3. Press **[START]**.
   - › Before starting delivery, verify the values.
4. Press ▲ **[Yes]** to start delivery.

Programming a Bolus (with ICU Medical MedNet Safety Software only)

- › A Bolus can be delivered from either Line A or Line B (while in the piggyback mode).
- › A Bolus can be completed only if the following conditions are present:
  - The line on which the bolus is to be delivered is currently infusing
  - Bolus Dose is enabled within the medication's selected profile
  - Rule Sets permit the medication to be delivered by bolus
  - There is adequate VTBI of the medication to complete the bolus dose
  - The device is in Piggyback mode (not Concurrent mode) if the bolus is to be delivered on Line B

1. Press ▲ **[A]**.

2. Press ▲ **[Bolus]**. The Bolus softkey is available only if the medication to be bolused is enabled in the drug library and is currently infusing.
3. On the Bolus programming screen enter:

Dose: _____

Duration: _____

The Rate and VTBI will be calculated.

4. Press **[START]** for confirmation.
5. Select ▲ **[Yes]** to start the delivery.

Nurse Callback

1. On the programming screen, press ▲ **[Add Callback]**.
2. Press **[START]** and confirm your order for accuracy.
3. Press ▲ **[Yes]** to start delivery.

Callback is available for Piggyback, Loading Dose, Multistep and Bolus deliveries.

Titrate Rate on Line A/B

1. On the Delivery (A/B) screen, select ▲ **[A]** or **[B]** – Line does not have to be stopped to titrate Rate.
2. Enter a new Rate/Dose.
3. Press **[START]** and confirm your order for accuracy.
4. Press ▲ **[Yes]** to start the titration.

Address VTBI Complete Alarm

Upon completion of delivery, the screen shows a flashing “VTBI completed Line A! –
Add more VTBI or Clear Line A” message and the audible alarm sounds.

You can change the default setting to one of the following:

— **KVO:** The infuser continues to deliver fluid at a Keep Vein Open (KVO) rate of 1 mL/hr. If the delivery rate of the infusion that just completed was less than 1 mL/hr , the KVO rate will continue at the same delivery rate.

— **RATE:** The infuser continues to deliver fluid at the programmed rate, maintaining the therapeutic rate until the VTBI Complete alarm can be resolved.

1. Press **[AUDIO PAUSED]** to stop the alarm sound.
2. Press ▲ **[A]**.
3. Ensure the VTBI field is highlighted – using the numeric keypad, enter a new VTBI.
4. Press **[START]** and confirm your order for accuracy.
5. Press ▲ **[Yes]** to start the titration.

Backprime

Before you begin a backprime, ensure that there is a line or a syringe on the secondary port to accept the backprimed fluid or expelled air. When you release ▲ **[Backprime]** the infuser performs a cassette test.

1. Press and hold ▲ **[Backprime]** until fluid pumped from Line A to Line B clears air from the cassette and from Line B (if present).

NOTE: If you press and hold the **[Backprime]** key for two minutes, a stuck key alarm sounds and the display screen shows Power Off then On. Replace pump if alarm continues.

2. If the cassette test detects that there is still air in the line, repeat Step1 until the cassette test is successful.
3. Press [START] to restart the delivery. If two lines were pumping when delivery stopped, press the appropriate softkey in response to the prompt.

Stop and Start with 1 Line Pumping

1. On the Delivery (A/B) screen, press [STOP].
2. Press [START] to resume the infusion.

Stop and Start when Line A and B Pumping

1. On the Delivery (A/B) screen, press [STOP].
2. Press ▲ [Stop All] or ▲ [Stop A] or ▲ [Stop B].

To Resume the infusion:

1. Press [START].
2. Press ▲ [Start All] or ▲ [Start A] or ▲ [Start B].

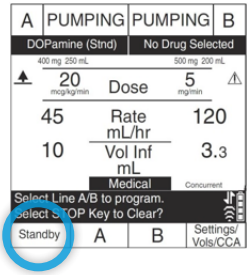
Standby – A/B Delivery Screen and Confirmation Screen

Standby – Enables the clinician to postpone starting the delivery for a period of 24-72 hours. Default is 72 hours.

If a line is in standby and the configured maximum standby time expires, the program is cleared and the infuser alarms 2 minutes later if there has been no interaction with the pump on either line.

To place the infusion in Standby – from the Delivery Screen:

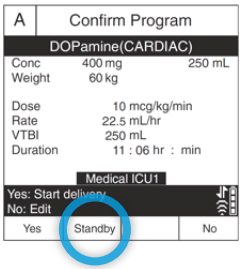
1. Press ▲ [Standby] and select the desired line to put in standby mode.
2. On the Confirm Standby screen – press ▲ [Yes]



To place the infusion in Standby – from the Confirmation Screen:

After entering program on desired line, press [START]. From the Confirm Program Screen:

1. Press ▲ [Standby] and select the desired line to put in standby mode.
2. On the Confirm Standby screen, press ▲ [Yes] to put the delivery in standby mode.



To restart the infusion from Standby:

1. Press [START].

The Cancel Standby screen displays. If both lines are in standby, the infuser will give you the option to select a line.

2. Select the appropriate softkey. Delivery resumes on the selected line(s).

Delayed Start

1. On the Program screen, press ▲ [Delay].
2. Enter time in hours and minutes up to 23:59 hh:mm and press ▲ [Done]. Delivery screen shows DELAYED and delay time countdown.
3. Press [START] and ▲ [Yes] to confirm to resume the infusion.
4. To clear a delay, choose the line, press ▲ [Delay], then change or clear the delay settings, then press ▲ [Done].

Loading Dose

1. After your medication is selected, press ▲ [Choose].
2. Press ▲ [Loading Dose] before entering any values on the programming screen. The Program Loading Dose screen appears.
3. Enter Rate and/or Dose, VTBI, and Duration as appropriate for the parameters displayed for 1 (Loading Dose).

   NOTE: On the Program Loading Dose screen, 1 represents the Loading Dose and 2 represents the Maintenance Dose.
4. After completely programming 1 (Loading Dose) navigate to 2 (Maintenance Dose) and program the Maintenance Dose parameters.
5. When both Loading Dose and Maintenance Dose are programmed, press [START].
6. Confirm that all programming is correct, and then press ▲ [Yes].

Multistep

1. After your medication is highlighted, press ▲ [Choose].
2. Press ▲ [Multistep] before entering any values on the programming screen.
3. Enter Rate and/or Dose, VTBI, and Duration as appropriate for the parameters displayed for Step 1.
4. After programming all values in 1 (Step 1), navigate to the 2 (Step 2), and program that step.
5. After programming all values in 2 (Step 2), continue with 3 (Step 3) if desired.
6. Press ▲ [To Steps 4-10] to program additional steps if needed.
7. When all steps are programmed, press [START].
8. Confirm that all programming is correct, and then press ▲ [Yes] to start the delivery for 1 (Step 1).

Lock Keypad (Method #1)

Using the Lock Keypad hardkey.

1. Press the [LOCK KEYPAD] hardkey.
2. The Passcode data entry screen appears on the display.
3. Enter the passcode using the numeric keypad.
4. Press the ▲ [Enter] softkey.

When the keypad is locked, the lock symbol appears in the bottom right corner of the delivery screen.

Lock Keypad (Method #2)

Via Settings/Vols/CCA

1. At the main delivery screen, press **[Settings/Vols/CCA]** softkey.
2. Press ▲ **[Lock Keypad]** – the Passcode data entry screen appears on the display.
3. Enter Passcode to Lock using the numeric keypad.
4. Press ▲ **[Enter]** softkey.

When the keypad is locked, the lock symbol appears in the bottom right corner of the delivery screen.

Unlock the Keypad

1. Press any key on the keypad to display the Passcode data entry screen.
2. Enter the passcode using the numeric keypad.
3. Press the ▲ **[Enter]** softkey.

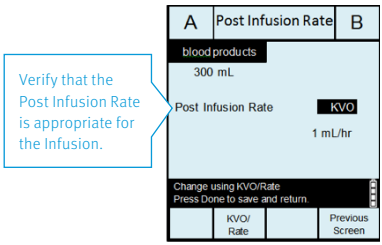
NOTE: During an infusion, pressing **[STOP]** or opening the cassette door, activates an alarm that cannot be silenced until the keypad is unlocked.

Set the Post Infusion Rate

NOTE: Prior to changing the Post Infusion Rate, the pump must be stopped.

1. On the Main Delivery screen, press ▲ **[Settings/Vols/CCA]**. The Settings/Vols/CCA screen appears, with the Post Infusion Rate highlighted.
2. Press ▲ **[Choose]**. The Post Infusion Rate screen appears, with the current setting highlighted.
3. To change the current setting, press ▲ **[KVO/Rate]**. To return to the previous setting, press ▲ **[KVO/Rate]** again.
4. Press ▲ **[Done]** to save your changes and return to the Settings/Vols/CCA screen and then press ▲ **[Previous Screen]** to return to the delivery screen.

NOTE: When changing the Post Infusion Rate from what is defaulted on the device, the new change will remain in place for any subsequent infusions programmed on the device unless manually changed back or, when powering the device back ON and ▲ **[Yes]** is answered to the "New Patient?" screen.



View/Clear Volumes Infused

1. On the Main Delivery screen, press ▲ **[Settings/Vols/CCA]**.
2. Use **[SELECT]** to highlight Volumes Infused and then press ▲ **[Choose]**.
   - › The Volumes Infused Screen displays the volumes infused on Line A, Line B and the total infused.
3. Document totals.
4. Press ▲ **[Clear A]** to clear the Line A total only (and subtract the total from the Total Volume).
5. Press ▲ **[Clear B]** to clear the Line B total only (and subtract the total from the Total Volume).

6. Press ▲ [Clear Total] to clear all values, including the Total Volume.
7. To return to the Settings/Vols/CCA screen, press ▲ [Previous Screen]. If you do not press a key in 30 seconds, the Delivery screen automatically returns.

NOTE: The volumes infused may be cleared before a cassette is inserted.

Adjust Display Lighting and Contrast

1. On the Main Delivery screen, press ▲ [Settings/Vols/CCA].
2. Use [SELECT] to highlight Lighting/Contrast and press ▲ [Choose]. The Lighting/Contrast screen appears, with the Backlight Intensity highlighted.
3. Use ▲ [Increase Setting] and ▲ [Decrease Setting] to adjust the backlight intensity.
4. Press [SELECT] to highlight Display Contrast.
5. Use ▲ [Increase Setting] and ▲ [Decrease Setting] to adjust the display contrast.
6. Press ▲ [Done] to save the current settings and return to the Settings/Vols/CCA screen or press ▲ [Previous Screen] to leave this screen without saving changes.
7. Press ▲ [Previous Screen] to return to the Settings/Vols/CCA screen.

View CCA and Infuser Settings

1. On the Main Delivery screen, press ▲ [Settings/Vols/CCA].
2. Select ▲ [CCA Settings] and press ▲ [Choose]. The CCA Settings screen displays.
3. Press ▲ [Page Up] and ▲ [Page Down] to view all the CCA and infuser settings.
4. When finished, press ▲ [Previous Screen] to return to the Settings/Vols/CCA screen. Press ▲ [Previous Screen] again to return to the delivery screen.

Set Distal Pressure Alarm Limit

NOTE: Prior to changing the Distal Pressure Alarm Limit, the infuser must be stopped.

1. On the Main Delivery screen, press ▲ **[Settings/Vols/CCA]**.
2. Use **[SELECT]** to highlight Distal Pressure Alarm Limit and press ▲ **[Choose]**. Change the Distal Pressure Alarm Limit.

⚠ CAUTION: **Do not** set the distal pressure alarm level lower than 3 PSI (155 mmHG) or higher than 12 psi (624 mmHG). Setting the alarm outside of that range may result in unreliable alarm functioning.

3. Use the keypad to press ▲ **[Done]** to save your changes and return to the Settings/Vols/CCA screen or press ▲ **[Previous Screen]** to view the settings without making changes.
4. Press ▲ **[Previous Screen]** to return to the Main Delivery screen.

Discontinue Electronic Flow Control and Setting Gravity Flow

⚠ WARNING: Close all clamps before opening the cassette door

1. Press **[STOP]**. If two lines were pumping, press ▲ **[Stop All]**.
2. Press ▲ **[ON/OFF]** to turn off the infuser.
3. Close all clamps.
4. Open the cassette door and remove the cassette.

5. If only 1 line was pumping, open all clamps.

   If 2 lines were pumping, you must choose one line for gravity flow. Open the clamps on that proximal line and on the distal line. Make sure one proximal line stays clamped.

6. Holding the cassette upright, set gravity flow by turning the flow regulator counter-clockwise.

7. Check the drip chamber to measure the flow rate. Refer to the administration set package for number of drops/mL.

Discontinue Fluid Administration

1. Press [STOP]. If two lines are pumping, press [Stop All].
2. Press [ON/OFF] to turn off the infuser.
3. Close all clamps.
4. Detach the distal line from the patient access device.
5. Open the cassette door and remove the cassette.
6. Close the cassette door.
7. Discard the set and fluid container per hospital policy/procedure.

Alarms and Troubleshooting

The Plum 360 infuser has an intelligent alarm system that handles more than one alarm at a time. Alarms are prioritized as high, medium, or low. You can distinguish the priority by the number of beeps:

Priority	Number of Beeps
High	10
Medium	3
Low	2

High Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
Power Off then On. Replace pump if alarm continues. **High** Various E### Alarms	Malfunction.	Power the infuser off, and then on. Replace infuser if this does not clear the alarm.
Replace pump. Audio alarm failure. **High** E301	Audio alarm is OFF but sensed ON, or ON but sensed OFF.	Power off the infuser.
Replace pump. Backlight failure. **High** E302	Backlight voltage out of range during operation.	Power off the infuser.
Line B VTBI complete in prior CCA! Press STOP key. **High** N160	Line B delivery VTBI=0; the line was programmed under a different CCA than the CCA currently used; and Line B has a Concurrent delivery programmed.	Stop the delivery on Line B or open the cassette door.
Distal OCCLUSION! Resolve then Backprime. **High** N180	Distal occlusion detected while attempting to backprime or during cassette check.	Examine the distal line for kinks. Resolve the distal occlusion and then either backprime or open and close the cassette door.

Distal OCCLUSION! Check IV line and site. **High** N186	A distal occlusion is detected and either the maximum auto-restarts have occurred for the infusion or auto-restart was set to zero.	Examine the distal line for kinks and correct any found.Restart the delivery. **NOTE:** The alarm can also be cleared by clearing the confirmed programs on any programmed line or opening the cassette door. See section in SOM on Avoiding a Bolus While Resolving a Distal Occlusion.

⚠ WARNING: The Plum 360 infuser does not have capability to detect infiltration to the patient

Pump too high above patient. Lower pump or replace set. **High** N187	Distal occlusion detected during delivery due to too much backpressure.	Resolve the occlusion by lowering the infuser on the pole to place it closer to the level of the patient's heart (see section on Delivery Accuracy in SOM) and then press [START]. **NOTE:** The alarm can also be cleared by clearing the confirmed programs on any programmed line or opening the cassette door.

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Data was cleared. Re-enter all programming. **High** N103	Corruption of retained delivery parameters is detected. Autoclear of SEEP requires fresh delivery setup.	Acknowledge the alarm.
Distal AIR! Disconnect/reprime. Press START. **High** N233/N234	The single air bolus or the cumulative air detected at the distal sensor exceeds the air detection threshold.	Open the cassette door. Clear programs. See section in SOM on Resolving a Distal Air-In-Line Alarm.
Door opened! Infusion stopped! Close Door. **High** N250	The cassette door was opened during a delivery.	Close the cassette door with the cassette inserted.
Cassette test failure! Check set. **High** N251	Faulty cassette, proximal or distal occlusion, or air was detected in the cassette during the cassette test.	Resolve occlusion and then open and close the cassette door. Press ▲ **[Backprime]**. Replace administration set.
Depleted Battery! Plug into AC now! **High** N252	The infuser is running on battery power and the battery voltage is below the depleted battery threshold. A 3 minute shut down sequence begins.	Plug into an AC (mains) power source. After plugging the device in, the pump will automatically reboot.
Keypad locked. Enter code to disable. **High** N255	While the keypad was locked, someone pressed **[STOP]** or opened the cassette door during delivery.	Enter valid keypad unlock code.

Medium Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
Door opened! Delayed Start! Close Door. **Medium** N108	The cassette door was opened while an infusion was in Delayed Start.	Close the cassette door with cassette inserted.
Distal OCCLUSION - Paused! Attempting restart. **Medium** N192	A distal occlusion was detected and the maximum number of autoresets is configured but has not occurred for the infusion.	Examine the distal line for kinks and correct any found. No action is necessary if the patient can resolve the alarm condition within 60 seconds of activation (for example, moving an arm to eliminate the occlusion) before the maximum retry number is reached. Open the cassette door.

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Low Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
Keep Plugged into AC! Service battery/replace pump. **Low** N56/N57	The battery or battery charge circuitry needs servicing.	Power off the infuser. Replace the infuser as soon as possible, so that it can be sent for repair.
Power Off then On. Replace pump if alarm continues. **Low** E325	Battery voltage is greater than the expected limit.	Power off the infuser.
Low Battery! Plug into AC power! **Low** N58	The battery charge level is low.	Plug into AC (mains) power.
Programming not complete! Action required! **Low** N102	No operator input for two minutes after the infuser is powered on in Clinical mode, except for situations that trigger an alarm.	Press any hardkey or softkey except the hardkey that silences alarms.

Line A – High Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
No Action Alarm! Start or Clear Line A. **High** N101	No operator action for 2 minutes when Line A has been stopped by the user and is not cleared or restarted. **NOTE:** Will reassert if the condition persists.	Press any key on the infuser except [AUDIO PAUSED]. Select Line A to program or clear it.
Line A VTBI complete in prior CCA! Press STOP key. **High** N161	Line A was programmed under a different CCA than is currently being used and delivery is complete.	Stop the delivery on Line A. Open cassette door.
VTBI Completed Line A! Add more VTBI or Clear A. **High** N161	Line A delivery is complete and line was programmed under the CCA that is currently being used.	Add VTBI on Line A. Stop Line A. Open cassette door.

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Proximal OCCLUSION A! Check Line A. **High** N190/N191	Proximal occlusion or air detected on Line A during delivery.	Examine the proximal line for kinks and correct any found. If the occlusion is caused by a closed clamp, open the clamp. If all clamps are open, the alarm may be caused by excessive air that is creating backpressure in the cassette. To remove air, see section in SOM on Backpriming. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines. Restart Line A. **NOTE:** The alarm can also be cleared by clearing the confirmed programs on any programmed line or opening the cassette door.
Proximal AIR Line A! Backprime. **High** N232	The single air bolus detected at the proximal sensor in Line A exceeds the air detection threshold.	Press ▲ **[Backprime]**. See section in SOM on Backpriming. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.

Line A – Medium Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
Callback to Line A! Silence audio to clear. **Medium** N105	A Callback Alarm was programmed for Line A, and the VTBI for Line A reaches 0 for a Loading Dose or any step in a multistep therapy except the last step.	Press [AUDIO PAUSED].
Proximal OCCLUSION A! Resolve then Backprime. **Medium** N184	Proximal occlusion was detected on Line A during backprime.	Examine Line A for kinks. Resolve the occlusion. Either backprime or open and close the cassette door. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.
Bolus complete on Line A! Silence audio to clear. **Medium** N107	Bolus delivery completes on Line A and a Nurse Callback was confgured.	Press [AUDIO PAUSED].

Continued on page 28

Proximal OCCLUSION A Startup! Open/close door or Backprime. **Medium** N185	A proximal occlusion was detected on Line A during the cassette integrity test.	Examine Line A for kinks. Resolve the occlusion. Either backprime or open and close the cassette door. See section in SOM on Opening the Cassette Door Completely. Check syringe size. See section in SOM on Administration Sets and Accessories Guidelines.

Line B – High Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
No Action Alarm! Start or Clear Line B. **High** N101	No operator action for 2 minutes when Line B has been stopped by the user and is not cleared or restarted. **NOTE:** Will reassert if the condition persists.	Press any key on the infuser except [AUDIO PAUSED]. Select Line B to program or clear it.
Line B VTBI complete in prior CCA! Clear Line B. **High** N160	A Line B Piggyback delivery that was programmed under a different CCA is complete, and no delivery is programmed on Line A.	Clear the delivery on Line B or open the cassette door.

VTBI Completed Line B! Add more VTBI or Clear B. **High** N160	A Piggyback delivery on Line B is complete and the line was programmed under the current CCA and no delivery is programmed to deliver on Line A. **NOTE:** Piggyback with a Line A delivery will not alarm; it will just transition to Line A delivery.	Add VTBI on Line B. Clear program on Line B. Open the cassette door.
VTBI Completed Line B! Add more VTBI or Clear B. **High** N160	A Concurrent delivery on Line B is complete and the Line was programmed under the current CCA.	Add VTBI on Line B. Stop delivery on Line B. Open the cassette door.
Proximal OCCLUSION B! Resolve then backprime. **High** N183	Proximal occlusion detected on Line B during backprime.	Examine Line B for kinks. Make sure a line or syringe is attached to the secondary port and that the line is unclamped or the syringe has enough free space to accept the backprimed fluid. Either backprime or open and close the cassette door. See section in SOM on Backpriming to remove the air. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.

Continued on page 30

Proximal OCCLUSION B! Check Line B. **High** N188/N189	Proximal occlusion detected on Line B during delivery.	Examine the proximal line for kinks and correct any found. Restart Line B. **NOTE:** The alarm can also be cleared by clearing the confirmed program or opening the cassette door.
Proximal AIR Line B! Backprime. **High** N231	The single air bolus detected at the proximal sensor in Line B exceeds the air detection threshold.	Press ▲ **[Backprime]**. See section in SOM on Backpriming. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.

Line B – Medium Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
Callback to Line B! Silence audio to clear. **Medium** N104	A Callback Alarm was programmed for Line B which is in Piggyback mode, Line A is programmed to resume when Line B completes, and the VTBI for Line B reaches 0 for a Piggy-back therapy, Loading Dose, Maintenance Dose or any step in a multistep therapy. OR A Callback Alarm was programmed for Line B, which is in Piggyback mode, Line A is not programmed to resume when Line B completes, and the VTBI for Line B reaches 0 for Loading Dose or any step in a multistep therapy except the last step. OR A Callback Alarm was programmed for Line B, which is in Concurrent mode, and the VTBI for Line B reaches 0 for a Loading Dose or any step in a multistep thera-py except the last step.	Press [AUDIO PAUSED].

Continued on page 32

Proximal OCCLUSION B. Resolve then Backprime. **Medium** N183	Proximal occlusion detected on Line B during cassette integrity test.	Examine Line B for kinks. Make sure a line or syringe is attached to the secondary port and that the line is unclamped or the syringe has enough free space to accept the backprimed fluid. Either backprime or open and close the cassette door. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.
Bolus complete on Line B! Silence audio to clear. **Medium** N106	Bolus delivery completes on LIne B and a Nurse Callback was configured.	Press [AUDIO PAUSED].

Line A and B – High Priority Alarms

Alarm Message and Priority	Possible Cause	Corrective Action
No Action Alarm! Acknowledge Alert. **High** N101	Rate was recalculated; operator has not acknowledged the alert within 30 seconds.	Press a labeled softkey.

Line not in STANDBY! Choose line(s) to Standby: **High** N101	No operator action for 15 seconds when the user has selected ▲ **[Standby]** when both lines are able to be put in standby, but has not selected a line (A, B or A & B) or selected ▲ **[Cancel]** to complete the action.	Press ▲ **[Standby All]**, ▲ **[Standby A]**, ▲ **[Standby B]**, or ▲ **[Cancel]**.
Delivery was not STOPPED! Choose line(s) to stop. **High** N101	No operator action for 15 seconds when the user has attempted to stop a delivery when both lines are delivering by pressing **[STOP]**, but has not selected a line (A, B or A & B) or selected ▲ **[Cancel]** to complete the action.	Press ▲ **[Stop All]**, ▲ **[Stop A]**, ▲ **[Stop B]**, or ▲ **[Cancel]**.
Delivery was not STARTED! Choose line(s) to start. **High** N101	No operator action for 15 seconds when the user has attempted to start a delivery when both lines are confirmed by pressing **[START]**, but has not selected a line (A, B or A & B) or selected ▲ **[Cancel]** to complete the action.	Press ▲ **[Start All]**, ▲ **[Start A]**, ▲ **[Start B]**, or▲ **[Cancel]**.

Continued on page 34

Yes: Start program No: Edit **High** N101	Standby is not possible and no operator action for 30 seconds when a titrated program is waiting to be confirmed.	Press ▲ **[Yes]** to confirm the program or ▲ **[No]** to go back to the Program screen.
No Action Alarm! Yes: Start No: Edit **High** N101 **NOTE:** Standby is intentionally not included in the instruction text.	Standby is possible and no operator action for 2 minutes when a new program is waiting to be confirmed or placed into Standby.	Press ▲ **[Yes]** to confirm the program or ▲ **[No]** to go back to the Program screen, or press ▲ **[Standby]**.
Yes: Start program No: Edit **High** N101 **NOTE:** Standby is intentionally not included in the instruction text.	Standby is possible and no operator action for 30 seconds when a titrated program is waiting to be confirmed or placed into Standby.	Press ▲ **[Yes]** to confirm the program or ▲ **[No]** to go back to the Program screen, or press ▲ **[Standby]**.
No Action Alarm! START: Confirm program **High** N101	No operator action for the 30 seconds when a line is titrated during infusion and the ◈ [START] hardkey has not been pressed for a program that can be started. **NOTE:** A delivery cannot be started if it is in a concurrency violation. If it is in a concurrency violation, an alarm will occur.	Press ◈ **[START]**. Press ▲ **[Return to A/B]**.

No Action Alarm! Yes: Override. No: Edit **High** N101	Soft limit override and no operator action for 2 minutes when a new program is waiting to be confirmed. OR Soft limit override and no operator action for 30 seconds when a titrated program is waiting to be confirmed.	Press ▲ **[Yes]** to confirm the program or ▲ **[No]** to go back to the Program screen.
No Action Alarm! Start or clear lines. **High** N101	No operator action for 2 minutes when both lines have been stopped by the user and not cleared or restarted. OR No operator action for 2 minutes after a Bolus has been cancelled (putting both lines into a stopped state). **NOTE:** Will reassert if the condition persists.	Press any hardkey except **[AUDIO PAUSED]**.
No Action Alarm! Yes: Start No: Edit **High** N101	Standby is not possible and there is no operator action for 2 minutes when a new program is waiting to be confirmed.	Press ▲ **[Yes]** or ▲ **[No]**.

Continued on page 36

Alarm Message and Priority	Possible Cause	Corrective Action
Proximal AIR! Backprime. **High** N230	The cumulative air detected at the proximal sensors in Line A and Line B exceeds the air detection threshold.	Press ▲ **[Backprime]**. See section in SOM on Backpriming. Check the syringe size. See section in SOM on Administration Sets and Accessories Guidelines.

icumedical
human connections

CADD-Solis PCA Pump (MUNSON)

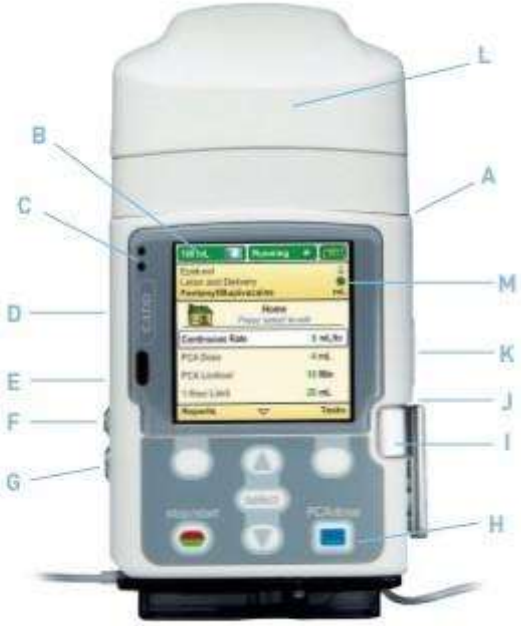
CADD-Solis PCA Pump (MUNSON)

Critical Notes!

6.19.2024

Critical Note!

PCA will have a gray faceplate. (PCEA will have a yellow faceplate.)



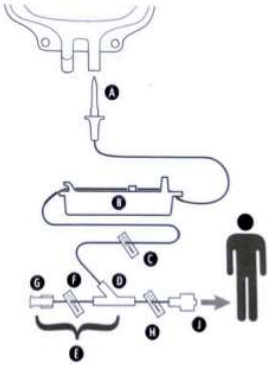
A	Battery Compartment	H	Keypad
B	Display	I	Cassette Latch
C	Indicator Lights	J	Cassette/Keypad Lock
D	USB Port	K	Power Button
E	Blue AC Power Light	L	Wireless Communication Module
F	AC Power Jack		
G	Remote Dose Cord Jack	M	Wireless Indicator

CADD PCA Pump Priming

1. Close clamps **C**, **F**. Remove protector cap from bag spike **A** and insert spike into medicated IV bag. Hang bag.

2. Attach cassette to pump. Remove end cap from male Luer **J** on long piece of tubing. Prime tubing to y-connection per Lippincott Procedures and *Operator's Manual*.

3. Prepare Y-extension side: Prepare primary IV fluid source and tubing, then attach to one-way check valve **G**. Close clamp **C**. Open clamps **F**, **H** and fill tubing to male Luer **J** with fluid. Close clamps **F**, **H**.



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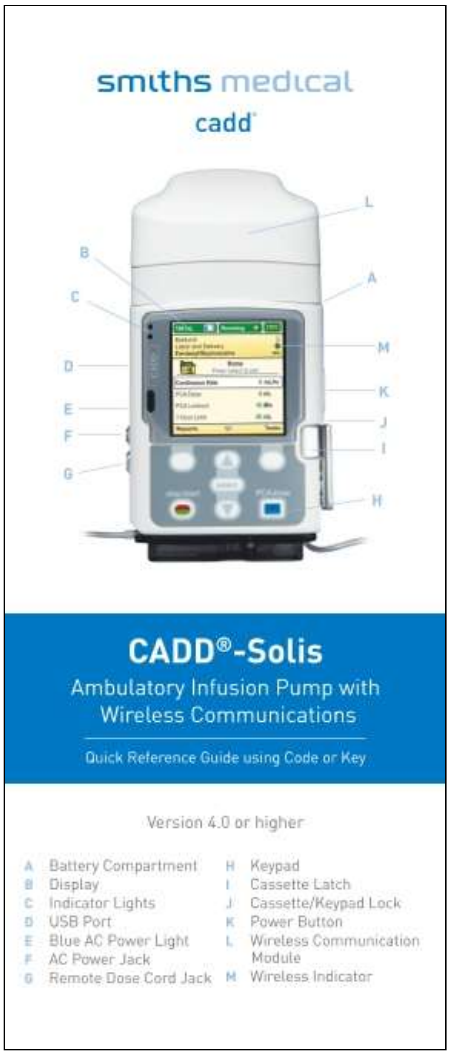

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Introduction

11.1.2021

Objective: To accurately use the CADD-Solis PCA Pump.

To Set up a PCA on a new patient

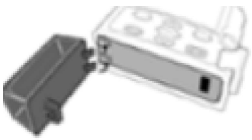
Verify the order in the patient's chart.

Obtain a PCA Pump. This will need a key to open a lock box. The pump can be locked to the pole if necessary, using the same key. The dose cord should be kept with the machine in the outlet. If it becomes disconnected, reconnect by fitting the two half-moon shapes opposite each other in the plug and pushing straight in. Twisting to insert the cord will break the internal pins.

Plug into a power source. Turn the PCA on using the power button on the right-hand side of the pump.

The Screen will display "Do you want to start a new patient?". Press Yes. Choose the correct profile and press Select. Follow the prompts to choose the correct therapy, qualifier, drug, and concentration. Unlock the keypad using the security code. Confirm your selections. Soft limits can be overridden by pressing Yes. Continue until all patient specific parameters have been reviewed and/or edited. Press Accept Value for each setting. A check mark will appear next to each setting you have accepted. When all values are accepted, press Next.

Spike your medication bag after all verifications have been done according to policy. Hang the bag behind the pump inside the lock box. Remove the blue clip from the cassette. The tubing will be clamped at this point. Open the cassette latch by pulling the handle downward. Insert your cassette by hooking it onto the pins and firmly latching the side of the cassette until you hear a click. Lift the latch into the closed position on the side of the pump. Lock with the key. The pump will alarm if not locked correctly.



When you latch the cassette to the pump, the prompt will appear "Prime Tubing?". Press Yes to prime the tubing. Using the pump to prime will maintain volume accuracy. "Disconnect tubing…" displays. Make sure your tubing is not connected to the patient and Press Prime. Press Stop Priming when complete. Prime to the Y-site only. "Continue Priming?" will appear. Press Yes or No. "Start Pump?" will display. Press Yes when you are ready to begin the infusion. The pump will begin running.

To change a patient's current program while the pump is running:

Scroll up or down to highlight the patient specific parameter you want to change. Press Select. Unlock the keypad using the security code. The patient specific parameter is displayed. Scroll up or down to the new value then press Save. Repeat these steps as necessary for each parameter that you want to change.

To Reset the reservoir volume without changing the tubing:

Stop the pump by pressing the Stop/Start. Press Yes when asked "Stop pump?" Aseptically remove the empty IV bag from the tubing and attach the new IV bag. Scroll down until Reservoir Vol is highlighted. Press Select. The screen will display "Reservoir Volume remaining: __ml Reset?" Press Yes. Unlock the keypad using the security code. The screen displays the current reservoir volume and a scroll range. Press Select to reset the reservoir volume to the amount displayed in blue text or scroll up or down to adjust the value. Press Save. Press Stop/Start. "Review pump settings" displays. Press Review. Verify dosing with another Nurse if necessary per

policy. Choose Accept Value to confirm the value is correct for the highlighted patient specific parameter or press Select to edit the highlighted parameter. Continue until all patient specific parameters have been reviewed, accepted and display checkmarks. Press Next. "Start Pump?" displays. Press Yes. If a code was used to unlock the keypad, it will automatically relock when the pump is started. You can also press No when "Start Pump?" appears to start the pump later. Lock the keypad by pressing the right soft key twice. Be sure the cassette is locked also by turning the cassette/keypad lock clockwise to the locked position.

To give a bolus dose while pump is running:

Press Tasks. "Give Clinician Bolus" is highlighted. Press Select. Unlock screen with security code. The screen will display the bolus scroll range available. Scroll up or down until the desired value appears. Press Deliver. NOTE- if the value is outside the soft limit, confirm the soft limit override by pressing Yes.

Choose Stop Bolus at any time during delivery to cancel the bolus. Bolus will not affect the patient's ability to push their own dose with their button before or after the clinician bolus.

To View Reports and Clear history:

Press Reports on the home screen. Scroll up or down to the desired report and press Select. You can also access Report from the Tasks button. Scroll up or down to the "Given and PCA Dose Counters" report. Press Select. Make sure to write down your numbers before clearing. Press Clear Given to clear Total Given and update the date/time stamp. Scroll down to "PCA doses Given/Attempted". Press Clear. Press Back to return to the report menu, and Back again to return to the Home screen.

POWER: The battery indicator is in the upper right-hand corner of the home screen. The CADD can only recharge when it is plugged into an external source.

- Green indicates a 50% charge or greater.
- Yellow indicates less than 25% charge, and the pump will emit 3 beeps every 5 minutes.
- Red indicates a depleted battery, and the pump will emit a continuous variable-tone alarm. The pump will stop delivery at this point.

ALARMS:

<u>High Priority Alarm</u> - If the pump is running, it always stops when a high priority alarm is activated. Accompanied by a red screen, it continues until acknowledged or until the condition that triggered the alarm goes away.

Some high priority alarms are:

1, "Air in line" - Press "Acknowledge" then prime tubing.

2. The pump has lost power and is no longer delivering - Clear this alarm by replacing the batteries or closing the battery door and turn the pump back on.

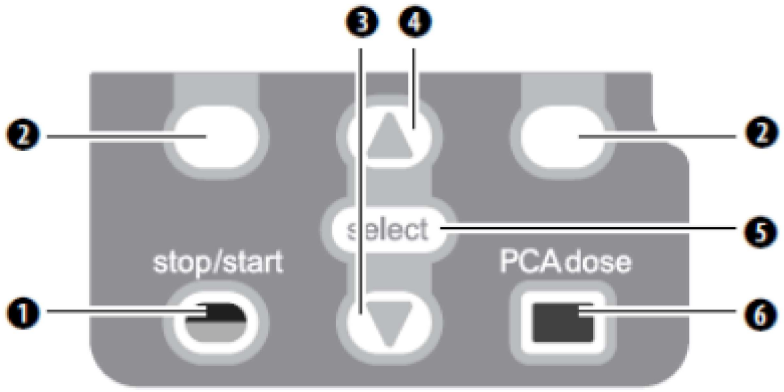
3. Downstream Occlusion – Stop the pump to silence the alarm for 2 minutes and clear the occlusion. Restart the pump.

4. Reservoir volume is zero. Pump stopped – Install a new reservoir.

Medium Priority Alarm – Does not stop the pump. Accompanied by an amber screen, it continues until acknowledged or until the condition that triggered the alarm goes away. One medium alarm is "Reservoir volume low" – prepare to install a new reservoir.

Low Priority Alarm – Does not stop the pump. Accompanied by a blue screen, the alarm automatically clears after 5 seconds or when the condition that triggered the alarm goes away. A low priority alarm is Delivery limit reached. Select Acknowledge to clear the alarm, or it will automatically clear after 5 seconds.

Informational Message – Does not stop the pump. This message appears in the status bar. It is displayed for 5 seconds and is generally silent, requiring no acknowledgement.



Key:

1. Stop and Start button – stops and starts delivery.
2. Soft keys – Allows you to answer a question on the pump's display and to navigate through some of the pump's screens.
3. Scroll down – Allows navigation through the menus on the pump and editing of values.
4. Scroll up – Allows navigation through the menus on the pump and editing of values.
5. Select – Used to select a menu item.
6. PCA dose – Allows a patient to request a PCA dose if the remote dose cord is not connected. If the remote dose cord is connected, this key will be inactive.

Procedure: CADD®-Solis Ambulatory Infusion Pump - Epidural (MUNSON)
Checklist: CADD®-Solis Ambulatory Infusion Pump - Epidural (MUNSON)
Evaluator's Name: _____ **Examinee's Name:** _____
Evaluator's ID: _____ **Examinee's ID:** _____
Evaluator's Dept: _____ **Examinee's Dept:** _____
Date: _____ **Meets criteria/Does not meet criteria:** _____
Select Evaluation Method:
☐ Clinical Observation ☐ Documentation Review
☐ Demonstration ☐ Verbalization

CADD®-Solis Ambulatory Infusion Pump - Epidural (MUNSON)

CADD®-Solis Ambulatory Infusion Pump - Epidural (MUNSON)
Objective: The appropriate clinical staff will be able to:

1. **Demonstrate proper use and programming of the CADD®-Solis ambulatory infusion pump.**
2. **Describe proper response to the CADD®-Solis ambulatory infusion pump alerts and alarms.**

State what population-served considerations you made (or would make) in providing care for the patient.
Pump Operations and Programming
☐ Wash hands
☐ Review provider's order
☐ Gather equipment - pump, medication cassette & tubing, key, tubing labels
☐ Scan and confirm patient
☐ Scan and confirm drug
☐ Push Power button on right side of pump
☐ Start a new patient
☐ Select the appropriate:

- **Therapy**
- **Qualifier**
- **Drug**

☐ Unlock keypad using the code or key
☐ Verify Therapy, Qualifier, and Drug

☐ Review pump settings

- To edit for a patient-specific parameters, press Selelct and scroll to new value and press Save

☐ Accept the values
Attaching Cassette/Administration Set
☐ Unlock pump with key
☐Attach, latch, and lock the cassette
☐ Prime the tubing
☐ Attach the pump to the lockable pole mount bracket
☐ Attach the remote dose cord, if applicable
Pump Operations and Programming
☐ Press **Yes** to start the pump
☐ Push Tasks to adjust backlight intensity as needed
☐ Push Tasks to adjust alarm volume as needed
☐ Deliver a bolus, if ordered

- Push Tasks
- Select Clinician Bolus
- Enter code
- Select amount

☐ Deliver a PCEA dose, if ordered
☐ Make a program change with the pump running, if ordered
☐ Stop the pump when ordered
☐ Change the reservoir with/without changing the administration set, enter code, view settings, accept values, and start pump
☐ Change/reset the reservoir volume, enter code, view settings, accept values, and start pump
Alarms
☐ Describe the difference between Informational, Low, Medium, and High Priority Alarms and respond accordingly

- A High Priority Alarm always stops the pump

☐ Troubleshoot these alarm conditions:

- Low battery
- Reservoir volume low
- Reservoir volume zero
- Upstream occlusion

- Downstream occlusion
- Air in line
- Battery depleted

Pump Reports
☐ View and clear pump reports, if applicable
Documentation
☐ Document time/date of site insertion, patient's response to treatment (including vital signs), dressing condition/insertion site, and amount infused (see epidural infusion policy)
Competence in the task will be recognized according to achievement of the indicators listed.
Need identified by: New equipment/procedure, medication administration, and job description.
Method of validation: Direct observation by peer/manager or return demonstration; monitor function.
Action Plan/Comment developed for all findings rated "Not Met" or "Fail".
Resource:
Smiths Medical ASD, Inc. (2012, March). CADD®-Solis Ambulatory Infusion Pump V3.0 Skills Performance Documentation for Health Care Personnel. St. Paul, MN.

End-Tidal Carbon Dioxide (EtC02) Monitoring (MUNSON)

End-Tidal Carbon Dioxide (EtC02) Monitoring (MUNSON)

Critical Notes!

Note: This is not the EtCO2 procedure for Procedural Sedation!

Introduction

Revised 6.9.2022

Objective: To monitor end-tidal carbon dioxide (EtC02) in patients using a PCA/PCEA and/or are at high risk for respiratory depression from other opiate use.

End-tidal carbon dioxide ($EtCO_2$) determines the carbon dioxide (CO_2) concentration in exhaled gas to provide information about a patient's pulmonary, cardiac, and metabolic status. This information aids patient management and helps prevent clinical compromise. In $EtCO_2$ monitoring, air is sampled during expiration from one of the nares through the cannula. A monitor converts this data to a CO_2 value and a corresponding waveform, or capnogram, if capnography is used.

$EtCO_2$ monitoring is recommended for use in the patient receiving epidural (PCEA), patient-controlled analgesia (PCA), or at high risk for respiratory depression from other opiate use. The use of EtCO2 monitoring has significantly increased patient safety. $EtCO_2$ monitoring is also recommended to guide ventilator management and has become the standard during anesthesia administration; as well as monitoring those patients receiving moderate sedation.

Why use an EtCO2 monitor?

- Acts as an early warning of hypoventilation or no breath.
- An alarm will sound so the nurse can act quickly to prevent further respiratory deterioration.

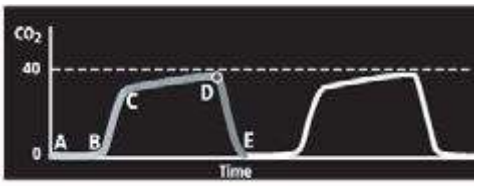
EtCO2 or SpO2 monitoring?

- EtCO2 monitoring is the preferred method, as it more accurately reflects breath to breath ventilation.
- SpO2 monitoring detects hypoxia and is used when the patient is using prescribed CPAP/BiPAP equipment.

Who do we monitor?

- All patients who have PCA or PCEA in use
- Provider order
- Any patient deemed at risk for respiratory sedation per nursing judgement

The Normal Capnogram waveform (Normal ventilation value 35-45)



Clinical findings: Normal breathing, Normal EtCO2 value

A - B: (Baseline period) End of inhalation and beginning of exhalation

B - C: Rapid rise in CO2 during exhalation begins

C - D: Sustained exhalation, alveolar plateau with alveolar gas exchange

D: End of expiration, Point where end tidal CO2 (EtCO2) value is measured

D - E: Inhalation and rapid decrease in CO2

Equipment

- Masimo module or SpaceLab module
- EtCO2 nasal cannula

Implementation

See content.

Procedure

- Confirm order or assess for risk of respiratory sedation.
- Gather equipment.
- Attach the EtC02 nasal cannula/tubing to the module.

- Power on by pressing and holding the Home button for more than two seconds, until one audible tone sounds. The Home button will illuminate green and the device will power on.
- Data is saved for the last 96 hours. If you need to clear data from a previous patient, touch the wheel button at the lower left, scroll to "Trends" and touch "Clear patient", and "yes".
- Place a cannula on the patient. Cannulas are single patient use only. Insert the prongs into the patient's nostrils and position the oral scoop, if present, in front of the mouth. Pass the cannula lines over the ears and adjust the slider for comfort and fit under the chin.
- Connect the cannula sampling line to the monitor by turning the connector clockwise into the monitor inlet until it cannot be turned anymore. The LEGI connector will illuminate colors depending on the state of the device.

  Steady green light indicates the system is OK.

  Blinking green light indicates the system zeroing is in progress.

  Steady red light indicates sensor error.

  Blinking red light indicates an occlusion alarm and that you should check the sampling line.

- Ensure the tubing is properly connected and that it is not twisted or crimped.
- Adjust the oxygen flow to the ordered amount.
- Attach the oxygen supply tubing to the oxygen source.
- Press the Main Menu icon at the bottom left corner of the Display View as shown below by the indicator #3.

- Once the Main Menu screen is displayed, swipe the screen left or right to pan the menu icons, or touch the arrow icon to return to the Display View. You can also touch the matching icons at the bottom of the screen to jump to other sections instead of swiping.

If there is no user interaction within one minute, the display times out and returns to the Display View.

- Confirm any settings by selecting OK or hit "Cancel". After one minute of inactivity, the screen will return to the Display View. To navigate to the previous screen, press the arrow at the top left corner of the touchscreen. To return to the Display View, press the Home button at any time (see below).

- Identify when it is clinically acceptable to discontinue monitoring, per order.
- To power off, press and hold the Home button for two seconds, until two audible tones sound. The Home button will flash orange. The device will power down and turn off.
- Clean monitor with purple top or orange top wipes and return it to the appropriate storage area.

- Charge the Rad-97, if not already charged (approximate battery charge time for initial use is six hours; three hours to recharge) by plugging the AC power cord into an AC power source. Verify that the battery is charging. When Rad-97 in ON and charging, the AC power indicator lightning bolt icon will appear on the screen. When Rad-97 is OFF and charging, the Home button will illuminate orange. When the battery is ON and fully charged, the AC power indicator will change to a plug icon. The battery has up to four hours of life.

Special Considerations

See content.

Patient Care

If the patient desires to eat, and the cannula has a scoop, the EtCO2 cannula will need to be removed. The nurse should assure the patient is upright in good position for breathing. Reapply the EtCO2 cannula immediately after eating and assure the alarms are turned back on.

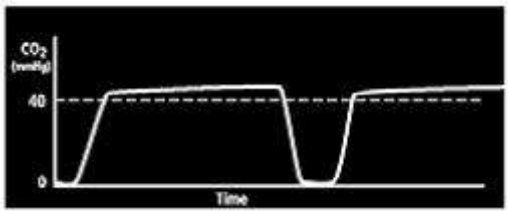
Complications

ALARM RESPONSE

- Repond to alarms promptly. Assess and intervene, as necessary.

Potential causes of HIGH alarms:

- Caused by hypoventilation/ decreased respiratory rate
- May be caused by recent carbonated beverage or antacid ingestion
- May be due to fever or shivering



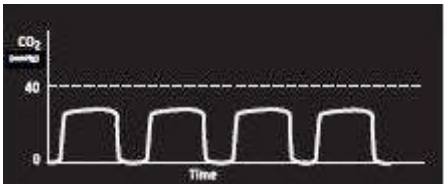
Hypoventilation waveform

Interventions for HIGH Alarms:

- Assess Pasero Opioid-induced Sedation Scale (POSS) score.
- Assess need to change $EtCO_2$ cannula
- Increase the head of the bed (HOB)
- Reposition patient in bed to take pressure/obstruction off neck
- Reposition $EtCO_2$ cannula
- Encourage cough & deep breathing
- Encourage Incentive Spirometer use
- Consider naloxone (Narcan) if over sedated
- Contact provider as needed

Potential causes of LOW alarms:

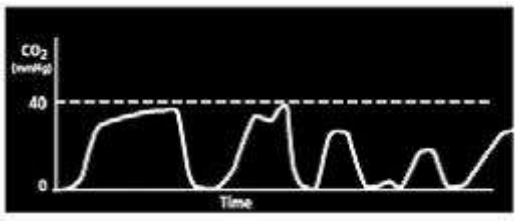
- Caused by increased respiratory rate/hyperventilation **OR** hypoventilation with shallow breathing
- Can be due to sedation or hypothermia
- Hypotension may decrease $EtCO_2$
- Pulmonary Edema (PE)



Hyperventilation waveform

Interventions for LOW Alarms:

- Assess Pasero Opioid-induced Sedation Scale (POSS) score.
- Encourage cough & deep breathing
- Ensure cannula is in place
- Encourage Incentive Spirometer use
- Consider naloxone (Narcan) if over sedated
- Increase O_2 or put patient on O_2, per order
- If due to oversedation, consider discontinuing continuous infusion on PCA/PCEA, if applicable
- Contact provider as needed



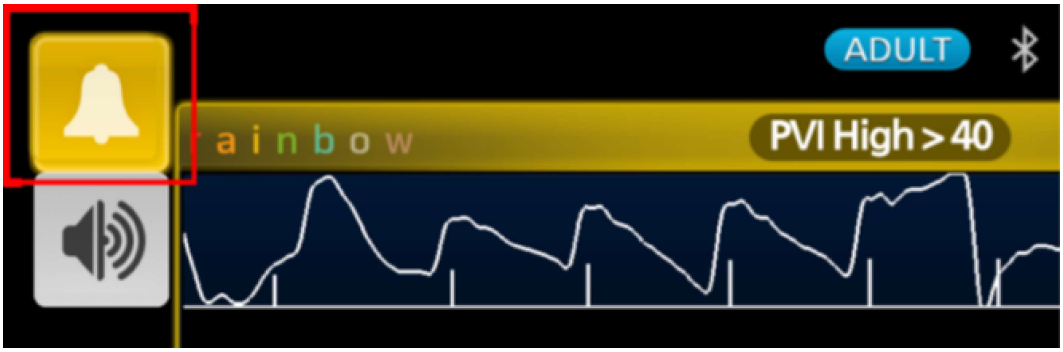
Partial Airway Obstruction waveform

A partial airway obstruction can show a high or low EtCO2

<u>Response to Alarms Key Points</u>

- Evaluate the patient-assess airway and breathing
- Use the PCA/PCEA protocol, POSS, or naloxone (Narcan) protocol, as appropriate
- Secure assistance from respiratory therapy
- Call an MRT as needed
- Contact the provider as needed
- Default alarm settings may not be changed without a provider order

- Touch the "Alarm Silence" button. (Alarms are audible, visual, or both.) If the alarm is for a specific parameter, you can touch the highlighted parameter to silence the alarm as well. Audible alarms that are temporarily suspended by pressing the "Alarm Silence" button can be unsuspended by pressing the "Alarm Silence" button again (see below).



Documentation

Patient and family education regarding the use of EtCO2 and patient safety.

EtCO2 values every four (4) hours, when a significant change in patient status occurs, during respiratory procedures, and other interventions unless otherwise ordered.

References

Oridion Medical Ltd. "Airway Breath Monitoring with Capnography" 2010. Accessed December 13.th, 2011. https://gm1.geolearning.com/geonext/oridion/dynamicopensite.geo?id=gA___eecEeisCj6VwdS0PU9gKZ%2fzeIzfcNLX6%2fRd%2fiybduerbnRPsSaRA%3d%3d&nav=English>

Oridion Medical Ltd. "Capnography Monitoring …Understanding the Basics." 2010. Accessed January 23.rd, 2012. http://www.carefusion.com/pdf/Infusion/clinical_documentation/faq_tip_sheets/IF_1415_Alaris_pain_management_portfolio_FAQs.pdf>

https://www.masimo.com/products/continuous/rad97-capnography/, Retrieved September 28, 2022.

https://www.masimo.com/siteassets/us/documents/pdf/plm-10050b_product_information_rad-97_nomoline_capnography_us.pdf,_

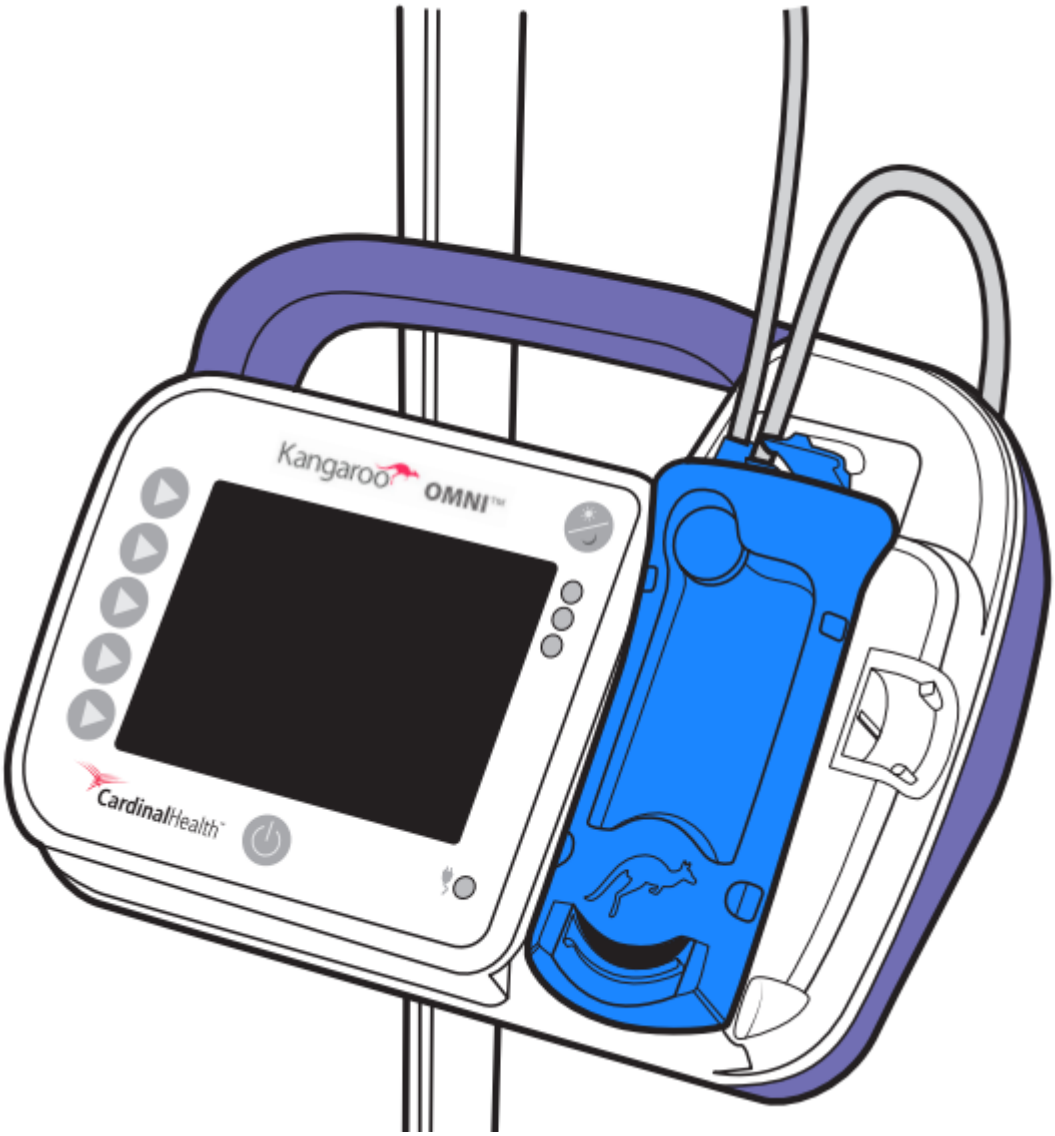
Retrieved September 28, 2022

Kangaroo Omni feeding pump

Video: [Kangaroo OMNI™ Inservice - Cardinal Health]

Introduction

Whether you are giving continuous feeding, or intermittent, the setup of the pump is the same. The Kangaroo OMNI™ Enteral Feeding Pump with Kangaroo OMNI™ Feeding Sets are intended for delivery of enteral fluids, including nutritional fluids and/or water to the gastrointestinal system via nasogastric, orogastric, nasojejunal, gastrostomy, and jejunostomy tubes. Not for use with neonates. Your first place to start is with the providers' order. There are many kinds of food that may be ordered. The food will make a difference what type of tubing you will need. The pump will be the same.



Equipment

Kangaroo Omni pump

Food according to order

Tubing (if food needs to be poured into a bag, choose the bag tubing; if the food needs to be spiked, choose the tubing with a spike). Both types of tubing will have a flush bag.

Preparation of Equipment

Inspect the pump and tubing for damage and malfunction. Inspect the food for expiration date, appearance, and smell for damage or contamination. If any of these items appear to be damaged, contaminated, or malfunctioning, remove from use and obtain replacements.

Implementation

Perform Hand hygiene.

Review Providers order.

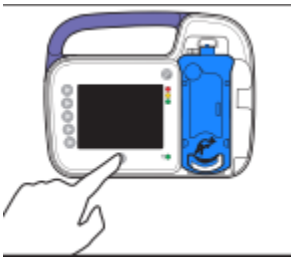
Gather equipment – pump, tubing, food ordered, water (sterile if the patient is immuno-compromised).

Plug in the pump. Avoid leaving wires, cords, or tubing in a pathway where a person could trip on them.

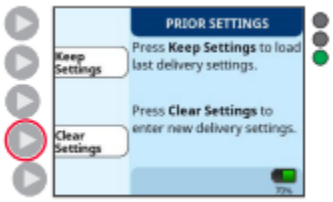
Confirm Patient.

Confirm feeding solution.

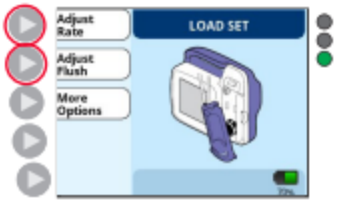
Push gray power button at center bottom of the pump on.



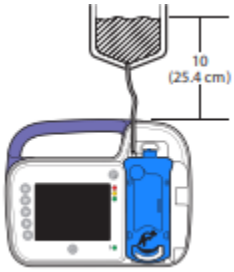
If the pump has been used before, a prior setting screen will appear. Otherwise, the “Load Set” screen will be shown. If this is a new patient, choose “Clear Settings” button.



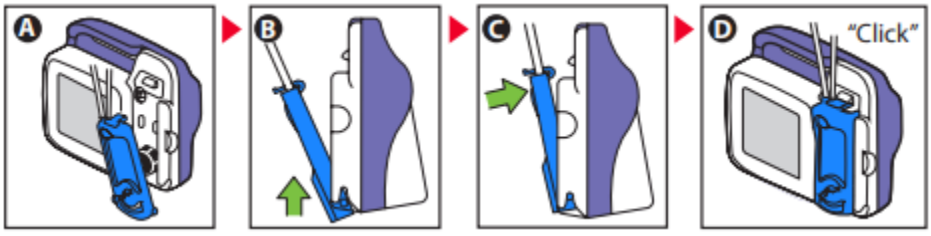
Press the “Adjust Rate” button or the “Adjust Flush” button and make any desired adjustments per order.



For closed system, spike bag. For open system, pour no greater than 4 hours amount of food into bag. Fill the flush bag with water. Use Sterile water only if the patient is immunocompromised. Label the bag with the patient’s name, date, and time. Hang the feeding bag or container so the highest level of enteral fluids is 10 inches above the pump.

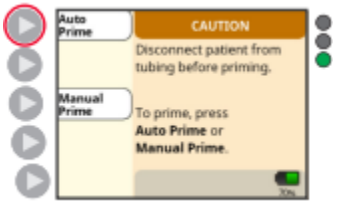


The pump will say “Load Set”. Install the cassette into the pump as shown until you hear a “click”. The screen will confirm that the pump has correctly identified the feeding set.



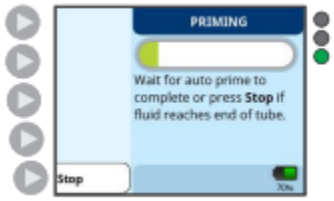
You are now ready to prime the tubing. If you have already primed the tubing, there is a "Skip Prime" option on the screen. If you still need to prime the tubing, choose the "Prime" button. ***WARNING** – Patient **must not** be connected to the feeding pump when priming is performed.

Please note: When using a Feed with Flush Feeding Set, always prime the flush tubing before the feed tubing when using Kangaroo OMNI™ Feed Sets with Flush Bags. The Auto Prime feature of Kangaroo OMNI™ will manage this for you. Priming the flush tubing after priming the feed tubing will introduce air in the tubing after the feeding solution, which will require the feed tubing to be primed again to remove the air.

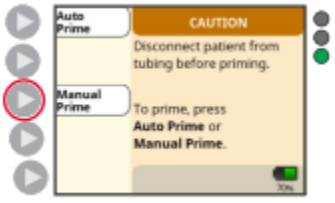


Press "Auto Prime" to automatically prime the feeding set.

The Omni pump will show a progress bar indicating the automatic prime is in process. Wait for priming to complete. A "Prime Feed" button will come up.



If manually priming the feed set, choose "Prime" and "Manual Prime". Hold the "Prime Feed" button until feeding solution just begins to exit the distal connector.

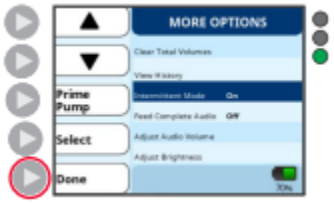


Press "Done" to continue set up. The "Ready to Feed" screen will appear.

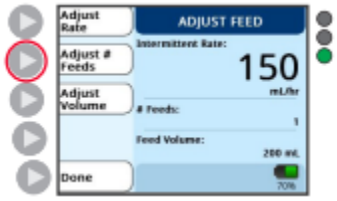
For Continuous feed mode, adjust rate to the continuous feeding rate ordered using plus and minus buttons. Choose “OK” when desired rate has been selected.

For Intermittent feed mode, a fixed volume will be delivered. Press the “More Options” button on the “Ready to Feed” Screen.

Press the arrow button up or down until “Intermittent Mode” is highlighted. Press the “Select” button. “On” or “Off” will be displayed to indicate the present Intermittent Mode state. Press “done” to return to the ready to feed screen. The “Adjust Feed” button will now appear, and feed settings can be adjusted.



To adjust the intermittent feed settings, press the “Adjust Feed” button. Press the “Adjust # Feeds” button. Then use the plus and minus buttons to choose the volume of feed to be delivered. Press “OK” to save settings and return to the “Adjust Feed” screen.



Press the “Adjust Interval” button to set the feed interval. This will not appear if the “# of Feeds” is set to “1”. Adjust with the plus and minus buttons as needed. Hit “OK” to save. Press “Done” to return to the “Ready to Feed” screen.

To adjust the flush, press the “Adjust Flush” button from the “Ready to Feed” Screen.

Press the “Adjust Volume” button and use the plus and minus buttons to input the desired volume. Pres the “OK” button to confirm the flush volume and return to the “Adjust Flush” screen. Press the “Adjust Interval” button and use the plus and minus buttons to input the desired time interval. Then press “OK” to confirm the time and return to the “Adjust Flush” screen. Press “Done” to confirm and return to the “Ready to Feed” screen.

Attach tubing to patient. Press “Start” to begin feeding. The “Start” button will only appear if all the feed and/or flush parameters have been entered. A Green screen with a moving droplet means the feeding is in progress.

Continuous Mode

Intermittent Mode

To make changes once the feeding has started, press the “Stop” button, then the “Adjust Rate” or “Adjust Flush”.

Once the feeding is complete, the pump will stop operation and display “Feed Complete”, and the status indicator will blink green. Press “Done” to clear the notification.

If you end the feeding before the pump is programmed to do so, press the “Stop” button. Press “More Options” and scroll down to “Feed Complete” is highlighted. Press the “Select” button to toggle the audio between “On” and “Off”. Then press “Done”.

To turn off the pump, press and hold the power button for 3 seconds.

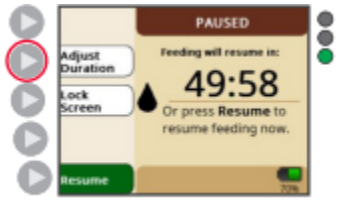
Remove and dispose of the feeding set.

Additional Options while feeding is in progress

To stop feeding, press the “Stop” button at any time.

To flush on demand, press the “Flush Now” button. Then use the plus and minus buttons to put in the desired flush volume and hit “Start”. Press the “Cancel Flush” button to stop a flush now that is in progress and return to feeding.

To pause feeding, you can push the “Timed Pause” button. The default is 5 minutes, but you can pause from 5-240 minutes. While paused, the pump will move a very small amount of feeding solution through the feeding set. The feeding will automatically resume when the pause duration ends. To adjust the pause time, press the “Adjust Duration” button. An amber screen with a stationary droplet means the feeding is paused.



You can also press the resume button at any time to resume the feeding.

Troubleshooting alarm conditions:

Pump Alarm Indicator Lights are on the upper right of the pump screen.

Solid Green = Pump Running

Blinking Green = Ready

Solid Yellow = Information

Blinking Yellow = Notification

Blinking Red = CRITICAL ALARM

The alarm can temporarily be silenced for two minutes by pushing the button next to the bell on the screen.

Some yellow alarms are:

“Feed Error”- These can include an empty bag, excessive foam, or blockage in the tubing.

“Low Battery”- The feeding pump will continue to deliver fluid during this alarm. Plug in to nearest outlet as soon as possible. You have 15 minutes left.

“Rotor Stuck”- This can be caused by buildup around the rotors. To fix this, unplug and turn off pump. Wipe rotor with a wet cloth, plug back in, attach tubing and restart.

Some red alarms are:

“Dead Battery”- This means a dead battery is imminent. Plug in immediately. The pump will have to be restarted.

“System Error” – Restart the pump as directed on the screen. If the pump does not restart and the error message continues, call Bio Med.

Kangaroo OMNI™ Enteral Feeding Pump Overview

Kangaroo OMNI™ Enteral Feeding Pump Overview: Front

Selection Buttons: Press the selection buttons next to the desired option on the screen.

Night Mode Button: Press once to switch screen to night mode. Press again to return to normal mode.

Power Indicator Light: Green light confirms Kangaroo OMNI™ Enteral Feeding Pump is connected to AC power.

Cassette: The feeding set component that attaches to the Kangaroo OMNI™ Enteral Feeding Pump.

Pump Rotor: Circular black wheel that drives fluid through the Kangaroo OMNI™ Feeding Set.

Occlusion Sensor: Pump component used to determine fluid presence and detect occlusions.

Valve Actuator: Pump component that opens and closes the Kangaroo OMNI™ Feeding Set valve used to prevent free flow of fluid.

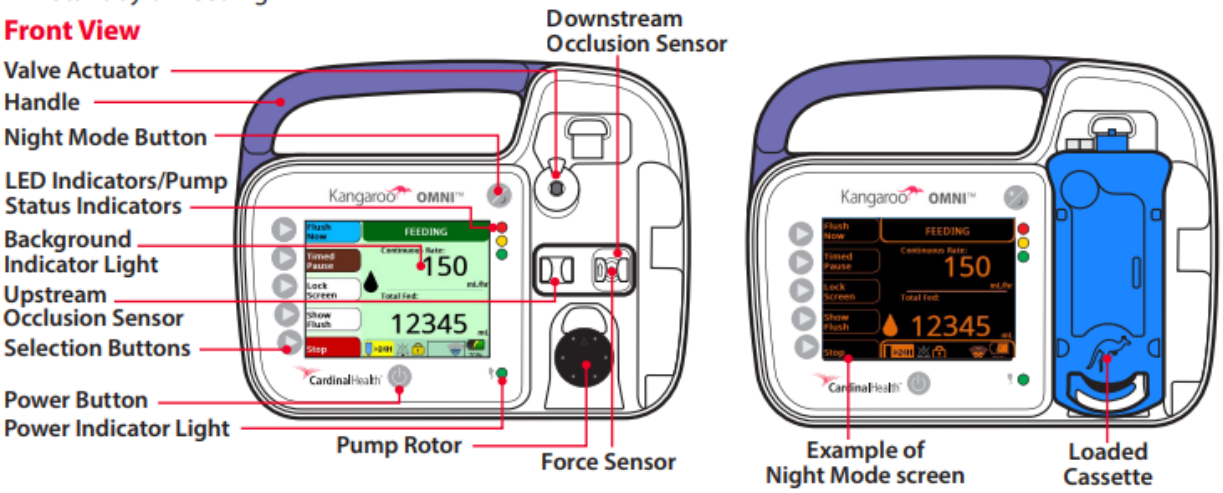
Status Indicators:

● = Warning Alarm

● = Information or Caution Alarm

● = Standby or Feeding

Front View



Kangaroo OMNI™ Enteral Feeding Pump Overview: Back & Side

Cord Retention Feature: Secures power supply cable when using standard (non-adjustable) pole clamp.

Pole Clamp Attachments: Attachment points for both standard (non-adjustable) and adjustable pole clamps.

Power Supply Port: Connection point for power supply/charge cable and Kangaroo OMNI™ Communications Cable.

ENFit™ Cap Holder: Location to store ENFit™ cap while not in use.

Audio Output: Outlet for audible alarms.

MUNSON HEALTHCARE

POLICYSTAT

BASIC USER

Terri L. Fries, MBA, PolicyStat Document Specialist
February 2026

Goal and Objectives

Goal

This course will explain how to access and search policies, procedures, guidelines, and protocols found in PolicyStat.

Objectives

1. Locate PolicyStat from the Intranet.
2. Find documents in PolicyStat using full-text searches and filters to obtain high precision results.
3. Print documents.
4. Locate additional help and resources.

Highlighted red text indicates it is your turn to complete the action.

What is PolicyStat?

PolicyStat is Munson Healthcare's document repository utilized for managing policies, procedures, guidelines, and protocols.

PolicyStat is a web-based tool that supports on-demand access to documents from any device with Internet connectivity.

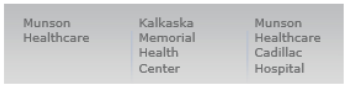
RLDatix™ | PolicyStat

How Do I Access PolicyStat?

MUNSON HEALTHCARE

2. Click 'Tools & Resources'.

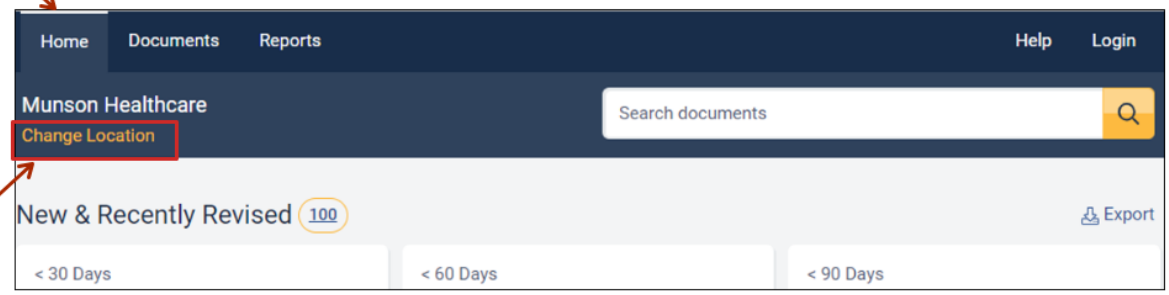
1. Click below on 'Munson Healthcare'.
(found at bottom of Intranet page)



3. Click 'PolicyStat'.

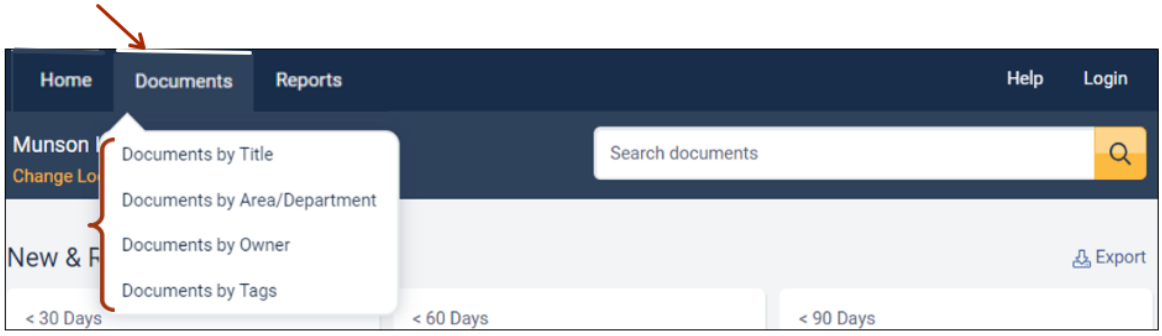
Your facility also has access to PolicyStat on your Intranet home page.

PolicyStat Home



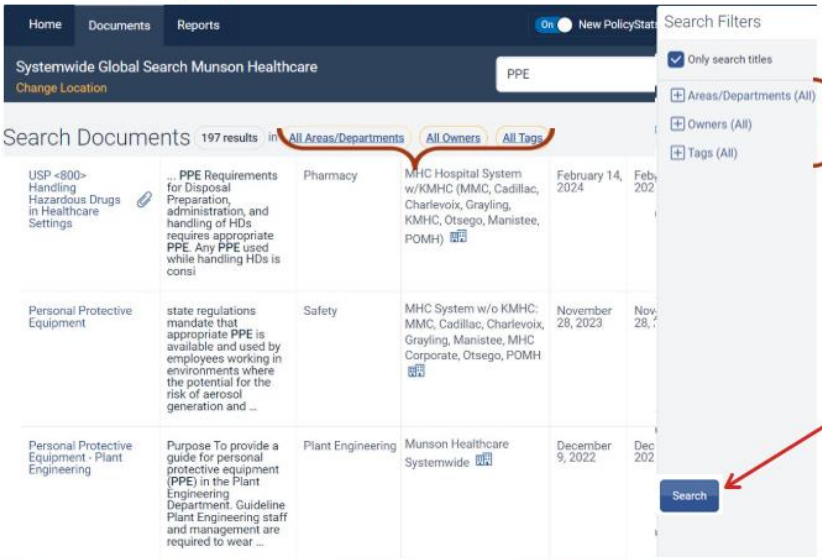
- Select entity location from the **Change Location** drop down menu.
- The Home tab provides an unfiltered search feature.
- Type your term in the search box.

Searching with Filters



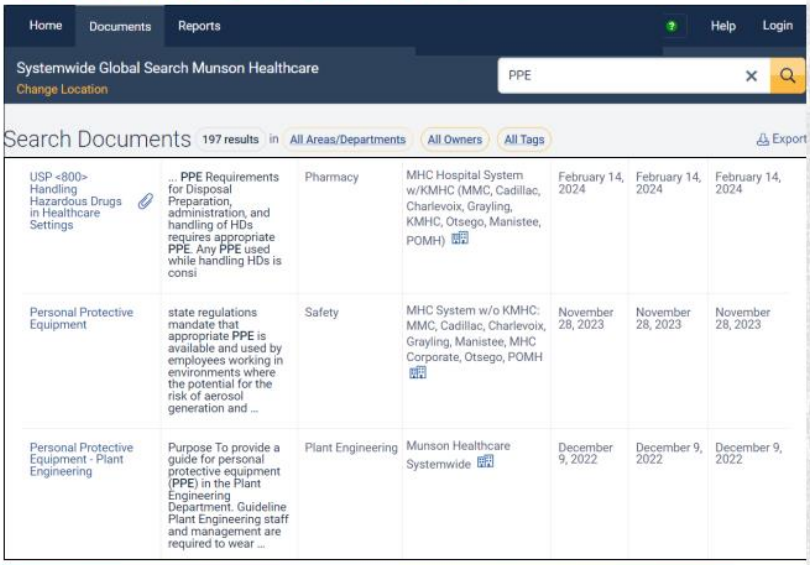
- To narrow your search results, select the Title, Area/Department, Owner, or Tags tab from the **Documents** dropdown menu.
  - Title search locates the term(s) in the title of a document.
  - Area/Department search provides an alphabetical list of areas/departments.
  - A search by Owner provides an alphabetical list of document owners.
  - A Tags search filters the document by type, i.e., policy, procedure, guideline, or protocol.

Searching with Filters *(cont.)*



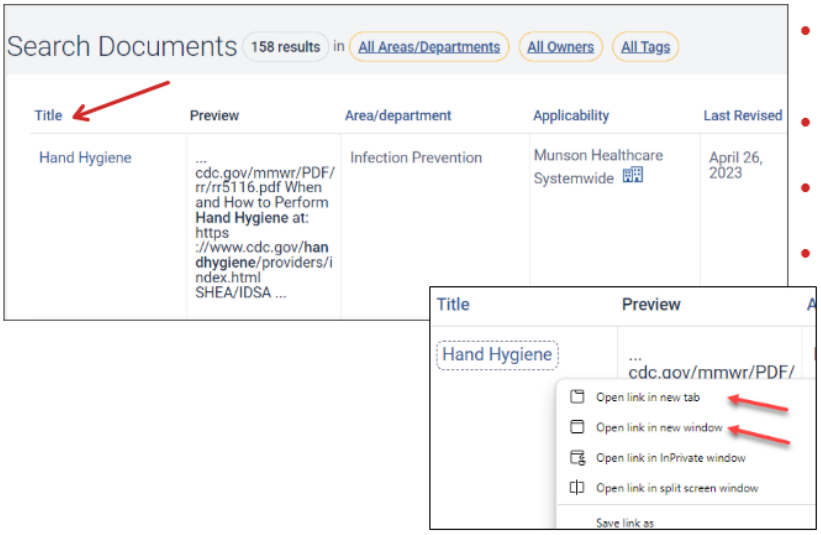
- The Title search can be further refined by applying Area/Depts, Owners, or Tags filters.
  - Expand each filter by clicking the + sign in front of each option.
  - Select appropriate option(s).
  - Click the Search command button.

Searching for Documents



- Results matching your search term(s) will appear as **bold** text in the preview.
- Attachments matching your search term(s) will appear as a paperclip icon.
- Entering terms surrounded by quotes will return all results with that exact phrase or term in the text of the document. Phrase searching can be applied to any search filter.

Search Results

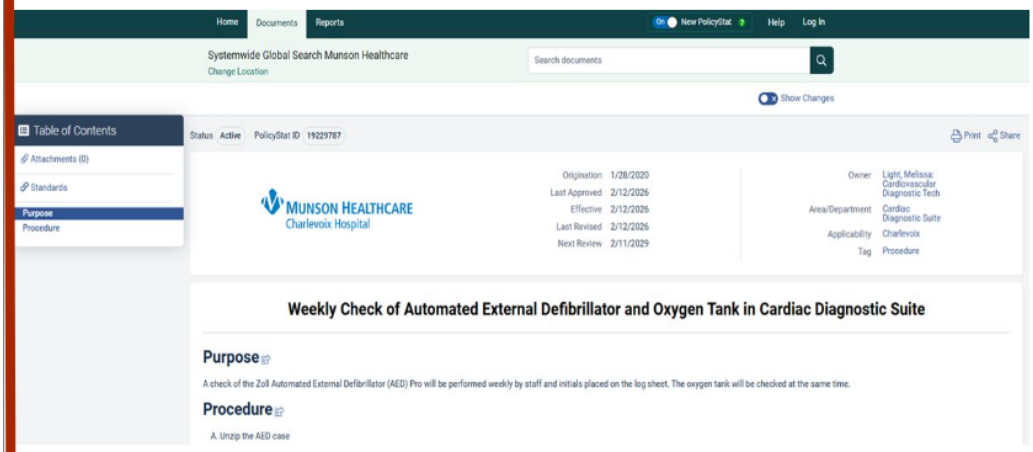


- Search results are limited to 500. Try applying filters to ensure a lower retrieval.
- The most relevant search results display first.
- Sort results by clicking the column headers.
- To open document:
  - Click the Title link to open in the same tab.

  OR
  - Right-click the Title link to open in a new tab or window.

Document at a Glance

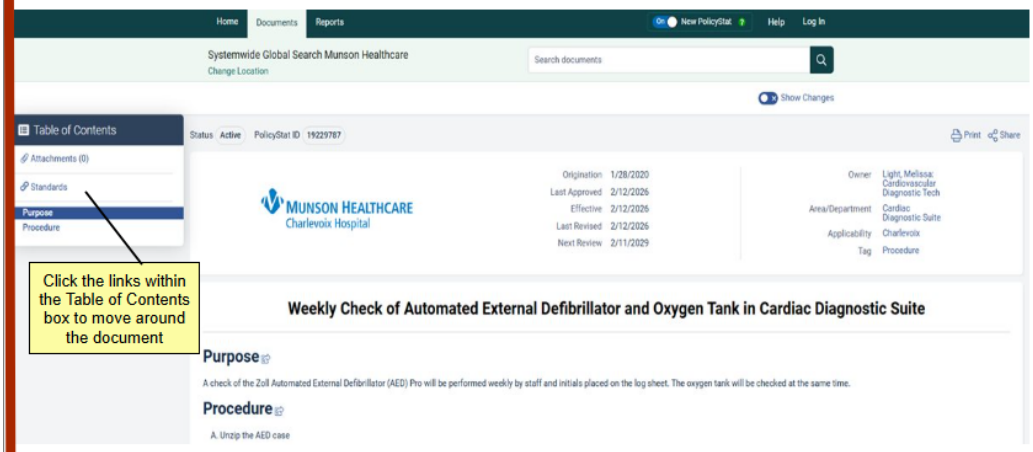
Click items listed on the right.



- Links to Areas Within Document
- Munson Entity
- Important Dates
- Owner & Department
- Applies to These Entities
- Type of Document
- Title of Document
- Document Contents

Document at a Glance

Click items listed on the right.



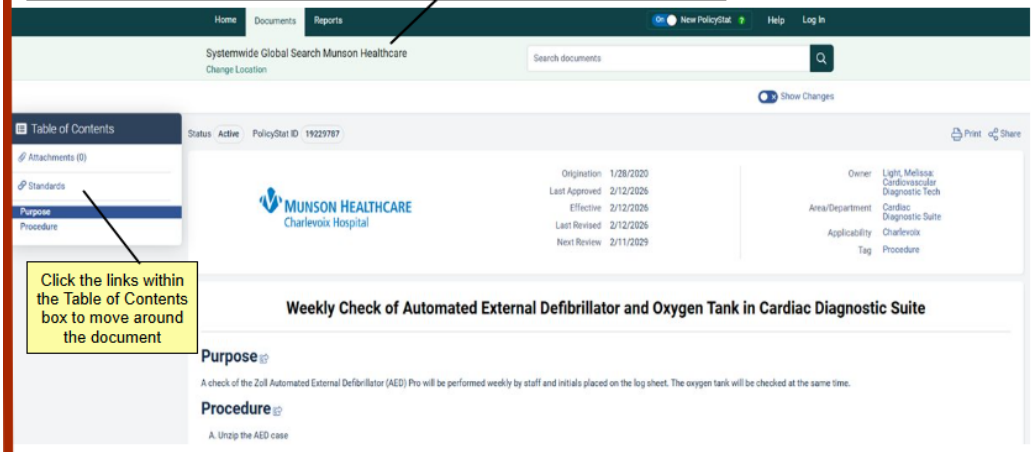
Click the links within the Table of Contents box to move around the document

- Munson Entity
- Important Dates
- Owner & Department
- Applies to These Entities
- Type of Document
- Title of Document
- Document Contents

Document at a Glance

Click items listed on the right.

Munson Entity
This is based on the location currently selected from the drop-down menu in the PolicyStat tool bar. The entity name will change if another location is selected.



Click the links within the Table of Contents box to move around the document

- Important Dates
- Owner & Department
- Applies to These Entities
- Type of Document
- Title of Document
- Document Contents

Page 10 of 13

Document at a Glance

Click items listed on the right.

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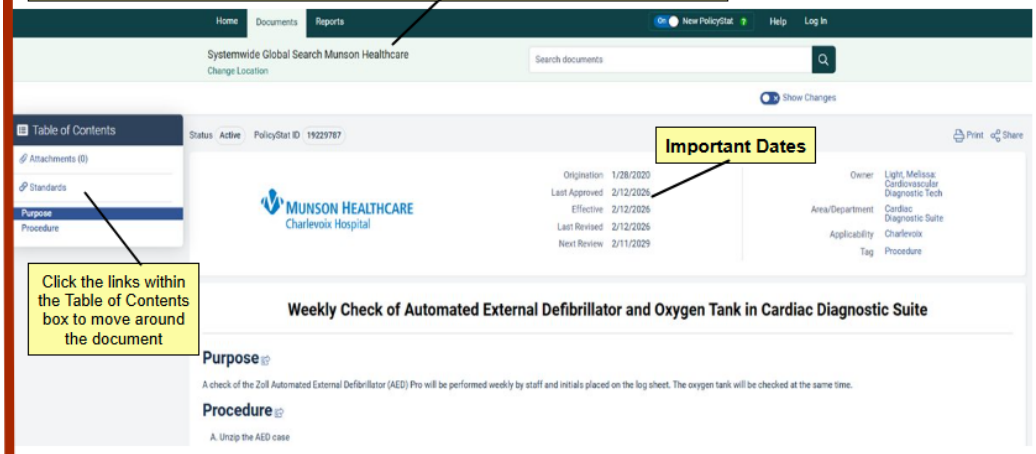

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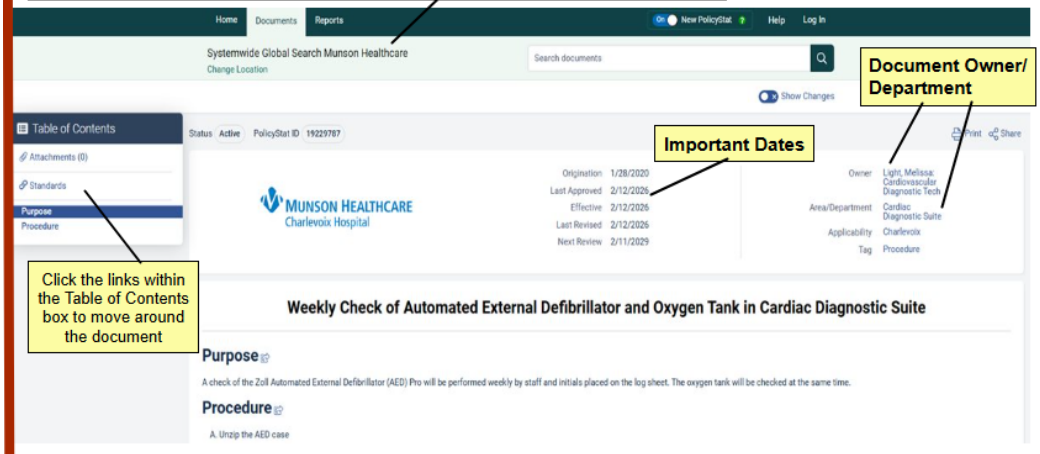

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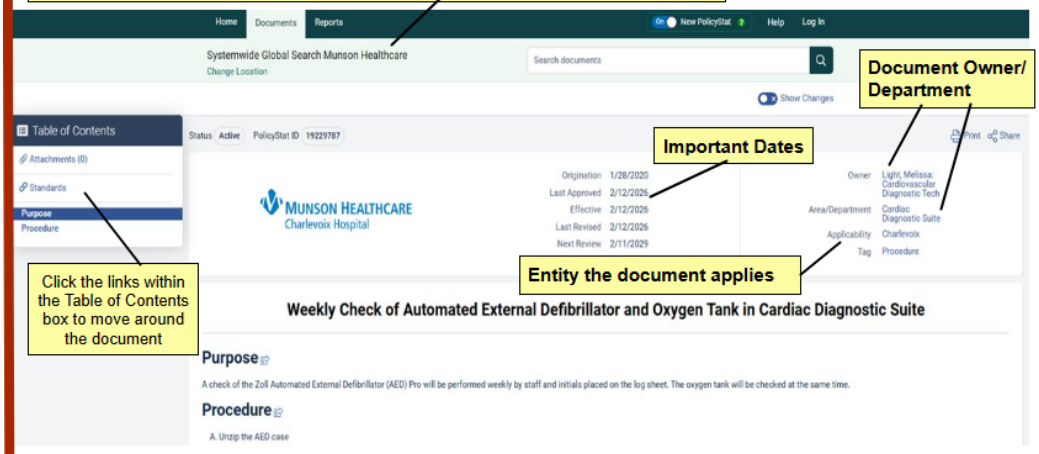

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Document Owner/ Department

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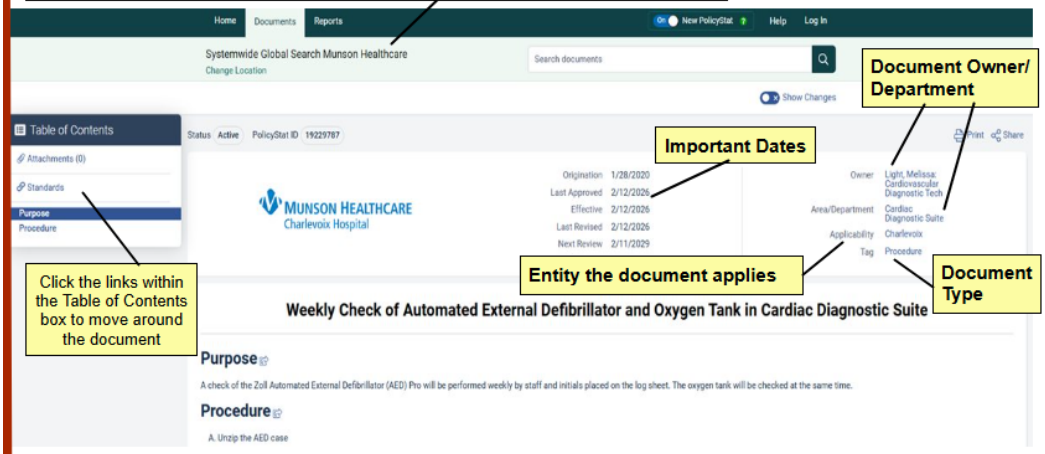

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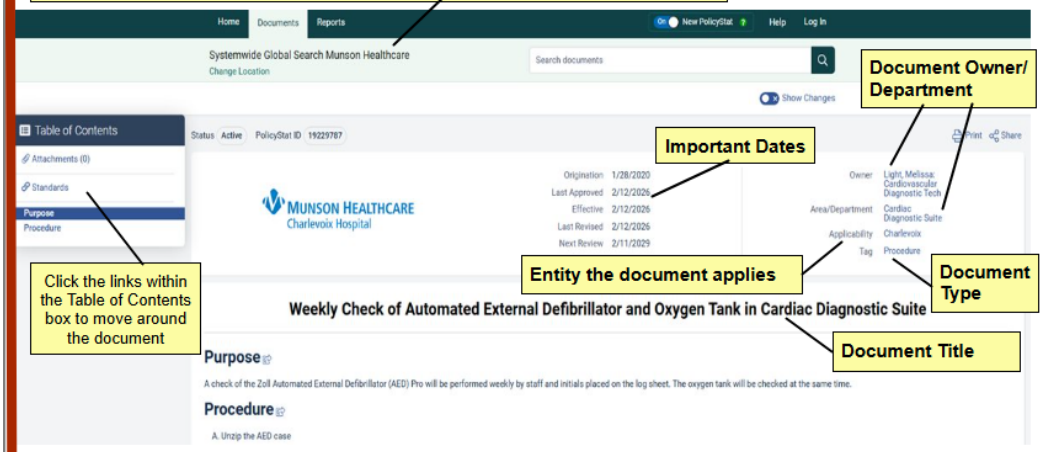

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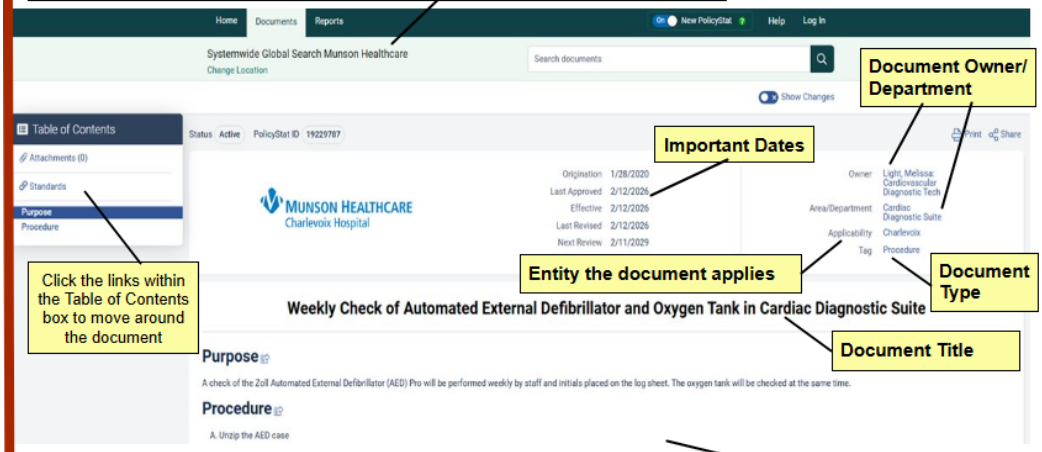

Important Dates

Document Owner/ Department

Entity the document applies

Document Type

Document Title

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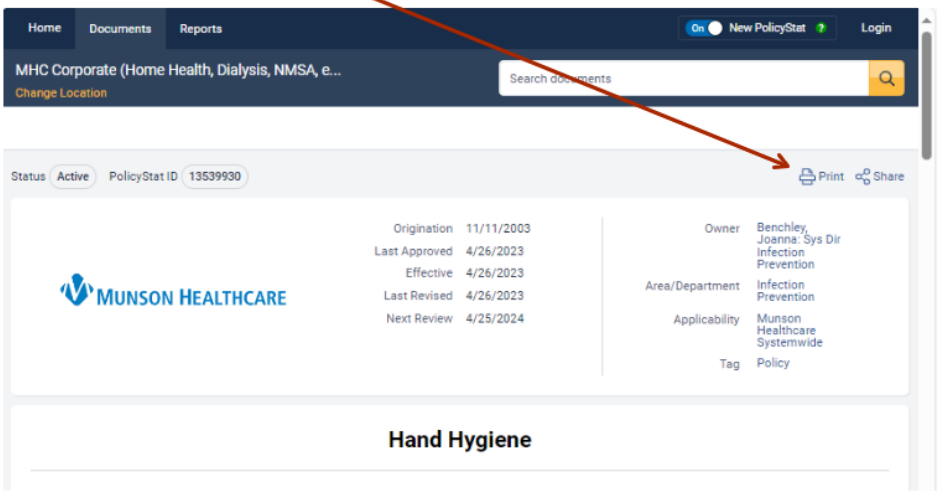
Document Content

Printing a Document

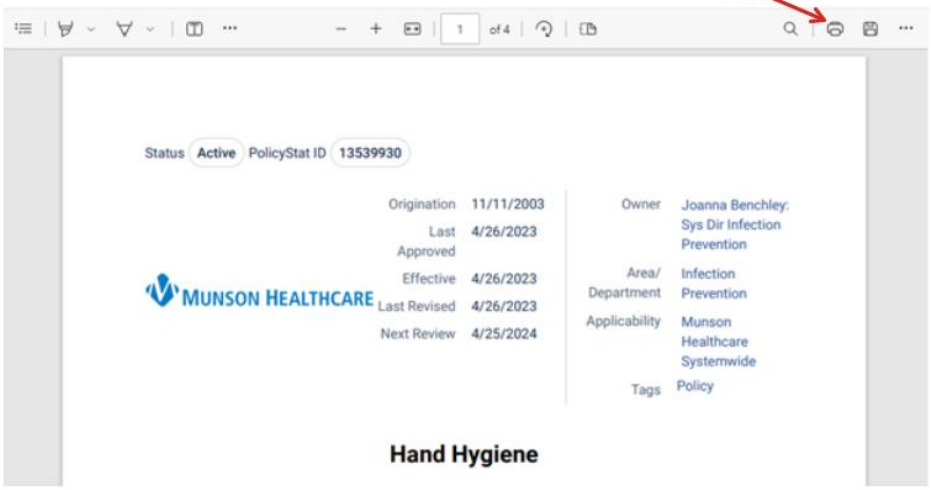
1. **Click** the Print button near the top right.



Printing a Document

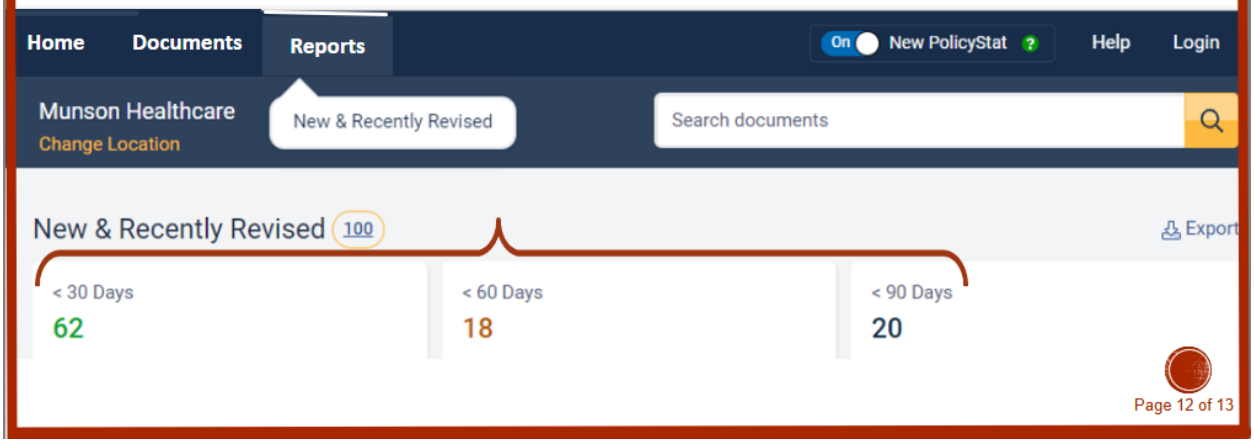
1. **Click** the Print button near the top right.

2. A new tab opens. Click the printer icon and select the correct printer.



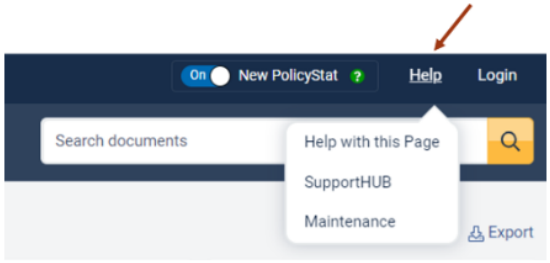
Reports

- The Reports tab displays any new and recently revised documents that can be filtered based on:
  - The last 30 days
  - The last 60 days
  - The last 90 days



PolicyStat Help

- The Help button is in the upper right corner.
- Click for Help with this Page, SupportHUB, or Maintenance.
  - **Help with this Page** provides information related to new updates and emerging topics.
  - **SupportHUB** provides access to support resources, feedback, and help ticket functions.
  - **Maintenance** provides dates for system upgrades and backups.
- For additional assistance, contact PolicyStatTeam@mhc.net



Safe Contact

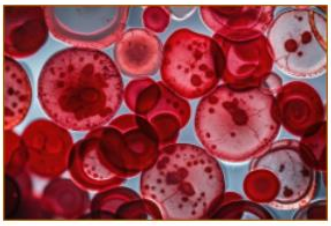
MUNSON HEALTHCARE

Clinical Version

December 2025

Safe Contact

Click each photo below to take the mini-course:



Bloodborne Pathogens

Joanna Benchley, RN, BSN, MHA
Kathy Sahs, BS, CHSP
Sarah Meehle, BSN

USP 800

Steven Bonkoski, PharmD
Tracey Dilas, MSN, RN, OCN
Kelly Ewing, MSN, RN, PCCN
Mariah Powell, MSN, RN, OCN
Angela Richardson-Gross, MSN, RN, OCN

Hand Hygiene

MHC Infection Prevention Team

***Throughout this course, you will see words bolded/underlined in bright orange. Hover over these words for definitions or more information.**

Bloodborne Pathogens: Workplace Safety

Goal

Provide education and training resources on bloodborne pathogens (BBP), including associated hazards and protective measures to reduce the risk of occupational exposure.

Objectives

After completing this course, you will be able to:

1. Identify common workplace activities that may increase risk for an exposure to BBP.
2. Explain protective measures to help prevent an exposure, including work practices and the proper use of PPE.
3. Identify resources: OSHA/MIOSHA Bloodborne Pathogen Standard, Munson Healthcare (MHC) Bloodborne Pathogen Exposure Plan.
4. Explain procedure for exposure incident and reporting process.

Bloodborne Pathogens

Definition

- Disease-causing microorganisms located in human blood and other potentially infectious material (OPIM).
- If contracted, these viruses can result in life-threatening illnesses in humans.
- Following safe work protective measures reduce the risk of occupational exposure.

Examples of BBP

- Hepatitis B (HBV)
- Hepatitis C (HCV)
- Human Immunodeficiency Virus (HIV) causing Acquired Immunodeficiency Syndrome (AIDS).

Risk/Responsibility

Exposure Risk | **Barrier Checklist** | **Sharps Safety**

Healthcare workers are at risk of BBP exposure via:

- Sharps injury
- Direct contact to mucous membranes
- Direct exposure to non-intact skin
- Splash exposures occur when the mucous membranes come into contact with blood or OPIM.
  - Routine activities that have high potential of splash risk:
    - Emptying catheter bag
    - Cleaning up blood/OPIM
    - Assisting with oral care

Risk/Responsibility

Exposure Risk | **Barrier Checklist** | **Sharps Safety**

Departments that have health care professionals with a potential exposure to blood and OPIM are responsible for:

- BBP Barrier Checklists in a location where staff can reference
- Using the additional sheet of BBP Barrier Checklists to create a department-specific checklist

Click on the image to the right to view and print the Bloodborne Pathogen Barrier Checklist.


MUNSON HEALTHCARE

BLOODBORNE PATHOGEN BARRIER CHECKLIST

Standard Precautions

Progress Page 3 of 7

Risk/Responsibility

Exposure Risk | **Barrier Checklist** | **Sharps Safety**

Prevent accidental sharps injuries:

- Locate nearest sharps container
  - Discard sharp immediately after use
- Assess container for need to exchange
  - Look at window
  - If full, exchange
  - Ask for help if you don't know how
- Sharps containers are designed to keep hands out. Never try to retrieve a discarded item.
- Dispose of the IV spike in the sharps container. Snip the TIP! (except hazardous drugs)

Personal Protective Equipment (PPE)

Standard Precautions | **Removal** | **Eye Protection**

Standard Precautions is a universal approach to infection prevention in which all human blood and OPIM are treated as if they are infectious.

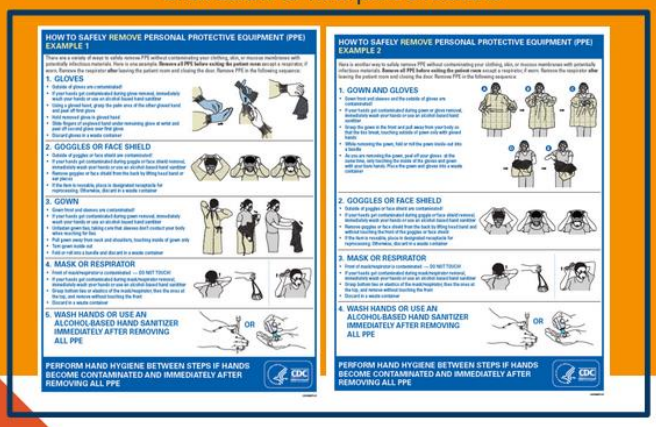
This means that proper PPE must be properly utilized whenever there is a possibility to exposure for blood or OPIM.

(Under the "Removal" tab, you can click to view this image larger and print if you'd like.)

Personal Protective Equipment (PPE)

Standard Precautions | Removal | Eye Protection

Sequence to Remove Personal Protective Equipment:
Click below to view/print directions



PPE Standards

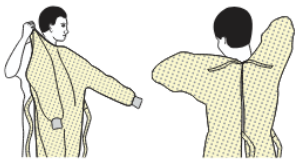
1 of 3 — Automatic Zoom

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

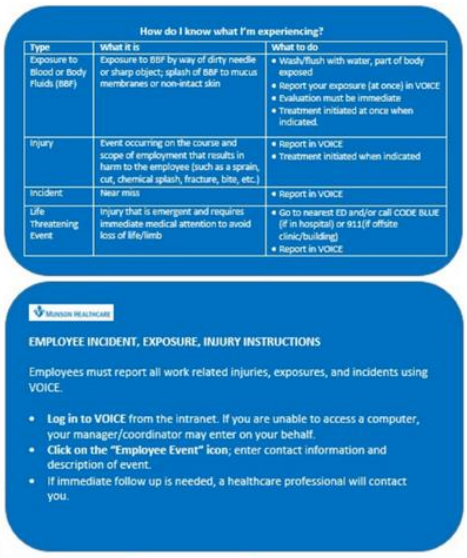
Personal Protective Equipment (PPE)

Standard Precautions | **Removal** | **Eye Protection**

- Effective eyewear protection and fluid resistant face masks helps prevent splash exposures.
- The effective eye protection consists of:
  - Comfortable, secure fit and sufficient peripheral vision.
  - Glasses and contacts **DO NOT** offer infection protection. Safety goggles should be worn with these.
  - Face shields wrap around the face to the point of the ears. This reduces the splash risk that can potentially reach the eyes.
- When removing eye protection, touch only the elastic straps or arms/earpieces of the safety glasses or goggles. After performing hand hygiene, put your fingers into both loops and peel forward without touching the outside of the mask. If reusing the safety glasses or goggles, disinfect them with a hospital-approved disinfectant wipe.

Bloodborne Pathogens

Badge Resource



How do I know what I'm experiencing?

Type	What it is	What to do
Exposure to Blood or Body Fluids (BBF)	Exposure to BBF by way of dirty needle or sharp object; splash of BBF to mucus membranes or non-intact skin	• Wash/flush with water, part of body exposed • Report your exposure (at once) in VOICE • Evaluation must be immediate • Treatment initiated at once when indicated
Injury	Event occurring on the course and scope of employment that results in harm to the employee (such as a sprain, cut, chemical splash, fracture, bite, etc.)	• Report in VOICE • Treatment initiated when indicated
Incident	Near miss	• Report in VOICE
Life Threatening Event	Injury that is emergent and requires immediate medical attention to avoid loss of life/limb	• Go to nearest ED and/or call CODE BLUE (if in hospital) or 911(if offsite clinic/building) • Report in VOICE

EMPLOYEE INCIDENT, EXPOSURE, INJURY INSTRUCTIONS

Employees must report all work related injuries, exposures, and incidents using VOICE.

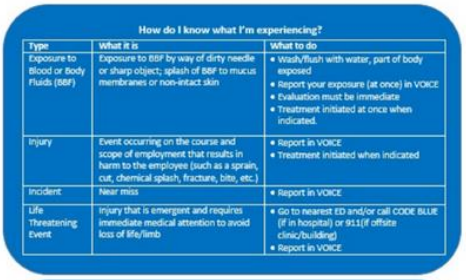
- **Log in to VOICE** from the intranet. If you are unable to access a computer, your manager/coordinator may enter on your behalf.
- **Click on the "Employee Event" icon**; enter contact information and description of event.
- If immediate follow up is needed, a healthcare professional will contact you.

In FY 2025, there were 139 exposures to blood/bodily fluid events and 113 needlestick/sharps events throughout MHC. *Note that some of the sharps incidents did not involve exposure to blood/body fluids.*

Click on the blue badge to reveal how to respond to an incident.

Bloodborne Pathogens

Badge Resource



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MUNSON HEALTHCARE

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- If immediate follow up is needed, a healthcare professional will contact you.

Response

If a blood or OPIM exposure should occur:

- Immediately wash or irrigate the exposed area.
- All incidents should be completed in the **VOICE reporting system**. Do not delay the reporting process. Doing so could impact the treatment options if exposed to a BBP. If known, the source patient will be tested.
  - Employee Health will contact you immediately after your **VOICE report** has been submitted to follow up and complete any testing or treatment that may be required.
- Personal scrubs or clothing items that have been contaminated by blood or bodily fluids should be processed at WMSHL. Domestic washers and chemicals do not provide the necessary action to ensure that the infectious materials are removed. See policy for greater details on this process.

Medical Waste

Includes...	Proper Disposal	Importance

Regulated Medical Waste includes:

- Biohazardous Waste
- Biohazardous- Sharps Waste
- Infectious Substances
- Pathological Waste
- Trace Chemotherapy
- Trace Chemotherapy- Sharps Waste
- Non-Hazardous Pharmaceutical

Medical Waste

Includes... | **Proper Disposal** | Importance

Proper Disposal of Medical Waste:
Biohazard Bag Tying- The only way to secure bags that is acceptable to the Department of Transportation is tying the bag at the top in a single knot.

1. Gather top of the bag and twist
2. Make loop then push bag end through
3. Pull on bag end to tighten knot

****Do not bunny ear or leave open*

Medical Waste

Includes... | **Proper Disposal** | Importance

Why is proper disposal important?

- Medical waste is regulated by the Department of Transportation.
- Improper handling and packing results in monetary fines.
- Inappropriate bagging and handling results in potential of a coworker having an exposure.
- If you are unfamiliar with disposal, please ask for assistance to ensure proper disposal.

Additional Information and Resources

West Michigan Shared Hospital Laundry Member Policies and Procedures Revised 5/2022.

OSHA Website- 1910.1030- 1910.1030 - Bloodborne pathogens. | Occupational Safety and Health Administration (osha.gov)

MIOSHA Website: LEO - Michigan Occupational Safety and Health Administration

MHC Policy: Bloodborne Pathogen
MHC Policy: Bloodborne Pathogen Exposure Control Plan

Safe Contact

Click each photo below to take the mini-course:

Bloodborne Pathogens

Joanna Benchley, RN, BSN, MHA
Kathy Sahs, BS, CHSP
Sarah Meehle, BSN

USP 800

Steven Bonkoski, PharmD
Tracey Dilas, MSN, RN, OCN
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Hand Hygiene

MHC Infection Prevention Team

***Throughout this course, you will see words bolded/underlined in bright orange. Hover over these words for definitions or more information.**

Purpose

Why

The purpose is to promote standard practice and handling of hazardous drugs and the environment in which these drugs are used across the Munson Healthcare (MHC) System.

Who this affects

- Pharmacists
- Pharmacy technicians
- Nurses
- Nurse assistants
- Providers
- Home healthcare workers
- Environmental services workers
- Maintenance
- Respiratory therapy
- Allied health workers
- NMSA workers

A safe level of occupational exposure to hazardous drugs for healthcare workers has not been determined. The safest level is NO occupational exposure. That is why precautions and guidelines are in place to reduce and eliminate exposure.

USP 800: Hazardous Drug Handling in Healthcare Settings

Goal

All personnel who handle hazardous drugs (HD) will be aware of the fundamental practices and precautions associated with hazardous drugs to prevent harm to patients, minimize exposure to personnel and minimize contamination of the work and patient care environments.

Objectives

After completing this course, you will be able to:

1. Distinguish between different categories of HD.
2. Locate job-specific information describing appropriate precautions to take prior to handling a HD or contaminated material.
3. Explain when, during the medication handling process, exposure to HDs may occur and strategies to minimize this risk.

Hazardous Drugs

Definition

- Carcinogenic (cancer-causing)
- Birth defects (teratogenicity or developmental toxicity)
- Reproductive toxicity in humans
- Organ toxicity at low doses in humans or animals
- Gene mutations (genotoxicity)
- New drugs that mimic existing drugs' structure and toxicity profiles

NIOSH Categories

- Group 1:
  - Antineoplastic drugs
- Group 2:
  - Non-antineoplastic drugs meeting one or more of the hazardous drug definitions
- Group 3:
  - Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breastfeeding

Assessment of Risk

MHC's policies and procedures apply to all HD handling.

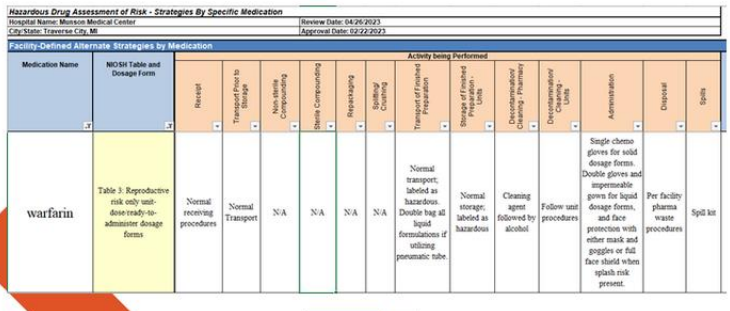
However, each facility may perform an Assessment of Risk for all HDs handled. An Assessment of Risk must consider:

- HD Group, Dosage Form, Risk of Exposure, Packaging, and Manipulations

An Assessment of Risk must be reviewed annually.

List of locations with an approved Assessment of Risk:

- Cadillac
- Manistee
- POMH
- TC- MMC
- TC- CFCC
- Kalkaska Memorial Health Center
- Charlevoix
- Grayling
- Otsego



Hazardous Drug Assessment of Risk - Strategies By Specific Medication

Hospital Name: Munson Medical Center	Review Date: 04/26/2023
City/State: Traverse City, MI	Approval Date: 02/22/2023

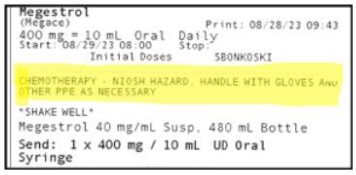
Facility-Defined Alternate Strategies by Medication

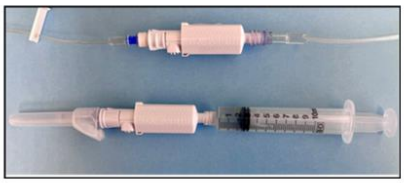
Medication Name	NIOSH Table and Dosage Form	Activity being Performed: Receipt	Transport Prior to Storage	Non-sterile Compounding	Sterile Compounding	Repackaging	Spotting/ Counting	Transport of Finished Preparation	Storage of Finished Preparation - Units	Decontamination/ Cleaning - Pharmacy	Decontamination/ Cleaning - Units	Administration	Disposal	Spills
warfarin	Table 3: Reproductive risk only unit-dose/ready-to-administer dosage forms	Normal receiving procedures	Normal Transport	N/A	N/A	N/A	N/A	Normal transport; labeled as hazardous. Double bag all liquid formulations if utilizing pneumatic tube.	Normal storage; labeled as hazardous	Cleaning agent followed by alcohol	Follow unit procedures	Single chemo gloves for solid dosage forms. Double gloves and impermeable gown for liquid dosage forms, and face protection with either mask and goggles or full face shield when splash risk present.	Per facility pharma waste procedures	Spill kit

Labels

All HDs will be labeled with precaution statements when dispensed from pharmacy. Review alerts and PPE requirements during administration.

Click on each image below to learn more.





Progress Page 5 of 10

Oral

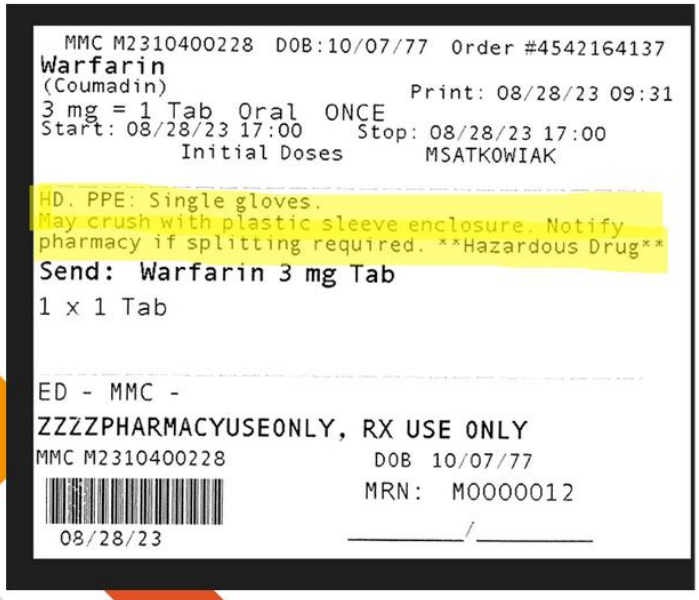
Megestrol
(Megace) Print: 08/28/23 09:43
400 mg = 10 mL Oral Daily
Start: 08/29/23 08:00 Stop:
Initial Doses SBONKOSKI

CHEMOTHERAPY - NIOSH HAZARD. HANDLE WITH GLOVES And OTHER PPE AS NECESSARY

SHAKE WELL
Megestrol 40 mg/mL Susp, 480 mL Bottle
Send: 1 x 400 mg / 10 mL UD Oral Syringe

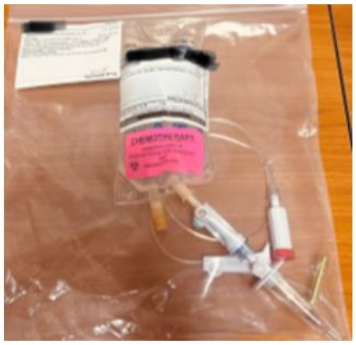
All Group 1 HDs will be labeled as Chemotherapy.

Oral



All Group 2/3 HDs will be labeled as HD.

Intravenous

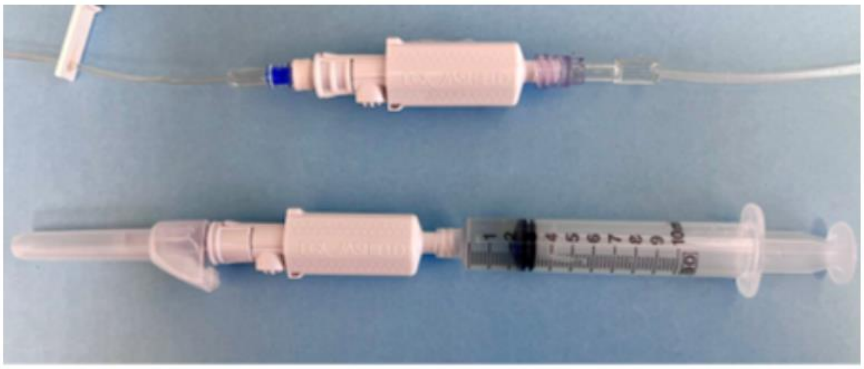


Group 1 HDs will be primed in Pharmacy with a compatible non-HD fluid (e.g., normal saline or dextrose 5% solution).

Group 2/3 HDs are to be back-primed with compatible non-HD solution.

Do not work above eye level unless wearing goggles.

Engineering Controls

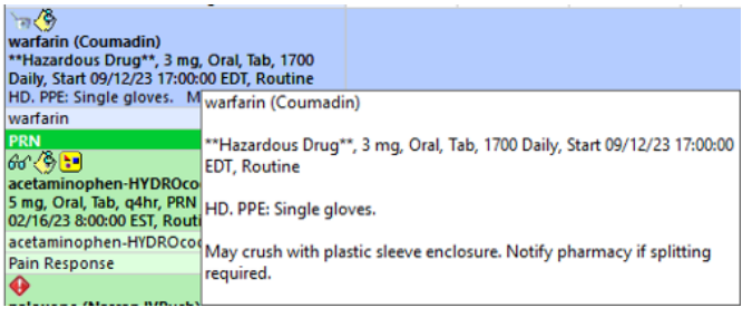


Closed system transfer devices (CSTD) will be utilized by Pharmacy and attached to completed intravenous (IV) and intramuscular (IM) products to help reduce the risk of exposure to healthcare workers. These will be all Group 1 HDs and specific Group 2 HDs.

Hover to Discover

Review Alerts

- Review alerts-order, label comments, and Pyxis.
- Hover on order in MAR for info on PPE and safe administration alerts.
- See order comments.



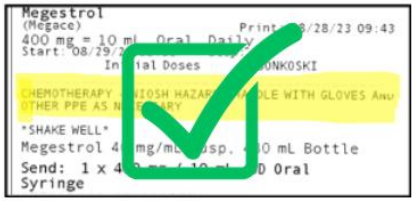
Manipulation

- Read alert to ensure that proper medication administration is maintained.
- Manipulation will primarily be performed by Pharmacy. Group 2/3 HD manipulation will be limited (splitting, opening capsules, crushed). Group 1 HDs should NEVER be manipulated outside of pharmacy.
- If crushed, use Silent Knight only and clean with bleach wipes after use.
- Remove outer glove prior to touching equipment.

Labels

All HDs will be labeled with precaution statements when dispensed from pharmacy. Review alerts and PPE requirements during administration.

Click on each image below to learn more.



PPE

When PPE is Needed	Patient Precautions Sign	Equipment Requirements

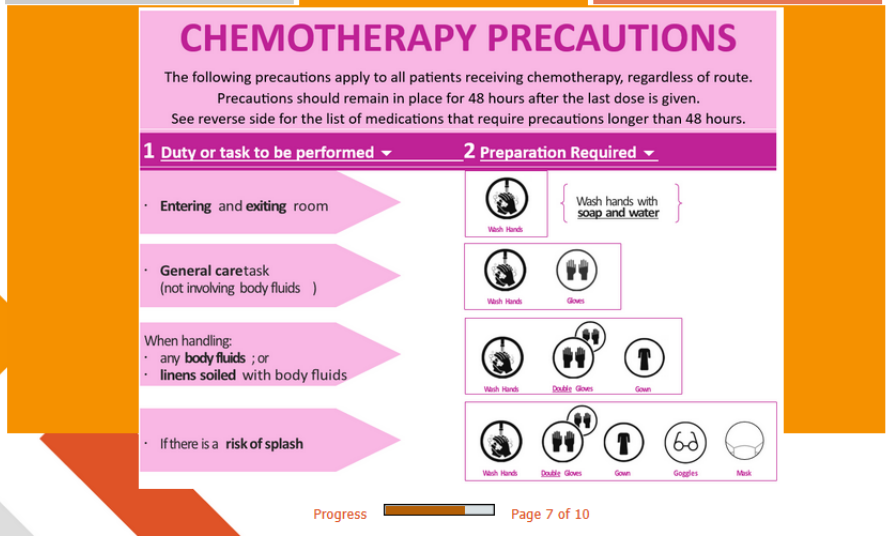
PPE must be worn when handling HDs during:

- Receipt
- Storage
- Transport
- Compounding
- Administration
- Deactivating/decontaminating
- Cleaning and disinfecting
- Waste disposal
- Spill management

For all other activities, there is a policy for PPE based on activity and risk. Refer to your facility's policies and procedures for required PPE based on activity.

PPE

When PPE is Needed	Patient Precautions Sign	Equipment Requirements



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PPE

When PPE is Needed	Patient Precautions Sign	Equipment Requirements

PPE specifics must meet the following requirements; what you will need to wear will depend on the circumstances:

Gloves
- ASTM standard D6978
- Powder-free

Gowns
- Always use when risk of splash or spill
- Disposable
- Resistant to permeability of HDs
- Tie closed in back, long-sleeved with elastic or cloth cuffs

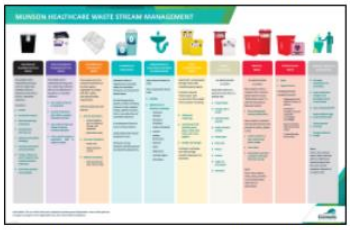
Eye/Face Protection
- Surgical mask or face shield is used to provide additional face protection
- Goggles are ALWAYS required when eye protection needed (face shield does not suffice)

Covers
- Head, hair, sleeve and/or shoe covers
- Required for compounding in Pharmacy

Respiratory Protection
- Required during spill management and for specified functions in Pharmacy

Disposal

Waste Stream Management



Click to view and print .pdf

Safe Disposal

- After administration:
  - Dispose of all PPE, HDs, and empty IV bags with tubing attached in appropriate bin.
  - **Do NOT snip the tip** of any intravenous HDs.
- Complete hand hygiene with soap and water, not rubbing alcohol.

Spills/Exposure

Small Spill | **Large Spill** | **Exposure/Reporting**

A small spill is less than 5 mLs (teaspoon) - spreads out to less than the size of a quarter.

1. Isolate area.
2. Obtain Spill Kit.
3. Contact EVS and Pharmacy for assistance.
4. Follow Spill Control and Management for Hazardous Drugs- Standard Operating Procedure

Spills/Exposure

Small Spill | **Large Spill** | **Exposure/Reporting**

A large spill is greater than or equal to 5 mLs (teaspoon).

1. Isolate area.
2. Activate Emergency Response (5-5555) Facility Alert: Hazardous Material Spill (or refer to your badge).
3. Follow Spill Control and Management for Hazardous Drugs- Standard Operating Procedure.

Primary Containment:

- Remove patient from the area.
- Isolate area.
- Triage Exposure.
- Obtain Spill Kit and Hazmat cart.
- Deactivate/Decontaminate HD

Secondary Containment:

- Bring additional cleaning supplies.
- Keep Hazmat cart.
- Triage personnel.
- Assist with cleaning.

Spills/Exposure

Small Spill	Large Spill	Exposure/Reporting

Exposure:
1. Remove contaminated clothing, linen, or PPE.
2. Wash the exposed area with soap and water. Use eye wash station to flush eyes.

Reporting:
1. Report the exposure and incident (including spills and responses) using VOICE reporting system.
2. If immediate follow up is needed, a healthcare professional will contact you.

Risk Acknowledgment

All MHC employees who handle hazardous drugs must sign an acknowledgement form documenting their consent.

Employees are expected to:

- Read and understand policies and procedures related to proper handling of hazardous drugs.
- Notify their supervisor, manager, or other designated individual with questions or safety concerns related to HDs.
- Confirm they understand the risk of handling HDs if reproductively capable.
- Discuss alternative job duties with their supervisor, manager, or other designated individual when appropriate.

Safe Contact

Click each photo below to take the mini-course:

Bloodborne Pathogens

Joanna Benchley, RN, BSN, MHA
Kathy Sahs, BS, CHSP
Sarah Meehle, BSN

USP 800

Steven Bonkoski, PharmD
Tracey Dilas, MSN, RN, OCN
Kelly Ewing, MSN, RN, PCCN
Mariah Powell, MSN, RN, OCN
Angela Richardson-Gross, MSN, RN, OCN

Hand Hygiene

MHC Infection Prevention Team

***Throughout this course, you will see words bolded/underlined in bright orange. Hover over these words for definitions or more information.**

Hand Hygiene

Goal

Following this course, the employee of Munson Healthcare will apply essential safety behaviors for the standard process of hand hygiene.

Objectives

After completing this course, you will be able to:

1. Identify the impact of hand hygiene for preventing infection.
2. Identify standard practices at MHC facilities for hand hygiene.
3. Identify the process for hand hygiene with alcohol-based gel.

Hand Hygiene Policy

Hand Hygiene is the single most important strategy for preventing hospital-acquired infections.

It is the responsibility of all employees and all providers to perform hand hygiene.

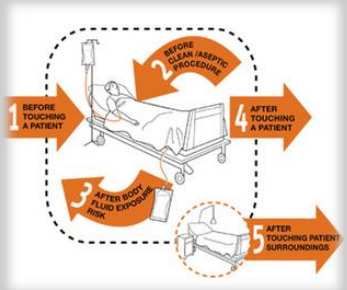
Hand Washing Basics

Hand Gel | **Soap and Water**

How do I sanitize with alcohol-based gel?

Sanitizing with alcohol-based gel is the required, safe practice in Munson Healthcare.

Please click the image below to learn more.



(Department of Hospital Epidemiology and Infection Control, 2019)

Hand Washing Basics

Hand Washing with Soap and Water Video (1:56)

Hand Washing Basics

Hand Gel	Soap and Water

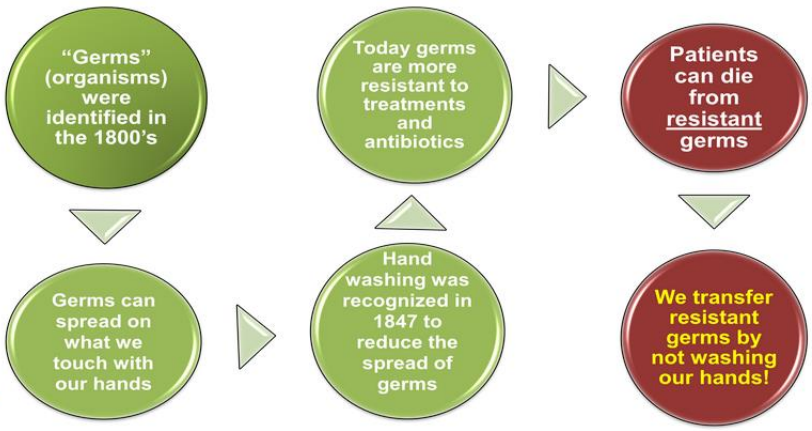
When do I need to wash with soap and water?
When hands are visibly soiled or contaminated with blood and body fluids.

Perform proper hand hygiene frequently.

- Wet your hands with clean, running water (warm or cold) and apply soap.
- Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse your hands well under clean, running water.
- Dry your hands using a clean towel or air dry; do not shake hands to dry.

If you aren't able to wash your hands with soap and water, use an alcohol-based hand sanitizer containing at least **60-95% alcohol**.

Hand Hygiene Facts



Proper Hand Hygiene prevents death by:

- Reducing the spread of germs
- Decreasing hospital-acquired infections

Drunk Driving vs. Hospital-Acquired Infection

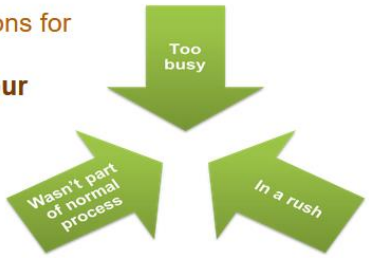
Drunk Driving	Hospital-acquired Infection
Drunk drivers killed 12,429 people in 2023 **34** people per day (National Highway Traffic Safety Administration, 2023)	Hospital-acquired infections (HAIs) kill 99,000 people per year **271** people per day (Center for Disease Control and Prevention, 2024)

Hospital-acquired infections (HAIs) kill almost eight times more people than drunk driving!

Not Washing Hands

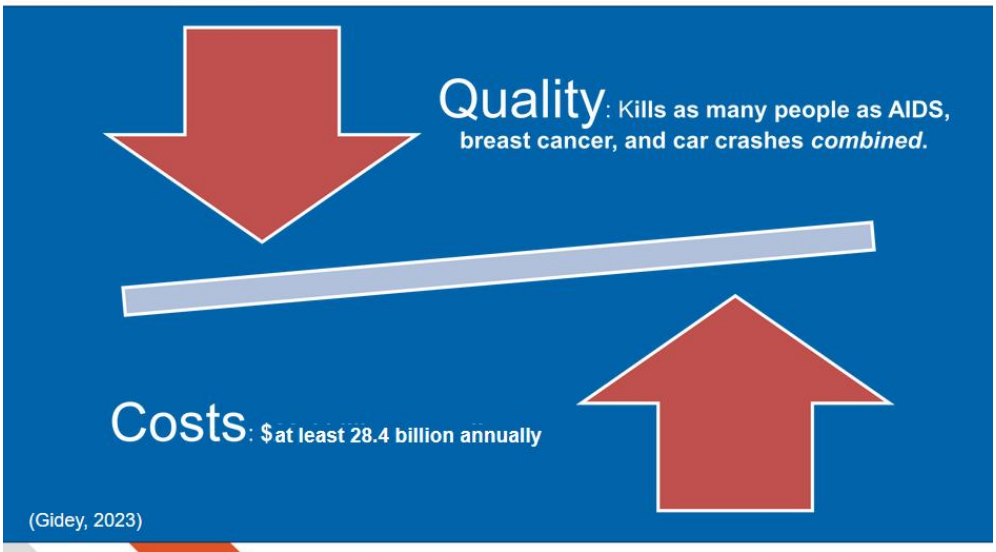
A recent survey revealed the following reasons for not washing hands.

What's the reason YOU don't wash your hands?



- If you have a sensitivity to gel or foam products, please try the Ecolab tabletop hand sanitizer.
  - If sensitivity continues, file a VOICE report for follow up and support.
- Ecolab Revitalizing Skin Lotion is available to moisturize your hands following hand hygiene.

Impacts of HAIs



Gloves and Required Hand Hygiene

Gloves vs. Hygiene | **Video** | **Other Requirements**

Do gloves replace hand hygiene?
NO! Gloves do not replace hand hygiene

You must always wash hands...

- Before and after direct contact
- Before putting on gloves and after taking gloves off
- When entering a patient room or when you leave
- After contact with objects in a patient's environment
- After hands meet soiled or contaminated equipment or objects, including computer keyboards

Gloves and Required Hand Hygiene

Gloves vs. Hygiene | Video | Other Requirements

Progress

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Gloves and Required Hand Hygiene

Gloves vs. Hygiene | Video | Other Requirements

- No artificial nails, wraps, gel, shellac, or tips
- Natural nails should be kept to 1/4 inch in length
- Nails must be clean
- Nail polish, if allowed by department, is to be in good repair (no chips)
- Only hospital-approved lotions are to be used

Progress

Page 9 of 12

Encourage Others to Prevent Infection

Please click on each green button below for helpful information:

Ask your peer a question

- "Hello, I didn't see you wash your hands. Did you perform hand hygiene?"

Request

- "There is hand product near the door. Please wash your hands."

Voice a Concern

- "I am concerned about risks of infection for patients without good hand hygiene."

Use the Chain-of-command

- If the person does not comply with your request to perform hand hygiene, report the incident to your manager.

Express thanks for reminders and perform the necessary hand hygiene.

Remember What Is Important!

Let's join hands against infection!

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Safe Contact

Click each photo below to take the mini-course:

Bloodborne Pathogens

Joanna Benchley, RN, BSN, MHA
Kathy Sahs, BS, CHSP
Sarah Meehle, BSN

USP 800

Steven Bonkoski, PharmD
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Hand Hygiene

MHC Infection Prevention Team

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Nova StatStrip Glucose Meter

Instructions and Guidance for Point of Care Testing at Munson Healthcare

July 2025

MUNSON HEALTHCARE

IMPORTANT!

Remember to use standard precautions when performing testing.

All body fluids are potentially infectious and should be treated as such.

Performing testing outside of the laboratory should only be performed by those personnel who have been deemed competent by a validator.

Goal and Objectives

Goal

This course provides the learner with information on the operating procedures for the Nova Biomedical StatStrip Glucose Meter.

Objectives

1. Perform Nova StatStrip Glucose Meter Point of Care testing.
2. Analyze test results after completion of Nova StatStrip Glucose Meter testing.

What This Test Detects

The Nova StatStrip is used to detect blood glucose levels in venous, arterial, and capillary blood.

Supplies Needed

- Nova StatStrip Blood Glucose Meter
- Nova StatStrip test strips
- Nova StatStrip quality controls
- Rechargeable 3.7V lithium battery
- NovaStatStrip docking/charging station
- Lancets
- Alcohol swab
- Gauze

Reagent Stability

Nova StatStrip test strips:

- Date when opened with expiration date - stable for 180 days after opening or until manufacturer's expiration date, whichever comes first.
- Stored at room temperature in the original container tightly sealed.

Nova StatStrip quality control solutions:

- Date when opened with expiration date - stable for 90 days after opening or until manufactures expiration date, whichever comes first.

Quality Control

- Material used: Nova StatStrip Xpress control solutions (Level 1 and 3)
- Test Strips: Come in a vial that protects the integrity of each test strip from light and exposure to air. The vial contains the lot information and manufacturer's expiration date.
- Frequency: Performed every 24 hours or when inaccurate test results are suspected.
- Tolerance of Control: Control ranges are printed on the control bottles. The two levels of controls must be within the quality control range to perform patient testing. If one or both controls are out of range, see troubleshooting.

Question Checkpoint

How often is quality control run?

- ○ With every patient
- ◉ Every 24 hours
- ○ Once a week
- ○ Once a month

Performing Test – Entering Operator and Patient Information

- Tap meter screen
- Press 'OK/Login' soft key at bottom of screen when GLU seen on the screen.
  - GLU LOCKED on opening screen indicates meter's QC needs to be run before patient testing.
- Scan operator identification (barcode on front of Munson employee badge) by pressing and releasing the scan soft key; press 'Accept' soft key once operator ID is verified as correct.
  - Operator ID can be manually typed, if needed.
- Scan the strip lot barcode.
- Scan patient identification from wristband.
  - Confirm patient ID is valid and press 'Accept'.
  - If the barcode is not recognized by the system, press down time override and continue to the next step.
- Open the test strip vial, remove one, and insert the gold end into the meter.

Performing Test *(cont.)*

- Wipe away the 1st drop of blood.
- Place end of test strip in contact with 2nd drop of blood.
  - Keep the meter level to avoid solution entering the meter.
  - The test strip must fill completely upon touching the sample.
  - Do NOT repeat touch the sample, if sample is inadequate, start over with a new strip.
  - Results are displayed in 6 seconds.
- A comment is required to connect with the result, choose 'COMMENT' at the bottom of the screen. Up to three comments can be added per result. (Capillary, Arterial, or Venous sample)
- 'Accept' or 'Reject' must be chosen, ensure results are documented in the patient's electronic medical record.
- Wipe down and clean meter after each use.

Reviewing Results

- From the patient test screen, press the 'Review' soft key.
- Sort by ID, Time/Date, or Type.
- When patient test is found, touch the line on meter's screen.
- Press 'View' - result will be on the screen.
  - 'Previous' and 'Next' soft keys may be used to proceed to another result on the list.

Cleaning and Disinfecting

All Glucometers MUST be cleaned between patient use with an Infection Prevention approved wipe.

Step 1: Clean the meter

- Remove fresh wipe from canister.
- Wipe external surface thoroughly to remove any visible blood, protein, dust, or debris.

Approved Cleaning Products

1 of 1 Automatic Zoom

Munson Healthcare

Clinical Cleaning Wipe Product Quick Reference

Product	Equipment			Dwell Time
	Bladder Scanner	Heated Hi Flow O2	Thermometers	3 Minutes
	Bone Density	Mechanical Lifts	Treadmills	
	Cardiac Testing Equipment	PAPR	Ventilators	
	CPAP/BiPAP Machines	Pill-crushers	Vital Machines	
	Desktops	Phones	Weight Scales	
	Echo Equipment	Portable Xray Machines	Xray Machines	
	Feeding Pump	Rehab Equipment		
	Keyboards	SCD Pumps	General Disinfection of Work Surfaces	
	Glucometers	Suction Machines		
	Ultrasound Probes & Machines	Echo equipment		
	Glucometers IV Pumps Laptops – not for use on screens Spacelabs Equipment Phillips Monitors Zimmer ROSA Robotics Mamogram Machines			4 Minutes
	Tablets and Phones Computer Screens PDAs Laptop Screens Use to remove disinfectant residue from electronic equipment as needed.			Wipe and wait until surfaces are dry *For cleaning only, not a disinfectant

- Gloves are to be worn when using disinfecting agents and cleaning
- Equipment must remain wet with disinfecting agent for the desired dwell time to be effective
- These will be the products available at Munson Healthcare

Updated 2/9/24

Cleaning and Disinfecting *(cont.)*

Step 2: Disinfect the meter

- Remove another fresh wipe.
- Thoroughly wipe the top, bottom, left side, right side, front, and back of the meter a minimum of three times vertically and three times horizontally.
- Gently wipe the surface of the test strip port, making sure no fluid enters port.
- Ensure the meter stays wet for the required DWELL time.

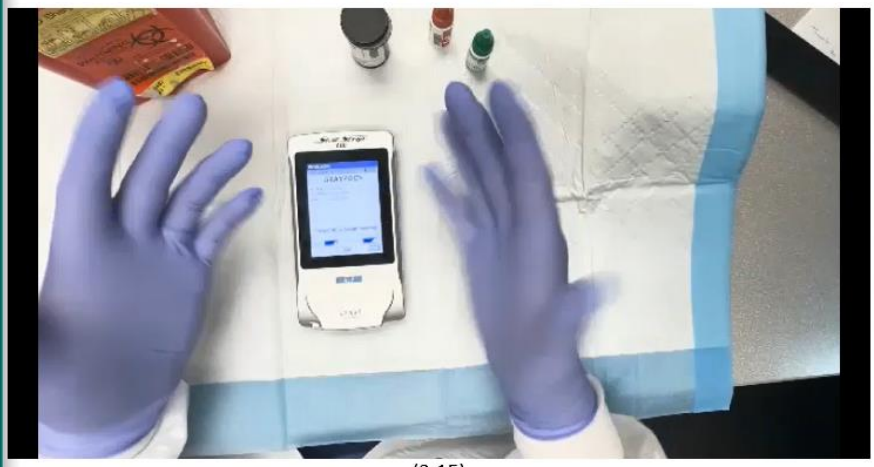
Cleaning and Disinfecting *(cont.)*

Step 3: To clean the docking station:

- Remove fresh wipe from container, wipe the external surface thoroughly to remove any visible dust or debris.
- Wipe down docking stations daily. Don't forget the inner section where the glucometer attaches to the docking station.

Ensure You Closed the Top of the Wipe Container

Demonstration

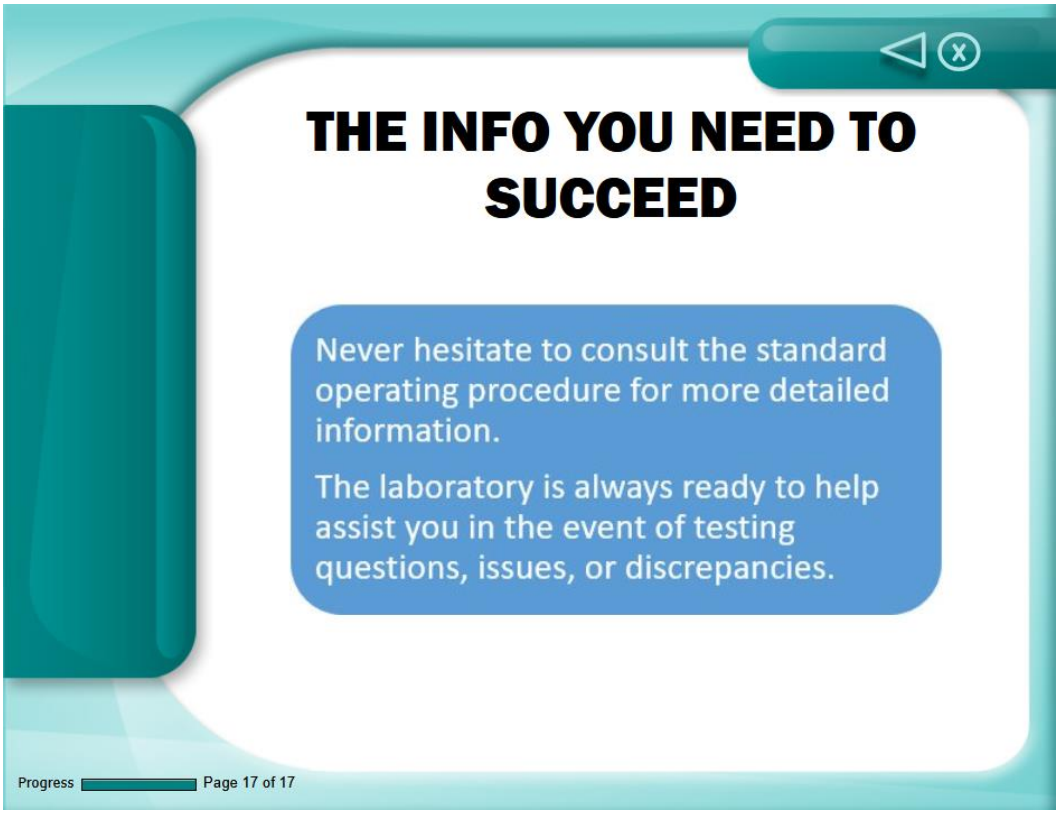


(2:15)

Knowledge Check *(cont.)*

Select the actions that will effectively clean and disinfect the glucose meter.

- [x] Use a fresh wipe to remove any visible blood, protein, dust, or debris.
- [ ] Use the available wipe next to the docking station.
- [x] Use another fresh wipe and thoroughly wipe all surfaces of the meter 3 times vertically and 3 times horizontally.
- [x] Ensure the meter stays wet for the required Dwell time
- [x] Use an Infection Prevention approved wipe
- [ ] Place the meter in the docking station if you notice dust or debris in the inner section


THE INFO YOU NEED TO SUCCEED
Never hesitate to consult the standard operating procedure for more detailed information.
The laboratory is always ready to help assist you in the event of testing questions, issues, or discrepancies.
Progress
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The Morse Fall Scale with Fall TIPS

The Munson Healthcare Fall Prevention Program

Megan Greenway MSN, RN, CNOR
Meredith Gipps MSN, RN, AGCNS-BC
Megan Smith LMSW

MUNSON HEALTHCARE

December 2024

IMPORTANT COMPETENCY INFORMATION

The completion of this course and post-test will satisfy RN competency for the Morse Fall Scale and Fall TIPS fall prevention program.

At the end of this course:

- **You will receive a post-test**
- **You have two (2) attempts to pass this test**
- **You must receive 100% to pass**
- **If you fail twice, you will need to re-take this course**

Goal and Objectives

Goal:
Introduce the Munson Healthcare standardized fall prevention program.

Objectives:
1. Accurately perform the Morse Fall Scale fall risk assessment.
2. Identify appropriate Fall TIPS patient-specific fall prevention interventions.
3. Communicate patient-specific plan of care with all representatives of the healthcare team.

Standardized Fall Prevention Program

MHC utilizes a 3-step fall prevention program that is simple and succinct. This evidence-based program has proven to significantly reduce patient falls and falls with injury.

1. Implement the ***Morse Fall Scale*** fall risk assessment.
2. Tailor fall prevention interventions for each patient using the evidence-based ***Fall TIPS (Tailoring Interventions for Patient Safety)*** program.
3. Maintain consistent communication with staff, patients, and their loved ones throughout their care.

Step 1: Fall Risk Assessment

The fall risk assessment includes:

- The ABCS Fall Injury Risk Screening
- The Morse Fall Scale

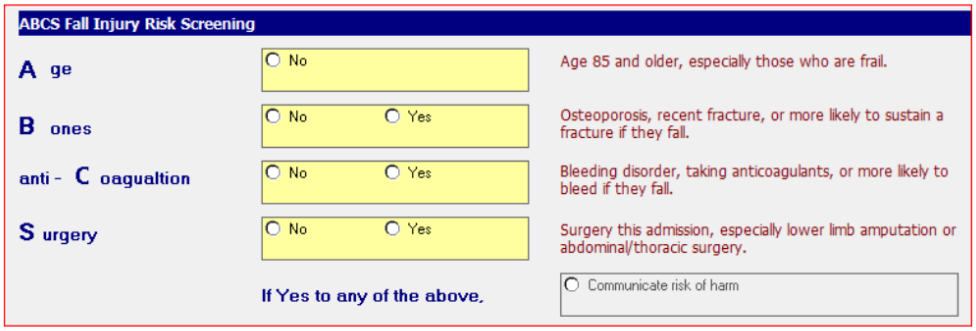
The ABCS

The ABCS Fall Injury Risk Screening:

- **A**ge: 85 and older, especially those who are frail
- **B**ones: Osteoporosis, recent fracture, or more likely to sustain a fracture if they fall
- anti-**C**oagulation: Bleeding disorder, taking anticoagulants, or more likely to bleed if they fall
- **S**urgery: Recent surgery (this admission), especially lower limb amputation or abdominal/thoracic surgery

ABCS Fall Risk Screening

PowerChart/FirstNet



The Morse Fall Scale

The Morse Fall Scale (MFS):

- Is a validated fall risk assessment tool.
- Provides information needed to tailor individual patient-specific fall prevention interventions through the **Fall TIPS** program.
- Involves the patient and their loved ones during the fall risk assessment.
- Is completed every 12 hours throughout hospitalization, at minimum.

Areas of Risk	Numeric Values
1. History of Falling	No 0 Yes 25
2. Secondary Diagnosis	No 0 Yes 15
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture	 0 15 30
4. IV or IV Access	No 0 Yes 20
5. Gait Normal/bed rest/wheelchair Weak Impaired	 0 10 20
6. Mental Status Oriented to own ability Overestimates or forgets limits	 0 15

MFS Identified Fall Risk Area

1. History of Falling

Assess the patient's history of falling.

Has the patient:

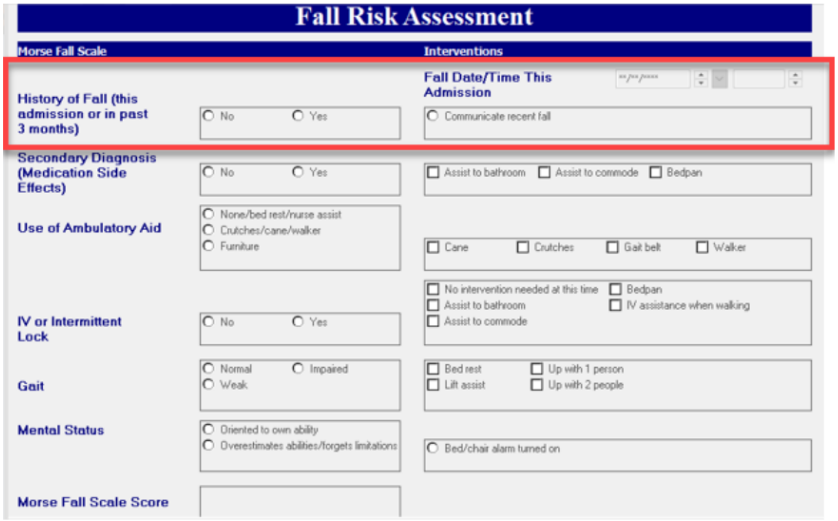
- fallen during the current hospitalization
- had immediate history of falls within the last 3 months

This is the most significant indicator for falling.

Rectangle 3

History of Falling

PowerChart/FirstNet



MFS Identified Fall Risk Area (cont.)

2. Secondary Diagnosis (Medication Side Effects)

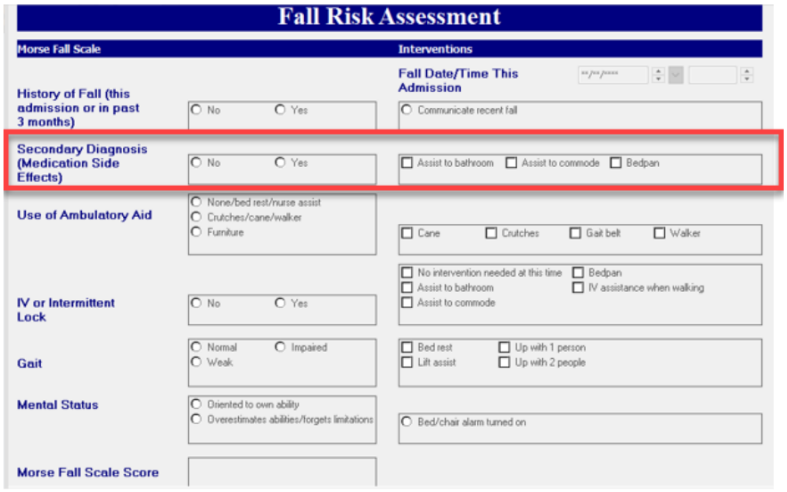
Assess the patient for more than one active medical diagnosis during this admission. *Must have ***more than one*** active medical diagnosis to score Yes.*

Additional primary diagnoses could increase the risk of complications, such as:

- Polypharmacy/multiple medications
- Hypotension
- Dizziness/unsteadiness
- Vision problems
- Frequent urination

Secondary Diagnosis

PowerChart/FirstNet



MFS Identified Fall Risk Area (cont.)

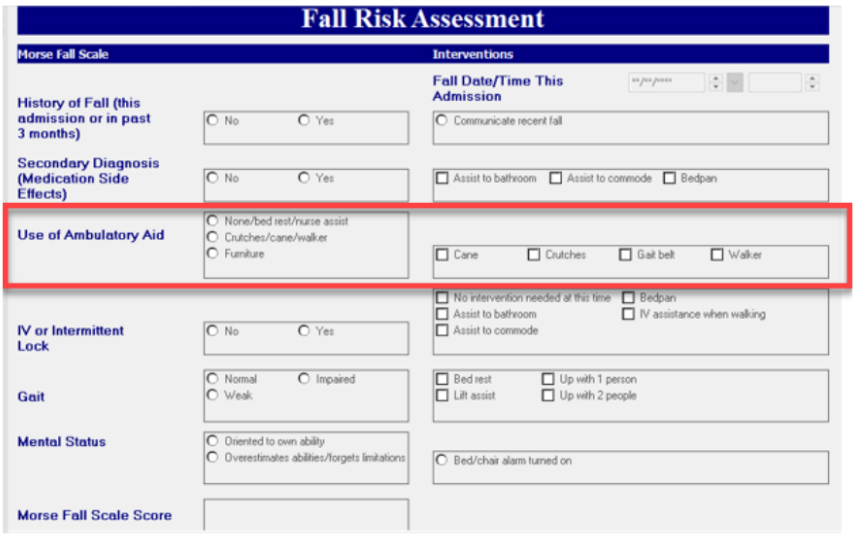
3. Ambulatory Aid

Assess for ambulatory aids:

- No walking aid is needed, uses a wheelchair, or is on bed rest (does not get up at all)
- Uses crutches or a walker
- Uses furniture for support; needs help but does not ask or is noncompliant with use of ambulatory aid or bed rest orders

Ambulatory Aid

PowerChart/FirstNet



Fall Risk Assessment

Morse Fall Scale		Interventions	
		Fall Date/Time This Admission	
History of Fall (this admission or in past 3 months)	○ No ○ Yes	○ Communicate recent fall	
Secondary Diagnosis (Medication Side Effects)	○ No ○ Yes	☐ Assist to bathroom ☐ Assist to commode ☐ Bedpan	
Use of Ambulatory Aid	○ None/bed rest/nurse assist ○ Crutches/cane/walker ○ Furniture	☐ Cane ☐ Crutches ☐ Gait belt ☐ Walker	
		☐ No intervention needed at this time ☐ Bedpan ☐ Assist to bathroom ☐ IV assistance when walking ☐ Assist to commode	
IV or Intermittent Lock	○ No ○ Yes		
Gait	○ Normal ○ Impaired ○ Weak	☐ Bed rest ☐ Up with 1 person ☐ Lift assist ☐ Up with 2 people	
Mental Status	○ Oriented to own ability ○ Overestimates abilities/forgets limitations	○ Bed/chair alarm turned on	
Morse Fall Scale Score			

MFS Identified Fall Risk Area (cont.)

4. IV or IV Access

Assess the patient's IV status.

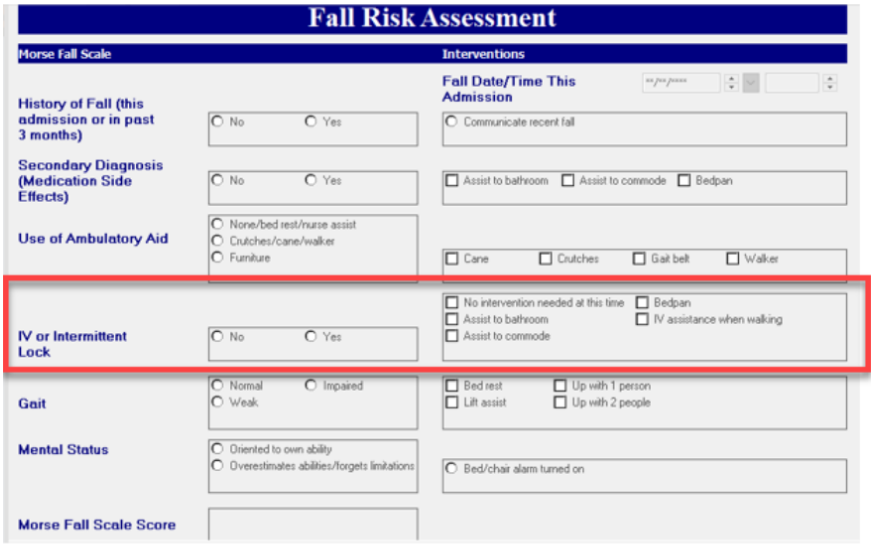
- Does not have an IV infusing or I-lock in place
- Has an IV infusing or I-lock in place

If the patient has an I-lock, but is not connected to an infusion, select the IV or Intermittent Lock risk factor. There is no intervention necessary at that time, but the patient's status may change quickly so it is a risk factor.
Score Yes if attached to other equipment (i.e., wound vac, nasal cannula).

Rectangle 3

IV or IV Access

PowerChart/FirstNet



MFS Identified Fall Risk Area (cont.)

5. Gait

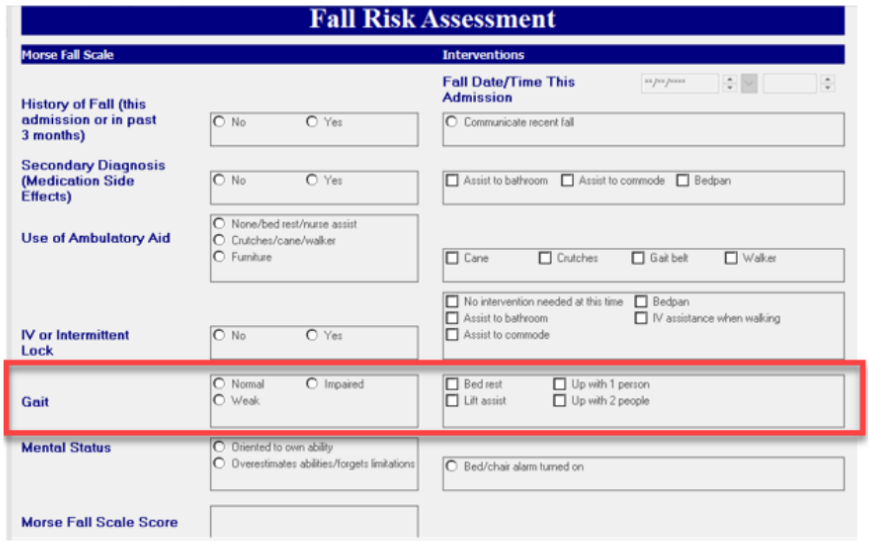
Assess the patient's current gait.

- The patient has a **normal gait** *(walks with head erect, arms swinging freely at the side, striding without hesitation)* or is on bed rest.
- The patient has a **weak gait** *(stooped, but able to lift head without losing balance, uses furniture as a guide, short steps, may shuffle)*.
- The patient has an **impaired gait** *(difficulty or multiple attempts rising from chair, head down, watches ground while walking, cannot walk without assist, grabs at whatever available, short/shuffling gait)*.
  Wheelchair: score according to gait used during transfer to wheelchair.

Rectangle 3

Gait

PowerChart/FirstNet



MFS Identified Fall Risk Area (cont.)

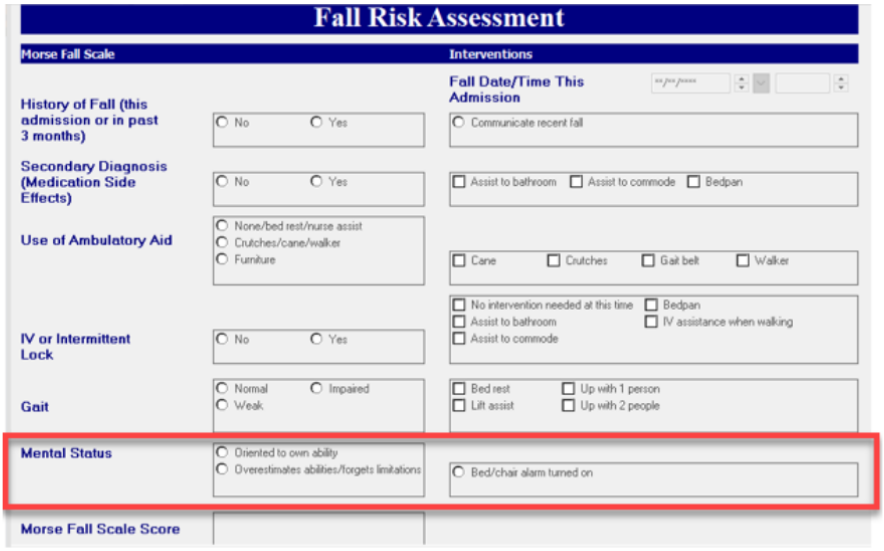
6. Mental Status

Assess the patient's judgement of their ability or limitations by asking *"Are you able to go to the bathroom alone or do you need assistance?"*

- The patient has a realistic opinion of their mobility ability.
- The patient overestimates their abilities or is forgetful of limitations.

Mental Status

PowerChart/FirstNet



Fall Risk Assessment

Morse Fall Scale		Interventions	
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IV or Intermittent Lock	○ No ○ Yes		
Gait	○ Normal ○ Impaired ○ Weak	☐ Bed rest ☐ Up with 1 person ☐ Lift assist ☐ Up with 2 people	
Mental Status	○ Oriented to own ability ○ Overestimates abilities/forgets limitations	○ Bed/chair alarm turned on	
Morse Fall Scale Score			

Fall Risk Calculation and Interventions

When the fall risk assessment is complete, the electronic medical record will automatically figure the patient's score.

While the Morse Fall Scale provides the fall risk score, the Fall TIPS interventions are based on the patient's specific fall risk factors and not the cumulative numeric value.

Universal Fall Precautions must be implemented for every patient, regardless of their specific fall risk factors, throughout their entire admission.

Click here to view Universal Fall Precautions.

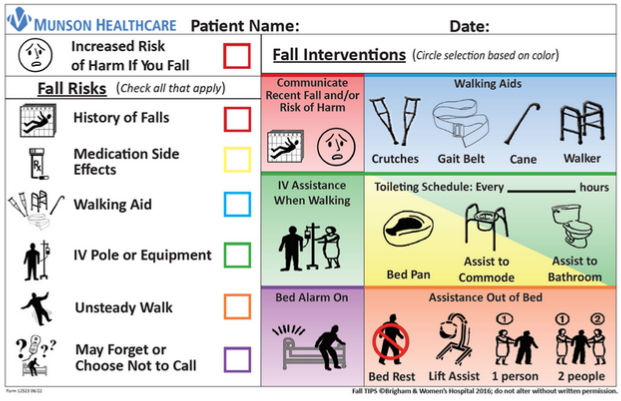
Universal Fall Precautions

1. Familiarize the patient with their environment.
2. Have the patient demonstrate call light use.
3. Maintain call light within reach.
4. Keep the patient's personal possessions within safe reach.
5. Place the hospital bed in a low position when patient is resting in bed. Raise bed to a comfortable height when the patient is transferring out of bed.
6. Keep hospital bed and stretcher brakes locked.
7. Keep wheelchair wheel locks in "locked" position when stationary.
8. Keep hospital issued non-slip socks on the patient.
9. Use night lights or supplemental lighting.
10. Keep floor surfaces clean and dry. Clean up all spills promptly and keep patient care areas uncluttered.
11. Follow safe patient handling practices.

Rectangle 3

Step 2: Fall TIPS

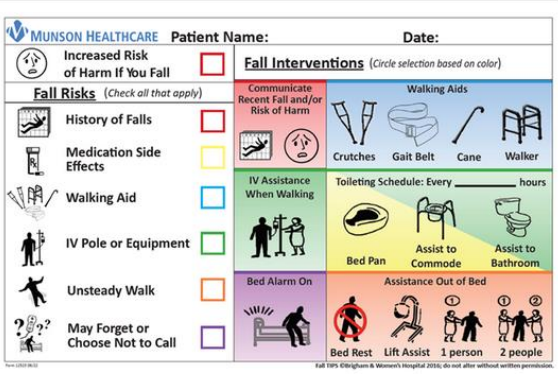
Using the Morse Fall Scale and information from the patient, the RN is responsible for updating the Fall TIPS poster in the patient room every shift. Engaging the patient during this process is key. If patients believe they are at risk of falling they are more likely to comply with the interventions as outlined by their RN.



Fall TIPS Instructions

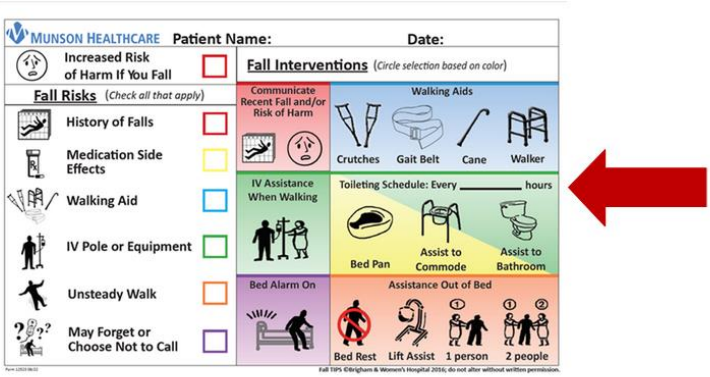
The fall interventions are based on the identified Morse Fall Scale risk factors and are color-coded to match the patient's specific risks for fall.

- Engage the patient and their loved ones by involving them in the Fall TIPS selection process.
- Identify the patient's fall risk areas by checking the color-coded box on the left side of the poster.



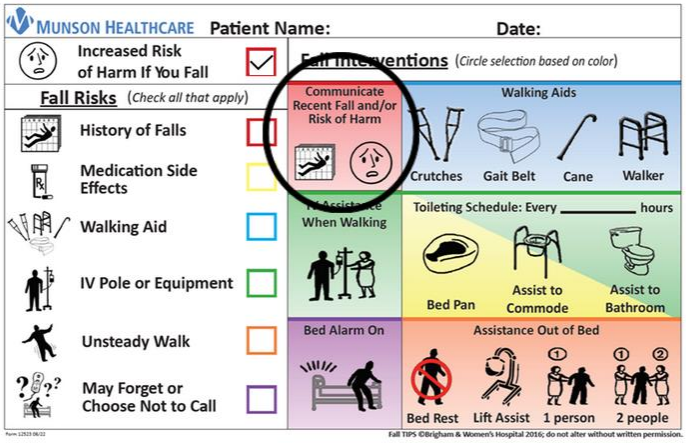
Fall TIPS Instructions (cont.)

- Locate the fall prevention interventions color-coded to match each selected fall risk area on the right side of the poster.
- Circle the most appropriate fall prevention intervention for each category.
  This is how the RN communicates the patients' required interventions to other members of the healthcare team who may be assisting the patient.



Fall TIPS – ABCS

Selecting **yes** to any of the ABCS qualifies patient for the risk factor of **Increased Risk of Harm If You Fall.**

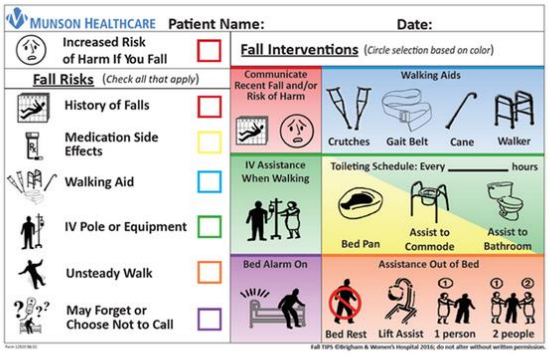


Test Your Knowledge

You have just completed a fall risk assessment on an 80-year-old patient who was admitted with pneumonia and congestive heart failure, has a history of falling, uses a walker and often chooses not to call for help getting up to the bathroom. Choose the four correct Fall Risks to check on the Fall TIPS poster?

Choose the **four** correct Falls Risks to check on the Fall TIPS poster.

- [x] History of Falls
- [ ] Medication Side Effects
- [ ] Walking Aid
- [x] IV Pole or Equipment
- [x] Unsteady Walk
- [x] May Forget or Choose Not to Call



The Fall Risk Assessment

The Morse Fall Scale fall risk assessment must be completed with the nursing assessment in the ED, upon admission and every 12 hours while hospitalized. This means the fall risk assessment score may change shift to shift, as can the corresponding fall prevention interventions.

However, if the patient's condition warrants a fall risk status change, a fall risk assessment can be completed prior to the next tasked fall assessment.

The patient's name and date must be updated on the Fall TIPS poster after every fall assessment even if the patient is not at risk of falling (Universal Fall Precautions) or if their fall risk status has not changed from the previous assessment. Patient engagement and review of the poster should also occur every shift.

Every patient is at risk of falling in the hospital. If they score 1 or more on the Fall Risk Assessment, they are considered a high risk for fall.

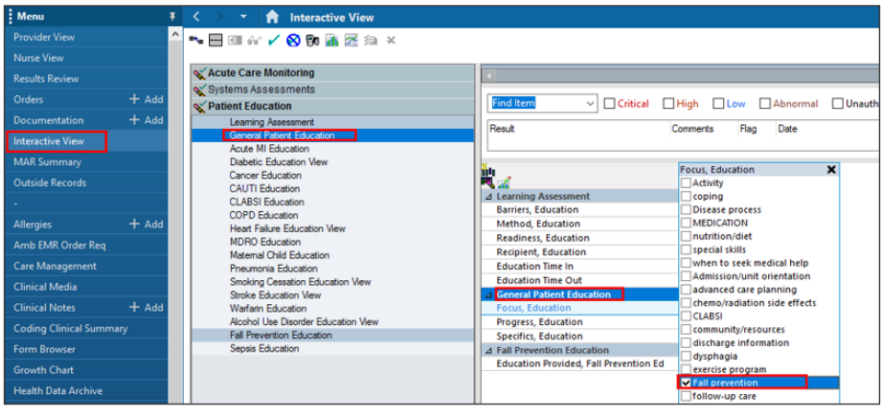
Rectangle 3

Patient Education Documentation

Fall prevention education should be documented when completing the Education Task BID.

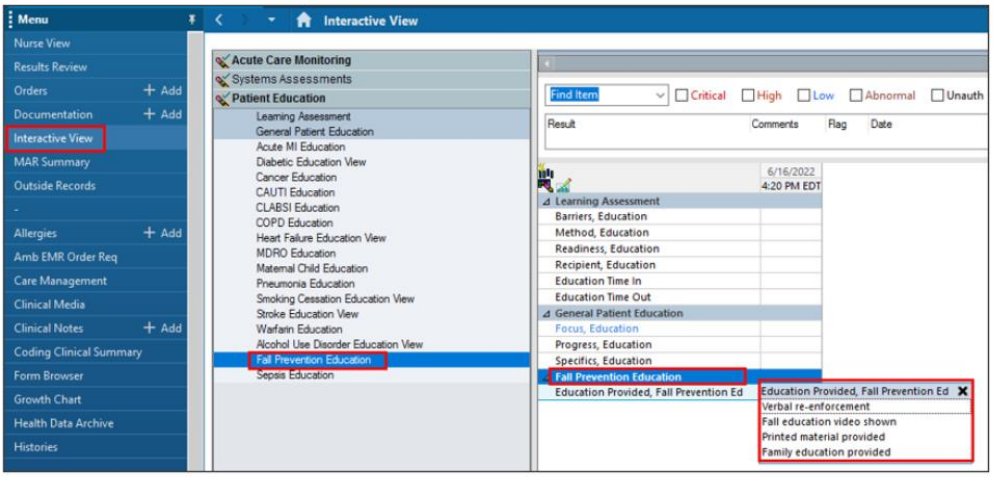
General Patient Education Documentation

PowerChart/FirstNet



Fall Prevention Education Documentation

PowerChart/FirstNet



Step 3: Consistent Implementation

The key to success lies in consistency.

- Consistently assess patient for fall risk changes.
- Consistently implement all interventions through Universal Precautions **AND** patient-specific fall interventions.
- Consistently engage the healthcare team. Always include the patient and their loved ones.

Patient Engagement

In the spirit of True North, it is important to keep the patient at the center of the fall prevention process. This means involving them in the fall risk assessment and when selecting the appropriate interventions on the Fall TIPS Poster.

Patients are more likely to ***believe*** they are at risk of falling when the nurse reviews their specific risk factors with them during the fall assessment.

Patients are also more likely to ***comply*** with their fall prevention interventions if involved in the development of their fall prevention plan, and if it is reinforced often by members of the healthcare team.

Test Your Knowledge

Why is it important to include the patient (if they are able) and/or their loves ones in the Fall TIPS poster updates? (Choose the 3 that apply)

- [x] A. A patient is more likely to believe they are at risk of a fall if the nurse reviews their fall risks with them during the fall risk assessment.
- [ ] B. Patient's loved ones only need to be engaged in the patient's fall risk status during discharge instructions.
- [x] C. Involving the patient and their loved ones in the fall prevention process demonstrates keeping the patient in the center of their care.
- [x] D. A patient is more likely to comply with their fall prevention interventions if they are involved in the intervention selection process using the Fall TIPS poster.

Resources

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- Morse, J. (2009). *Preventing patient falls* (2nd ed.). New York, NY: Springer Publishing Company, LLC.

MUNSON HEALTHCARE

Munson Healthcare
Resuscitation Policies

Code Status in a Hospital Setting
DNR orders in an Ambulatory/Non-Hospital Setting

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November 2024

Goal & Objectives

Goal

This learning module will enable the learner to understand the MHC Resuscitation Policies, as applicable, in both a hospital and non-hospital setting.

Objectives

1. Define CPR, including the clinical indications and interventional aspects.
2. Associate Code Status orders with resuscitation attempts in a hospital setting.
3. Distinguish between Code Status order options, including the clinical response expectations in a hospital setting.
4. Recognize how advance directives and Out of Hospital DNR orders impact Code Status orders in a hospital.
5. Compare DNR orders in a non-hospital setting to DNR orders in a hospital setting.

What is CPR?

Cardiopulmonary Resuscitation (CPR) is a major emergency medical procedure that attempts to restart a person's heart.

CPR keeps blood moving to circulate oxygen to vital organs after cardiac arrest.

If CPR is not performed after cardiac arrest, a natural death will occur.

What Does CPR Involve?

CPR involves several advanced medical interventions that are inherently associated with one another.

Interventions include, but are not limited to:

- Chest compressions
- Potent IV medication administration
- Cardiac defibrillation
- Intubation with mechanical ventilation (or other advanced airway management)
- Other advance life support techniques

CPR Risks and Benefits

Due to the universally accepted notion that CPR will be performed unless a DNR order is present, healthcare professionals have an ethical duty to ensure their patients are informed of the risks and benefits of CPR.

Click each button.

Benefits

- When successful, CPR will restart a person's heartbeat.

Risks

- Sore chest, broken ribs, and/or collapsed lung due to chest compressions
- Brain injury due to lack of blood flow to the brain
- Loss of independence

CPR Outcomes

CPR outcomes are associated with how quickly a resuscitation attempt occurs after a person's heart stops beating, the person's health condition, and their age.

Click each button.

Health Conditions Factor

Health Conditions	Survival Rate after CPR
Cancer	7%
COVID-19	3%
Diabetes	16%
Heart Failure	17%
Liver Failure	7%
Renal Dialysis	14%
Sepsis/Infection	8%
Stroke	11%

Age Factor

Among patients 65 and older who received CPR in the hospital:
- 49% died during resuscitation
- 34% died before hospital discharge
- 17% survived to discharge
- 10% were alive 1 year after discharge

If CPR is not attempted within the first 5-10 minutes after a person's heart stops beating, there is nearly zero chance of their heartbeat restarting.

What is Code Status?

Code Status is an electronic medical order required for all patients receiving care in a hospital setting which indicates how clinicians should respond in only two clinical scenarios.

1. Cardiac Arrest
2. Severe Respiratory Failure

Code Status Order Applicability

Click each button for the definition.

Cardiac Arrest

Cardiac arrest occurs when there is cessation of cardiac activity as confirmed by the absence of signs of pulse/circulation.

Severe Respiratory Failure

Severe respiratory failure occurs when respirations are completely absent or inadequate to maintain oxygenation and proper gas exchange so severe that intubation with mechanical ventilation is warranted (a pulse is present).

Case Scenario: Betty

Interpretation of Code Status Orders

Betty has been admitted for pneumonia. Over the past two days, her respiratory status has become more tenuous with oxygen saturations at 88-90%. Additional therapies, such as BiPAP, have been initiated, but her oxygen saturations are not improving. Intubation with mechanical ventilation is indicated.

Betty's code status is: DNR

Based on your understanding of this code status order, intubation with mechanical ventilation should be initiated.

- (●) True
- ( ) False

Case Scenario: Betty

Interpretation of Code Status Orders

TRUE

DNR means Betty does not want CPR;
DNR does not mean Do Not Treat.

Betty is experiencing severe respiratory failure and has a pulse. Therefore, the clinical team should prepare for intubation with mechanical ventilation.

Resuscitation Policies

- ***MHC Resuscitation Policy: Code Status in a Hospital Setting***
- ***MHC DNR Orders in an Ambulatory/Non-Hospital Setting***

The purpose of these policies is to provide guidelines to healthcare professionals throughout the Munson Healthcare System about Code Status orders in hospital settings and out of hospital DNR orders in an Ambulatory/Non-Hospital setting.

Code Status Order Options in a Hospital Setting

Under the *MHC Resuscitation Policy: Code Status Orders in a Hospital Setting*, all patients admitted to a hospital will have THREE Code Status Order options.

1. Full

2. Do Not Resuscitate (DNR)

Patient Armband: **DNR**

3. Do Not Resuscitate / Do Not Intubate (DNR/DNI)

Patient Armband: **DNR/DNI**

Clinical Response Expectations per Code Status

FULL	In the event of cardiac arrest (per life support protocols for adults, minors, and newborns) or severe respiratory failure, staff should **call a CODE BLUE** and **initiate CPR**.
DNR	➢ In the event of cardiac arrest (per life support protocols for adults, minors, and newborns), staff should **NOT initiate CPR**. Instead, staff will **allow natural death**. ➢ In the event of severe respiratory failure (patient with pulse), staff should **initiate the Medical Response Team (MRT)** and **prepare for endotracheal intubation** with mechanical ventilation.
DNR/DNI	• In the event of cardiac (per life support protocols for adults, minors, and newborns) or severe respiratory failure, staff should **NOT initiate CPR or endotracheal intubation** with mechanical ventilation. Instead, staff will **allow natural death**. • Any other respiratory therapies will be maintained/introduced (unless otherwise delineated) to maintain patient comfort.

Case Scenario: John

Do Not Intubation (DNI) orders

John is admitted for nausea and vomiting related to his cancer therapy. During the code status discussion, John states that he does not want to be intubated, under any circumstances, but he would be willing to have CPR.

Is a DNI Code Status order an option under the Munson Healthcare Resuscitation Policy?

- ○ Yes
- ◉ No

Case Scenario: John

Do Not Intubation (DNI)

NO. Code Status Order options include FULL, DNR, & DNR/DNI.

Rationale:

Airway/breathing is an integral part of ACLS, PALS, and NRP protocols. There are no professional recommendations or guidelines that support the administration of partial or limited CPR.

Therefore, DNI is ethically problematic as studies have shown no survival benefit and have potential to cause more harm to patients.

Code Status and Procedures

At times, a patient with a DNR or a DNR/DNI code status order may undergo a procedure that requires general anesthesia or sedation.

In this circumstance, clinicians must recognize the following:

1. DNR or DNR/DNI orders should **NOT** be a contraindication to procedures.
2. Some procedures (e.g., cardiac surgery) may require suspension of a DNR or DNR/DNI order to ensure the procedure is successful.

Respecting Patient's Rights

In harmony with respecting a patient's right to participate in treatment decisions, a DNR or DNR/DNI order shall **NEVER** automatically be rescinded or revoked without discussing the circumstances with the patient or the patient's representative.

Clinicians may consider using Form 4511:
Treatment Decisions During Surgical Procedures
to document code status decisions.
(Click here to view form.)

**If a patient has a strong opposition to resuscitation, upholding this right may result in certain procedures being unsuccessful.
In these instances, an alternative treatment plan may be necessary.**

Form #4511 (10/23)

Code Status During and/or After a Procedure

PATIENT NAME: _____ DOB: _____

PHYSICIAN NAME: _____ PROCEDURE: _____

Definitions:

"***Procedure***" means any medical procedure that involves the use of general anesthesia (i.e., during major surgery) or sedation (i.e., during a colonoscopy, minor surgery, etc.).

"***Resuscitate***" means perform cardiopulmonary resuscitation (CPR) involving pushing very hard on the chest, using a machine that gives shocks to the heart, intubation with mechanical ventilation, and giving strong medications. CPR is performed when a person's heart stops beating and they stop breathing.

"***Intubation with mechanical ventilation***" means inserting a tube into the throat and hooking it to a machine to help a person breathe.

"***General anesthesia***" means giving medication to keep someone from awaking up and feeling pain.

"***Sedation***" means giving medications to keep someone in an awake state of calmness.

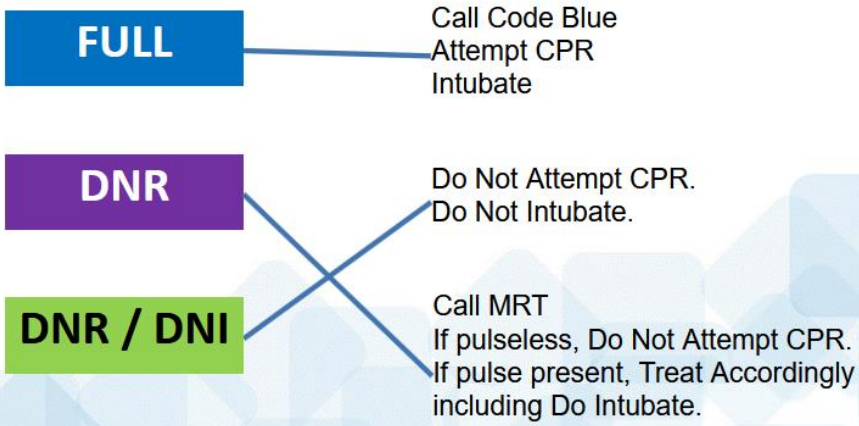
---

1. I understand that a procedure involving general anesthesia will require intubation with mechanical ventilation for the safe and successful outcome of the procedure.

2. During and immediately after my procedure, should my heart stop and/or I stop breathing, I

Knowledge Check

Match the Clinical Response Expectations to the appropriate Code Status Order.



Case Scenario: Carol

DNR orders and surgical intervention.

Carol is a 77-year-old patient who was recently admitted for a fall. Work up reveals she will need to undergo surgical intervention to fix her broken hip.

Her current Code Status order is DNR.

Does the DNR order impact her treatment plan or surgery?

- ○ Yes
- ◉ No

Case Scenario: Carol

DNR orders and surgical intervention

NO. A DNR order should not impact this situation.

A DNR code status is not a contraindication for surgery.

A patient with a DNR code status should be offered the same treatment options as a patient with a FULL Code status order.

As part of the informed consent process for the procedure, the surgeon and/or anesthesiologist should discuss the DNR order with the patient, or the patient's representative, and conclude whether the DNR order will be rescinded for the procedure.

DNR Orders in a Non-Hospital Setting

Like hospitalized patients, patients in a non-hospital setting have a right to participate in treatment decisions about resuscitation.

It is universally known and accepted that CPR will be performed unless a DNR order is present.

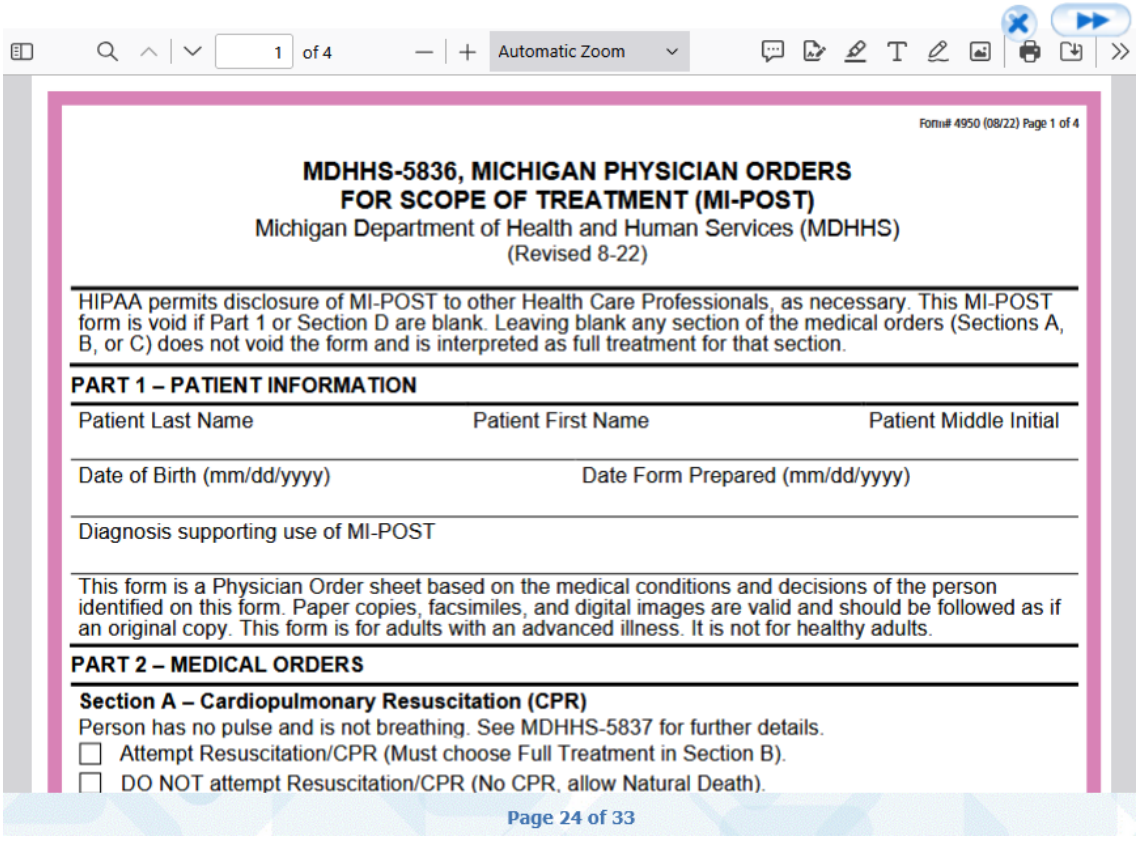
OOH-DNR Order Types

In accordance with Michigan law and under the MHC *DNR Orders in an Ambulatory/NonHospital Setting policy*, there are two types of Out of Hospital DNR orders directing resuscitation efforts in an ambulatory/ non-hospital setting.

Click each button.

Physician Order for Scope of Treatment (MI-POST)

Out of Hospital Do Not Resuscitate Order (OOH-DNR)



1 of 4 — Automatic Zoom

Form# 4950 (08/22) Page 1 of 4

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)

Michigan Department of Health and Human Services (MDHHS)

(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Initial
Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)	
Diagnosis supporting use of MI-POST		

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

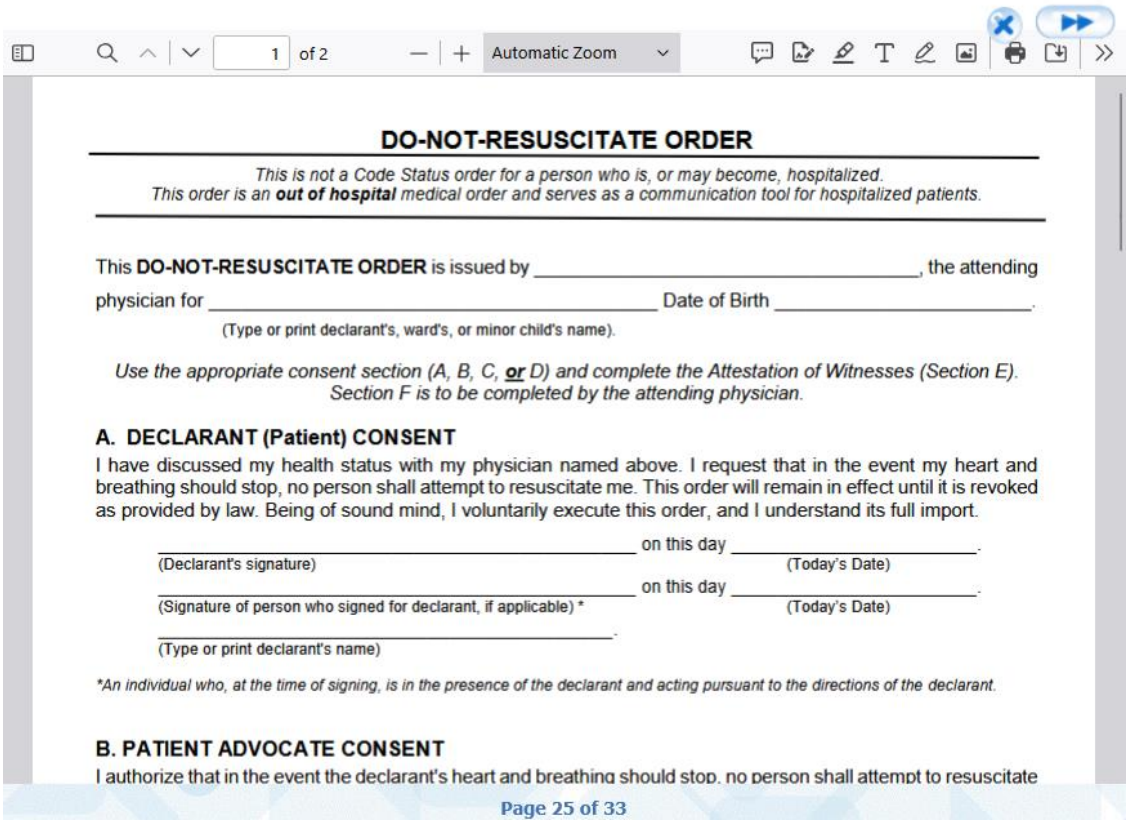
PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).

☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).



DO-NOT-RESUSCITATE ORDER

This is not a Code Status order for a person who is, or may become, hospitalized.
*This order is an **out of hospital** medical order and serves as a communication tool for hospitalized patients.*

This **DO-NOT-RESUSCITATE ORDER** is issued by _____, the attending physician for _____ Date of Birth _____.
(Type or print declarant's, ward's, or minor child's name).

*Use the appropriate consent section (A, B, C, **or** D) and complete the Attestation of Witnesses (Section E). Section F is to be completed by the attending physician.*

A. DECLARANT (Patient) CONSENT

I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ on this day _____.
(Declarant's signature) (Today's Date)

_____ on this day _____.
(Signature of person who signed for declarant, if applicable) * (Today's Date)

_____.
(Type or print declarant's name)

**An individual who, at the time of signing, is in the presence of the declarant and acting pursuant to the directions of the declarant.*

B. PATIENT ADVOCATE CONSENT

I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate

Out of Hospital DNR (OOH-DNR) Order Types *(cont.)*

It's important for healthcare professionals to recognize the MI-POST order allows the individual to choose:

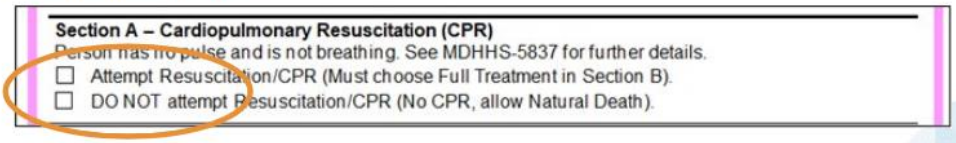
Attempt Resuscitation/CPR ***or*** **Do Not Attempt Resuscitation/CPR**

Therefore, an MI-POST order must be read to understand the individuals' decision about CPR.

Out of Hospital Medical Order Distinctions

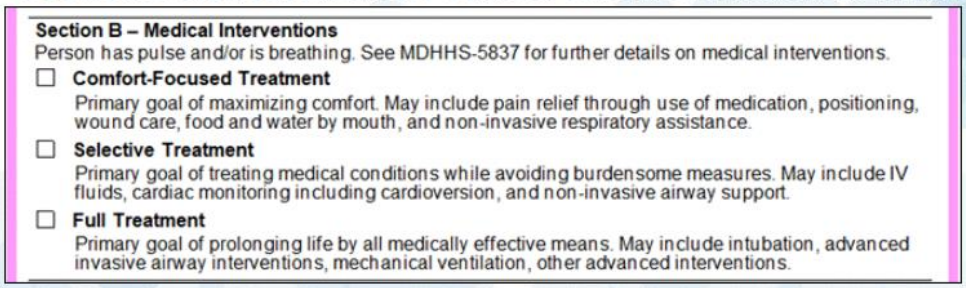
The MI-POST is different from an OOH- DNR because one can chose Attempt CPR in *Section A* while *Section B* indicates medical interventions outside of CPR.

- **SECTION A:** A person can choose “Attempt Resuscitation/CPR” OR "Do Not Attempt Resuscitation/CPR”.



Section A – Cardiopulmonary Resuscitation (CPR)
Person has no pulse and is not breathing. See MDHHS-5837 for further details.
☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

- **SECTION B:** A person can choose Comfort-Focused, Selective, or Full Treatment.



Section B – Medical Interventions
Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.
☐ **Comfort-Focused Treatment**
Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
☐ **Selective Treatment**
Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
☐ **Full Treatment**
Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

How do Out of Hospital Medical Orders Impact Code Status Orders in a Hospital?

Out of Hospital Medical Orders are informative tools providing insight into the patient's treatment goals and/ or resuscitation decisions.

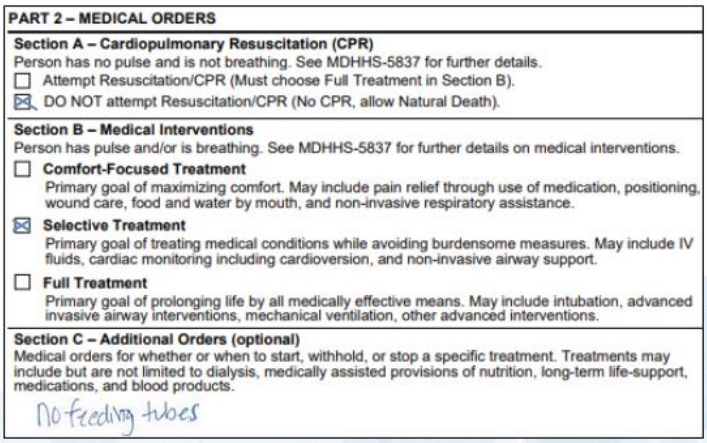
Important points to consider:

- Out of hospital medical orders indicating DNR or selective medical interventions should guide discussions about Code Status **during** a patient's hospitalization.
- At times, a patient may change their mind and/or have a different resuscitation decision in a hospital setting compared to a non-hospital setting.

Case Scenario: Judy

Continuum of Care

Judy is an 87-year-old patient who has been experiencing progressive dementia and frailty. She is brought to the ED with confusion and weakness, and she has the following MI-POST [see image].



PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)
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☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
☒ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions
Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.
☐ **Comfort-Focused Treatment**
Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.
☒ **Selective Treatment**
Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.
☐ **Full Treatment**
Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.
No feeding tubes

Which hospital code status orders best reflects her MI-POST decisions:

- ○ Full
- ○ DNR
- ◉ DNR/DNI

Case Scenario: Judy

Continuum of Care

c) DNR/DNI

Section A of the MI-POST indicates that Judy does not want CPR as evidence by the selection of "DO NOT attempt Resuscitation/ CPR)"

Section B of the MI-POST indicates that Judy's primary goal is to avoid burdensome measures, such as advanced invasive airway interventions or mechanical ventilation, as evidence by her selection of "Selective Treatments".

Summary

- CPR is a major and emergent medical procedure that entails several medical interventions all interconnected to one another.
- All Healthcare providers have a responsibility to inform their patients of the risks and benefits of CPR, especially patients who have advanced illness and/or frailty.
- MHC's Resuscitation policies describe code status options, clinical expectations, and details about supporting patient's DNR decisions in settings outside of a hospital.
- Code Status is only applicable in only **two** clinical scenarios: Cardiac Arrest or Severe Respiratory Failure.
- Out of hospital Medical Orders, such as the MI-POST, are informative tools providing insight into the patient's treatment goals and/or decisions about resuscitation.

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GIFT of LIFE MICHIGAN | 50 years 1971–2021
ORGAN AND TISSUE DONATION

Organ & Tissue Donation:

What Healthcare Professionals Need to Know

Leslie Casperson, MSN, RN
Hospital Donation Advocate

Barbara Reynolds, BSN, RN, CCRN-K
Healthcare Educator

August 2025

Goal and Objectives

Goal

This course provides information to familiarize the learner with Gift of Life Michigan, an organ procurement organization (OPO).

Objectives

1. Identify Gift of Life as Michigan's Organ Procurement Organization (OPO).
2. State the laws and regulations regarding donation.
3. Explain the differences between Brain Death and Donation after Cardiac Death (DCD).
4. Verbalize the clinical triggers for when to call Gift of Life Michigan (GOLM).
5. Identify who can talk with family about donation.
6. Describe which organs and tissue can be donated.
7. Recognize the steps involved in the donation process.
8. Describe what is expected of healthcare team members.

Gift of Life Michigan (GOLM) Overview

- Independent, non-profit based in Ann Arbor serving 9.9 million people.
- Federally designated organ & tissue recovery organization for Michigan.
- Founded in 1971 by 5 transplant surgeons.
- Liaison between 175 hospitals and nine transplant centers.
- Maintains the confidential Michigan Organ Donor Registry in collaboration with the Secretary of State.
- The Donor Care Center in Ann Arbor is open 24 / 7 / 365.
  - It has its own ICU, surgical suite, and independent lab.
  - Serology testing is done and the allocation process begins to locate potential recipients.

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Federal Regulations

Conditions of Participation

- Every eligible decedent's family must be offered the option of donation (prior to extubation).
- Report every imminent death within 1 hour.
- Report every death to GOLM within 1 hour.
- Grant GOLM access to patient medical records.
- Only GOLM staff may discuss donation with family.
- HIPAA allows hospitals to release information in order to facilitate donation.

CMS

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Disclosure of Protected Health Information (PHI)

HIPAA Privacy Rule permits:

Hospitals and healthcare providers to "disclose protected health information (PHI) to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation and transplantation."
45 CFR § 164.512(h).

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Donation Authorization

Family Discussions

- Please do not mention donation or Gift of Life to family.
  - This is called a *pre-approach* and is non-compliant with CMS standards.
  - Only designated requestors are to approach family for donation.
- Who are designated requestors?
  - Gift of Life staff
- To avoid a pre-approach, which is non-compliant with CMS standards, please:
  - Do not discuss any area of donation.
  - Do not answer questions regarding donation.
  - Do not mention the word "donation".
  - Do not mention "Gift of Life".

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Donation Authorization *(cont.)*

Family Discussions *(cont.)*

Hospital staff responds to a family-initiated donation discussion by immediately offering to contact:

- "The organization that has expertise in the field."
- "The individuals that can help you with your questions."
- "The End-of-Life team who can best provide that information."
- "That is not my area of expertise. Let me get someone who can answer your questions."

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First Person Authorization

- Donor's wishes are paramount – not revocable after death.
- Signing up on the Michigan Organ Donor Registry is legal and binding. It holds the same weight as a last will and testament. Family cannot override the donor's wishes.
- Registry status comes into play after a person has been declared legally brain dead. For donation after cardiac death, the decision to donate is made by the legal next of kin.
- Currently, 66% of Michigan residents are on the Michigan Organ Donor Registry.

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Organ Donation Pathways (Click each heading.)

Brain Death Donation

- Once patient is declared brain dead, GOLM approaches family, if appropriate.
- Pt stays on ventilator maintaining hemodynamics until organ recovery (24-72 hrs).
- GOLM takes over management of the patient once authorization is obtained.
- All organs will be evaluated to optimize donation potential.
- These patients are transferred to the GOLM Donor Care Center for organ recovery.

Donation After Circulatory Death (DCD)

- Family will not be approached until after they have made the decision to withdraw support.
- The hospital manages the patient until death.
- Extubation takes place in or near the OR; family can be present if they wish.
- OR recovery takes place after patient is declared by circulatory death. If the patient doesn't expire in the OR, they go back to their room with comfort care.
- Because patients are not brain dead, they may still possess some basic reflexes, such as eyes opening, blinking, cough, extremity movement.
- Patient stays at MHC hospital for organ recovery.

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The Donation Process (Click each arrow title.)

Referral	Evaluate	Approach	Management & Allocation	Recovery
Identification and referral	Onsite response	Designated requestor	Donor management	Medical examiner
Triage coordinator role	Medical suitability	Donor registry search	Organ allocation	Organ/Tissue recovery
	Brain death declaration	Approach and authorization	Donor flag flown	Family follow-up
	DCD evaluation		Honor walk possible	

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Clinical Triggers

When to call GOLM (make the Referral)

Call GOLM within ***ONE HOUR* of a patient meeting ***ONE*** of these triggers:**

- Every vented patient with a Glasgow Coma Scale (GCS) of 5 or lower
- Every vented patient being evaluated for Brain Death
- Every vented patient whose family is considering Withdrawal of Life Sustaining Therapy (to comfort care)
- Anytime a family member mentions donation or GOLM
- After every patient death

This is time sensitive!

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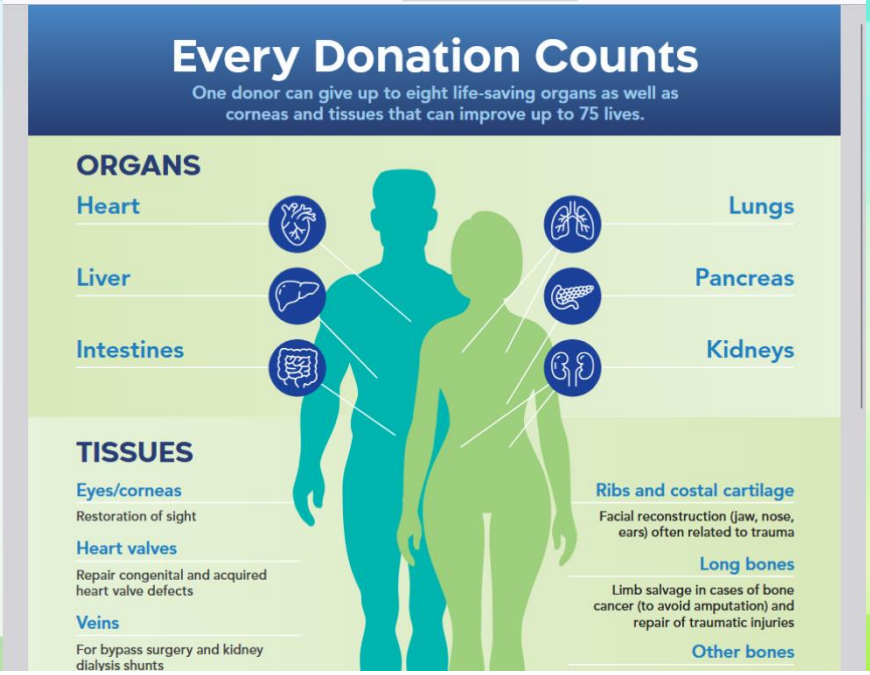

Your Role in the Donation Process

- Identify when a patient meets the clinical triggers for donation.
- Call GOLM (1-800-482-4881) within **one hour** of the patient meeting the clinical trigger.
- Do not discuss donation with family members.
- Huddle with GOLM staff prior to any family approach.
- Support family members as they process end-of-life care options for their loved one.
- Collaborate with a multi-disciplinary healthcare team to honor the wishes of the donor and their families.

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Policy

View

Show Changes

MUNSON MEDICAL CENTER
MUNSON HEALTHCARE

Origination	2/19/2007
Last Approved	5/23/2025
Effective	5/23/2025
Last Revised	5/23/2025
Next Review	5/22/2028
Owner	Standfest, Jennifer: CNO
Area/Department	Nursing
Applicability	MMC, KMHC, POMH
Tag	Procedure

Organ Donation: Brain Death Organ Donation, Eye and Tissue Donation, and Organ Donation After Circulatory Death

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Thank you for All You Do!

You are an integral part of this life-saving and life-enhancing process!

Leslie Casperson, MSN, RN
Hospital Donation Advocate
Gift of Life Michigan
lcasperson@golm.org

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Compounding Sterile Preparations in Patient Care Areas/Immediate Use Compounding

Training Module

Neeley Reece, CPhT, CSPT
February 2024

MUNSON HEALTHCARE

Goal

There are times when IV admixture is needed to be completed by a provider or registered nurse in the patient care areas. Providers and Registered nurses must be aware of the fundamental practices and precautions associated with sterile admixture of medications in patient care areas.

Objectives

1. State the roles and responsibilities of personnel who compound sterile preparations (CSPs) outside of a classified area.
2. Recognize the potential sources of contamination when preparing CSPs.
3. Explain the proper handling of syringes, vials, and ampules while compounding sterile preparations.
4. Define the labeling requirements for CSPs including beyond-use-date (BUD) and time.
5. Describe the safe use of single-dose and multi-dose vials.

Training and Competency Assessment

Staff who prepare CSPs outside of a classified area must have documented competence demonstrating their ability to perform this skill. This includes training, competency evaluation, and assessment.

Definitions

- **Compounded Sterile Preparation (CSP):** A preparation intended to be sterile (i.e., IV or irrigation solution) that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.
- **Aseptic Technique:** A set of methods used to keep objects and areas free of microorganisms and thereby minimize infection risk to the patient. It is accomplished through practices that maintain the microbe count at an irreducible minimum.
- **Classified Area:** An area that maintains an air quality classification based on the ISO standards required in USP Chapter <797>.
- **Immediate-Use CSPs:** A CSP meeting certain conditions that may be prepared outside of a classified area (e.g., patient care unit) for immediate (within one hour) administration.
- **Beyond-Use-Date (BUD) and Time:** The date, or the hour and date, after which a CSP must not be used, stored, or transported. The date is determined from the date and time the preparation is compounded. BUD applies up to the time of administration, BUD does *not* apply to the duration of the administration and does *not* limit the infusion time. Once the infusion is started, the medication is considered 'used'.

Pharmacy Sterile Compounding

"A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product's stability is short."

Source: Joint Commission Hospital Accreditation Manual MM.05.01.07 EP.1

Why does pharmacy have to mix our IVs?

- To assure the **safety and quality** of admixed sterile preparations (CSPs) mixed at the facility, regulation mandates strict adherence to all applicable state, federal, and professional standards.
- Pharmacy is equipped with engineering control devices that filter the air to maintain a compounding environment that is much cleaner than room air.
- Pharmacy compounding personnel receive training and pass various tests to assure they are competent with sterile IV admixture techniques.
- Pharmacy maintains an environmental monitoring plan and quality assurance program specific to sterile compounding.

Immediate-Use Compounding

There are times when it is necessary to prepare a CSP outside of a classified area (i.e., outside of the pharmacy sterile compounding area).

Patient care personnel performing this task must employ strategies to minimize the likelihood of microbial contamination when preparing sterile admixtures for immediate use.

USP 797 Immediate-Use Provision

- Compounded sterile preparations (CSPs) prepared outside of a classified area are for immediate use.
- Immediate-use CSPs are for direct and immediate administration and may **not** be stored for anticipated use.
- Aseptic techniques, processes, and procedures are used to minimize the risk of contamination and to maintain a clean, uncluttered, and designated workspace (separate from other functions) for medication preparation.
- Preparation follows approved labeling and evidence-based information for physical and chemical compatibility.
- Preparation is limited to simple transfers of **no more than three (3)** different sterile products.
- Single-dose containers are not used for more than one (1) patient. Any unused portion of a single-dose container is discarded.
- Administration begins within **one hour** following the start of the preparation. If administration is *not* started within one hour, the CSP is discarded.
- Unless completely administered by the person who prepared it, the medication must be labeled with the exact **1 hour** Beyond-Use-Date (BUD) and time.

Contamination Sources

When preparing a CSP, the goal is to maintain the sterility of the ingredients during manipulation by minimizing the potential for contamination.

Touch Contamination

- The most common source of microbial contamination is touch.
- Organisms shed from skin, hair, and respiratory track.

Particulate Contamination

Undissolved substances present in the CSP. Common sources include:

- Glass from ampules
- Rubber from rubber stoppers cored by the needle
- Paper fibers from the syringe packaging or alcohol wipe
- Dust from the environment
- Precipitates from saturated solutions (such as mannitol) or medication incompatibilities

Designated Medication Preparation Area

To minimize the risk of contamination:

- Maintain a clean, functionally separate area for medication preparation
- The area should be well lit, uncluttered, and **not** immediately adjacent to a sink, drain, or other 'dirty' area.
- Clean the preparation area *before* use.

Before preparing:

- Gather necessary supplies
- Double-check the medical order, ingredients, and calculations

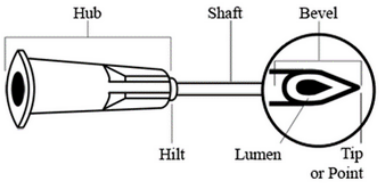
Hand Hygiene

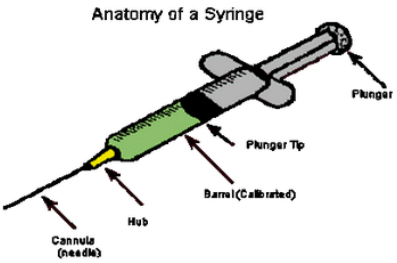
- Wash hands with an antiseptic agent prior to admixing medications. For routine hand washing, a 20 second soap and water wash is performed.
- The hospital-approved, alcohol-based hand rub may be used when hands are not visibly soiled.

Source: https://munsonhealthcare-all.policystat.com/policy/13539930/latest

Syringes and Needles

- Proper handling of the needle and syringe are key to avoiding touch contamination.
- Use the syringe size that will accurately measure the required volume.
- Do **not** push the needle and syringe through the paper wrapper when opening.
- Assemble the needle and syringe without touching any area that comes in contact with the medication or fluid (i.e., needle tip, hub, syringe tip, plunger).
- Do **not** wrap your hand around the needle and vial or touch the plunger.
- Use a syringe and needle **one time only.**



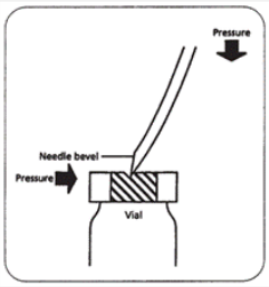


Ampules

- Disinfect the neck of the ampule with an alcohol swab.
- To avoid particulate contamination from glass particles, **a filter needle or straw** must always be used.
- Attach the filter needle or straw to the syringe and withdraw the desired amount from the ampule.
- Remove the filter needle or straw and replace with a regular needle.
- Remove any air bubbles.
- Double-check the medication and volume to be added.
- Swab the additive port of the IV bag/container with an alcohol swab.
- Add the medication to the bag/container.
- Mix the content by inverting the bag a few times – Do **not** shake.
- Inspect for particulate matter.
- Label.
- Dispose of unused materials.

Vials

- Disinfect the vial stopper with an alcohol swab. *Note*: The stopper under the vial cap is **not sterile**.
- Add a volume of air almost equal to the amount to be removed from the vial.
- Insert the needle into the vial at a 45° angle with the bevel of the needle up. This is to avoid coring.
- Inject air into the vial.
- Turn vial upside down and withdraw desired amount.
- Remove any air bubbles.
- Double-check medication and volume to be added; and inspect the syringe for particulate matter.
- Disinfect the additive port with an alcohol swab. Allow to dry.
- Add medication to IV bag/container.
- Mix the contents by inverting the bag a few times – Do **not** shake.
- Inspect for particulate matter.
- Label.
- Dispose of used materials.



Inspection

- Inspect IV bottle/bag/containers for cracks, particulate matter, clarity, and color.
- When in doubt, throw it out!

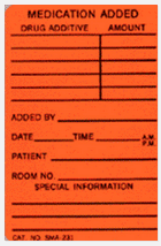
Incompatibilities

- ✓ Consult a pharmacist with any questions regarding IV admixture incompatibilities.
- ✓ Report incompatibilities to VOICE.

Labeling

Label the CSP with the following:

- Patient identification information
- Names and amounts of all ingredients
- Name or initials of the person who prepared
- The exact **1-hour** beyond-use-date (BUD) and time



Medications must be labeled in a standardized manner according to hospital policy, applicable laws and regulation, and standards of practice to minimize errors.

Safe Use of Single-dose Vials (SDV)

Single-dose or single-use vials/containers are labeled as such by the manufacturer and typically lack an antimicrobial preservative.

- SDVs are used **one time** for a single patient/case/procedure/injection.
- SDVs should only be entered **one time**.
  - Note: If a SDV is entered more than once for a single patient as part of a single procedure, a **new needle** and **new syringe** is used. The vial is discarded at the end of the procedure and **not** stored for future use.
- Any unused portion of a SDV is discarded. The unused portion may **not** be stored, pooled, or combined for future use.

Source: https://www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html

Safe Use of Multi-dose Vials (MDV)

Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacterial *but* has no effect on viruses and does not protect against contamination due to failure to follow safe injection practices.

- MDVs should be dedicated to a single patient whenever possible.
- MDVs used for more than one patient should **not** be kept or accessed in the immediate patient treatment area including patient rooms or bays, and operating rooms.
- MDVs that enter the immediate patient treatment area should be dedicated to that patient only and discarded after use.
- MDVs that are opened/accessed (e.g., needle-punctured) and retained for use, must be labeled within a **28-day BUD**, unless the manufacturer specifies a shorter or longer use date.

Source: https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html

Conclusion

- ✓ Immediate-use compounding (i.e., compounding outside of the classified area in the pharmacy) should only be performed by trained non-pharmacy staff to meet an immediate patient care need.
- ✓ Staff who prepare immediate-use CSPs must have documented training and demonstrate competence.
- ✓ Pharmacy maintains engineered compounding facilities and is obligated by regulation to mix **ALL** non-emergent CSPs.
- ✓ Touch contamination is the most common source of microorganisms shed from hair, skin, and respiratory track.
- ✓ Hand hygiene and proper handling of syringes, needles, vials, and ampules is key to minimizing the risk of touch contamination.
- ✓ Administration of CSPs prepared outside of a classified area begins ***within one hour*** of mixing.
- ✓ Single-dose vials are for one patient only. Open SDVs cannot be combined and/or stored for later use.
- ✓ Multi-dose vials should be used for one patient when possible, accessed or entered outside the immediate patient treatment area, and appropriately labeled with a BUD.

References and Resources

Benchley, J. (2023, April 26). Hand Hygiene. Retrieved February 14, 2024, from Munson Healthcare PolicyStat: https://munsonhealthcare-all.policystat.com/policy/13539930/latest

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CDC Hand Hygiene Saves Lives https://www.cdc.gov/handwashing/index.html

CDC Injection Safety Resource http://www.cdc.gov/injectionsafety/

CDC One and Only Campaign http://www.cdc.gov/injectionsafety/1anOnly.html

CDC Safe Injection Practices FAQ http://www.cdc.gov/injectionsafety/providers/provider_faqs.html

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TJC SEA 52: Preventing Infection from Misuse of Vials https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-issue-52-preventing-infection-from-the-misuse-of-vials/

United States Pharmacopeia (USP) Chapter <797> Pharmaceutical Compounding- Sterile Preparations

MUNSON HEALTHCARE

Oversedation Reversal Agents

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April 2024

Goal and Objectives

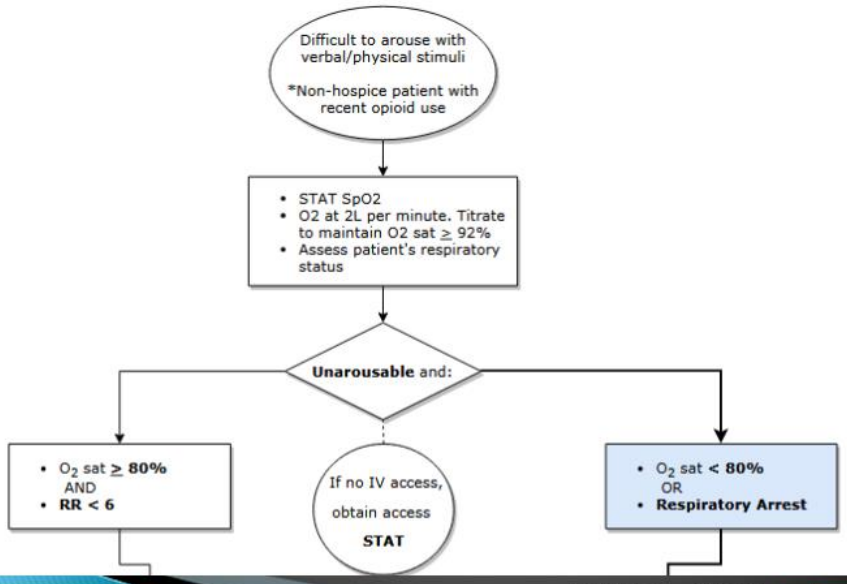
Goal

To instruct the RN on the use, implementation, and administration of naloxone and flumazenil per MHC Protocol.

Objectives

1. State how to assess the patient via the defined parameters within the naloxone and flumazenil protocols.
2. Describe the process for ordering the Naloxone Standing Order/Protocol.
3. Describe the process for ordering the Flumazenil Reversal Protocol.
4. Differentiate between using a Standing Order and a Protocol.

Standing Order/Protocol for Adult Naloxone (Narcan) 061.069



MUNSON HEALTHCARE

Effective 02/2024
Last Revised 02/2022
Next Review 02/2025

Area/Department Pharmacy
Applicability MHC Hospital System w/KMHC (MMC, Cadillac, Charlevoix, Grayling, KMHC, Otsego, Manistee, POMH)

Standing Order/Protocol for Adult Naloxone (Narcan)

Purpose

To provide a policy for Adult Naloxone (Narcan) standing orders/protocols.

Policy Copy Link

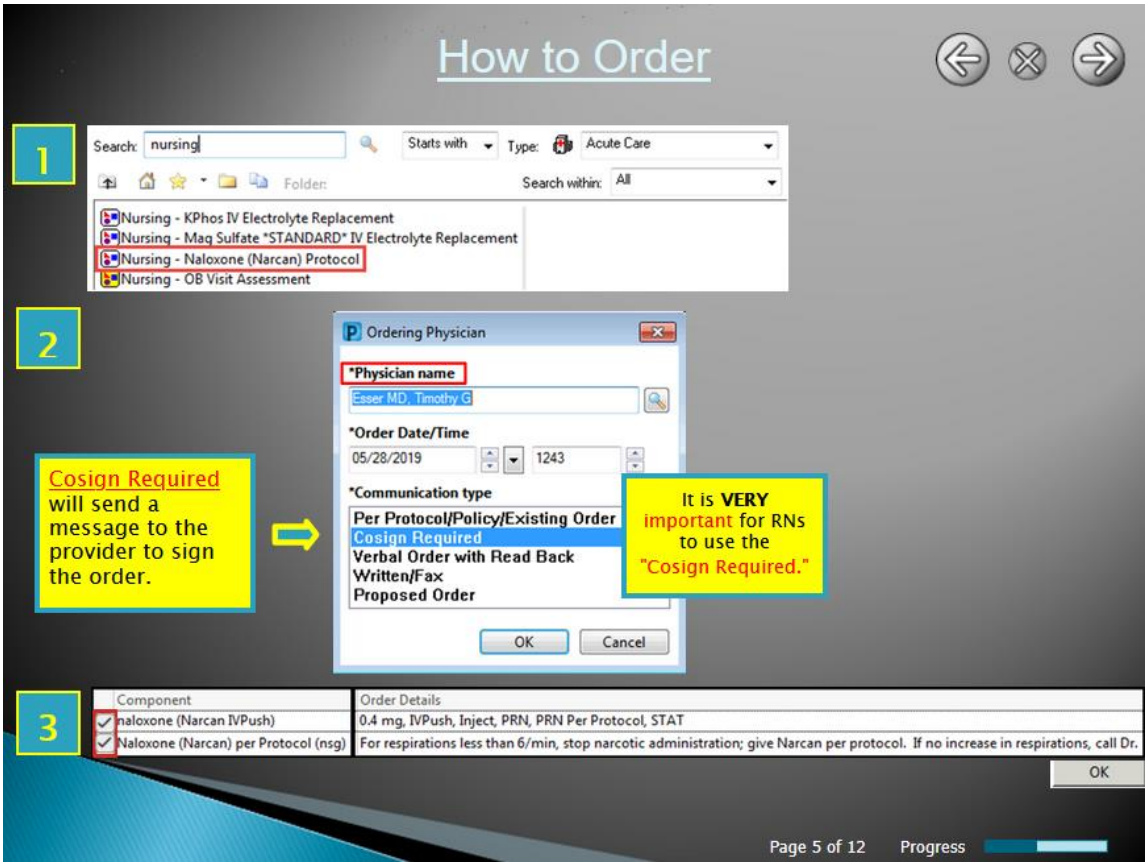
A. The Protocol for Adult Naloxone (Narcan) shown below, is approved as a standing order and may be initiated by a Registered Nurse (RN) without a provider order for any patient if:

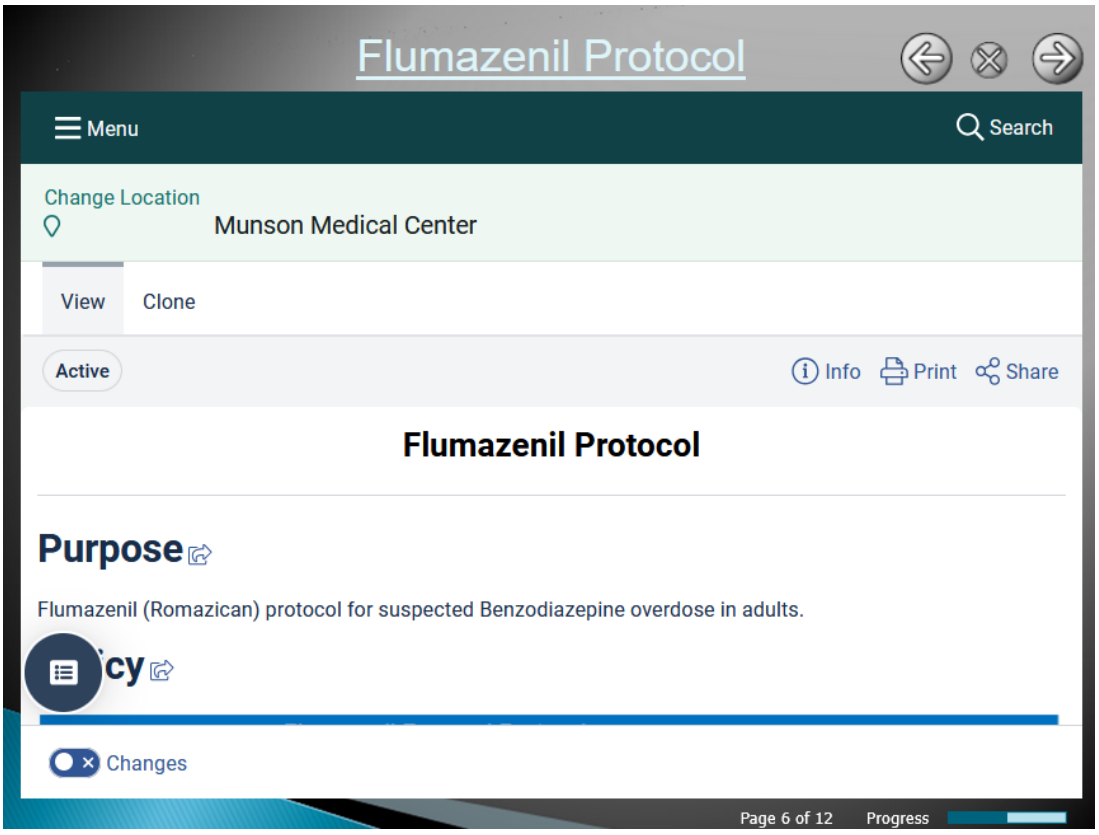
1. Patient is difficult to arouse with verbal/physical stimuli ~AND~
2. Patient is on, or recently was on, opioids or suspected that the patient has consumed opioids

B. This protocol is not applicable for end of life/palliative or comfort care/hospice patients. Call provider to clarify if any questions.

C. If criteria above are met then the initiating RN would enter by Physician Order Entry (POE) using the CareSet "Nursing - Naloxone (Narcan) Protocol" using the 'Co-Sign required' communication type unless an active previous provider order exists. The provider will co-sign the order via normal process.

RNs must use the 'Cosign Required' communication type. Message will be sent to the provider that the Naloxone Protocol was initiated.


How to Order
1
Search: nursing
Starts with
Type: Acute Care
Folder:
Search within: All
Nursing - KPhos IV Electrolyte Replacement
Nursing - Mag Sulfate *STANDARD* IV Electrolyte Replacement
Nursing - Naloxone (Narcan) Protocol
Nursing - OB Visit Assessment
2
Cosign Required will send a message to the provider to sign the order.
Ordering Physician
*Physician name
Esser MD, Timothy G
*Order Date/Time
05/28/2019
1243
*Communication type
Per Protocol/Policy/Existing Order
Cosign Required
Verbal Order with Read Back
Written/Fax
Proposed Order
OK
Cancel
It is VERY important for RNs to use the "Cosign Required."
3
Component
Order Details
naloxone (Narcan IVPush)
0.4 mg, IVPush, Inject, PRN, PRN Per Protocol, STAT
Naloxone (Narcan) per Protocol (nsg)
For respirations less than 6/min, stop narcotic administration; give Narcan per protocol. If no increase in respirations, call Dr.
OK
Page 5 of 12
Progress


Flumazenil Protocol
Menu
Search
Change Location
Munson Medical Center
View
Clone
Active
Info
Print
Share
Flumazenil Protocol
Purpose
Flumazenil (Romazican) protocol for suspected Benzodiazepine overdose in adults.
Changes
Page 6 of 12
Progress

Which Reversal Agent to Choose?

When a patient has received or taken **both** an opioid and a benzodiazepine, and a reversal agent is needed, **naloxone (Narcan) should be given first**.

Reasons:

- Opioids can cause more devastating effects, such as respiratory depression.
- Flumazenil (Romazicon) can cause seizures in patients with a history of long-term use of benzodiazepines.

Standing Order vs. Protocol

What's the difference?

Standing Order	Protocol
Initiated by RN (or other specified caregiver) without provider order under **well-defined circumstances using specific criteria**	Ordered by physician or other licensed provider, to be followed at a specific time or under clearly defined conditions
Entered using **provider name** and communication type "**Cosign Required**"	Defined components of protocol are ordered using "**Nurse, Use Per Protocol**" and communication type "**Per Protocol/Policy/Existing Order**"
Details of standing order are spelled out in policy	Details of protocol must be readily retrievable in medical record
Example: Influenza standing order	Example: Electrolyte replacement protocol
Naloxone for opioid reversal is by STANDING ORDER	**Flumazenil for benzodiazepine reversal is a PROTOCOL**

Key Points

- Nursing has the autonomy and authority to order and administer naloxone via the Standing Order policy.
- When ordering naloxone, enter a provider name and the communication type, **'Cosign Required'.**
  This sends a message to the provider to sign the order.
- You must obtain a physician order prior to implementing the flumazenil protocol.
- **All crash carts have the Naloxone Standing Order/Protocol and Flumazenil Protocol laminated and attached.**

Knowledge Check

Which communication type should the RN use when initiating the Naloxone Protocol?

- Written/Fax
- Cosign Required
- Per Protocol/Policy/Existing Order
- Verbal Order with Read Back
- Proposed Order

VOICE

A VOICE file must be created after a patient has been reversed from oversedation.

References

Munson Healthcare Policies and Procedures. (2024, March 18). *Flumazenil protocol.* PolicyStat.

Munson Healthcare Policies and Procedures. (2022, February 21). *Standing order/ protocol for adult naloxone (narcan).* PolicyStat.

Status **Active** PolicyStat ID **15241927**

Origination	5/6/2010
Last Approved	2/20/2024
Effective	2/20/2024
Last Revised	2/20/2024
Next Review	2/19/2027
Owner	Vicki Graczyk: Dir Sr HR Business Partner
Area/ Department	Human Resources
Applicability	Munson Healthcare Systemwide
Tags	Policy

Employee Code of Conduct Policy

Purpose

This policy establishes expectations that individuals involved in the delivery of care (both direct and indirect) will promote and maintain a culture of quality and safety for all patients and staff. All individuals have the responsibility to work together as a healthcare team for the effective delivery of patient care, either directly or indirectly.

Scope

This policy applies to all employees, physicians, volunteers, contractors, and others who are involved in the delivery of patient care.

Responsibilities

A. Individuals who are covered by this policy have the responsibility to:
    1. Know and adhere to this policy; and
    2. Immediately bring to management's attention any observation of conduct that doesn't promote patient safety.

B. Management has the responsibility to:
    1. Communicate expectations;
    2. Encourage reporting of violations;
    3. Take appropriate action when issues are brought forward; and

4. Disallow retaliation for reporting violations

Policy

Conduct That Impacts Patient Safety

A. ***Acceptable Professional Behavior*** that is expected of all individuals covered by this policy includes:?

1. Addresses concerns about clinical and non-clinical judgments promptly, directly and privately
2. Addresses dissatisfaction with policies through appropriate channels
3. Seeks solutions to problems, rather than complain about them or blame someone for them
4. Treats everyone with courtesy, dignity and respect, regardless of one's title or status
5. Works together as a team and establishes and maintains healthy interpersonal relationships, affirming contributions of team members
6. Cooperates with patients in their care
7. Supports an environment in which ideas and concerns can be expressed freely
8. Values differences of opinion, and when conflicts occur, deals with them by going to the person(s) directly and constructively; and asking others to do the same when complaints are voiced to team members others than those directly involved
9. Promotes an environment of safety for all patients and staff, including use of all available safety equipment

B. Behaviors That Undermine a Culture of Safety that are disallowed and could potentially impact patient care includes:

1. Threatens or retaliates against individuals who report disruptive or inappropriate behaviors
2. Intimidates or shows disrespect to others, e.g. uses foul language (verbal or written), criticizes in an abusive non-constructive way, undermines confidence, belittles or implies stupidity or incompetence, shows unrestrained anger, bullies, etc.
3. Behaves in a way to weaken critical collaborative communication among health care team members
4. Affects the reputation of the institution and/or the health care provider in a negative way
5. Makes impertinent and inappropriate comments (or illustrations made in a patient medical record or other official document) that bring into question the quality of care at Munson Healthcare (MHC) or that attack a particular physician, caregiver or policy
6. Criticizes other caregivers in front of patients, visitors or other staff
7. Disregards or doesn't use available safety equipment designed to protect patients and staff

8. Accesses, uses or discloses confidential information that is not for a verifiable job-related need.
9. Disrupts operations
10. Affects ability of others to do their jobs
11. Creates a hostile or intimidating work environment
12. Interferes with an individual's ability to work competently
13. Demonstrates any behavior that endangers patients, medical staff or employee safety
14. Other similar disruptive conduct, whether overt or passive

C. This policy does not prevent employees from addressing work-related issues and sharing information about working conditions with co-workers or exercising any other rights under the National Labor Relations Act.

Informal Complaint Process

A. Anyone covered under this policy that believes they have been treated inappropriately is encouraged to resolve the issue through normal communication channels if possible.

B. An example of an informal resolution would be promptly talking to the individual who is causing the issue or talking with your manager.

Formal Complaint Process

A. Anyone covered under this policy that believes they have been subject to behaviors that undermine a culture of safety and are not able to resolve it informally, should report the incident to their manager and file a written report through Munson's on-line patient safety event reporting system.?

B. The Manager of Human Resources (HR) or the employee's Manager can assist the employee in reporting an incident through Munson's on-line reporting system.

C. The filing should detail the factual specifics of the situation or incident including

1. Date,
2. Time,
3. Location,
4. Witnesses, if any, and
5. Circumstances that precipitated the incident

Investigation/Follow-up Process

A. The report will be referred to the appropriate person/s for investigation and resolution as indicated below.?

B. Vice President, Medical Affairs (VPMA) or his/her designee for incidents involving physicians will:

1. Interview physicians identified in complaint
2. Take appropriate action in line with medical staff policies
3. Notify manager of employee filing complaint that investigation has occurred and appropriate action has been taken

C. The Manager or his/her designee who have incidents involving employees, volunteers, and contractors within their area of responsibility will:
    1. Interview employees/others identified in complaint
    2. Take appropriate action in line with hospital policies
    3. Notify individual filing complaint that investigation has occurred and appropriate action has been taken
    4. Communicate incident to others as needed, e.g. Volunteer Services for incidents involving volunteers, Plant Engineering/Northern Michigan Supply Alliance (NMSA) for incidents involving contractors

D. HR will:
    1. Participate in investigation, as appropriate and in coordination with VPMA/Manager
    2. Communicate result of investigation, as appropriate and in coordination with VPMA/Manager

Corrective Action

A. MHC management will be responsible for appropriate follow-up including any corrective action deemed necessary for employees and non-physicians. The VPMA is responsible for appropriate follow-up including any corrective action involving a physician.

B. In determining the appropriate corrective action, the following consideration will be given:
    1. Were expectations clear?
    2. Does the individual accept responsibility?
    3. Is the individual willing to follow the policy?
    4. Does the individual have the necessary skills?
    5. Will the system allow the appropriate action?

C. Any individual, who is found to have engaged in behaviors that undermine a culture of safety, will be subject to the following action, as appropriate for their status with the organization and based on the nature of the incident:
    1. Documented discussion with the individual
    2. Corrective action, up to and including termination of employment as defined in Munson's corrective action policy
    3. Loss/suspension of privileges
    4. Sanctions that in Munson's sole discretion are deemed appropriate to prevent further inappropriate/disruptive behavior or to remedy a situation that may compromise patient safety

5. Loss/suspension of ability to conduct business at MHC
6. Indefinite removal of the individual from all properties of MHC
7. Potential legal action, or
8. Other action needed to fulfill the responsibility for patient safety

References - Related Policies

1. HR: Anti-Harassment Policy
2. HR: Violence in the Workplace Policy
3. Medical Staff: Code of Conduct/Medical Staff Behavior Policy

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/20/2024
VP Human Resources	Shelley Spencer: Chief Human Resources Officer	2/14/2024
Document Owner	Vicki Graczyk: Dir Sr HR Business Partner	2/14/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **16815863**

Origination	10/21/2011	Owner	Vicki Graczyk: Dir Sr HR Business Partner
Last Approved	10/3/2024		
Effective	10/3/2024	Area/ Department	Human Resources
Last Revised	10/3/2024	Applicability	Munson Healthcare Systemwide
Next Review	10/3/2027	Tags	Policy

Social Media

Purpose

Munson Healthcare (MHC) recognizes that Social Media provides unique opportunities for MHC and its Workforce Members to share information and participate in interactive discussions online. Social Media is also a popular platform to educate, engage, and motivate our audiences to make MHC the first choice for health care services, charitable giving, employment, and a place to practice. We need to ensure that content posted to Social Media platforms about MHC is engaging, accurate, and relevant; and gives our audience the confidence and the tools to take the next step in their journey with MHC while maintaining security, integrity, and confidentiality to protect our audience.

Scope

This applies to all MHC entities and Workforce Members.

Definitions

1. **Protected Health Information (PHI):** defined by the Health Insurance Portability and Accessibility Act (HIPAA). In general, it refers to any individually identifiable information regarding a patient that was collected, received, created, transmitted, or retained by MHC in connection with the person's status as a patient.
2. **Social media:** all means of sharing or posting information or content through virtual communities and networks, including personal blogs and websites, social networking platforms such as Facebook, YouTube, Instagram, TikTok or X (Twitter), and other interactive media technologies.

3. **Workforce Member:** employees, physicians, volunteers, trainees, students, vendors, and contractors whose conduct, in the performance of work for MHC, is under the direct control of MHC, whether or not MHC pays the individual.

Policy

A. The use of Social Media by MHC Workforce Members, whether for personal or business reasons, involves certain risks and requires Workforce Members to exercise certain responsibilities. To assist Workforce Members in making responsible decisions about using Social Media and to protect MHC's programs, patients, and communication systems, MHC has established this policy for the appropriate use of Social Media. This policy covers a Workforce Member's personal and business uses of Social Media.

B. This policy is not to be applied or interpreted in a manner that interferes with any activities protected by state or federal law, including the National Labor Relations Act. In particular, MHC employees should feel free to discuss the terms and conditions of their employment with each other and to raise concerns about working conditions for the mutual aid and protection of their co-workers.

Personal Use of Social Media (Not related to MHC business)

A. Workforce Members may not post any PHI of an MHC patient on Social Media.

B. Workforce Members may not post any MHC internal reports, policies, procedures, or other internal business-related confidential communications, employee information, or patient information. They may not post any MHC trade secrets, financial information, procedures, know-how, or intellectual property.

C. A Workforce Member's personal use of MHC's computer or communications equipment (such as workstations, phones, laptops, or network infrastructure) to access Social Media must be minimal, occasional, limited to non-work times, may not interfere with a Workforce Member's job performance or interfere in any way with the business needs and operations of MHC, and may not impose costs on MHC.

D. A Workforce Member may not use their MHC email address to register for an account on any Social Media website for personal use.

E. If a Workforce Member's Social Media activity violates any of MHC's policies in another forum, it will also violate them online. Workforce Member's use of Social Media must be consistent with all other applicable MHC policies, including, but not limited to the Anti-Harassment Policy, Employee Code of Conduct Policy, Corporate Code of Conduct, Confidentiality and Systems Usage Breach, HIPAA Compliance Policy, Confidentiality of Patient Information, Patient Photography, and Filming, Photography, Videotaping, and Digital Recording policies. For example, Workforce Members should refrain from posts on Social Media that constitute illegal harassment, discrimination, bullying, or threatening violence. For more information, please see the MHC policies listed in this paragraph.

F. Workforce Members should refrain from posting anything on personal Social Media accounts that might reasonably create the impression that they are communicating on behalf of MHC

unless the poster and post are approved by the Corporate Marketing Communications team. For example, a Workforce Member should not identify themselves as a Workforce Member or employee of MHC when expressing their personal views/opinions unrelated to MHC online. When creating Social Media content related to MHC on behalf of MHC employees must have approval from the Corporate Marketing Communications team. Workforce Members must be clear and open that their personal views do not represent those of MHC (for example, by saying, “the views and comments stated are personal and do not necessarily reflect the views of MHC").

G. Workforce Members should be honest and accurate when posting information or news on Social Media and promptly correct any mistakes. A Workforce Member should never post any information or rumors known to be false about MHC or people working on behalf of MHC.

MHC Business Use of Social Media

A. MHC’s Marketing and Corporate Communications Department is designated with the responsibility to post information to MHC-maintained websites and Social Media accounts. No other MHC Workforce Members may post any information on any MHC-maintained website or Social Media accounts without the advanced written authorization of the Chief Marketing & Communications Officer.

B. Workforce Members who post messages and content on MHC-maintained websites or Social Media accounts understand that they are posting on behalf of MHC and must adhere to MHC’s professional standards, values, policies, and applicable laws at all times. Any content posted must be current, accurate, and professional. If a Workforce Member makes an error, they should quickly take responsibility for it and correct it. Workforce Members should understand and abide by the terms of use of any Internet or Social Media platforms used for business-related purposes. They should be mindful of the intellectual property rights of others and may not infringe on the copyright or trademark of another individual using an MHC-maintained website or Social Media account. For example, Workforce Members may not repost copyrighted material without the written authorization of the copyright holder.

C. When posting for authorized, business-related purposes, employees may not post, share, or express a viewpoint on another’s post (such as by “liking” a Facebook post) regarding anything that MHC, its Workforce Members, or patients could find offensive, including racial or ethnic slurs, discriminatory comments, profanity, abusive language or obscenity. Further Workforce Members may not post or express any information that is defamatory, libelous, threatening, harassing, or intimidating to another person or entity. Examples of such conduct might include offensive posts meant to intentionally harm someone’s reputation or posts that could contribute to a hostile work environment based on race, sex, disability, religion, or any other status protected by law or MHC policy.

Implementation and Enforcement

A. When using Social Media, Workforce Members should be aware that any conduct that adversely affects patients, MHC’s legitimate business interests, their job performance, or the working conditions or performance of other Workforce Members or that otherwise constitutes a violation of this policy may result in corrective action up to and including termination of employment.

B. The terms set out in this policy apply in conjunction with and do not replace or amend, any terms or conditions of employment outlined in any collective bargaining agreement between a union and MHC. Wherever terms in this policy differ from the terms expressed in a collective bargaining agreement, the terms of the collective bargaining agreement control.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	10/3/2024
VP Human Resources	Shelley Spencer: Chief Human Resources Officer	10/2/2024
Document Owner	Vicki Graczyk: Dir Sr HR Business Partner	10/1/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **19280945**

Origination	11/27/2023
Last Approved	11/18/2025
Effective	11/18/2025
Last Revised	11/18/2025
Next Review	11/17/2028
Owner	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer - G
Area/ Department	Nursing
Applicability	Munson Healthcare Systemwide
Tags	Policy, Procedure

Management of Suicidal Patients

Purpose

The purpose of this policy is to describe the process for managing patients for suicidal/self-harm risk and develop a plan of care to address the identified level of risk to facilitate a safe discharge.

Definitions

1. **Assessment**: Gathering detailed information needed to identify a treatment plan. May be performed by a behavioral health specialist, such as a social worker (Central Access Center [CAC]/Community Mental Health [CMH]), qualified behavioral health specialist, licensed provider (LP), psychiatrist, etc.
2. **Attending provider**: The provider who is supervising care, treatment, or services. In outpatient settings, this is the provider who wrote the order for the care, treatment, or services the organization is providing.
3. **Behavioral Health Conditions (BHC):** Any Diagnostic Statistical Manual diagnosis or condition/ symptomology, including those related to substance abuse. Symptoms may include but are not limited to depression, anxiety, suicidal thoughts, hallucinations, or substance abuse.
4. **Behavioral Health Specialist:** A clinical staff member trained and competent in the assessment and treatment of behavioral health conditions including mental illness, substance use disorder and suicide risk. Examples of staff may include licensed mental health professionals, the CAC team or CMH staff.

5. **Ligature Resistant Environment:** A highly specialized environment without points where a cord, rope, bed sheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life.
6. **Ligature Reduced Environment:** A patient room or environment where possibilities of personal harm are limited. All physical risks not required for the treatment of the patient that can be removed, are removed. Appropriate level of surveillance is implemented if self-harm risks remain in the environment.
7. **One on One Observation:** Constant visual observation provided by a Patient Observer for one patient, including while patient sleeps, toilets, and bathes. **Under no circumstances will the patient be unobserved**. However, if there are concerns for staff safety, the individual is not required to remain in the room, but must still continually observe and be able to immediately intervene on unsafe behaviors.
8. **Patient Observer:** A staff member competent and trained to directly observe one or more patients and available to immediately intervene on unsafe behaviors or to alert nursing personnel of patient needs. The individual can provide hands on patient care if within their scope of practice or license. If hands on patient care is outside of their scope of practice, the individual will provide no patient care. All Patient Observers provide safety primarily through direct line of sight and summoning help when needed.
9. **Training and Competency:** Training and competency assessment of staff who care for patients at risk for suicide shall occur upon hire and periodically thereafter
10. **Patient Belongings:** Any items the patient has brought to the care setting. Examples: Clothes, electronic devices (cell phones, laptops, etc.), jewelry, medication, etc. Patient belongings will be secured, as appropriate, per organizational policy.
11. **Safety Monitoring:** A qualified individual who performs rounding based observations at regular intervals identified as part of the patient's plan of care (eg., every 15-minute checks).
12. **Screening**: A brief process to evaluate the possible presence of a particular problem.
13. **Secure Area:** An area specifically designated to be ligature resistant for patients at risk of suicide.
14. **Serious Risk**: Equivalent to high risk.
15. **Suicide:** Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
16. **Suicide attempt:** A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
17. **Suicidal ideation:** Thinking about, considering, or planning suicide.
18. **Suicide Risk:** A combination of individual, relationship, community, and societal factors that provide clues about a person's probability of attempting or completing a suicide attempt.
19. **Validated Tool:** Validated tool appropriate for specific patient populations (e.g. care settings, ages, etc.) used to screen for specific conditions, outcomes, or risks. The tools used may vary by location and/or electronic medical record used (ex. not all inclusive: the Columbia-Suicide Severity Rating Scale (C-SSRS), Patient Health Questionnaire Depression Module(PHQ-9), etc.).

Policy

The approach to the care of the suicidal patient is multidisciplinary. All patients 12 years and older that present to the Emergency Department (ED), Ambulatory Clinics or hospital, who are being treated or evaluated for a BHC as their primary reason for care and all patients who express suicidal ideation during the course of care regardless of their registration status, shall be screened for suicide risk using an age-appropriate, validated tool or transferred to an appropriate level of care. Patients under 12 years of age will be screened using an age appropriate validated tool.

Acute Care Setting

A. Timing of initial screening may vary based on patient presentation and clinical judgment. In the event the patient is unable to participate in the screening or assessment, i.e. the patient is unconscious, intoxicated, or mentally unable to respond, or medical instability will not permit, the screening or assessment will be postponed until the patient can participate or otherwise appropriate.

B. Screening for patients being treated or evaluated for a BHC as their primary reason for care will be conducted by the intake staff at the location (eg. medical assistant [MA], licensed practical nurse [LPN], registered nurse [RN], etc.) with the risk documented in the patient record.

C. If the staff determines the patient is potentially at higher risk than the screening indicated, higher risk suicide precautions may be instituted while awaiting an assessment.

D. For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work, CAC, CMH or other contracted mental health screening services for outpatient resources if requested by the patient.

E. Patients with a previous known suicide attempt or suicidal ideation should receive information about the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255) or 988.

F. For patients who screen at high or moderate risk for suicide, the provider will review the suicide risk screening and will recommend additional interventions, treatments, or consultations as needed to determine the appropriate location of service and the appropriate level of monitoring/observation.

G. After an initial assessment by a behavioral health specialist, reassessments should occur periodically or if behavioral health symptoms change. All changes will be documented.

H. A provider or other qualified personnel trained in advanced assessment of BHC, including suicide, may discontinue or downgrade precautions with documentation of clinical rationale.

I. If necessary, limits may be placed on patient telephone privileges to prevent the patient from sustaining substantial and serious physical or mental harm.

J. The presence of a visitor does NOT preclude the need for one on one observation. A family member or visitor is not allowed to act as a patient observer, including those employed with Munson Healthcare (MHC).

K. Visitors will not be allowed to bring personal items into the patient's room.

L. When a patient transfers to a psychiatric facility, the patient must remain in a hospital gown

and hospital undergarments. No scrub bottoms or personal clothing items will be allowed. Clothing and all belongings are bagged and labeled with the patient name, including cell phones. Belongings MUST be carried by staff, security, or Emergency Medical Services (EMS) personnel. Belongings are NOT to be returned to the patient.

Procedures

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
Assessment / Consultations	For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work or CAC for outpatient resources if requested by the patient.	• RN to notify attending provider. • Provider to consult behavioral health specialist for further assessment when patient is appropriate for evaluation. • A behavioral health specialist performs assessment. • Patient will be re screened periodically.	• RN to notify attending provider. • Provider to consult behavioral health specialist for further assessment when patient is appropriate for evaluation. • A behavioral health specialist performs assessment. • Patient will be re screened periodically.
Patient Placement / Physical Environment		• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See Suicide Risk Room Checklist or Powerchart. • Patient	• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See Suicide Risk Room Checklist or Powerchart. • Patient

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
		belongings shall be removed from patient room* **Individualized planning may occur to allow specific low-risk items to be given back to the patient, as needed.* • NOTE: When patients are receiving oxygen, continuous positive airway pressure (CPAP), intravenous (IV) fluids, etc., the patient may be a candidate for one-on-one observation, depending on assessment.	belongings (including all clothing) shall be removed from patient room.
Observation		• Perform frequent Safety Checks • If deemed necessary by staff or provider, consider one on one observation or in line of sight. Consider supervised bathroom visits. • **One on one observation required for patients in ED waiting room**	• One on one observation required. • Direct supervision for bathroom visits and for transport to other units. • **One on one observation required for patients in ED waiting room** • Hand-off report using SBAR format. • MHC Patient

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
			Observer Log will be completed by the Patient Observer at 15-minute intervals.
Observation in Ligature Resistant Rooms. Applies to Munson Medical Center (MMC) only. (i.e., ED rooms with garage doors closed and medical equipment including bed/ stretcher frames removed from the room, with only a mattress on the floor for safety.			• Monitoring at least every 15 minutes. A designated individual performs continual monitoring / rounding and documents observations. · Based on RN or provider judgment, a one-on-one • Observer may be used in place of continual rounding.
Discharge Planning / Education		• Behavioral Health Specialist provide resources to assist with care plan, coordinate referrals and develop a safety plan and provide at discharge. • Staff to provide suicide resources (e.g., Patient education "Recognizing Suicide Warning Signs in Yourself" and National	• Behavioral Health Specialist provide resources to assist with care plan, coordinate referrals and develop a safety plan and provide at discharge. • Staff to provide suicide resources (e.g., Patient education "Recognizing Suicide Warning Signs in Yourself" and National

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
		Suicide Prevention Hotline) at 1-800-273-TALK (1-800-273-8255).	Suicide Prevention Hot-line at 1-800-273-TALK (1-800-273-8255).
**Associated colors are for Meditech Hospitals only. All Cerner and Community Works hospitals should use Low, Moderate and High Risk.*			

Ambulatory Clinics

The following outlines the specific procedures to prevent patient harm for patients who screen moderate or high risk for suicide in the ambulatory setting.

Procedure

Patients Presenting at Ambulatory Clinics for Primary BHCs

Screening	Low Risk	Moderate or High Risk
Assessment / Consultations	For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work or CAC for outpatient resources if requested by the patient.	• Staff to notify attending provider. • Attending provider or behavioral health resource to assess patient to determine next steps.
Patient Placement / Physical Environment		• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See the Suicide Risk Room Checklist Form #11832. • If possible, remove patient belongings from room. **Individualized planning may occur to allow specific low risk items to remain with the patient, as needed. Mitigation for high-risk patients include 1:1 observation of physical environment and patient

Screening	Low Risk	Moderate or High Risk
		belongings.
Observation		• **For Moderate Risk:** Perform frequent safety checks. Consider supervised bathroom visits. • **For High Risk:** One on One observation with patient in line of sight for immediate intention. Direct supervision for bathroom visits and for transport to appropriate level of care. • If further evaluation and management in ED or crisis facility is the recommended plan of care by the Attending provider, staff are to contact Law Enforcement (not EMS unless there is an immediate medical emergency) for transport of patient to the ED for further assessment. *Note: Law Enforcement is the only entity that can require a person to get an evaluation- this is on the Michigan Mental Health Code.
Discharge Planning / Education		• Attending provider or behavioral health resource to assist with care plan, coordinate referrals and develop a safety plan (Patient Safety Plan Form #11567). • Staff to provide suicide resources (eg., 211, Krames patient education "Recognizing Suicide Warning Signs in Yourself" and National Suicide Prevention hot-line. • Staff to provide safety plan (Patient Safety Plan Form

Screening	Low Risk	Moderate or High Risk
		#11567) at discharge. • **Above discharge education/ planning forms for urgent or emergent care transfers may not apply.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	11/18/2025
CNO Council	Jennifer Standfest: CNO	11/18/2025
Document Owner	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer - G	11/11/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Transport and Hand-Off of Patients: SBAR and Ticket to Ride

Purpose

To provide a guide for establishing a standardized process for safely transporting adult, pediatric, and neonatal patients, identifying the level of clinical supervision required during patient transport, communicating individual patient care requirements between the sending and receiving clinical departments, and providing continuity of patient care during transport.

Definitions

1. **Hemodynamically Stable:** Patient with the following:
    a. Hear rate and blood pressure within prescribed parameters and have been for some time (at least 2 hours).
2. **Hemodynamically Unstable:** Patient with any of the following:
    a. Heart rate or blood pressure is outside prescribed parameters
    b. Chest pain
    c. Ongoing life-threatening arrhythmias
    d. Shock
3. **Hand-off:** a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another to ensure the continuity and safety of the patient's care.
4. **Responsible Nurse:** Registered Nurse (RN) assigned to the patient.
5. **Situation, Background, Assessment, and Recommendation (SBAR):** is a standardized

approach used to facilitate communication and promote accurate and thorough identification of issues and concerns about the care and safety of the patient. An opportunity to ask questions should be offered to the individual receiving the hand-off report or telephone call before ending the communication. A standardized tool is available to use, as needed.

6. **Ticket to Ride:** a standardized tool to communicate relevant medical history, important assessment findings, and special safety concerns, and provides an opportunity to ask questions about a patient being temporarily transported off-unit.

Guidelines

Transport of Patients

A. Clinical judgment and ongoing assessment are required to determine patient needs during the transport.

B. The bedside nurse (in collaboration with the provider) determines if/when the patient is safe to transport and with what level of supervision/care.

C. Provider order will determine whether the patient requires electrocardiogram (ECG) monitoring during transport.

D. Patients will be accompanied by staff members trained in the appropriate care and monitoring required at the time of transport.

E. Any backup or emergency equipment required by patient-specific conditions should always travel with the patient (ventricular assist device (VAD), tracheostomy supplies, etc.)

F. Patients with infection prevention precautions should be transported according to the Standard and Transmission-Based Isolation Precautions policy.

Transport of Patients from/within the Emergency Department (ED)

RN	Paramedic	Emergency Department Technician (EDT)/Nurses Aide (NA) and/or Central Transport

• Patients with a tracheostomy
• All intubated patients
• All patients on the following intravenous (IV) continuous infusions
  ◦ Narcan
  ◦ Insulin
  ◦ Titratable
	• Patients requiring greater than 5 liters (L) of oxygen (O2), including BIPAP
	• Patients who have had a seizure (suspected or actual) in the
		• Patient on potassium drip for replacement
		• Patient on a magnesium drip for replacement
		• Patient on a heparin drip
		• Patient that has admission orders

RN	Paramedic	Emergency Department Technician (EDT)/Nurses Aide (NA) and/or Central Transport
medications (ex: Nitro, Cardene, dopamine, Levophed, etc.) ◦ Antiarrhythmics (ex: Amiodarone, Cardizem, lidocaine, etc.) ◦ Sedation medications (Propofol, Fentanyl, Versed, Dexmedetomidine, etc.) • All patients currently receiving a blood transfusion. (If transfusion finished, must have end set of vitals) • All patients currently undergoing an Acute Stroke Call Down (if neurologist deems there is no indication for tPA or intervention, Paramedic / ED NA ok to transfer from that point on) • All patients that have developed new or worsening neurological symptoms while in the ED • All patients in restraints • Any patients that the nurse prefers to transport	past 72 hours • Patients being transported to the floor with an admission diagnosis of alcohol withdrawal • Patients with major burns • Patients with jaw wired shut • Patients who have a left ventricular assist device (LVAD). • Patients with a chest tube • Patients with a Troponin greater than 50 **All patients from the lower acuity list as well	for neuro checks every 4 hours, every shift, or every day (RN to transport neuro checks every 15 minutes, 1 hour, or 2 hours) • Patients that have admission orders for seizure precautions but have not had a seizure in 72 hours

Transport of Patients within Munson Medical Center (MMC)

	RN	NA/NT and/or Central Transport
Clinical Criteria	• Patients acutely compromised by cardiac, respiratory, or neurological complications. • Patients with a high risk of being acutely compromised by cardiac, respiratory, or neurological complications. • Recent, acute mental status changes • Critical Care level of care patients • Intermediate level of care for pediatric patients • Hemodynamically unstable patients • Patients that are in the acute phase of an overdose of medications that could result in potential for cardiac toxicity (e.g., tricyclic, digitalis, antidepressants/ arrhythmic). ◦ *Contact the pharmacy for questions regarding the duration of the acute phase*	• Hemodynamically stable patients at low risk of becoming unstable. • Pediatric patients with general medical orders with developmentally appropriate consideration which may include an additional support person
Surveillance Requirements	• Patients actively receiving blood products. • Patients in restraints • Patients in active alcohol/ opioid withdrawal requiring medication in the last 1 hour or patients with a risk of escalating behavior during time off unit	• Patients that do not require continuous surveillance/ monitoring by a nurse. • Suicide precaution patients **must be accompanied by a patient observer** • Patients at high risk for elopement **must be accompanied by a patient observer** (consider a security

	RN	NA/NT and/or Central Transport
		escort) • Patients with potential for violence **(consider security escort)**
Hemodynamic Monitoring	• Patients on continuous pulse oximetry • Patient with ECG monitoring who is hemodynamically unstable or is at risk of having life-threatening arrhythmia. • Any invasive hemodynamic monitoring	• Patients on ECG monitoring that are hemodynamically stable (follow the process outlined in the Cardiac Telemetry Monitoring policy)
Airway, Ventilation, or O2 Support Needed	• Patients requiring supplemental oxygen therapy greater than or equal to 5L to maintain goal O2 sats. • Patients requiring BiPAP except for the indication of chronic sleep apnea. • Patients requiring airway or ventilator assistance /management.	• Patients receiving O2 support less than 5L per nasal cannula. ◦ **For home O2 patients**: Stable on home O2 of up to 2x normal rate if greater than 40%.
Trach and/or Airway Stoma	• New or surgically revised airway stoma within 24 hours • Patient having secretions that may require airway suctioning frequently • Patient on trach mask greater than 35%	• Minimal secretions that can be managed by the patient (or suction every shift) • Trach mask 34% or lower
Continuous IV Meds	Patients on continuous medications that may require titration or adjustment during the diagnostic test or procedure or with special handling precautions: • Cytotoxic (chemotherapy) or biotherapy medications actively infusing. Patients on continuous medications	Patients on continuous IV fluids or medications that are not life-sustaining, suppressing life-threatening arrhythmias or that will not require titration during the time off the unit.

	RN	NA/NT and/or Central Transport
	that are life-sustaining and/or suppressing life-threatening arrhythmias. • Milrinone • Dopamine • Dobutamine • Amiodarone Continuous medication that may impact hemodynamic stability that has been initiated or required titration within the last 24 hours including but not limited to: • Diltiazem, nitroglycerin, nicardipine, amiodarone, esmolol	
VADs	Any patient with an implanted VAD	

Hand-off Communication

A. Hand-off communications occur in the following situations:
    1. Interdepartmental transfers, shift change, or any other situation where the care of the patient is transferred to a new care provider.
    2. When patients leave their assigned unit or the ED and are transported to various areas of MMC for procedures, surgery, tests, or therapies (Ticket to Ride). The Ticket to Ride does not apply if the nurse remains in attendance with the patient.
    3. When patients return to their assigned unit or ED (Ticket to Ride).

SBAR Communication

A. Hand-off (SBAR) may be used when care is transferred to a new nurse/provider and/or when a call is placed to a provider about a condition change or need for orders. SBAR Checklist Form # 8601 is an example of format and details to consider including.
B. When a provider must be paged for discussion, please include relevant data to address specific concerns.
    1. Consider whether all relevant data has been collected. This may include:
        a. VItal signs (respiratory rate, heart rate/pulse, O2 saturation, temperature)
        b. Signs/symptoms (pain, behavior, patient's perception)
        c. Other measurements (urine output, cardiac rhythm, lab values)
        d. Relevant history, current treatment, and plan of care

2. When possible, include relevant information about the situation and urgency within a Telmediq text page. Including "urgent" or "not urgent" enables prioritization. For patients at risk, an MRT may be appropriate.
    a. Example: Instead of paging, *Critical HGB 7.5. Call Sally at 231-213-0000*, page this: *Critical HGB 7.5, down from 11.2 yesterday AM. HR 122, BP 92/65, c/o SOB. Call Sally at 231-213-0000,* or this: *Critical HGB 7.5, improved from 7.0. HR 75, BP 120/80, asymptomatic. Call Sally at 231-213-0000.* The details provide important context.
3. If the issue is resolved or a return call is no longer needed, send a page "disregard earlier page" with a short note.

C. If the appropriate provider is unable to be reached, or the provider's plan does not reflect the situation and/or best interest of the patient's safety, the nurse should follow the Chain of Command in Obtaining Necessary Medical Assistance or Resolving Questions of Care and Questions of Scope of Care (Privileges) policy.

Ticket to Ride Communication

A. Hand-off (Ticket to Ride) communication process when patients leave their assigned unit or the ED and are transported to various areas of MMC for procedures, surgery, tests, or therapies:
    1. A transport ticket (Ticket to Ride Form# 8890) is utilized to identify patient safety concerns and acknowledge that the patient is ready for transport.
    2. The ticket accompanies the patient during the off-unit travel.
    3. The transport personnel (transporter, nursing assistant, tech, etc.) shall not transport the patient until the nurse completes the ticket.
    4. The communication ticket does not replace an appropriate hand-off reporting among healthcare providers.

Ticket to Ride Process

A. The responsible nurse will verify if the patient is appropriate for transport without a clinical staff accompanying using the above guidelines.

B. The transport personnel will receive notification from their department, of the transport needs.

C. The transport personnel will go to the appropriate unit and obtain the patient's chart and ticket.

D. The transport personnel will verify the correct patient, using two patient identifiers, by asking the patient his or her name and birth date.

E. The responsible nurse will complete all sections of the ticket.

F. The responsible nurse will determine if the patient is ready for transport.
    1. If the responsible nurse cannot fill out the transport ticket, the transport personnel needs to OK the transfer with the covering nurse or charge nurse, who will fill out the transport ticket as described above.

G. The responsible nurse will verbally communicate any safety concerns written on the ticket with

the transport personnel.

H. The transport personnel will verbally communicate patient safety concerns and give the ticket to the holding area nurse or test/procedure area healthcare professional.

I. At the test/procedure area, the healthcare professional can then call the patient's nurse using the information on the transport ticket if they have any questions or concerns regarding the patient.

J. The healthcare professional will verbally communicate transporting issues with the transport personnel. A call to the patient's nurse will be made if any patient care/condition concerns arise during the test/procedure.

K. If the patient is to have more than one test/procedure, each healthcare professional must write their name, pager/phone number, test/procedure performed, and the end time in the appropriate area on the ticket. If a patient concern arises, the healthcare professional must contact the patient's nurse.

L. The transport personnel then returns the patient to his or her home unit and shares the transport ticket with the nurse. If the nurse has any questions or concerns, a page/phone call can be made to the healthcare provider who performed the test/procedure.

M. The completed transport ticket will be disposed of appropriately, per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, to be shredded.

Reference

1. Provision of Care Standard PC.02.02.01, EP 2: The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	5/7/2025
CNO	Tamara Putney: VP and CNO Patient Care Services	5/5/2025
Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	4/22/2025
Document Owner	Amber Bowers: Mgr Nursing Services	4/22/2025

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Use of Restraints and Seclusion: Ordering, Monitoring and Documentation Requirements

Purpose

To provide a policy for ordering, monitoring, and documenting the use of restraints and seclusion.

Scope

This policy governs the use of restraint/seclusion in all areas of applicable organizations within Munson Healthcare (MHC) except the inpatient behavioral health unit. For policies governing that area, please see the Use of Physical Restraint- Mental Health and Seclusion Use- Behavioral Health Unit policies

Definitions

1. **Alternative Measures:** methods, other than restraint, utilized to provide safe and effective patient care. Examples include family involvement or education, verbal intervention/education for the patient, placement of patient for close observation, diversional activities, de-escalation techniques, limit setting, scheduled toileting, patient safety sitters, bed alarms.
2. **Provider:** refers to physicians, including locum tenens and residents, physician assistants (PA), and nurse practitioners (NP) practicing at any MHC facility with the authority to order restraints.
3. **Restraint:** any manual method, physical or mechanical device, material, equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint is used only as a last resort and when the patient's behavior presents as an immediate danger to the safety of the patient, other patients, or staff. The least restrictive measure will be initiated to maintain the safety of the patient and staff.

a. **Medication (Chemical) Restraint:** a drug or medication when it is used as a restriction to manage the patient's behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient's condition. The use of a medication to prevent imminent harm to self or others or restrict the patient's freedom of movement.

b. **Physical Restraint:** any manual method, 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.

c. **Non-Violent:** used for **non-self-destructive or non-violent** behavior interfering with medical care, devices, tube/drains. The least restrictive device will be initiated to maintain the safety of the patient and staff.

d. **Physical Hold:** holding a patient in a manner that restricts the patient's movement against the patient's will.

e. **Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving and can only be used for violent or self-destructive behavior, such as locking the door.

f. **Violent Restraint:** used only in situations where the patient's behavior becomes **self-destructive**, violent, aggressive, or assaultive and presents an immediate danger to the safety of the patient, other patients, or staff. The least restrictive device will be initiated to maintain the safety of the patient and staff.

Exceptions

A. The following situations are exceptions to this policy and are not considered restraints:

1. Orthopedically prescribed devices such as surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.
2. Use of an intravenous (IV) arm board to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.
3. Mechanical supports (braces) used to achieve proper body position, balance, or alignment to allow greater freedom of mobility. Example: Geri chair.
4. Positioning or securing devices used to maintain position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures. Example: magnetic resonance imaging (MRI) positioning device.
5. Medically necessary restraint used during recovery from anesthesia that occurs when the patient is in a critical care area or post anesthesia unit.
6. Methods that involve the physical holding of a patient for the purpose of conducting physical examinations, procedures, or tests when a patient or legal guardian has the right to refuse treatment. Example: papoose board.

7. Any device that can easily be intentionally removed by a patient.
8. Age or developmentally appropriate protective safety interventions such as cribs with raised side rails, crib covers, stroller safety belts, swing safety belts, or highchair lap belts that would normally be used outside the healthcare setting.
9. Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.
10. A physical escort would include a “light” grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint, and all the requirements would apply. May include self-releasing belt.
11. Side rails when a patient is on a gurney, recovering from anesthesia, sedated experiencing involuntary movement, or on certain specialty beds that require side rails to be up to prevent a patient from falling out of bed.
12. Side rails when a patient is immobile and side rails have no impact on the patient's freedom of movement.
13. Padded side rails used when a patient is placed on Seizure Precautions.
14. Seat belts when transporting a patient in a wheelchair.
15. The use of handcuffs or other restrictive devices applied by law enforcement officials who are not employees of the hospital for custody, detention, and public safety reasons. Employees are still responsible for the assessment of any limb/body-part restrained using law enforcement restraints.
16. Medications to support an individual to regain control of their behavior [including as needed (PRN) medications] when used as a part of the patient's treatment plan or that are a standard treatment for the patient's condition. An additional component of “standard treatment” for a medication is the expectation that the standard use of a medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them, than would be possible without the use of the medication.
17. Mitts when used alone and not attached to a bed rail or otherwise tied down. Mitts will be considered a restraint if applied so tightly that the hands or fingers are immobilized, are so bulky that the patient's ability to use hands is significantly reduced or are used in conjunction with a wrist restraint.
18. Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

Policy

General Information

A. Type of restraint/seclusion will be the least restrictive intervention to protect the patient, a

staff member, or others from harm.

B. Standard Interventions for patients in restraints based on electronic charting are:
    1. Signs of injury associated with restraint/seclusion.
    2. Nutrition and hydration status.
    3. Circulation and range of motion (ROM).
    4. Vital signs (as appropriate).
    5. Hygiene and elimination.
    6. Physical and psychologic status and comfort.
    7. Readiness for discontinuation of restraint or seclusion.

C. There must be documentation in the patient's medical record of the following:
    1. A description of the patient's behavior and the interventions used.
    2. Alternatives or other less restrictive interventions attempted.
    3. The patient's condition or symptom(s) that warranted the use of the restraint/ seclusion; and
    4. The patient's response to the intervention(s), including the rationale for continued use of the intervention.

D. In addition, for the duration of the use of the restraint:
    1. Patient care plan elements must be enacted. Specific care tasks can be delegated to a non-licensed person, if they have been trained to complete the task (e.g., bathing, ROM, oral care, restraint removal/reapplication while providing care).
    2. Documentation must occur in the electronic health record. The exact type, location and number of restraint points applied must match the exact type of restraint ordered by the Provider. If restraint use is modified (including the number of points or a different type of restraint) then a new order must be obtained within minutes.

E.

	Non-Violent	Violent
Reason for Restraint	Used for **non-self-destructive or non-violent** behavior interfering with medical care, devices, tube/ drains.	Used only in situations where the patient's behavior becomes **self-destructive**, violent, aggressive, or assaultive and presents an immediate danger to the safety of the patient, other patients, or staff.
Order Entry	Electronic order (during downtime use the Restraint Orders for Non-Violent Patients Form #2193 or Restraint Orders for Violent Patients Form #8406) Prior to application; however, in an emergent situation, a Registered Nurse (RN) may initiate intervention during or immediately after (within minutes) of application of restraints, the provider must be notified, and orders obtained.	
Order Duration	Daily	Time-limited renewal order must

	Non-Violent	Violent
		occur in accordance with the following time frames for a maximum of 24 hours: • Every 4 hours for adults 18 years of age or older • Every 2 hours for children and adolescents 9-17 years of age; or • Every 1 hour for children under 9 years of age
Face to Face Assessment Required	No	Within 1 hour of initial restraint application. After 24 hours, ***before*** entering a new order, a provider must see, assess, and document a face-to-face assessment: • The patient's immediate situation. • The patient's reaction to the intervention. • The patient's medical and behavioral condition; and • The need to continue or terminate the restraint or seclusion.
Monitoring Documentation Requirements	RN will assess every 2 hours, documenting in the electronic record. (Downtime: Non-Violent Restraint Initiative/Care Plan Form #2194)	RN will assess every 15 minutes, documenting in the electronic record. (Downtime: Violent Restraint / Seclusion Initiation Care Plan Form #2219) ** When using restraint and seclusion simultaneously, the patient must be constantly observed, uninterrupted, using 1:1 Patient Observer or constant audio and video monitoring.

Discontinuing a Restraint/Seclusion

A. Restraint/seclusion should be discontinued at the earliest possible time, regardless of the length of time identified in the order. This discontinuation is based on the assessment of an RN or Provider caring for the patient.

B. If restraint/seclusion is discontinued and the patient later demonstrates behavior requiring restraint/seclusion, a new order from a Provider must be obtained.

C. When the patient no longer meets requirements for restraint/seclusion as defined in the care plan, the restraint should be removed by the RN, and the discontinuation documentation should be completed.

Restraint Death Reporting Guidelines

A. All deaths in restraints must be reported via the event reporting system:

    1. Each death that occurs while a patient is in restraints or seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    3. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

B. Appropriate staff will report the following deaths to Centers for Medicare & Medicaid Services (CMS) per recommended route no later than the close of business on the next business day following knowledge of the patient's death:

    1. Each death that occurs while a patient is in 4-limb soft, rigid, chair or 2-limb rigid restraints or seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from 4-limb soft, rigid, chair or 2-limb rigid restraints or seclusion.
    3. Each death known to the hospital that occurs within 1 week after 4-limb soft, rigid, chair or 2-limb rigid restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.
    4. Staff reporting the death to CMS must document in the patient's medical record the date and time the death was reported to CMS.

C. For patients in 2-limb soft wrist restraint only, in addition to the report via the event reporting system, the staff must document in the patient's medical record the date and time the death was recorded in the event reporting system.

Education and Training

A. Training should be done before performing any actions, as part of orientation and subsequently on periodic basis.

B. Staff education, training, and demonstrated knowledge may include clinical appropriateness,

preventative/alternative strategies to restraint use, safe application, monitoring, ongoing assessment/re-assessment of the patient's condition, care of the patient in restraints, and documentation requirements.

C. Providers authorized to order restraint or seclusion have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

D. Upon restraint/seclusion application, family should be notified, and education provided.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	4/11/2024
CNO Council	Jennifer Standfest: CNO	4/11/2024
Nursing Services	Kristine Johnson: Chief Operations Officer/Chief Nursing Officer	4/10/2024
Nursing Services	Cristen Brandsma: Chief Operations Officer/Chief Nursing Officer	4/5/2024
Nursing Services	Jeremy Cannon: VP Nursing Services	4/5/2024
Nursing Services	Dawn Halleck: VP and CNO Patient Care Services	4/4/2024
Nursing Services	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer	4/4/2024
Nursing Services	Tamara Putney: VP and CNO Patient Care Services	4/4/2024
Document Owner	Jennifer Standfest: CNO	4/4/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Next Review	2/3/2027	Tags	Policy

Medical Response Team Protocol for Adult Patients

Purpose

To provide a process to respond to a change or deterioration in an adult (greater than 17 years) patient's condition by calling the Medical Response Team (MRT) for assistance.

Policy

Calling the MRT

A. Hospital personnel should consider calling the MRT when a patient, including patients with a do-not-resuscitate (DNR) code status order, has a decline or change in condition which includes (but is not limited to):
    - Acute change in vital signs
    - Change in mental status
    - Heart attack symptoms
    - If the patient has symptoms of stroke, a "Stroke MRT" should be called.
    - Any hospital personnel with a concern about a patient.

B. MMC MRT will respond to D6 Inpatient Behavioral Health-a service of Munson Healthcare Cadillac

C. The Pediatric Response Team (PRT) should be called for patients under the age of 18. The team consists of similar personnel with pediatric expertise, equipment, and protocols.

D. A Code Blue rather than an MRT should be activated when:
    - There are concerns about the condition of a visitor, employee or outpatient who is does not have patient identification band.

- When the location of the event is in a public or outpatient location
- When a patient is in imminent danger of a cardiac or respiratory arrest and they have a FULL code order.

Activation of MRT

A. Any hospital personnel can activate the MRT by completing the following steps:
    1. Dial "55555".
    2. Request the operator page the MRT.
    3. Provide the operator with the exact location of the patient.

B. Hospital personnel may also request the operator page the patient's attending provider at the same time as the MRT.

C. Hospital personnel should immediately notify the patient's primary registered nurse (RN) and/or charge RN after calling the MRT.

D. The switchboard operator will place a group page to the members of the MRT and the patient's attending provider if requested.

E. If the paging system is down, the operator will use the overhead paging system to notify the MRT.

The Team

A. The MRT will consist of the following:
    - Two Advanced Cardiovascular Life Support (ACLS) certified RNs, typically one from the Intensive Care Unit (ICU) and one from A3, trained in responding to medical emergencies.
    - Respiratory therapist (RT)
    - Physician or advanced practice provider (APP)
    - Patient's primary RN
    - Vascular Access Specialty Team (VAST) RN
    - Phlebotomist

B. Other staff may respond if requested by the MRT including the nursing administrative supervisor, pharmacist, attending provider, and/or other healthcare team members.

Scope of Action for MRT

A. Receive report from the primary RN

B. Complete a focused assessment of the patient and initiate treatment/interventions as needed.

C. If the patient needs to be transferred to a higher level of care, and no bed is readily available, the MRT will determine who needs to stay with the patient until the transfer can be made.

D. Complete MRT Call Record. Place original in patient's chart and send duplicate to Clinical

Quality.

E. At the conclusion of MRT response, ensure primary reason for call was addressed and orders are documented as needed.

F. The Post Medical Response Team Debrief should be completed and sent to Clinical Quality.

Related Forms

A. Form #6781 Medical Response Team Call Record

B. Form #6910 Stroke Protocol Resource Packet

C. Form #10121 Inpatient STEMI Evaluation Process

D. Form #8979 Inpatient STEMI Nurse Champion Flowsheet

E. Form #12058 Sepsis and Septic Shock Checklist

F. Form #12666 Post Medical Response Team Debrief

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/3/2026
Interim CNO Patient Care Services	Shari Wilson: President Post-Acute Care	2/2/2026
Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	2/2/2026
Document Owner	Amber Bowers: Mgr Nursing Services	2/2/2026

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Pediatric Response Team Protocol for Pediatric Patients

Purpose

The goal of the Pediatric Response Team (PRT) is to provide quick assessment and stabilization of an acutely ill pediatric patient or visitor in an effort to reduce the incidence of cardio/respiratory arrest and improve outcomes. The team will respond to a summons from any Munson Medical Center (MMC) staff who has identified an at risk child under the age of 18.

Protocol

PRT Members

A. The following will be activated via a PRT page:
    1. Pediatric Patient Care Coordinator (PCC)/Charge Nurse
    2. Pediatric Hospitalist on Call
    3. Neonatologist and Neonatal Nurse Practitioner on Call; Will respond to a page for a child 6 months of age and younger
    4. Emergency Department (ED) Charge Nurse
    5. Newborn Intensive Care Unit (NICU) Charge Nurse
    6. A3 or ICU Nurse
    7. Neonatal Respiratory Therapist (RT) and C3 RT
    8. Nursing Administrative House Supervisor
    9. Pharmacy, Lab, and Intravenous (IV) Therapy

Criteria to Summon PRT

A. Criteria for calling a PRT may include any change in the patient's baseline condition as observed by staff, for example:
    1. Change in vital signs, Pediatric Early Warning Score (PEWS), or blood oxygenation levels
    2. Change in mental status, including prolonged seizure
    3. Any pediatric patient requiring non-invasive positive pressure ventilation or non-emergent intubation
    4. Difficulty controlling pain or agitation
    5. Request from a family member

Activation of PRT

A. All staff, inpatient or outpatient, will activate the PRT by dialing "55555" for the operator. The staff member will state the following:
    1. Request to have PRT paged
    2. The location and age of the patient

B. If the PRT occurs outside of the Pediatrics unit, the Pediatric PCC/Charge Registered Nurse (RN) will respond to the area with the Pediatric Airway Bag, the glidescope with blades sizes 1-4, and the intraosseous (IO) kit. The ED RN will respond with the Pediatric Crash Cart.

C. If the pager system is down the switchboard operator will use the overhead paging system for notification of the PRT.

Responsibilities of the PRT

A. Collaborates to provide recommendations for patient care in response to the identified condition change, utilizing the American Heart Association (AHA) Pediatric Advanced Life Support (PALS) guidelines and MMC protocols as appropriate.

B. If the Pediatric Hospitalist is unable to respond immediately, they will call the location of the PRT to collaborate and direct the team.

C. The Pediatric RN, with the assistance of the responding RNs:
    1. Verifies the patient's code status
    2. Provides the team with pertinent patient history
    3. Ensures a computer/patient's electronic health record (EHR) is available
        a. Initiates PRT orders in Power Chart if appropriate
    4. Ensures the PRT record is initiated; located on the top of the Pediatric Crash Carts (#8128)
    5. Updates the family as needed
    6. Ensures all documentation is entered into Powerchart including the assessment,

vital signs and a focus note detailing the event and interventions.

7. Ensures needed equipment is at the bedside on the pediatric unit ie: Pediatric Crash Cart, suction, cardiorespiratory monitor, IV pole/pump, glucometer, EZ-IO
8. A3 RN to assist with documentation

D. The responsibilities of all team members responding to the PRT is to remain at the bedside until deemed not necessary; ie lab, IV therapy

E. If the patient's condition worsens or warrants emergent intubation, activate a Code Blue-Pediatric by dialing 55555 and state the following to the operator: Code Blue- Pediatric, patient location and age.

F. In the event the PRT determines the patient requires transfer to a tertiary care center, the team will huddle to determine the best location for immediate care needs prior to transfer. The transfer coordinator will be contacted to initiate the transfer process.

G. When a PRT is responding to a pediatric visitor or outpatient, the child may be transported to the ED for further assessment and treatment as appropriate.

References

1. Institute for Healthcare Improvement, *Getting started kit: rapid response teams*. Retrieved 12/22/2006 from: http://www.ihi.org/IHI/Programs/Campaign/.
2. Institute for Healthcare Improvement **.** ***8/03/2006. IHI.org story: children count in the 100,000 lives campaign*** **. Retrieved 12/26/2006 from: h**ttp:// www.ihi.org/IHI/Topics/Critical Care/IntensiveCare/ImprovementStories/ChildrenCountinthe100000LivesCampaign.htm
3. **Miller.; Zhan.** Pediatric patient safety in hospitals: a national picture in 2000**.** *Pediatrics*. June 2004; 113(6): pp.1741-1746 **113 (6): 1741. (2004)**
4. Pediatric Rapid Response Teams: Guidelines for Implementing a team. Retrieved 5/14/20 from: https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/prrt20113.pdf

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	6/5/2025
VP and CNO Patient Care Services	Tamara Putney: VP and CNO Patient Care Services	6/3/2025
Document Owner	Marta Wiesen: Mgr Nursing Services - NICU/C3	5/29/2025

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Next Review	2/2/2029	Tags	Guideline

Cardiopulmonary Resuscitation Team Coverage

Purpose

Provide staff a process to respond to a Code Blue Medical Emergency by calling the Code Blue Team for assistance.

Policy

Areas of Code Blue Team Response

A. The Code Blue Team will respond to all paged Code Blue Medical Emergencies- Adult or Pediatric in the main hospital building, the ground floor of the Munson Professional Building, the on-site childcare center and D6 Inpatient Behavioral Health-a Service of Munson Healthcare Cadillac Hospital (CAD).

   1. For ground floor public and non-patient care areas, Emergency Department (ED) staff will also respond.

B. The Cardiac Catheterization/Electrophysiology (EP) Labs, ED, Operating Room (OR), Post-Anesthesia Care Unit (PACU), A2, Intensive Care Unit (ICU) and Neonatal Intensive Care Unit (NICU) may provide their own coverage for Code Blue situations. The Code Blue Team is available for assistance if the unit staff calls a Code Blue Medical Emergency.

C. The parking structure, childcare playground, patient and employee parking lots, and the Energy Center are not considered to be part of the main hospital building. In the event of an emergency, call Emergency Medical Services (EMS) (911).

D. Ambulatory practices follow Medical Emergencies Presenting at Munson Healthcare Practices or Clinics.

E. For Pediatric Code Blue response, refer to Code Blue- Pediatric Response Plan.

Code Blue Team Activation

A. Any hospital personnel may activate the Code Blue Team by completing the following steps:
    1. Dial "55555".
    2. Request the operator call a Code Blue Medical Emergency- Adult or Pediatric.
    3. Provide the operator with the exact location of the patient.

B. Employees at the location of the emergency should designate individuals to assist with directing the code team members to the location of the emergency as they arrive.

Response Roles and Responsibilities

A. **Provider**
    1. The first provider responding to the code will:
        a. Assume responsibility for the code until the code team arrives.
        b. The responding provider may delegate code team leadership to another provider or to a designated Advanced Cardiac Life Support (ACLS) certified registered nurse (RN).
    2. The provider assuming responsibility for the code will:
        a. Direct the activity of the team.
        b. Review and sign completed Code Blue Flowsheet (form #1144).

B. **Designated ACLS certified nurses**
    1. One designated ACLS certified nurse, typically from A3.
        a. Lead the code in the absence of a provider or as designated by the provider per ACLS protocol.
        b. Verify Intraosseous (IO) Access kit is available.
    2. The other designated ACLS certified nurse, typically from ICU.
        a. Assist with code leadership and ACLS protocol.
        b. Verify video fluoroscope is available.
        c. Monitor and announce time intervals for interventions.
        d. Document all events on the cardiopulmonary resuscitation (CPR) Flow Sheet and obtain necessary signatures.
        e. File original CPR flow sheet in the patient's chart and send copy to Clinical Quality along with completed Code Critique Form (form #1887).

C. **VAST RN**
    1. Assist with venous and IO access as needed.

D. **Respiratory Therapist (RT)**

1. Perform airway management and ventilation.
2. If indicated, a qualified RT may intubate.

E. **Primary RN**

1. Provide focused summary of patient's history and events proceeding the arrest.
2. Remain at patient's bedside for additional assistance.
3. Report to the nurse assuming responsibility for the patient should a transfer occur.

F. **Unit RN/Charge RN**

1. Ensure resuscitation initiated per Basic Life Support (BLS)/ACLS protocols.
2. Verify Code Blue was activated (55555).
3. Ensure crash cart, defibrillator, and other necessary equipment are present.
4. Assist with crowd control.

G. **Pharmacist**

1. Bring medication kit and prepare medications as needed.

H. **Phlebotomist**

1. Bring handheld blood analyzer.
2. Perform or assist with lab draws.
3. Deliver blood samples to the laboratory and inform of need for STAT analysis and reporting.

Related Materials

1. Highlights of the 2020 American Heart Association Guidelines for CPR and ECC
2. Code Blue Flowsheet (form #1144)
3. Code Critique Form (form #1887)
4. Cardiopulmonary resuscitation (CPR), two-person (Lippincott Procedures)
5. Cardiopulmonary resuscitation (CPR), one-person (Lippincott Procedures)

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/3/2026
Interim CNO Patient Care Services	Shari Wilson: President Post-Acute Care	2/2/2026

Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	2/2/2026
Document Owner	Amber Bowers: Mgr Nursing Services	2/2/2026

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Owner	Heather Tolfree: Mgr Pharmacy - CPS
Area/ Department	Pharmacy
Applicability	MHC Hospital System w/KMHC (MMC, Cadillac, Charlevoix, Grayling, KMHC, Otsego, Manistee, POMH)
Tags	Policy

Medication Administration

Purpose

To ensure medications are administered by authorized individuals in a safe and timely manner to meet the needs of the patient. The policy does *not* define procedures for administrating medication by various routes of administration or administration techniques

Definitions[1,2]

1. **Medications Not Eligible for Scheduled Dosing Times:** Medications requiring exact or precise timing of administration based on diagnosis type, treatment requirements, or therapeutic goals.
2. **Medications Eligible for Scheduled Dosing Times:** Medications prescribed on a repeated cycle of frequency, such as once a day, twice a day (BID), three times a day (TID), hourly intervals (every 1, 2, 3 or more hours), etc.
    1. **Non-Time Critical Scheduled Medications:** Medications for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm.
    2. **Time-Critical Scheduled Medications:** Medications for which an early or late administration of greater than thirty minutes might cause harm or have significant,

negative impact on the intended therapeutic or pharmacological effect.

Policy

A. Medications are administered by authorized, licensed, independent practitioners and clinical staff authorized to do so by state law, federal law, and hospital policy.

B. Medications and biologicals are administered upon the order of a provider responsible for the care of the patient or another provider acting in accordance with state law, including scope of practice laws, hospital policy and procedures, and medical staff by laws, rules, and regulations.

C. Categories of licensed personnel and the types of medication they are authorized to administer are defined in policy.

D. Training and staff education is provided for personnel authorized to administer medication and biologicals. Training and competency assessments are documented.

E. Bar code medication administration (BCMA) is utilized at the bedside prior to medication administration at all times unless there are extenuating circumstances (i.e. code blue or trauma, technology down time, or technology not available).

F. Timing of medication administration takes into account the complex nature and variability among medications, the indications for use, the clinical situation, and the needs of the patient.

G. Medications eligible for scheduled dosing times, medications not eligible for scheduled dosing times, and time-critical scheduled medications are defined.

H. Dose administration times are standardized for eligible scheduled medications.

I. Guidelines are established for initiating administration of first doses and missed or delayed doses of scheduled medications.

Training and Competency Assessment

A. Personnel authorized to administer medications receive training during orientation and ongoing education about topics related to safe medication handling, preparation, administration, and patient monitoring. Chemotherapy and investigational medications may only be administered by individuals who have completed specialized training pertaining to these agents.

B. Training and competency assessments are documented per hospital policy.

Categories of Individuals Authorized to Administer Medications by Medication Type

A. **Physicians** may administer medications for diagnosis and treatment in accordance with medical staff bylaws and provider credentials.

B. **Certified Registered Nurse Anesthetists, Nurse Practitioners, Physicians Assistants**, and **Clinical Nurse Specialists** may administer medications by all routes within their scope of practice.

C. Registered Nurses (RN): May administer all parenteral, oral, rectal, and topical medications

including blood and blood products, if not specifically excluded elsewhere by medical staff by-laws or rules and regulations.

D. Respiratory Therapists: May administer aerosol and nebulizer medications.

E. Respiratory Interns and Technicians: May administer aerosol and nebulizer medications under supervision by Respiratory Therapist.

F. Radiology Technicians: May administer contrast media per medical staff approved hospital protocol while under the supervision of a Licensed Independent Practitioner (LIP).

G. Cardiovascular Technologist/Registered Cath Lab Invasive Specialist: May administer specific medications under direct supervision of LIP.

H. Medical Assistants (MA) and Licensed Practical Nurses (LPNs) at Munson Healthcare (MHC) Owned Offices/Practices: May administer site specific oral and parenteral medications outlined in job description and/or policy/procedure and assessed by training and competency.

I. Physical Therapists, Physical Therapy Assistants (Supervised by Physical Therapists), Occupational Therapists, Certified Occupational Therapist Assistants (Supervised by Occupational Therapist): May apply topical medications for wound care treatment, ultrasound, and iontophoresis.

J. Clinical Pharmacists/Pharmacy Residents: May administer parenteral and oral medications.

K. Other clinical staff authorized to administer medication by state and federal law, hospital policy/job descriptions, and supported, when applicable, by training/competency.

L. Students of accredited schools of medicine, nursing, physical therapy, respiratory therapy, or other healthcare fields authorized in this policy may administer medications only under the direct supervision of a registered healthcare professional who has ultimate responsibility for the medication administration process.

M. Anyone may administer intranasal naloxone.

Timing of Medication Administration[2]

Medications Eligible for Scheduled Dosing Times

A. Medications eligible for scheduled dosing times are those prescribed on a repeated cycle of frequency, such as once a day, BID, TID, hourly intervals (every 1, 2, 3 or more hours), etc.

Medications Not Eligible for Scheduled Dose Administration Times

A. The following medication orders are not eligible for standardized scheduled dosing times and require timing of administration based on the pharmacokinetics of the prescribed medication, the specific clinical application, and patient risk factors:

    1. STAT/Now doses
    2. First time or loading doses

3. One-time doses specifically timed for procedures
4. Time-sequenced doses and doses timed for serum drug levels
5. Investigational drugs
6. Medications prescribed on an as needed (PRN) basis

Standardized Dose Times for Scheduled Medications

A. Unless the prescriber orders otherwise, scheduled medications are administered at standard times as approved by the Pharmacy and Therapeutics (P&T) Committee.
    1. **Note:** Refer to attachment ***Guidelines for Maintaining Standard Times*** below

B. Select groups of medications may be assigned specific administration times by the P&T Committee (i.e. warfarin, digoxin).

C. New orders for antibiotics and specified drug classes, as defined by the P&T Committee, will be administered as soon as possible after receipt from the Pharmacy.

D. e-MAR alerts are used to highlight doses that will soon be due, overdue, or have been omitted.

E. Pharmacists should make every attempt to schedule medication on standard times.

Time Critical Scheduled Medications

A. Time critical scheduled medications are administered within 30 minutes before or after their scheduled dosing time for a total window of 1 hour.

B. Time critical scheduled medications include:
    1. Carbidopa
    2. Carbidopa/Levodopa
    3. Entacapone
    4. Mycophenolate IVPB
    5. Mycophenolate Mofetil
    6. Cyclosporin (Oral and IVPB, not ophthalmic)
    7. Nonmodified cyclosporine
    8. Tacrolimus
    9. Leucovorin IVPB

Non-Time Critical Scheduled Medications

A. Medications prescribed less frequently than every 4 hours are administered within 1 hour before or after the scheduled dosing time for a total window that does not exceed 2 hours.

Procedure

A. Do NOT use medications dispensed to or labeled for another patient.

B. Medications are prepared for one patient at a time.

C. Medications are prepared in a clean, functionally separate area designated for medication preparation.

D. Unit-dose packages and individually wrapped intravenous infusion bags remain intact until immediately prior to administration.

E. Solid oral dosage forms needing to be crushed or split prior to administration are assessed for suitability.

    1. Enteric coated and sustained release products may not be crushed or split unless allowed by manufacturer.
    2. Only tablets with a functional score may be split.
    3. No NIOSH medication should be crushed or split outside of proper environmental controls in the Pharmacy.
        a. **Note:** Refer to the USP <800> Handling Hazardous Drugs in Healthcare Settings policy for more information on how to handle hazardous drugs during administration.
    4. Tablet splitting and crushing devices are cleaned before and after each use; and/or a plastic sleeve is used to minimize the potential for cross contamination of products; or disposable products are used as single patient products.
    5. Unused tablet portions are not saved but are immediately discarded in accordance with the hospital's Pharmaceutical Waste Management policy. Any unused portion of a controlled substance must be wasted with a witness and documented per hospital policy.
        a. **Note:** Refer to the Controlled Substances policy for more information regarding handling of controlled substances.
    6. Contact pharmacy for guidance or to discuss alternatives.

F. Multi-dose vials (MDVs) are utilized only when single-dose containers (SDC) are not available or do not meet the needs in the provision of patient care and when used are controlled in a manner that assures their sterility, chemical stability, and quality. Single-dose containers used outside ISO Class 5 environment are only entered and used one time. Any controlled substance packaged in a dose larger than the dose being administered should have excess amounts wasted before administration.

    1. **Note:** Refer to the Multi-Dose Vials and Single-Dose Containers policy for more information on MDV and SDC. Refer to the "Waste and Disposal" section of the Controlled Substances policy for more information on handling of controlled substances.

G. A filter needle is used to withdraw medications from an ampule.

H. Personal protective equipment (PPE) is used when handling and administering chemotherapy and other NIOSH designated drugs.

    1. **Note:** Refer to the USP <800> Handling Hazardous Drugs in Healthcare Settings policy for more information on how to handle hazardous drugs during

administration.

I. Medications are administered immediately after the medication is prepared without a break in process by the individual who prepares the dose.
    1. **Note:** This does not apply to medications prepared by Pharmacy or medications that have been appropriately labeled for administration.

J. Before administering a medication, the authorized individual administering the medication completes the following:
    1. Verifies the medication selected for administration is correct based on the medication order and product label.
    2. Visually inspects the medication for potential loss of integrity (i.e. no particulates or discoloration).
    3. Verifies the medication has not expired.
    4. Verifies there is no contraindication with respect to allergy, sensitivity, or diagnosis.
    5. Verifies the medication is administered in the correct dose and the dose does not reflect an unsafe dosage level (i.e. a dose that is too high or too low).
    6. Verifies the medication is administered by the correct route and the route is appropriate for the medication and patient.
    7. For IV medications, verifies the type of IV access is appropriate for the medication and patient.
    8. Verifies the medication is administered at the appropriate time to ensure adherence to the prescribed frequency and time of administration.
    9. Discusses any unresolved, significant concerns about the medication with the prescriber and/or relevant staff involved with the patient's care.
    10. Advises the patient, or if appropriate, the patient's family about any potential clinically significant adverse reaction or other concerns about administering a new medication.
    11. If applicable, advises the patient and/or the patient's representative about the patient assessment and monitoring process which might include awakening the patient in order to assess the effects of the medication.

K. Positively identify the patient before administering the medication. Check the patient's identification (ID) with two hospital approved identifiers and ask the patient (when possible) to state his/her name and date of birth. See Appendix 1 for Alternate ID Process.

L. Double check the order if the patient questions or expresses doubts about a medication, dose, administration route, or technique.

M. Properly position the patient, if necessary, before administering the medication.

N. Administer the medication. Offer additional liquid if appropriate.

O. Observe the patient take the medication. Stay with the patient until he/she has swallowed the medication.

P. Document the exact time the medication is administered. Do NOT document prior to

administration.

Q. Return unused, intact (sealed) medications to the patient's supply, automated dispensing cabinet, or Pharmacy per hospital policy.

R. Discard unusable medications per hospital policy.

    1. **Note:** Refer to the Outdated/Expired and Unusable Medications policy for more information.

S. Isolate defective or questionable medications and return them to the Pharmacy.

T. Monitor the effects of the medication to ensure effective patient response (i.e. pain assessment, blood pressure monitoring, etc.).

U. Monitor patient response to first doses to assess for adverse effects.

V. Communicate all relevant information regarding patient's medication risk factors and monitoring requirements during hand-offs of the patient to other clinical staff (e.g. internal transfers from one unit to another, shift report at shift change, etc.).

W. Report medication administration errors, adverse drug events and incompatibilities immediately to the attending physician. Prepare and submit reports as defined by organizational policy.

Missed or Delayed Administration of Scheduled Medications

A. When medications eligible for a scheduled dosing time are not administered within the defined time period:

    1. Document the reason the dose was missed or delayed (i.e. patient refused, patient off unit, etc.).
    2. Reschedule missed or delayed doses, as appropriate, based on the facility specific standard dose administration times.
    3. Notify the prescribing/attending provider if the delay poses an immediate patient care issue.
    4. Medication errors that are the result of missed or late dose administration must be reported to the attending provider and to the hospital incident reporting system in accordance with hospital policy.

Medication Administration Based on Patient Preference

A. PRN medication administration may be deferred to the patient's preference only in the following circumstances[3]:

    1. When the patient requests a ***less potent*** (e.g., different) medication that is prescribed
        a. **Note:** Potency is established with an evidence-based tool (i.e. morphine equivalents).

2. A ***lower dose*** in a prescribed dose range.
3. A ***less intrusive route*** of administration if multiple routes are prescribed.
    a. Parenteral, oral, and rectal routes:
        i. Enteral route will be used, unless patient not able to take medication via an enteral route (excluding the rectal route).
        ii. Rectal route of administration will be reserved if unable to give via other enteral routes or via a parenteral route.
4. An ordered medication indicated for a *lower level of pain* than scored on the most recent pain assessment (e.g., patient requests treatment with a medication indicated for mild pain when pain assessment scores indicates patient is experiencing moderate pain).

B. It is not acceptable to administer a medication of stronger potency based on patient preference.
    1. Patient preference is *only* applicable for administration of a different, less potent agent that is prescribed. It is not acceptable to change or lower the dose of the same medication unless the dose is defined in a range order.

C. If administering a controlled substance part of a range order, waste any excessive dose at the time of procurement (e.g. removal from automated dispensing machine) for all non-emergent situations. Any partially used controlled substance cannot be saved for later use.
    1. **Note:** Refer to the Controlled Substances policy for more information regarding handling of controlled substances.

Documentation

A. The use of PRN medications to control medical symptoms (such as pain, nausea, insomnia, extra-pyramidal side effects) requires the following documentation:
    1. Documentation of the symptom or indication for use.
    2. Documentation of the medication and dose administered.
    3. Documentation in the medical record of the results achieved.
    4. Documentation in the medical record when medication administration is deferred to the patient's preference (see above for criteria).

Evaluation of Medication Administration Timing

A. The organization periodically evaluates medication administration timing to include:
    1. Evaluation of staff adherence to the policy
    2. Tracking and analysis of reported medication events related to the timing of medication administration

Personnel

A. All Clinical Staff

References

1. State operations manual. CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Updated February 21, 2020. Accessed September 19, 2022.
2. Institute For Safe Medication Practices. ISMP acute care guidelines for timely administration of scheduled medications. ISMP: Institute For Safe Medication Practices. https://www.ismp.org/sites/default/files/attachments/2018-02/tasm.pdf. Published 2011. Accessed October 2023.
3. The Joint Commission. (2024, January 30). Are there circumstances when a provider may write PRN medication orders that allow variation in administration based on patient preference such as in the following examples ? Retrieved September 21, 2025, from Standards FAQ: https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000002058

Related Policy

1. Controlled Substances
2. Outdated/Expired and Unusable Medications
3. Pharmaceutical Waste Management
4. USP <800> Handling Hazardous Drugs in Healthcare Settings

Author: Heather Tolfree, PharmD

Appendix

Alternate Patient ID for Barcode Medication Administration (BCMA) Process at MHC

Purpose

To maintain staff safety with medication administration when caring for a potentially violent/physically aggressive patient. Scanning the patient wrist band in such situations can pose a safety risk for the nurse. An alternate process for patient ID is outlined below. This process is ONLY to be implemented when safety concerns are an **imminent** risk at the time of medication administration.

A. **Step One:** Review patient's current criteria with the PCC/charge RN to support the implementation of the Alternate Patient ID BCMA Process.

B. **Step Two:** If determined clinically appropriate, print second patient ID band.

C. **Step Three:** Store second patient ID band in the gray medication bin in the locked med drawer assigned to the patient. (Note; if there is no locked med drawer, for example, in an ED setting, the patient chart will suffice).

D. **Step Four:** The RN may scan the secondary ID band to initiate the medication preparation steps so this may occur in a safe, separate location where all medications can be scanned. Tap out.

E. **Step Five (D6 Only):** Transfer all prepared medications and the secondary band into the Medication Transfer Bin and locate the patient for medication administration.

F. **Step Six:** Using normal ID procedures, PLUS comparing the secondary ID band to the band on the patient, confirm identity and administer medications.

G. **Step Seven:** Immediately tap in. Sign off all medications that were administered. Return ID band to locked medication bin.

Attachments

Guidelines for Maintaining Standard Times.docx

IV Antibiotics and IVP Steroids.docx

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/17/2026
System P&T Committee	Cathi Cornelius: Clin Pharmacy Utilization Spec	2/13/2026
Document Owner	Heather Tolfree: Mgr Pharmacy - CPS	1/22/2026

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Owner	Amber Bowers: Mgr Nursing Services
Area/ Department	Nursing
Applicability	Munson Healthcare Systemwide

Blood Transfusion Therapy & Transfusion Reaction

Purpose

To provide a process for safe and effective replacement of blood components as required by patient condition and best practice.

Scope

This policy applies to all locations within Munson Healthcare (MHC) where standard, non-emergent blood transfusion therapy occurs.

Definitions

The following definitions provide a brief description of blood components dispensed by Blood Bank.

1. **Red Blood Cells (RBC):** Red blood cells with most of the plasma removed and a preservative added. Administered to enhance the oxygen (O2) carrying capacity of the blood. Types of RBCs available include autologous, homologous/allogenic directed, leuko-reduced, irradiated, and incompatible.
2. **Irradiated Blood Products:** Blood products that have been exposed to a measured amount of radiation thereby rendering donor lymphocytes incapable of replication. Given to prevent transfusion graft versus host disease.
3. **Leuko-Reduced Red Blood Cells (RBC):** RBCs in which the leukocyte number has been reduced by centrifuge washing or filtration at the blood center. Given to prevent recurrence of febrile non-hemolytic transfusion reactions and transmission of Cytomegalovirus (CMV).
4. **Incompatible Red Blood Cells (RBC):** Blood containing RBCs which are agglutinated (clumped) or hemolyzed by the serum of the recipient in the crossmatch procedure. The blood types are incompatible. In these cases, the pathologist and the patient's physician have assessed the need for transfusion against the possible risks of transfusion and determined the patient's need for

transfusion to be greater than the risk. The pathologist has selected the best possible unit.

5. **Fresh Frozen Plasma (FFP):** Contains all the components of blood plasma (albumin, globulins, antibodies) including the clotting factors. FFP is beneficial to patients with demonstrated multiple coagulation deficiencies. It should not be used for volume expansion since it carries the risk of disease transmission.
6. **Platelets:** Obtained by separating the platelet-rich plasma from one unit of fresh whole blood. Platelets contain a phospholipid that enhances the conversion of prothrombin to thrombin. Types of platelets available are from a single donor by apheresis. Administered to control or prevent bleeding associated with deficiencies in platelet number or function.
7. **Cryoprecipitate:** Concentrate containing Fibrinogen; Factors VIII and XIII, vonWillebrand Factor (vWF) extracted from cold-thawed plasma.
8. **Rh Immune Globulin (RhIG):** Concentrate of IgG anti-D derived from plasma. Administered by intramuscular (IM) injection to Rh-negative individuals to prevent Rh alloimmunization after being exposed to Rh-positive cells through transfusion or pregnancy. The infusion is not subject to consent procedures associated with the administration of blood products above.

Policy

A. The following blood components are distributed by pharmacy and subject to the policies governing medication administration.
    1. Albumin
    2. Prothrombin Complex Concentrate and Anti-inhibitor Complex Concentrate
    3. C1 Esterase Inhibitor
    4. Antithrombin III
    5. Immune Globulin (intravenous [IV] and IM)

B. A Registered Nurse (RN) may administer blood components intravenously upon receipt of provider order entry (POE) by a practitioner privileged to do so.

C. Blood Transfusion Patient education sheet will be provided to patient prior to administration of blood products. Patient education should be provided again after ninety (90 days) or after discharge. Any patient questions will be addressed by provider.

D. In case of refusal a Confirmation of Choice to Refuse Designated Treatments Utilizing Blood Products (Adult) Form #318 must be signed. Refer to the Managing Refusal of Blood Transfusion policy.

E. On rare occasions it may not be possible for the Blood Bank to provide Red Blood Cells that are serologically compatible with the recipient. The Blood Bank will inform the patient's Physician/ Health Care Provider when an incompatibility is identified. In these cases, the pathologist and the patient's provider have assessed the need for transfusion against the possible risks of transfusion and determined need for transfusion to be greater than the risk.

F. Temperature, pulse, respirations, blood pressure (BP) and O2 saturation must be taken no more than one hour before beginning the transfusion. If temp 38.8°C or greater, notify ordering provider before obtaining blood component. An elevated temp is not a contraindication to the transfusion, but it may complicate assessment of a transfusion reaction.

G. Verify that patient has patent IV site with minimum of 24 gauge or larger prior to obtaining the

blood product.

H. Normal saline (0.9% NaCl) will be used as priming solution.

I. SURGICAL SERVICES ONLY: In the pre-op, intra-op or post-operative departments (while under the direction of the anesthesiologist), blood products may be co-administered with Normosol-R or Plasma-Lyte in place of Normal saline. (Normosol-R and Plasma-Lyte are isotonic solutions of balanced electrolytes in water that do not contain dextrose or calcium).

    1. Note: Dextrose solutions may cause hemolysis when in contact with RBCs. Lactated Ringers solutions contain calcium and may contribute to formation of micro-emboli.

J. When obtaining blood from the Blood Bank, personnel trained in the procedure and the lab technician checking out the component must check the following information and the product must not be issued, unless all information is identical:

    1. Patient name
    2. Medical record number
    3. Blood component
    4. Blood type of donor and recipient
    5. Rh factor of donor and recipient
    6. Blood unit number
    7. Expiration date

K. All information must again be checked by two staff qualified, in the presence of the recipient and trained to assist with blood administration before blood component is started. In the case of extracorporeal membrane oxygenation (ECMO) therapy a registered respiratory therapist may check the information along with the qualified staff. All information must be identical. Conscious patients should be asked to state their first and last name and date of birth in addition to checking ID band. Do not remove any patient identification bands during transfusion. The following verifications are required before the start of the transfusion:

    1. The transfusionist must verify that the recipient's name and MRN present on the patient armband match the information on the unit label.
    2. The unit number and donor ABO/Rh type on the blood component label must match the attached tag.
    3. The recipients ABO group (and Rh type if required) must be compatible with that of the unit. Interpretation of the crossmatch tests must also be verified.
    4. The transfusionist must verify that the component to be transfused matches the provider's order and that any special processing requests (ie. irradiation, blood warmer, washed, etc) was performed.
    5. The transfusion of the unit must start before the expiration date or time has passed.
    6. An active transfusion order must be validated at the bedside during the two person verification process.

L. If there are any discrepancies between the Crossmatch Transfusion Tag, blood bag, or patient identification band, the unit cannot be administered. Return the blood to the Blood Bank and complete a Safety Event Report. A blood component must be started within 30 minutes from the time of receipt, or it must be returned to the Blood Bank. Blood cannot be stored on the unit. The

exception is fresh frozen plasma which can be maintained up to 4 hours at 20-25°C (68-77°F).External pressure infusion devices designed specifically for blood administration that do not exceed 300-mmHg pressure, may be used to infuse blood.

M. Fluid warmers may be used for patients with cold agglutinins, massive or rapid transfusions, or exchange transfusions in the neonate.
    1. Note: Competency must be documented before use of this equipment is attempted.

N. If a blood component is not administered or is damaged it must be returned to the Blood Bank and document the reason.

O. A unit of blood and its associated filter/tubing should not hang for longer than four (4) hours. The frequency of tubing changes is dependent on the type of filter used and flow rate. If more than 30 minutes elapse between subsequent transfusions, discard the tubing.

P. An infusion pump may be used to administer blood.
    1. If the patient's clinical status dictates an extremely slow rate, contact the Blood Bank. They may divide the unit.
    2. Pediatrics and neonate patients do require the use of an infusion pump.

Q. No medication or IV solutions can be administered in the same line as a blood infusion.

R. RN spiking the blood bag must wear mask, goggles, and gloves. If a patient is transferred to another unit or department during transfusion, the Transfusion Record and a verbal report to the licensed clinician assuming care of the patient using hand-off guidelines (SBAR) is required.

S. Frequency of patient assessment and vital signs is based on patient clinical status and must be frequent enough to provide for assessment of physiologic status. The nurse should remain with the patient for the first fifteen (15) minutes after beginning the transfusion, at initial rate, to observe for signs of a transfusion reaction. See table for additional requirements.

Product	Volume	Rate	Vital Signs	Special Considerations
RBCs	Typically, 250-300 ml. Read unit bag for specific volume	First 15 minutes: 1-2 mL/min (60-120 mL/hr) After 15 minutes: as rapidly as tolerated (4 mL/min or 240 mL/hr). Faster or slower rates dictated by clinical condition.	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	All RBC products are leuko-reduced • **Observe patient constantly for first 15 minutes** • **Must not exceed 4 hours** A blood warmer may be indicated for use in: • Plasma exchange transfusion

Product	Volume	Rate	Vital Signs	Special Considerations
				• Surgery • Trauma • Cold agglutinin disease ***Pediatric Considerations:** • Dose: 10-20 mL/kg; NOT to exceed adult dose • Must be administered on a pump at a controlled rate; First 15 minutes at 25% of goal rate (goal is over 4 hours if patient is stable, or as indicated by provider order) ****Neonatal Considerations:** • ONLY O- RBCs will be administered • Dose: 10-20 mL/kg • CMV-, Leukoreduced, Irradiated • Comes in a syringe pre-filtered • Administered over time ordered by Provider

Product	Volume	Rate	Vital Signs	Special Considerations
Incompatible/ Least Incompatible RBCs	250-310	Start slowly at 1 mL/min for the first 15 minutes complete entire process for EACH unit of incompatible RBCs transfused. Not to exceed 4 hours	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Follow instructions that come with unit from Blood Bank • **Observe patient constantly for first 15 minutes** • If no symptoms of reaction after 30 minutes, proceed and monitor **Pediatric Considerations:** • Dose: 10-20 mL/kg; NOT to exceed adult dose • Must be administered on a pump at a controlled rate; See admin guidance above for initial rate **Neonatal Considerations:** • N/A, we never administer incompatible RBCs to a neonate
Cryoprecipitate	5 units per pool	Rapidly as tolerated	BP, temperature, pulse, respiratory and O2: • before • 15 minutes	Infuse as soon as possible after collection release of component. Always gravity flow cryoprecipitate. • Do not use

Product	Volume	Rate	Vital Signs	Special Considerations
			• 30 minutes • Completion of transfusion (more frequent if clinically indicated)	rapid infuser to administer cryoprecipitate • Special populations such as peds/ neonatal intensive care unit (NICU) may have alternate infusion procedures (see below) **Pediatric Considerations:** • Dose: 1 mL/kg NOT to exceed adult dose • Must be administered at a controlled rate • Syringe pump is acceptable for administration; NOT normal IV Pump • Administration usually over 30 minutes **Neonatal Considerations:** • Dose: 5-10 mL/kg • Comes in a syringe pre-filtered • Administered over time ordered by

Product	Volume	Rate	Vital Signs	Special Considerations
				Provider
FFP	Typically, 250-300 ml. Read unit bag for specific volume	First 15 minutes: 2-5 mL/min (120-300 mL/hr) After 15 minutes: as rapidly as tolerated, 300 mL/hr	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	**Pediatric Considerations:** • Dose: 10-15 mL/kg; NOT to exceed adult dose (MAX-500 mL or 2 Units) • Must be administered on a pump at a controlled rate, may use syringe pump if volume appropriate **Neonatal Considerations:** • Dose: 10 mL/kg • Administered over time ordered by Provider
Platelets	Varies. Read unit bag for specific volume	First 15 minutes: 2-5 mL/min (120-300 mL/hr) After 15 minutes: 300 mL/hr as tolerated	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Always gravity flow platelets to adult patients • Do not use rapid infuser to administer platelets • Human leukocyte antigens (HLA) Platelets - Special order. Panel-reactive antibody (PRA) & HLA

Product	Volume	Rate	Vital Signs	Special Considerations
				testing required • 1 unit apheresis equivalent to “5 Pack” (pooled unit) • Special populations such as peds/ NICU may have alternate infusion procedures (see below) ***Pediatric Considerations:** • Dose: 10 mL/ kg; NOT to exceed adult dose (MAX- 300 mL or one 5-pack) • Must be administered at a controlled rate • Syringe pump is acceptable for administration; NOT normal IV Pump • Administration usually over 30 minutes ****Neonatal Considerations:** • Dose: 10-15 mL/kg • Comes in a syringe pre-

Product	Volume	Rate	Vital Signs	Special Considerations
				filtered • Administered over time ordered by Provider
Whole Blood	Provider Discretion	As tolerated but not to exceed 4 hours. Faster or slower rates dictated by clinical condition.	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Administration Inclusion Criteria: • Male: 15 years of age and OLDER • Female: 55 years of age and OLDER • At Trauma Surgeon discretion • Will primarily be administered in the ED at this time, and will arrive in a BLUE colored cooler

T. Symptoms of a Transfusion Reaction includes:

1. Temperature elevation (1.0°C during or within 2 hours of transfusion)
2. Chills, with or without rigors
3. Respiratory distress
4. Abdominal, chest, flank or back pain
5. Hypertension
6. Hypotension
7. Pain/oozing at the infusion site
8. Rash/hives/itching
9. Jaundice
10. Hemoglobinuria
11. Nausea/vomiting
12. Abnormal bleeding
13. Oliguria/anuria

U. Symptoms related to other health conditions to observe for include:
    1. Tachycardia
    2. Tachypnea
    3. Anxiety
    4. Headache
    5. Hematuria
    6. Cardiac arrest

V. If a transfusion reaction is suspected, immediately stop the transfusion by disconnecting the blood tubing from the IV and cap with a sterile cap. Convert the IV to an intermittent lock and begin an infusion of 0.9% normal saline until the situation can be assessed. Do not discontinue the IV.

W. Notify the primary physician and the Blood Bank. Complete the Reaction Transfusion Reaction Investigation Form #2874. Pending results, the Blood Bank will notify the nursing unit on how to proceed.

X. Upon completion of the transfusion, discard the bag and tubing in biohazard bin using Standard Precautions.

Y. Document patient education, response to therapy, vital signs, and blood unit information in the appropriate location of the medical record.

Procedure

A. See the on-line procedure manual for additional information, procedural steps, nursing considerations.
    1. Lippincott Procedures - Blood and Blood Product Transfusion
    2. Lippincott Procedures - Blood and Blood Product Transfusion, Pediatric
    3. Lippincott Procedures - Blood and Blood Product Transfusion, Neonatal

B. Consult product literature for specific instructions.

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4. "Use of Cryoprecipitate in Newborn Infants." *Newborn (Clarksville)*, vol. 2, no. 1, 2023, pp. 11–18. doi:10.5005/jp-journals-11002-0045.
5. Standards for Blood Banks and Transfusion Services, 33rd Edition, AABB, April 2022, pp 47-50
6. Technical Manual, 21st Edition, AABB, 2023, pp 557, 567-580

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blood, blood product, transfusion, blood components, red blood cells, RBC, fresh frozen plasma, FFP, cryoprecipitate, platelets, Rh Immune Globulin, RhIG, blood bank

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	12/10/2025
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Document Owner	Amber Bowers: Mgr Nursing Services	11/25/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Owner	Thomas Schermerhorn: Chief Medical Officer
Area/ Department	Medical Staff
Applicability	MMC
Tags	Policy

Chain of Command: Paging Response Time and Resolving Questions of Care or Safety

Purpose

To provide a policy for paging response time and resolving questions of care of safety for the chain of command.

Policy

A. It is the responsibility of all providers (or their designated cover) to answer a routine page within fifteen minutes of a message being received. If not answered, a second page will be initiated. A stat page should be answered immediately. If a page is not answered within this prescribed time frame, and circumstances warrant, the individual initiating the page will follow the chain of command outlined below until contact has been made with an appropriate staff member.

B. It is the responsibility of the unit manager or designee to be aware of the condition of every patient on the unit.

C. The attending/responsible physician shall be immediately notified of the following by the nurse:

1. Any marked deterioration of the patient's condition (Initiate MRT protocols as appropriate)
2. Any untoward drug reactions
3. Occurrence of life threatening medication errors
4. Critical test results

5. Any other incidents which significantly affect the patient's condition
6. Any other specific parameters ordered by the provider

D. The nurse shall immediately notify the coordinator or charge nurse/manager/administrative supervisor to implement the Medical Staff Chain of Command, if either of the following situations occurs:
    1. The attending/responsible physician fails to respond in a timely manner or is unavailable to address an urgent/emergent patient care situation.
    2. The quality or appropriateness of care being provided to a patient is in question and there is potential for patient injury.

E. The coordinator or charge nurse/manager/administrative supervisor shall notify the appropriate Medical Staff leadership to obtain assistance and provide for medical care of the patient in the following order: (Provision for medical care in this instance is considered an administrative responsibility and is indemnified and insured by the hospital.)
    1. Chief Medical Officer (CMO)
    2. Administrator on Call (if the CMO is not available)

F. Physicians who have the above concerns can contact the CMO for assistance.

G. For questions regarding scope of care and current privileges, the manager/supervisor or designee shall consult Munson Medical Center (MMC) Intranet-Physicians-Privileges or contact Medical Staff Services. If the scope is unclear or if the Medical Staff office is not available, the appropriate Medical Staff leadership shall be contacted as listed above.

H. The manager/supervisor shall notify the appropriate Director of Nursing and the Vice President of Patient Care Services of any cases where medical leadership has been contacted by nursing for assistance in resolving questions of care. Such incidents may be referred to Medical Staff leadership as a policy violation.

Document ID: 019.037

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	8/16/2022
Medical Executive Committee	Katryna Glettler: Sr Spec Lead, Med Staff Services	8/16/2022
Policy Owner	Walter Noble: Chief Medical Officer	8/16/2022

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Owner	Jennifer Standfest: CNO
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Applicability	MHC Hospital System w/KMHC (MMC, Cadillac, Charlevoix, Grayling, KMHC, Otsego, Manistee, POMH)

Nursing Documentation Guidelines

Purpose

To provide guidance for electronic inpatient and observation nursing documentation. Please refer to Hospital Nursing Documentation | Munson Healthcare for additional information and specific job aides. In addition to the specific procedures within this policy, all employees must adhere to general documentation guidelines within the Medical Record Entries policy.

Guidelines

General Documentation

A. All entries into the electronic document must be made under the individual's authorized log in. Information should be entered into the computer at time of collection to the extent possible.

B. All admission forms will be completed and documented within 24 hours of admission and according to unit standard, by a Registered Nurse (RN).

C. Nursing Assessment will be completed and documented at a minimum of every 8 hours, or more frequently per unit standards.

D. All patients are screened for pain at hospital admission and at a minimum of every shift to determine if pain is present. When present, assessment and reassessment will occur as appropriate per the Pain Management policy.

E. Medication administration: For a unit that uses barcoding for medications, including intravenous (IV) fluids, medications should be scanned prior to administration or upon transfer

from a non-electronic medication administration record (eMAR) unit.

1. For continuous or titratable drips, chart dose on IView in the IV Drips sections when changed or at least hourly for critical patients, and every 4 hours for non-critical patients. For all drips, enter zero when IV is temporarily stopped or permanently discontinued.
2. Patient-Controlled Analgesia (PCA): Document PCA every 4 hours.
3. Epidurals: Document Epidurals every 4 hours. Enter the 'Running Total'.

F. Intake and Output (I & O): Documentation of fluid volume required as ordered or according to unit standard. Document bowel movements on I & O, enter zero if none.

G. Activity/Ambulation/ADLs: Documentation required at least every shift and with care provided. Patient hygiene documented once every 24 hours.

H. Patient Education: Documented at least once per shift and more frequently, as occurs.

I. Plan of Care (POC): The nursing portion of the plan of care is initiated by the RN on admission and used throughout the hospital stay to document expected outcomes with goal timeframes, and interventions. The POC is reviewed and/or updated by the RN every shift and with any change in condition.

1. At discharge any unmet POC outcomes must be addressed in the comment field on the POC Overview Page. POC is available as a link on the Pre-Discharge Assessment Powerform.
2. The Event Summary may be updated as significant events occur.

J. Shift Summary: Documented at least once per shift.

1. Synopsis of shift activity.
2. Documentation of significant changes and interventions.
3. Document progress toward patient goals, related to POC.

K. Focus Notes should not replace other discrete documentation fields, but rather are used to supplement the record of events which cannot be adequately described by discrete fields alone.

L. All other documentation shall be based on patient specific needs and consistent with hospital or department standards of care. Documentation shall communicate pertinent information needed for clinical decision making and will demonstrate the interventions and level of care being provided.

M. Care which is declined by the patient is documented in the electronic health record (EHR).

Documentation of RN Supervision of Students, Non-Licensed & Licensed Personnel

A. Nursing Students:

1. For medications administered by nursing students, the RN instructor or RN preceptor observing the medication administration will cosign or note observation(s) in the

medical record.

2. For non-medication entries into the medical record, the nursing student's documentation will be reviewed, modified as needed, and noted by the RN preceptor in the medical record.

B. Nursing Assistants and/or Licensed Practical Nurse (LPN):

1. Will document data collected and/or delegated aspects of care in the medical record.
2. The RN will review and modify documentation as needed.

Keywords

electronic inpatient documentation, observation nursing documentation, electronic documentation

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	3/18/2025
Executive Council	Ashley Moeggenberg: Executive Assistant	3/17/2025
Document Owner	Jennifer Standfest: CNO	1/28/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Owner	Vicki Graczyk: Dir Sr HR Business Partner
Area/ Department	Human Resources
Applicability	Munson Healthcare Systemwide
Tags	Policy

Employee Code of Conduct Policy

Purpose

This policy establishes expectations that individuals involved in the delivery of care (both direct and indirect) will promote and maintain a culture of quality and safety for all patients and staff. All individuals have the responsibility to work together as a healthcare team for the effective delivery of patient care, either directly or indirectly.

Scope

This policy applies to all employees, physicians, volunteers, contractors, and others who are involved in the delivery of patient care.

Responsibilities

A. Individuals who are covered by this policy have the responsibility to:
    1. Know and adhere to this policy; and
    2. Immediately bring to management's attention any observation of conduct that doesn't promote patient safety.

B. Management has the responsibility to:
    1. Communicate expectations;
    2. Encourage reporting of violations;
    3. Take appropriate action when issues are brought forward; and

4. Disallow retaliation for reporting violations

Policy

Conduct That Impacts Patient Safety

A. ***Acceptable Professional Behavior*** that is expected of all individuals covered by this policy includes:?

1. Addresses concerns about clinical and non-clinical judgments promptly, directly and privately
2. Addresses dissatisfaction with policies through appropriate channels
3. Seeks solutions to problems, rather than complain about them or blame someone for them
4. Treats everyone with courtesy, dignity and respect, regardless of one's title or status
5. Works together as a team and establishes and maintains healthy interpersonal relationships, affirming contributions of team members
6. Cooperates with patients in their care
7. Supports an environment in which ideas and concerns can be expressed freely
8. Values differences of opinion, and when conflicts occur, deals with them by going to the person(s) directly and constructively; and asking others to do the same when complaints are voiced to team members others than those directly involved
9. Promotes an environment of safety for all patients and staff, including use of all available safety equipment

B. Behaviors That Undermine a Culture of Safety that are disallowed and could potentially impact patient care includes:

1. Threatens or retaliates against individuals who report disruptive or inappropriate behaviors
2. Intimidates or shows disrespect to others, e.g. uses foul language (verbal or written), criticizes in an abusive non-constructive way, undermines confidence, belittles or implies stupidity or incompetence, shows unrestrained anger, bullies, etc.
3. Behaves in a way to weaken critical collaborative communication among health care team members
4. Affects the reputation of the institution and/or the health care provider in a negative way
5. Makes impertinent and inappropriate comments (or illustrations made in a patient medical record or other official document) that bring into question the quality of care at Munson Healthcare (MHC) or that attack a particular physician, caregiver or policy
6. Criticizes other caregivers in front of patients, visitors or other staff
7. Disregards or doesn't use available safety equipment designed to protect patients and staff

8. Accesses, uses or discloses confidential information that is not for a verifiable job-related need.
9. Disrupts operations
10. Affects ability of others to do their jobs
11. Creates a hostile or intimidating work environment
12. Interferes with an individual's ability to work competently
13. Demonstrates any behavior that endangers patients, medical staff or employee safety
14. Other similar disruptive conduct, whether overt or passive

C. This policy does not prevent employees from addressing work-related issues and sharing information about working conditions with co-workers or exercising any other rights under the National Labor Relations Act.

Informal Complaint Process

A. Anyone covered under this policy that believes they have been treated inappropriately is encouraged to resolve the issue through normal communication channels if possible.

B. An example of an informal resolution would be promptly talking to the individual who is causing the issue or talking with your manager.

Formal Complaint Process

A. Anyone covered under this policy that believes they have been subject to behaviors that undermine a culture of safety and are not able to resolve it informally, should report the incident to their manager and file a written report through Munson's on-line patient safety event reporting system.?

B. The Manager of Human Resources (HR) or the employee's Manager can assist the employee in reporting an incident through Munson's on-line reporting system.

C. The filing should detail the factual specifics of the situation or incident including

1. Date,
2. Time,
3. Location,
4. Witnesses, if any, and
5. Circumstances that precipitated the incident

Investigation/Follow-up Process

A. The report will be referred to the appropriate person/s for investigation and resolution as indicated below.?

B. Vice President, Medical Affairs (VPMA) or his/her designee for incidents involving physicians will:

1. Interview physicians identified in complaint
2. Take appropriate action in line with medical staff policies
3. Notify manager of employee filing complaint that investigation has occurred and appropriate action has been taken

C. The Manager or his/her designee who have incidents involving employees, volunteers, and contractors within their area of responsibility will:
    1. Interview employees/others identified in complaint
    2. Take appropriate action in line with hospital policies
    3. Notify individual filing complaint that investigation has occurred and appropriate action has been taken
    4. Communicate incident to others as needed, e.g. Volunteer Services for incidents involving volunteers, Plant Engineering/Northern Michigan Supply Alliance (NMSA) for incidents involving contractors

D. HR will:
    1. Participate in investigation, as appropriate and in coordination with VPMA/Manager
    2. Communicate result of investigation, as appropriate and in coordination with VPMA/Manager

Corrective Action

A. MHC management will be responsible for appropriate follow-up including any corrective action deemed necessary for employees and non-physicians. The VPMA is responsible for appropriate follow-up including any corrective action involving a physician.

B. In determining the appropriate corrective action, the following consideration will be given:
    1. Were expectations clear?
    2. Does the individual accept responsibility?
    3. Is the individual willing to follow the policy?
    4. Does the individual have the necessary skills?
    5. Will the system allow the appropriate action?

C. Any individual, who is found to have engaged in behaviors that undermine a culture of safety, will be subject to the following action, as appropriate for their status with the organization and based on the nature of the incident:
    1. Documented discussion with the individual
    2. Corrective action, up to and including termination of employment as defined in Munson's corrective action policy
    3. Loss/suspension of privileges
    4. Sanctions that in Munson's sole discretion are deemed appropriate to prevent further inappropriate/disruptive behavior or to remedy a situation that may compromise patient safety

5. Loss/suspension of ability to conduct business at MHC
6. Indefinite removal of the individual from all properties of MHC
7. Potential legal action, or
8. Other action needed to fulfill the responsibility for patient safety

References - Related Policies

1. HR: Anti-Harassment Policy
2. HR: Violence in the Workplace Policy
3. Medical Staff: Code of Conduct/Medical Staff Behavior Policy

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/20/2024
VP Human Resources	Shelley Spencer: Chief Human Resources Officer	2/14/2024
Document Owner	Vicki Graczyk: Dir Sr HR Business Partner	2/14/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Last Revised	10/3/2024	Applicability	Munson Healthcare Systemwide
Next Review	10/3/2027	Tags	Policy

Social Media

Purpose

Munson Healthcare (MHC) recognizes that Social Media provides unique opportunities for MHC and its Workforce Members to share information and participate in interactive discussions online. Social Media is also a popular platform to educate, engage, and motivate our audiences to make MHC the first choice for health care services, charitable giving, employment, and a place to practice. We need to ensure that content posted to Social Media platforms about MHC is engaging, accurate, and relevant; and gives our audience the confidence and the tools to take the next step in their journey with MHC while maintaining security, integrity, and confidentiality to protect our audience.

Scope

This applies to all MHC entities and Workforce Members.

Definitions

1. **Protected Health Information (PHI):** defined by the Health Insurance Portability and Accessibility Act (HIPAA). In general, it refers to any individually identifiable information regarding a patient that was collected, received, created, transmitted, or retained by MHC in connection with the person's status as a patient.
2. **Social media:** all means of sharing or posting information or content through virtual communities and networks, including personal blogs and websites, social networking platforms such as Facebook, YouTube, Instagram, TikTok or X (Twitter), and other interactive media technologies.

3. **Workforce Member:** employees, physicians, volunteers, trainees, students, vendors, and contractors whose conduct, in the performance of work for MHC, is under the direct control of MHC, whether or not MHC pays the individual.

Policy

A. The use of Social Media by MHC Workforce Members, whether for personal or business reasons, involves certain risks and requires Workforce Members to exercise certain responsibilities. To assist Workforce Members in making responsible decisions about using Social Media and to protect MHC's programs, patients, and communication systems, MHC has established this policy for the appropriate use of Social Media. This policy covers a Workforce Member's personal and business uses of Social Media.

B. This policy is not to be applied or interpreted in a manner that interferes with any activities protected by state or federal law, including the National Labor Relations Act. In particular, MHC employees should feel free to discuss the terms and conditions of their employment with each other and to raise concerns about working conditions for the mutual aid and protection of their co-workers.

Personal Use of Social Media (Not related to MHC business)

A. Workforce Members may not post any PHI of an MHC patient on Social Media.

B. Workforce Members may not post any MHC internal reports, policies, procedures, or other internal business-related confidential communications, employee information, or patient information. They may not post any MHC trade secrets, financial information, procedures, know-how, or intellectual property.

C. A Workforce Member's personal use of MHC's computer or communications equipment (such as workstations, phones, laptops, or network infrastructure) to access Social Media must be minimal, occasional, limited to non-work times, may not interfere with a Workforce Member's job performance or interfere in any way with the business needs and operations of MHC, and may not impose costs on MHC.

D. A Workforce Member may not use their MHC email address to register for an account on any Social Media website for personal use.

E. If a Workforce Member's Social Media activity violates any of MHC's policies in another forum, it will also violate them online. Workforce Member's use of Social Media must be consistent with all other applicable MHC policies, including, but not limited to the Anti-Harassment Policy, Employee Code of Conduct Policy, Corporate Code of Conduct, Confidentiality and Systems Usage Breach, HIPAA Compliance Policy, Confidentiality of Patient Information, Patient Photography, and Filming, Photography, Videotaping, and Digital Recording policies. For example, Workforce Members should refrain from posts on Social Media that constitute illegal harassment, discrimination, bullying, or threatening violence. For more information, please see the MHC policies listed in this paragraph.

F. Workforce Members should refrain from posting anything on personal Social Media accounts that might reasonably create the impression that they are communicating on behalf of MHC

unless the poster and post are approved by the Corporate Marketing Communications team. For example, a Workforce Member should not identify themselves as a Workforce Member or employee of MHC when expressing their personal views/opinions unrelated to MHC online. When creating Social Media content related to MHC on behalf of MHC employees must have approval from the Corporate Marketing Communications team. Workforce Members must be clear and open that their personal views do not represent those of MHC (for example, by saying, “the views and comments stated are personal and do not necessarily reflect the views of MHC").

G. Workforce Members should be honest and accurate when posting information or news on Social Media and promptly correct any mistakes. A Workforce Member should never post any information or rumors known to be false about MHC or people working on behalf of MHC.

MHC Business Use of Social Media

A. MHC’s Marketing and Corporate Communications Department is designated with the responsibility to post information to MHC-maintained websites and Social Media accounts. No other MHC Workforce Members may post any information on any MHC-maintained website or Social Media accounts without the advanced written authorization of the Chief Marketing & Communications Officer.

B. Workforce Members who post messages and content on MHC-maintained websites or Social Media accounts understand that they are posting on behalf of MHC and must adhere to MHC’s professional standards, values, policies, and applicable laws at all times. Any content posted must be current, accurate, and professional. If a Workforce Member makes an error, they should quickly take responsibility for it and correct it. Workforce Members should understand and abide by the terms of use of any Internet or Social Media platforms used for business-related purposes. They should be mindful of the intellectual property rights of others and may not infringe on the copyright or trademark of another individual using an MHC-maintained website or Social Media account. For example, Workforce Members may not repost copyrighted material without the written authorization of the copyright holder.

C. When posting for authorized, business-related purposes, employees may not post, share, or express a viewpoint on another’s post (such as by “liking” a Facebook post) regarding anything that MHC, its Workforce Members, or patients could find offensive, including racial or ethnic slurs, discriminatory comments, profanity, abusive language or obscenity. Further Workforce Members may not post or express any information that is defamatory, libelous, threatening, harassing, or intimidating to another person or entity. Examples of such conduct might include offensive posts meant to intentionally harm someone’s reputation or posts that could contribute to a hostile work environment based on race, sex, disability, religion, or any other status protected by law or MHC policy.

Implementation and Enforcement

A. When using Social Media, Workforce Members should be aware that any conduct that adversely affects patients, MHC’s legitimate business interests, their job performance, or the working conditions or performance of other Workforce Members or that otherwise constitutes a violation of this policy may result in corrective action up to and including termination of employment.

B. The terms set out in this policy apply in conjunction with and do not replace or amend, any terms or conditions of employment outlined in any collective bargaining agreement between a union and MHC. Wherever terms in this policy differ from the terms expressed in a collective bargaining agreement, the terms of the collective bargaining agreement control.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	10/3/2024
VP Human Resources	Shelley Spencer: Chief Human Resources Officer	10/2/2024
Document Owner	Vicki Graczyk: Dir Sr HR Business Partner	10/1/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Owner	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer - G
Area/ Department	Nursing
Applicability	Munson Healthcare Systemwide
Tags	Policy, Procedure

Management of Suicidal Patients

Purpose

The purpose of this policy is to describe the process for managing patients for suicidal/self-harm risk and develop a plan of care to address the identified level of risk to facilitate a safe discharge.

Definitions

1. **Assessment**: Gathering detailed information needed to identify a treatment plan. May be performed by a behavioral health specialist, such as a social worker (Central Access Center [CAC]/Community Mental Health [CMH]), qualified behavioral health specialist, licensed provider (LP), psychiatrist, etc.
2. **Attending provider**: The provider who is supervising care, treatment, or services. In outpatient settings, this is the provider who wrote the order for the care, treatment, or services the organization is providing.
3. **Behavioral Health Conditions (BHC):** Any Diagnostic Statistical Manual diagnosis or condition/ symptomology, including those related to substance abuse. Symptoms may include but are not limited to depression, anxiety, suicidal thoughts, hallucinations, or substance abuse.
4. **Behavioral Health Specialist:** A clinical staff member trained and competent in the assessment and treatment of behavioral health conditions including mental illness, substance use disorder and suicide risk. Examples of staff may include licensed mental health professionals, the CAC team or CMH staff.

5. **Ligature Resistant Environment:** A highly specialized environment without points where a cord, rope, bed sheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life.
6. **Ligature Reduced Environment:** A patient room or environment where possibilities of personal harm are limited. All physical risks not required for the treatment of the patient that can be removed, are removed. Appropriate level of surveillance is implemented if self-harm risks remain in the environment.
7. **One on One Observation:** Constant visual observation provided by a Patient Observer for one patient, including while patient sleeps, toilets, and bathes. **Under no circumstances will the patient be unobserved**. However, if there are concerns for staff safety, the individual is not required to remain in the room, but must still continually observe and be able to immediately intervene on unsafe behaviors.
8. **Patient Observer:** A staff member competent and trained to directly observe one or more patients and available to immediately intervene on unsafe behaviors or to alert nursing personnel of patient needs. The individual can provide hands on patient care if within their scope of practice or license. If hands on patient care is outside of their scope of practice, the individual will provide no patient care. All Patient Observers provide safety primarily through direct line of sight and summoning help when needed.
9. **Training and Competency:** Training and competency assessment of staff who care for patients at risk for suicide shall occur upon hire and periodically thereafter
10. **Patient Belongings:** Any items the patient has brought to the care setting. Examples: Clothes, electronic devices (cell phones, laptops, etc.), jewelry, medication, etc. Patient belongings will be secured, as appropriate, per organizational policy.
11. **Safety Monitoring:** A qualified individual who performs rounding based observations at regular intervals identified as part of the patient's plan of care (eg., every 15-minute checks).
12. **Screening**: A brief process to evaluate the possible presence of a particular problem.
13. **Secure Area:** An area specifically designated to be ligature resistant for patients at risk of suicide.
14. **Serious Risk**: Equivalent to high risk.
15. **Suicide:** Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
16. **Suicide attempt:** A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
17. **Suicidal ideation:** Thinking about, considering, or planning suicide.
18. **Suicide Risk:** A combination of individual, relationship, community, and societal factors that provide clues about a person's probability of attempting or completing a suicide attempt.
19. **Validated Tool:** Validated tool appropriate for specific patient populations (e.g. care settings, ages, etc.) used to screen for specific conditions, outcomes, or risks. The tools used may vary by location and/or electronic medical record used (ex. not all inclusive: the Columbia-Suicide Severity Rating Scale (C-SSRS), Patient Health Questionnaire Depression Module(PHQ-9), etc.).

Policy

The approach to the care of the suicidal patient is multidisciplinary. All patients 12 years and older that present to the Emergency Department (ED), Ambulatory Clinics or hospital, who are being treated or evaluated for a BHC as their primary reason for care and all patients who express suicidal ideation during the course of care regardless of their registration status, shall be screened for suicide risk using an age-appropriate, validated tool or transferred to an appropriate level of care. Patients under 12 years of age will be screened using an age appropriate validated tool.

Acute Care Setting

A. Timing of initial screening may vary based on patient presentation and clinical judgment. In the event the patient is unable to participate in the screening or assessment, i.e. the patient is unconscious, intoxicated, or mentally unable to respond, or medical instability will not permit, the screening or assessment will be postponed until the patient can participate or otherwise appropriate.

B. Screening for patients being treated or evaluated for a BHC as their primary reason for care will be conducted by the intake staff at the location (eg. medical assistant [MA], licensed practical nurse [LPN], registered nurse [RN], etc.) with the risk documented in the patient record.

C. If the staff determines the patient is potentially at higher risk than the screening indicated, higher risk suicide precautions may be instituted while awaiting an assessment.

D. For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work, CAC, CMH or other contracted mental health screening services for outpatient resources if requested by the patient.

E. Patients with a previous known suicide attempt or suicidal ideation should receive information about the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255) or 988.

F. For patients who screen at high or moderate risk for suicide, the provider will review the suicide risk screening and will recommend additional interventions, treatments, or consultations as needed to determine the appropriate location of service and the appropriate level of monitoring/observation.

G. After an initial assessment by a behavioral health specialist, reassessments should occur periodically or if behavioral health symptoms change. All changes will be documented.

H. A provider or other qualified personnel trained in advanced assessment of BHC, including suicide, may discontinue or downgrade precautions with documentation of clinical rationale.

I. If necessary, limits may be placed on patient telephone privileges to prevent the patient from sustaining substantial and serious physical or mental harm.

J. The presence of a visitor does NOT preclude the need for one on one observation. A family member or visitor is not allowed to act as a patient observer, including those employed with Munson Healthcare (MHC).

K. Visitors will not be allowed to bring personal items into the patient's room.

L. When a patient transfers to a psychiatric facility, the patient must remain in a hospital gown

and hospital undergarments. No scrub bottoms or personal clothing items will be allowed. Clothing and all belongings are bagged and labeled with the patient name, including cell phones. Belongings MUST be carried by staff, security, or Emergency Medical Services (EMS) personnel. Belongings are NOT to be returned to the patient.

Procedures

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
Assessment / Consultations	For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work or CAC for outpatient resources if requested by the patient.	• RN to notify attending provider. • Provider to consult behavioral health specialist for further assessment when patient is appropriate for evaluation. • A behavioral health specialist performs assessment. • Patient will be re screened periodically.	• RN to notify attending provider. • Provider to consult behavioral health specialist for further assessment when patient is appropriate for evaluation. • A behavioral health specialist performs assessment. • Patient will be re screened periodically.
Patient Placement / Physical Environment		• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See Suicide Risk Room Checklist or Powerchart. • Patient	• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See Suicide Risk Room Checklist or Powerchart. • Patient

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
		belongings shall be removed from patient room* **Individualized planning may occur to allow specific low-risk items to be given back to the patient, as needed.* • NOTE: When patients are receiving oxygen, continuous positive airway pressure (CPAP), intravenous (IV) fluids, etc., the patient may be a candidate for one-on-one observation, depending on assessment.	belongings (including all clothing) shall be removed from patient room.
Observation		• Perform frequent Safety Checks • If deemed necessary by staff or provider, consider one on one observation or in line of sight. Consider supervised bathroom visits. • **One on one observation required for patients in ED waiting room**	• One on one observation required. • Direct supervision for bathroom visits and for transport to other units. • **One on one observation required for patients in ED waiting room** • Hand-off report using SBAR format. • MHC Patient

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
			Observer Log will be completed by the Patient Observer at 15-minute intervals.
Observation in Ligature Resistant Rooms. Applies to Munson Medical Center (MMC) only. (i.e., ED rooms with garage doors closed and medical equipment including bed/ stretcher frames removed from the room, with only a mattress on the floor for safety.			• Monitoring at least every 15 minutes. A designated individual performs continual monitoring / rounding and documents observations. · Based on RN or provider judgment, a one-on-one • Observer may be used in place of continual rounding.
Discharge Planning / Education		• Behavioral Health Specialist provide resources to assist with care plan, coordinate referrals and develop a safety plan and provide at discharge. • Staff to provide suicide resources (e.g., Patient education "Recognizing Suicide Warning Signs in Yourself" and National	• Behavioral Health Specialist provide resources to assist with care plan, coordinate referrals and develop a safety plan and provide at discharge. • Staff to provide suicide resources (e.g., Patient education "Recognizing Suicide Warning Signs in Yourself" and National

Screening	Low Risk (Yellow*)	Moderate Risk (Orange*)	High Risk (Red*)
		Suicide Prevention Hotline) at 1-800-273-TALK (1-800-273-8255).	Suicide Prevention Hot-line at 1-800-273-TALK (1-800-273-8255).
**Associated colors are for Meditech Hospitals only. All Cerner and Community Works hospitals should use Low, Moderate and High Risk.*			

Ambulatory Clinics

The following outlines the specific procedures to prevent patient harm for patients who screen moderate or high risk for suicide in the ambulatory setting.

Procedure

Patients Presenting at Ambulatory Clinics for Primary BHCs

Screening	Low Risk	Moderate or High Risk
Assessment / Consultations	For patients who screen low risk, no further assessment is required, however staff may choose to re-screen at any time or may consult 211, Social Work or CAC for outpatient resources if requested by the patient.	• Staff to notify attending provider. • Attending provider or behavioral health resource to assess patient to determine next steps.
Patient Placement / Physical Environment		• Consider moving patient to room closer to staff, and/or leaving door open. • Staff assess area and remove objects, when possible, which could be used for self-harm. See the Suicide Risk Room Checklist Form #11832. • If possible, remove patient belongings from room. **Individualized planning may occur to allow specific low risk items to remain with the patient, as needed. Mitigation for high-risk patients include 1:1 observation of physical environment and patient

Screening	Low Risk	Moderate or High Risk
		belongings.
Observation		• **For Moderate Risk:** Perform frequent safety checks. Consider supervised bathroom visits. • **For High Risk:** One on One observation with patient in line of sight for immediate intention. Direct supervision for bathroom visits and for transport to appropriate level of care. • If further evaluation and management in ED or crisis facility is the recommended plan of care by the Attending provider, staff are to contact Law Enforcement (not EMS unless there is an immediate medical emergency) for transport of patient to the ED for further assessment. *Note: Law Enforcement is the only entity that can require a person to get an evaluation- this is on the Michigan Mental Health Code.
Discharge Planning / Education		• Attending provider or behavioral health resource to assist with care plan, coordinate referrals and develop a safety plan (Patient Safety Plan Form #11567). • Staff to provide suicide resources (eg., 211, Krames patient education "Recognizing Suicide Warning Signs in Yourself" and National Suicide Prevention hot-line. • Staff to provide safety plan (Patient Safety Plan Form

Screening	Low Risk	Moderate or High Risk
		#11567) at discharge. • **Above discharge education/ planning forms for urgent or emergent care transfers may not apply.

Approval Signatures

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System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	11/18/2025
CNO Council	Jennifer Standfest: CNO	11/18/2025
Document Owner	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer - G	11/11/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Transport and Hand-Off of Patients: SBAR and Ticket to Ride

Purpose

To provide a guide for establishing a standardized process for safely transporting adult, pediatric, and neonatal patients, identifying the level of clinical supervision required during patient transport, communicating individual patient care requirements between the sending and receiving clinical departments, and providing continuity of patient care during transport.

Definitions

1. **Hemodynamically Stable:** Patient with the following:
    a. Hear rate and blood pressure within prescribed parameters and have been for some time (at least 2 hours).
2. **Hemodynamically Unstable:** Patient with any of the following:
    a. Heart rate or blood pressure is outside prescribed parameters
    b. Chest pain
    c. Ongoing life-threatening arrhythmias
    d. Shock
3. **Hand-off:** a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another to ensure the continuity and safety of the patient's care.
4. **Responsible Nurse:** Registered Nurse (RN) assigned to the patient.
5. **Situation, Background, Assessment, and Recommendation (SBAR):** is a standardized

approach used to facilitate communication and promote accurate and thorough identification of issues and concerns about the care and safety of the patient. An opportunity to ask questions should be offered to the individual receiving the hand-off report or telephone call before ending the communication. A standardized tool is available to use, as needed.

6. **Ticket to Ride:** a standardized tool to communicate relevant medical history, important assessment findings, and special safety concerns, and provides an opportunity to ask questions about a patient being temporarily transported off-unit.

Guidelines

Transport of Patients

A. Clinical judgment and ongoing assessment are required to determine patient needs during the transport.

B. The bedside nurse (in collaboration with the provider) determines if/when the patient is safe to transport and with what level of supervision/care.

C. Provider order will determine whether the patient requires electrocardiogram (ECG) monitoring during transport.

D. Patients will be accompanied by staff members trained in the appropriate care and monitoring required at the time of transport.

E. Any backup or emergency equipment required by patient-specific conditions should always travel with the patient (ventricular assist device (VAD), tracheostomy supplies, etc.)

F. Patients with infection prevention precautions should be transported according to the Standard and Transmission-Based Isolation Precautions policy.

Transport of Patients from/within the Emergency Department (ED)

RN	Paramedic	Emergency Department Technician (EDT)/Nurses Aide (NA) and/or Central Transport

• Patients with a tracheostomy
• All intubated patients
• All patients on the following intravenous (IV) continuous infusions
  ◦ Narcan
  ◦ Insulin
  ◦ Titratable
	• Patients requiring greater than 5 liters (L) of oxygen (O2), including BIPAP
	• Patients who have had a seizure (suspected or actual) in the
		• Patient on potassium drip for replacement
		• Patient on a magnesium drip for replacement
		• Patient on a heparin drip
		• Patient that has admission orders

RN	Paramedic	Emergency Department Technician (EDT)/Nurses Aide (NA) and/or Central Transport
medications (ex: Nitro, Cardene, dopamine, Levophed, etc.) ◦ Antiarrhythmics (ex: Amiodarone, Cardizem, lidocaine, etc.) ◦ Sedation medications (Propofol, Fentanyl, Versed, Dexmedetomidine, etc.) • All patients currently receiving a blood transfusion. (If transfusion finished, must have end set of vitals) • All patients currently undergoing an Acute Stroke Call Down (if neurologist deems there is no indication for tPA or intervention, Paramedic / ED NA ok to transfer from that point on) • All patients that have developed new or worsening neurological symptoms while in the ED • All patients in restraints • Any patients that the nurse prefers to transport	past 72 hours • Patients being transported to the floor with an admission diagnosis of alcohol withdrawal • Patients with major burns • Patients with jaw wired shut • Patients who have a left ventricular assist device (LVAD). • Patients with a chest tube • Patients with a Troponin greater than 50 **All patients from the lower acuity list as well	for neuro checks every 4 hours, every shift, or every day (RN to transport neuro checks every 15 minutes, 1 hour, or 2 hours) • Patients that have admission orders for seizure precautions but have not had a seizure in 72 hours

Transport of Patients within Munson Medical Center (MMC)

	RN	NA/NT and/or Central Transport
Clinical Criteria	• Patients acutely compromised by cardiac, respiratory, or neurological complications. • Patients with a high risk of being acutely compromised by cardiac, respiratory, or neurological complications. • Recent, acute mental status changes • Critical Care level of care patients • Intermediate level of care for pediatric patients • Hemodynamically unstable patients • Patients that are in the acute phase of an overdose of medications that could result in potential for cardiac toxicity (e.g., tricyclic, digitalis, antidepressants/ arrhythmic). ◦ *Contact the pharmacy for questions regarding the duration of the acute phase*	• Hemodynamically stable patients at low risk of becoming unstable. • Pediatric patients with general medical orders with developmentally appropriate consideration which may include an additional support person
Surveillance Requirements	• Patients actively receiving blood products. • Patients in restraints • Patients in active alcohol/ opioid withdrawal requiring medication in the last 1 hour or patients with a risk of escalating behavior during time off unit	• Patients that do not require continuous surveillance/ monitoring by a nurse. • Suicide precaution patients **must be accompanied by a patient observer** • Patients at high risk for elopement **must be accompanied by a patient observer** (consider a security

	RN	NA/NT and/or Central Transport
		escort) • Patients with potential for violence **(consider security escort)**
Hemodynamic Monitoring	• Patients on continuous pulse oximetry • Patient with ECG monitoring who is hemodynamically unstable or is at risk of having life-threatening arrhythmia. • Any invasive hemodynamic monitoring	• Patients on ECG monitoring that are hemodynamically stable (follow the process outlined in the Cardiac Telemetry Monitoring policy)
Airway, Ventilation, or O2 Support Needed	• Patients requiring supplemental oxygen therapy greater than or equal to 5L to maintain goal O2 sats. • Patients requiring BiPAP except for the indication of chronic sleep apnea. • Patients requiring airway or ventilator assistance /management.	• Patients receiving O2 support less than 5L per nasal cannula. ◦ **For home O2 patients**: Stable on home O2 of up to 2x normal rate if greater than 40%.
Trach and/or Airway Stoma	• New or surgically revised airway stoma within 24 hours • Patient having secretions that may require airway suctioning frequently • Patient on trach mask greater than 35%	• Minimal secretions that can be managed by the patient (or suction every shift) • Trach mask 34% or lower
Continuous IV Meds	Patients on continuous medications that may require titration or adjustment during the diagnostic test or procedure or with special handling precautions: • Cytotoxic (chemotherapy) or biotherapy medications actively infusing. Patients on continuous medications	Patients on continuous IV fluids or medications that are not life-sustaining, suppressing life-threatening arrhythmias or that will not require titration during the time off the unit.

	RN	NA/NT and/or Central Transport
	that are life-sustaining and/or suppressing life-threatening arrhythmias. • Milrinone • Dopamine • Dobutamine • Amiodarone Continuous medication that may impact hemodynamic stability that has been initiated or required titration within the last 24 hours including but not limited to: • Diltiazem, nitroglycerin, nicardipine, amiodarone, esmolol	
VADs	Any patient with an implanted VAD	

Hand-off Communication

A. Hand-off communications occur in the following situations:
    1. Interdepartmental transfers, shift change, or any other situation where the care of the patient is transferred to a new care provider.
    2. When patients leave their assigned unit or the ED and are transported to various areas of MMC for procedures, surgery, tests, or therapies (Ticket to Ride). The Ticket to Ride does not apply if the nurse remains in attendance with the patient.
    3. When patients return to their assigned unit or ED (Ticket to Ride).

SBAR Communication

A. Hand-off (SBAR) may be used when care is transferred to a new nurse/provider and/or when a call is placed to a provider about a condition change or need for orders. SBAR Checklist Form # 8601 is an example of format and details to consider including.
B. When a provider must be paged for discussion, please include relevant data to address specific concerns.
    1. Consider whether all relevant data has been collected. This may include:
        a. VItal signs (respiratory rate, heart rate/pulse, O2 saturation, temperature)
        b. Signs/symptoms (pain, behavior, patient's perception)
        c. Other measurements (urine output, cardiac rhythm, lab values)
        d. Relevant history, current treatment, and plan of care

2. When possible, include relevant information about the situation and urgency within a Telmediq text page. Including "urgent" or "not urgent" enables prioritization. For patients at risk, an MRT may be appropriate.
    a. Example: Instead of paging, *Critical HGB 7.5. Call Sally at 231-213-0000*, page this: *Critical HGB 7.5, down from 11.2 yesterday AM. HR 122, BP 92/65, c/o SOB. Call Sally at 231-213-0000,* or this: *Critical HGB 7.5, improved from 7.0. HR 75, BP 120/80, asymptomatic. Call Sally at 231-213-0000.* The details provide important context.
3. If the issue is resolved or a return call is no longer needed, send a page "disregard earlier page" with a short note.

C. If the appropriate provider is unable to be reached, or the provider's plan does not reflect the situation and/or best interest of the patient's safety, the nurse should follow the Chain of Command in Obtaining Necessary Medical Assistance or Resolving Questions of Care and Questions of Scope of Care (Privileges) policy.

Ticket to Ride Communication

A. Hand-off (Ticket to Ride) communication process when patients leave their assigned unit or the ED and are transported to various areas of MMC for procedures, surgery, tests, or therapies:
    1. A transport ticket (Ticket to Ride Form# 8890) is utilized to identify patient safety concerns and acknowledge that the patient is ready for transport.
    2. The ticket accompanies the patient during the off-unit travel.
    3. The transport personnel (transporter, nursing assistant, tech, etc.) shall not transport the patient until the nurse completes the ticket.
    4. The communication ticket does not replace an appropriate hand-off reporting among healthcare providers.

Ticket to Ride Process

A. The responsible nurse will verify if the patient is appropriate for transport without a clinical staff accompanying using the above guidelines.

B. The transport personnel will receive notification from their department, of the transport needs.

C. The transport personnel will go to the appropriate unit and obtain the patient's chart and ticket.

D. The transport personnel will verify the correct patient, using two patient identifiers, by asking the patient his or her name and birth date.

E. The responsible nurse will complete all sections of the ticket.

F. The responsible nurse will determine if the patient is ready for transport.
    1. If the responsible nurse cannot fill out the transport ticket, the transport personnel needs to OK the transfer with the covering nurse or charge nurse, who will fill out the transport ticket as described above.

G. The responsible nurse will verbally communicate any safety concerns written on the ticket with

the transport personnel.

H. The transport personnel will verbally communicate patient safety concerns and give the ticket to the holding area nurse or test/procedure area healthcare professional.

I. At the test/procedure area, the healthcare professional can then call the patient's nurse using the information on the transport ticket if they have any questions or concerns regarding the patient.

J. The healthcare professional will verbally communicate transporting issues with the transport personnel. A call to the patient's nurse will be made if any patient care/condition concerns arise during the test/procedure.

K. If the patient is to have more than one test/procedure, each healthcare professional must write their name, pager/phone number, test/procedure performed, and the end time in the appropriate area on the ticket. If a patient concern arises, the healthcare professional must contact the patient's nurse.

L. The transport personnel then returns the patient to his or her home unit and shares the transport ticket with the nurse. If the nurse has any questions or concerns, a page/phone call can be made to the healthcare provider who performed the test/procedure.

M. The completed transport ticket will be disposed of appropriately, per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, to be shredded.

Reference

1. Provision of Care Standard PC.02.02.01, EP 2: The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

Document ID: 070.G030

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	5/7/2025
CNO	Tamara Putney: VP and CNO Patient Care Services	5/5/2025
Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	4/22/2025
Document Owner	Amber Bowers: Mgr Nursing Services	4/22/2025

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Next Review	4/11/2027		

Use of Restraints and Seclusion: Ordering, Monitoring and Documentation Requirements

Purpose

To provide a policy for ordering, monitoring, and documenting the use of restraints and seclusion.

Scope

This policy governs the use of restraint/seclusion in all areas of applicable organizations within Munson Healthcare (MHC) except the inpatient behavioral health unit. For policies governing that area, please see the Use of Physical Restraint- Mental Health and Seclusion Use- Behavioral Health Unit policies

Definitions

1. **Alternative Measures:** methods, other than restraint, utilized to provide safe and effective patient care. Examples include family involvement or education, verbal intervention/education for the patient, placement of patient for close observation, diversional activities, de-escalation techniques, limit setting, scheduled toileting, patient safety sitters, bed alarms.
2. **Provider:** refers to physicians, including locum tenens and residents, physician assistants (PA), and nurse practitioners (NP) practicing at any MHC facility with the authority to order restraints.
3. **Restraint:** any manual method, physical or mechanical device, material, equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint is used only as a last resort and when the patient's behavior presents as an immediate danger to the safety of the patient, other patients, or staff. The least restrictive measure will be initiated to maintain the safety of the patient and staff.

a. **Medication (Chemical) Restraint:** a drug or medication when it is used as a restriction to manage the patient's behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient's condition. The use of a medication to prevent imminent harm to self or others or restrict the patient's freedom of movement.

b. **Physical Restraint:** any manual method, 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.

c. **Non-Violent:** used for **non-self-destructive or non-violent** behavior interfering with medical care, devices, tube/drains. The least restrictive device will be initiated to maintain the safety of the patient and staff.

d. **Physical Hold:** holding a patient in a manner that restricts the patient's movement against the patient's will.

e. **Seclusion:** the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving and can only be used for violent or self-destructive behavior, such as locking the door.

f. **Violent Restraint:** used only in situations where the patient's behavior becomes **self-destructive**, violent, aggressive, or assaultive and presents an immediate danger to the safety of the patient, other patients, or staff. The least restrictive device will be initiated to maintain the safety of the patient and staff.

Exceptions

A. The following situations are exceptions to this policy and are not considered restraints:

1. Orthopedically prescribed devices such as surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.
2. Use of an intravenous (IV) arm board to stabilize an IV line is generally not considered a restraint. However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.
3. Mechanical supports (braces) used to achieve proper body position, balance, or alignment to allow greater freedom of mobility. Example: Geri chair.
4. Positioning or securing devices used to maintain position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures. Example: magnetic resonance imaging (MRI) positioning device.
5. Medically necessary restraint used during recovery from anesthesia that occurs when the patient is in a critical care area or post anesthesia unit.
6. Methods that involve the physical holding of a patient for the purpose of conducting physical examinations, procedures, or tests when a patient or legal guardian has the right to refuse treatment. Example: papoose board.

7. Any device that can easily be intentionally removed by a patient.
8. Age or developmentally appropriate protective safety interventions such as cribs with raised side rails, crib covers, stroller safety belts, swing safety belts, or highchair lap belts that would normally be used outside the healthcare setting.
9. Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.
10. A physical escort would include a “light” grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint, and all the requirements would apply. May include self-releasing belt.
11. Side rails when a patient is on a gurney, recovering from anesthesia, sedated experiencing involuntary movement, or on certain specialty beds that require side rails to be up to prevent a patient from falling out of bed.
12. Side rails when a patient is immobile and side rails have no impact on the patient's freedom of movement.
13. Padded side rails used when a patient is placed on Seizure Precautions.
14. Seat belts when transporting a patient in a wheelchair.
15. The use of handcuffs or other restrictive devices applied by law enforcement officials who are not employees of the hospital for custody, detention, and public safety reasons. Employees are still responsible for the assessment of any limb/body-part restrained using law enforcement restraints.
16. Medications to support an individual to regain control of their behavior [including as needed (PRN) medications] when used as a part of the patient's treatment plan or that are a standard treatment for the patient's condition. An additional component of “standard treatment” for a medication is the expectation that the standard use of a medication to treat the patient’s condition enables the patient to more effectively or appropriately function in the world around them, than would be possible without the use of the medication.
17. Mitts when used alone and not attached to a bed rail or otherwise tied down. Mitts will be considered a restraint if applied so tightly that the hands or fingers are immobilized, are so bulky that the patient's ability to use hands is significantly reduced or are used in conjunction with a wrist restraint.
18. Timeout is not considered seclusion. Timeout is an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

Policy

General Information

A. Type of restraint/seclusion will be the least restrictive intervention to protect the patient, a

staff member, or others from harm.

B. Standard Interventions for patients in restraints based on electronic charting are:
    1. Signs of injury associated with restraint/seclusion.
    2. Nutrition and hydration status.
    3. Circulation and range of motion (ROM).
    4. Vital signs (as appropriate).
    5. Hygiene and elimination.
    6. Physical and psychologic status and comfort.
    7. Readiness for discontinuation of restraint or seclusion.

C. There must be documentation in the patient's medical record of the following:
    1. A description of the patient's behavior and the interventions used.
    2. Alternatives or other less restrictive interventions attempted.
    3. The patient's condition or symptom(s) that warranted the use of the restraint/ seclusion; and
    4. The patient's response to the intervention(s), including the rationale for continued use of the intervention.

D. In addition, for the duration of the use of the restraint:
    1. Patient care plan elements must be enacted. Specific care tasks can be delegated to a non-licensed person, if they have been trained to complete the task (e.g., bathing, ROM, oral care, restraint removal/reapplication while providing care).
    2. Documentation must occur in the electronic health record. The exact type, location and number of restraint points applied must match the exact type of restraint ordered by the Provider. If restraint use is modified (including the number of points or a different type of restraint) then a new order must be obtained within minutes.

E.

	Non-Violent	Violent
Reason for Restraint	Used for **non-self-destructive or non-violent** behavior interfering with medical care, devices, tube/ drains.	Used only in situations where the patient's behavior becomes **self-destructive**, violent, aggressive, or assaultive and presents an immediate danger to the safety of the patient, other patients, or staff.
Order Entry	Electronic order (during downtime use the Restraint Orders for Non-Violent Patients Form #2193 or Restraint Orders for Violent Patients Form #8406) Prior to application; however, in an emergent situation, a Registered Nurse (RN) may initiate intervention during or immediately after (within minutes) of application of restraints, the provider must be notified, and orders obtained.	
Order Duration	Daily	Time-limited renewal order must

	Non-Violent	Violent
		occur in accordance with the following time frames for a maximum of 24 hours: • Every 4 hours for adults 18 years of age or older • Every 2 hours for children and adolescents 9-17 years of age; or • Every 1 hour for children under 9 years of age
Face to Face Assessment Required	No	Within 1 hour of initial restraint application. After 24 hours, ***before*** entering a new order, a provider must see, assess, and document a face-to-face assessment: • The patient's immediate situation. • The patient's reaction to the intervention. • The patient's medical and behavioral condition; and • The need to continue or terminate the restraint or seclusion.
Monitoring Documentation Requirements	RN will assess every 2 hours, documenting in the electronic record. (Downtime: Non-Violent Restraint Initiative/Care Plan Form #2194)	RN will assess every 15 minutes, documenting in the electronic record. (Downtime: Violent Restraint / Seclusion Initiation Care Plan Form #2219) ** When using restraint and seclusion simultaneously, the patient must be constantly observed, uninterrupted, using 1:1 Patient Observer or constant audio and video monitoring.

Discontinuing a Restraint/Seclusion

A. Restraint/seclusion should be discontinued at the earliest possible time, regardless of the length of time identified in the order. This discontinuation is based on the assessment of an RN or Provider caring for the patient.

B. If restraint/seclusion is discontinued and the patient later demonstrates behavior requiring restraint/seclusion, a new order from a Provider must be obtained.

C. When the patient no longer meets requirements for restraint/seclusion as defined in the care plan, the restraint should be removed by the RN, and the discontinuation documentation should be completed.

Restraint Death Reporting Guidelines

A. All deaths in restraints must be reported via the event reporting system:

    1. Each death that occurs while a patient is in restraints or seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    3. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.

B. Appropriate staff will report the following deaths to Centers for Medicare & Medicaid Services (CMS) per recommended route no later than the close of business on the next business day following knowledge of the patient's death:

    1. Each death that occurs while a patient is in 4-limb soft, rigid, chair or 2-limb rigid restraints or seclusion.
    2. Each death that occurs within 24 hours after the patient has been removed from 4-limb soft, rigid, chair or 2-limb rigid restraints or seclusion.
    3. Each death known to the hospital that occurs within 1 week after 4-limb soft, rigid, chair or 2-limb rigid restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.
    4. Staff reporting the death to CMS must document in the patient's medical record the date and time the death was reported to CMS.

C. For patients in 2-limb soft wrist restraint only, in addition to the report via the event reporting system, the staff must document in the patient's medical record the date and time the death was recorded in the event reporting system.

Education and Training

A. Training should be done before performing any actions, as part of orientation and subsequently on periodic basis.

B. Staff education, training, and demonstrated knowledge may include clinical appropriateness,

preventative/alternative strategies to restraint use, safe application, monitoring, ongoing assessment/re-assessment of the patient's condition, care of the patient in restraints, and documentation requirements.

C. Providers authorized to order restraint or seclusion have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

D. Upon restraint/seclusion application, family should be notified, and education provided.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	4/11/2024
CNO Council	Jennifer Standfest: CNO	4/11/2024
Nursing Services	Kristine Johnson: Chief Operations Officer/Chief Nursing Officer	4/10/2024
Nursing Services	Cristen Brandsma: Chief Operations Officer/Chief Nursing Officer	4/5/2024
Nursing Services	Jeremy Cannon: VP Nursing Services	4/5/2024
Nursing Services	Dawn Halleck: VP and CNO Patient Care Services	4/4/2024
Nursing Services	Michael Hodnett: Chief Operations Officer/Chief Nursing Officer	4/4/2024
Nursing Services	Tamara Putney: VP and CNO Patient Care Services	4/4/2024
Document Owner	Jennifer Standfest: CNO	4/4/2024

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Next Review	2/3/2027	Tags	Policy

Medical Response Team Protocol for Adult Patients

Purpose

To provide a process to respond to a change or deterioration in an adult (greater than 17 years) patient's condition by calling the Medical Response Team (MRT) for assistance.

Policy

Calling the MRT

A. Hospital personnel should consider calling the MRT when a patient, including patients with a do-not-resuscitate (DNR) code status order, has a decline or change in condition which includes (but is not limited to):
    - Acute change in vital signs
    - Change in mental status
    - Heart attack symptoms
    - If the patient has symptoms of stroke, a "Stroke MRT" should be called.
    - Any hospital personnel with a concern about a patient.

B. MMC MRT will respond to D6 Inpatient Behavioral Health-a service of Munson Healthcare Cadillac

C. The Pediatric Response Team (PRT) should be called for patients under the age of 18. The team consists of similar personnel with pediatric expertise, equipment, and protocols.

D. A Code Blue rather than an MRT should be activated when:
    - There are concerns about the condition of a visitor, employee or outpatient who is does not have patient identification band.

- When the location of the event is in a public or outpatient location
- When a patient is in imminent danger of a cardiac or respiratory arrest and they have a FULL code order.

Activation of MRT

A. Any hospital personnel can activate the MRT by completing the following steps:
    1. Dial "55555".
    2. Request the operator page the MRT.
    3. Provide the operator with the exact location of the patient.

B. Hospital personnel may also request the operator page the patient's attending provider at the same time as the MRT.

C. Hospital personnel should immediately notify the patient's primary registered nurse (RN) and/or charge RN after calling the MRT.

D. The switchboard operator will place a group page to the members of the MRT and the patient's attending provider if requested.

E. If the paging system is down, the operator will use the overhead paging system to notify the MRT.

The Team

A. The MRT will consist of the following:
    - Two Advanced Cardiovascular Life Support (ACLS) certified RNs, typically one from the Intensive Care Unit (ICU) and one from A3, trained in responding to medical emergencies.
    - Respiratory therapist (RT)
    - Physician or advanced practice provider (APP)
    - Patient's primary RN
    - Vascular Access Specialty Team (VAST) RN
    - Phlebotomist

B. Other staff may respond if requested by the MRT including the nursing administrative supervisor, pharmacist, attending provider, and/or other healthcare team members.

Scope of Action for MRT

A. Receive report from the primary RN

B. Complete a focused assessment of the patient and initiate treatment/interventions as needed.

C. If the patient needs to be transferred to a higher level of care, and no bed is readily available, the MRT will determine who needs to stay with the patient until the transfer can be made.

D. Complete MRT Call Record. Place original in patient's chart and send duplicate to Clinical

Quality.

E. At the conclusion of MRT response, ensure primary reason for call was addressed and orders are documented as needed.

F. The Post Medical Response Team Debrief should be completed and sent to Clinical Quality.

Related Forms

A. Form #6781 Medical Response Team Call Record

B. Form #6910 Stroke Protocol Resource Packet

C. Form #10121 Inpatient STEMI Evaluation Process

D. Form #8979 Inpatient STEMI Nurse Champion Flowsheet

E. Form #12058 Sepsis and Septic Shock Checklist

F. Form #12666 Post Medical Response Team Debrief

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/3/2026
Interim CNO Patient Care Services	Shari Wilson: President Post-Acute Care	2/2/2026
Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	2/2/2026
Document Owner	Amber Bowers: Mgr Nursing Services	2/2/2026

Applicability

Munson Medical Center

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No standards are associated with this document

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Pediatric Response Team Protocol for Pediatric Patients

Purpose

The goal of the Pediatric Response Team (PRT) is to provide quick assessment and stabilization of an acutely ill pediatric patient or visitor in an effort to reduce the incidence of cardio/respiratory arrest and improve outcomes. The team will respond to a summons from any Munson Medical Center (MMC) staff who has identified an at risk child under the age of 18.

Protocol

PRT Members

A. The following will be activated via a PRT page:
    1. Pediatric Patient Care Coordinator (PCC)/Charge Nurse
    2. Pediatric Hospitalist on Call
    3. Neonatologist and Neonatal Nurse Practitioner on Call; Will respond to a page for a child 6 months of age and younger
    4. Emergency Department (ED) Charge Nurse
    5. Newborn Intensive Care Unit (NICU) Charge Nurse
    6. A3 or ICU Nurse
    7. Neonatal Respiratory Therapist (RT) and C3 RT
    8. Nursing Administrative House Supervisor
    9. Pharmacy, Lab, and Intravenous (IV) Therapy

Criteria to Summon PRT

A. Criteria for calling a PRT may include any change in the patient's baseline condition as observed by staff, for example:
    1. Change in vital signs, Pediatric Early Warning Score (PEWS), or blood oxygenation levels
    2. Change in mental status, including prolonged seizure
    3. Any pediatric patient requiring non-invasive positive pressure ventilation or non-emergent intubation
    4. Difficulty controlling pain or agitation
    5. Request from a family member

Activation of PRT

A. All staff, inpatient or outpatient, will activate the PRT by dialing "55555" for the operator. The staff member will state the following:
    1. Request to have PRT paged
    2. The location and age of the patient

B. If the PRT occurs outside of the Pediatrics unit, the Pediatric PCC/Charge Registered Nurse (RN) will respond to the area with the Pediatric Airway Bag, the glidescope with blades sizes 1-4, and the intraosseous (IO) kit. The ED RN will respond with the Pediatric Crash Cart.

C. If the pager system is down the switchboard operator will use the overhead paging system for notification of the PRT.

Responsibilities of the PRT

A. Collaborates to provide recommendations for patient care in response to the identified condition change, utilizing the American Heart Association (AHA) Pediatric Advanced Life Support (PALS) guidelines and MMC protocols as appropriate.

B. If the Pediatric Hospitalist is unable to respond immediately, they will call the location of the PRT to collaborate and direct the team.

C. The Pediatric RN, with the assistance of the responding RNs:
    1. Verifies the patient's code status
    2. Provides the team with pertinent patient history
    3. Ensures a computer/patient's electronic health record (EHR) is available
        a. Initiates PRT orders in Power Chart if appropriate
    4. Ensures the PRT record is initiated; located on the top of the Pediatric Crash Carts (#8128)
    5. Updates the family as needed
    6. Ensures all documentation is entered into Powerchart including the assessment,

vital signs and a focus note detailing the event and interventions.

7. Ensures needed equipment is at the bedside on the pediatric unit ie: Pediatric Crash Cart, suction, cardiorespiratory monitor, IV pole/pump, glucometer, EZ-IO
8. A3 RN to assist with documentation

D. The responsibilities of all team members responding to the PRT is to remain at the bedside until deemed not necessary; ie lab, IV therapy

E. If the patient's condition worsens or warrants emergent intubation, activate a Code Blue-Pediatric by dialing 55555 and state the following to the operator: Code Blue- Pediatric, patient location and age.

F. In the event the PRT determines the patient requires transfer to a tertiary care center, the team will huddle to determine the best location for immediate care needs prior to transfer. The transfer coordinator will be contacted to initiate the transfer process.

G. When a PRT is responding to a pediatric visitor or outpatient, the child may be transported to the ED for further assessment and treatment as appropriate.

References

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Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	6/5/2025
VP and CNO Patient Care Services	Tamara Putney: VP and CNO Patient Care Services	6/3/2025
Document Owner	Marta Wiesen: Mgr Nursing Services - NICU/C3	5/29/2025

Applicability

Munson Medical Center

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **19809231**

Origination	12/7/2007	Owner	Amber Bowers: Mgr Nursing Services
Last Approved	2/3/2026		
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Last Revised	2/3/2026	Applicability	MMC
Next Review	2/2/2029	Tags	Guideline

Cardiopulmonary Resuscitation Team Coverage

Purpose

Provide staff a process to respond to a Code Blue Medical Emergency by calling the Code Blue Team for assistance.

Policy

Areas of Code Blue Team Response

A. The Code Blue Team will respond to all paged Code Blue Medical Emergencies- Adult or Pediatric in the main hospital building, the ground floor of the Munson Professional Building, the on-site childcare center and D6 Inpatient Behavioral Health-a Service of Munson Healthcare Cadillac Hospital (CAD).

   1. For ground floor public and non-patient care areas, Emergency Department (ED) staff will also respond.

B. The Cardiac Catheterization/Electrophysiology (EP) Labs, ED, Operating Room (OR), Post-Anesthesia Care Unit (PACU), A2, Intensive Care Unit (ICU) and Neonatal Intensive Care Unit (NICU) may provide their own coverage for Code Blue situations. The Code Blue Team is available for assistance if the unit staff calls a Code Blue Medical Emergency.

C. The parking structure, childcare playground, patient and employee parking lots, and the Energy Center are not considered to be part of the main hospital building. In the event of an emergency, call Emergency Medical Services (EMS) (911).

D. Ambulatory practices follow Medical Emergencies Presenting at Munson Healthcare Practices or Clinics.

E. For Pediatric Code Blue response, refer to Code Blue- Pediatric Response Plan.

Code Blue Team Activation

A. Any hospital personnel may activate the Code Blue Team by completing the following steps:
    1. Dial "55555".
    2. Request the operator call a Code Blue Medical Emergency- Adult or Pediatric.
    3. Provide the operator with the exact location of the patient.

B. Employees at the location of the emergency should designate individuals to assist with directing the code team members to the location of the emergency as they arrive.

Response Roles and Responsibilities

A. **Provider**
    1. The first provider responding to the code will:
        a. Assume responsibility for the code until the code team arrives.
        b. The responding provider may delegate code team leadership to another provider or to a designated Advanced Cardiac Life Support (ACLS) certified registered nurse (RN).
    2. The provider assuming responsibility for the code will:
        a. Direct the activity of the team.
        b. Review and sign completed Code Blue Flowsheet (form #1144).

B. **Designated ACLS certified nurses**
    1. One designated ACLS certified nurse, typically from A3.
        a. Lead the code in the absence of a provider or as designated by the provider per ACLS protocol.
        b. Verify Intraosseous (IO) Access kit is available.
    2. The other designated ACLS certified nurse, typically from ICU.
        a. Assist with code leadership and ACLS protocol.
        b. Verify video fluoroscope is available.
        c. Monitor and announce time intervals for interventions.
        d. Document all events on the cardiopulmonary resuscitation (CPR) Flow Sheet and obtain necessary signatures.
        e. File original CPR flow sheet in the patient's chart and send copy to Clinical Quality along with completed Code Critique Form (form #1887).

C. **VAST RN**
    1. Assist with venous and IO access as needed.

D. **Respiratory Therapist (RT)**

1. Perform airway management and ventilation.
2. If indicated, a qualified RT may intubate.

E. **Primary RN**

1. Provide focused summary of patient's history and events proceeding the arrest.
2. Remain at patient's bedside for additional assistance.
3. Report to the nurse assuming responsibility for the patient should a transfer occur.

F. **Unit RN/Charge RN**

1. Ensure resuscitation initiated per Basic Life Support (BLS)/ACLS protocols.
2. Verify Code Blue was activated (55555).
3. Ensure crash cart, defibrillator, and other necessary equipment are present.
4. Assist with crowd control.

G. **Pharmacist**

1. Bring medication kit and prepare medications as needed.

H. **Phlebotomist**

1. Bring handheld blood analyzer.
2. Perform or assist with lab draws.
3. Deliver blood samples to the laboratory and inform of need for STAT analysis and reporting.

Related Materials

1. Highlights of the 2020 American Heart Association Guidelines for CPR and ECC
2. Code Blue Flowsheet (form #1144)
3. Code Critique Form (form #1887)
4. Cardiopulmonary resuscitation (CPR), two-person (Lippincott Procedures)
5. Cardiopulmonary resuscitation (CPR), one-person (Lippincott Procedures)

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/3/2026
Interim CNO Patient Care Services	Shari Wilson: President Post-Acute Care	2/2/2026

Mgr Nursing Services	Amber Bowers: Mgr Nursing Services	2/2/2026
Document Owner	Amber Bowers: Mgr Nursing Services	2/2/2026

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Owner	Heather Tolfree: Mgr Pharmacy - CPS
Area/ Department	Pharmacy
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Tags	Policy

Medication Administration

Purpose

To ensure medications are administered by authorized individuals in a safe and timely manner to meet the needs of the patient. The policy does *not* define procedures for administrating medication by various routes of administration or administration techniques

Definitions[1,2]

1. **Medications Not Eligible for Scheduled Dosing Times:** Medications requiring exact or precise timing of administration based on diagnosis type, treatment requirements, or therapeutic goals.
2. **Medications Eligible for Scheduled Dosing Times:** Medications prescribed on a repeated cycle of frequency, such as once a day, twice a day (BID), three times a day (TID), hourly intervals (every 1, 2, 3 or more hours), etc.
    1. **Non-Time Critical Scheduled Medications:** Medications for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm.
    2. **Time-Critical Scheduled Medications:** Medications for which an early or late administration of greater than thirty minutes might cause harm or have significant,

negative impact on the intended therapeutic or pharmacological effect.

Policy

A. Medications are administered by authorized, licensed, independent practitioners and clinical staff authorized to do so by state law, federal law, and hospital policy.

B. Medications and biologicals are administered upon the order of a provider responsible for the care of the patient or another provider acting in accordance with state law, including scope of practice laws, hospital policy and procedures, and medical staff by laws, rules, and regulations.

C. Categories of licensed personnel and the types of medication they are authorized to administer are defined in policy.

D. Training and staff education is provided for personnel authorized to administer medication and biologicals. Training and competency assessments are documented.

E. Bar code medication administration (BCMA) is utilized at the bedside prior to medication administration at all times unless there are extenuating circumstances (i.e. code blue or trauma, technology down time, or technology not available).

F. Timing of medication administration takes into account the complex nature and variability among medications, the indications for use, the clinical situation, and the needs of the patient.

G. Medications eligible for scheduled dosing times, medications not eligible for scheduled dosing times, and time-critical scheduled medications are defined.

H. Dose administration times are standardized for eligible scheduled medications.

I. Guidelines are established for initiating administration of first doses and missed or delayed doses of scheduled medications.

Training and Competency Assessment

A. Personnel authorized to administer medications receive training during orientation and ongoing education about topics related to safe medication handling, preparation, administration, and patient monitoring. Chemotherapy and investigational medications may only be administered by individuals who have completed specialized training pertaining to these agents.

B. Training and competency assessments are documented per hospital policy.

Categories of Individuals Authorized to Administer Medications by Medication Type

A. **Physicians** may administer medications for diagnosis and treatment in accordance with medical staff bylaws and provider credentials.

B. **Certified Registered Nurse Anesthetists, Nurse Practitioners, Physicians Assistants**, and **Clinical Nurse Specialists** may administer medications by all routes within their scope of practice.

C. Registered Nurses (RN): May administer all parenteral, oral, rectal, and topical medications

including blood and blood products, if not specifically excluded elsewhere by medical staff by-laws or rules and regulations.

D. Respiratory Therapists: May administer aerosol and nebulizer medications.

E. Respiratory Interns and Technicians: May administer aerosol and nebulizer medications under supervision by Respiratory Therapist.

F. Radiology Technicians: May administer contrast media per medical staff approved hospital protocol while under the supervision of a Licensed Independent Practitioner (LIP).

G. Cardiovascular Technologist/Registered Cath Lab Invasive Specialist: May administer specific medications under direct supervision of LIP.

H. Medical Assistants (MA) and Licensed Practical Nurses (LPNs) at Munson Healthcare (MHC) Owned Offices/Practices: May administer site specific oral and parenteral medications outlined in job description and/or policy/procedure and assessed by training and competency.

I. Physical Therapists, Physical Therapy Assistants (Supervised by Physical Therapists), Occupational Therapists, Certified Occupational Therapist Assistants (Supervised by Occupational Therapist): May apply topical medications for wound care treatment, ultrasound, and iontophoresis.

J. Clinical Pharmacists/Pharmacy Residents: May administer parenteral and oral medications.

K. Other clinical staff authorized to administer medication by state and federal law, hospital policy/job descriptions, and supported, when applicable, by training/competency.

L. Students of accredited schools of medicine, nursing, physical therapy, respiratory therapy, or other healthcare fields authorized in this policy may administer medications only under the direct supervision of a registered healthcare professional who has ultimate responsibility for the medication administration process.

M. Anyone may administer intranasal naloxone.

Timing of Medication Administration[2]

Medications Eligible for Scheduled Dosing Times

A. Medications eligible for scheduled dosing times are those prescribed on a repeated cycle of frequency, such as once a day, BID, TID, hourly intervals (every 1, 2, 3 or more hours), etc.

Medications Not Eligible for Scheduled Dose Administration Times

A. The following medication orders are not eligible for standardized scheduled dosing times and require timing of administration based on the pharmacokinetics of the prescribed medication, the specific clinical application, and patient risk factors:

    1. STAT/Now doses
    2. First time or loading doses

3. One-time doses specifically timed for procedures
4. Time-sequenced doses and doses timed for serum drug levels
5. Investigational drugs
6. Medications prescribed on an as needed (PRN) basis

Standardized Dose Times for Scheduled Medications

A. Unless the prescriber orders otherwise, scheduled medications are administered at standard times as approved by the Pharmacy and Therapeutics (P&T) Committee.
    1. **Note:** Refer to attachment ***Guidelines for Maintaining Standard Times*** below

B. Select groups of medications may be assigned specific administration times by the P&T Committee (i.e. warfarin, digoxin).

C. New orders for antibiotics and specified drug classes, as defined by the P&T Committee, will be administered as soon as possible after receipt from the Pharmacy.

D. e-MAR alerts are used to highlight doses that will soon be due, overdue, or have been omitted.

E. Pharmacists should make every attempt to schedule medication on standard times.

Time Critical Scheduled Medications

A. Time critical scheduled medications are administered within 30 minutes before or after their scheduled dosing time for a total window of 1 hour.

B. Time critical scheduled medications include:
    1. Carbidopa
    2. Carbidopa/Levodopa
    3. Entacapone
    4. Mycophenolate IVPB
    5. Mycophenolate Mofetil
    6. Cyclosporin (Oral and IVPB, not ophthalmic)
    7. Nonmodified cyclosporine
    8. Tacrolimus
    9. Leucovorin IVPB

Non-Time Critical Scheduled Medications

A. Medications prescribed less frequently than every 4 hours are administered within 1 hour before or after the scheduled dosing time for a total window that does not exceed 2 hours.

Procedure

A. Do NOT use medications dispensed to or labeled for another patient.

B. Medications are prepared for one patient at a time.

C. Medications are prepared in a clean, functionally separate area designated for medication preparation.

D. Unit-dose packages and individually wrapped intravenous infusion bags remain intact until immediately prior to administration.

E. Solid oral dosage forms needing to be crushed or split prior to administration are assessed for suitability.

    1. Enteric coated and sustained release products may not be crushed or split unless allowed by manufacturer.
    2. Only tablets with a functional score may be split.
    3. No NIOSH medication should be crushed or split outside of proper environmental controls in the Pharmacy.
        a. **Note:** Refer to the USP <800> Handling Hazardous Drugs in Healthcare Settings policy for more information on how to handle hazardous drugs during administration.
    4. Tablet splitting and crushing devices are cleaned before and after each use; and/or a plastic sleeve is used to minimize the potential for cross contamination of products; or disposable products are used as single patient products.
    5. Unused tablet portions are not saved but are immediately discarded in accordance with the hospital's Pharmaceutical Waste Management policy. Any unused portion of a controlled substance must be wasted with a witness and documented per hospital policy.
        a. **Note:** Refer to the Controlled Substances policy for more information regarding handling of controlled substances.
    6. Contact pharmacy for guidance or to discuss alternatives.

F. Multi-dose vials (MDVs) are utilized only when single-dose containers (SDC) are not available or do not meet the needs in the provision of patient care and when used are controlled in a manner that assures their sterility, chemical stability, and quality. Single-dose containers used outside ISO Class 5 environment are only entered and used one time. Any controlled substance packaged in a dose larger than the dose being administered should have excess amounts wasted before administration.

    1. **Note:** Refer to the Multi-Dose Vials and Single-Dose Containers policy for more information on MDV and SDC. Refer to the "Waste and Disposal" section of the Controlled Substances policy for more information on handling of controlled substances.

G. A filter needle is used to withdraw medications from an ampule.

H. Personal protective equipment (PPE) is used when handling and administering chemotherapy and other NIOSH designated drugs.

    1. **Note:** Refer to the USP <800> Handling Hazardous Drugs in Healthcare Settings policy for more information on how to handle hazardous drugs during

administration.

I. Medications are administered immediately after the medication is prepared without a break in process by the individual who prepares the dose.
    1. **Note:** This does not apply to medications prepared by Pharmacy or medications that have been appropriately labeled for administration.

J. Before administering a medication, the authorized individual administering the medication completes the following:
    1. Verifies the medication selected for administration is correct based on the medication order and product label.
    2. Visually inspects the medication for potential loss of integrity (i.e. no particulates or discoloration).
    3. Verifies the medication has not expired.
    4. Verifies there is no contraindication with respect to allergy, sensitivity, or diagnosis.
    5. Verifies the medication is administered in the correct dose and the dose does not reflect an unsafe dosage level (i.e. a dose that is too high or too low).
    6. Verifies the medication is administered by the correct route and the route is appropriate for the medication and patient.
    7. For IV medications, verifies the type of IV access is appropriate for the medication and patient.
    8. Verifies the medication is administered at the appropriate time to ensure adherence to the prescribed frequency and time of administration.
    9. Discusses any unresolved, significant concerns about the medication with the prescriber and/or relevant staff involved with the patient's care.
    10. Advises the patient, or if appropriate, the patient's family about any potential clinically significant adverse reaction or other concerns about administering a new medication.
    11. If applicable, advises the patient and/or the patient's representative about the patient assessment and monitoring process which might include awakening the patient in order to assess the effects of the medication.

K. Positively identify the patient before administering the medication. Check the patient's identification (ID) with two hospital approved identifiers and ask the patient (when possible) to state his/her name and date of birth. See Appendix 1 for Alternate ID Process.

L. Double check the order if the patient questions or expresses doubts about a medication, dose, administration route, or technique.

M. Properly position the patient, if necessary, before administering the medication.

N. Administer the medication. Offer additional liquid if appropriate.

O. Observe the patient take the medication. Stay with the patient until he/she has swallowed the medication.

P. Document the exact time the medication is administered. Do NOT document prior to

administration.

Q. Return unused, intact (sealed) medications to the patient's supply, automated dispensing cabinet, or Pharmacy per hospital policy.

R. Discard unusable medications per hospital policy.

    1. **Note:** Refer to the Outdated/Expired and Unusable Medications policy for more information.

S. Isolate defective or questionable medications and return them to the Pharmacy.

T. Monitor the effects of the medication to ensure effective patient response (i.e. pain assessment, blood pressure monitoring, etc.).

U. Monitor patient response to first doses to assess for adverse effects.

V. Communicate all relevant information regarding patient's medication risk factors and monitoring requirements during hand-offs of the patient to other clinical staff (e.g. internal transfers from one unit to another, shift report at shift change, etc.).

W. Report medication administration errors, adverse drug events and incompatibilities immediately to the attending physician. Prepare and submit reports as defined by organizational policy.

Missed or Delayed Administration of Scheduled Medications

A. When medications eligible for a scheduled dosing time are not administered within the defined time period:

    1. Document the reason the dose was missed or delayed (i.e. patient refused, patient off unit, etc.).
    2. Reschedule missed or delayed doses, as appropriate, based on the facility specific standard dose administration times.
    3. Notify the prescribing/attending provider if the delay poses an immediate patient care issue.
    4. Medication errors that are the result of missed or late dose administration must be reported to the attending provider and to the hospital incident reporting system in accordance with hospital policy.

Medication Administration Based on Patient Preference

A. PRN medication administration may be deferred to the patient's preference only in the following circumstances[3]:

    1. When the patient requests a ***less potent*** (e.g., different) medication that is prescribed
        a. **Note:** Potency is established with an evidence-based tool (i.e. morphine equivalents).

2. A ***lower dose*** in a prescribed dose range.
3. A ***less intrusive route*** of administration if multiple routes are prescribed.
    a. Parenteral, oral, and rectal routes:
        i. Enteral route will be used, unless patient not able to take medication via an enteral route (excluding the rectal route).
        ii. Rectal route of administration will be reserved if unable to give via other enteral routes or via a parenteral route.
4. An ordered medication indicated for a *lower level of pain* than scored on the most recent pain assessment (e.g., patient requests treatment with a medication indicated for mild pain when pain assessment scores indicates patient is experiencing moderate pain).

B. It is not acceptable to administer a medication of stronger potency based on patient preference.
    1. Patient preference is *only* applicable for administration of a different, less potent agent that is prescribed. It is not acceptable to change or lower the dose of the same medication unless the dose is defined in a range order.

C. If administering a controlled substance part of a range order, waste any excessive dose at the time of procurement (e.g. removal from automated dispensing machine) for all non-emergent situations. Any partially used controlled substance cannot be saved for later use.
    1. **Note:** Refer to the Controlled Substances policy for more information regarding handling of controlled substances.

Documentation

A. The use of PRN medications to control medical symptoms (such as pain, nausea, insomnia, extra-pyramidal side effects) requires the following documentation:
    1. Documentation of the symptom or indication for use.
    2. Documentation of the medication and dose administered.
    3. Documentation in the medical record of the results achieved.
    4. Documentation in the medical record when medication administration is deferred to the patient's preference (see above for criteria).

Evaluation of Medication Administration Timing

A. The organization periodically evaluates medication administration timing to include:
    1. Evaluation of staff adherence to the policy
    2. Tracking and analysis of reported medication events related to the timing of medication administration

Personnel

A. All Clinical Staff

References

1. State operations manual. CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Updated February 21, 2020. Accessed September 19, 2022.
2. Institute For Safe Medication Practices. ISMP acute care guidelines for timely administration of scheduled medications. ISMP: Institute For Safe Medication Practices. https://www.ismp.org/sites/default/files/attachments/2018-02/tasm.pdf. Published 2011. Accessed October 2023.
3. The Joint Commission. (2024, January 30). Are there circumstances when a provider may write PRN medication orders that allow variation in administration based on patient preference such as in the following examples ? Retrieved September 21, 2025, from Standards FAQ: https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000002058

Related Policy

1. Controlled Substances
2. Outdated/Expired and Unusable Medications
3. Pharmaceutical Waste Management
4. USP <800> Handling Hazardous Drugs in Healthcare Settings

Author: Heather Tolfree, PharmD

Appendix

Alternate Patient ID for Barcode Medication Administration (BCMA) Process at MHC

Purpose

To maintain staff safety with medication administration when caring for a potentially violent/physically aggressive patient. Scanning the patient wrist band in such situations can pose a safety risk for the nurse. An alternate process for patient ID is outlined below. This process is ONLY to be implemented when safety concerns are an **imminent** risk at the time of medication administration.

A. **Step One:** Review patient's current criteria with the PCC/charge RN to support the implementation of the Alternate Patient ID BCMA Process.

B. **Step Two:** If determined clinically appropriate, print second patient ID band.

C. **Step Three:** Store second patient ID band in the gray medication bin in the locked med drawer assigned to the patient. (Note; if there is no locked med drawer, for example, in an ED setting, the patient chart will suffice).

D. **Step Four:** The RN may scan the secondary ID band to initiate the medication preparation steps so this may occur in a safe, separate location where all medications can be scanned. Tap out.

E. **Step Five (D6 Only):** Transfer all prepared medications and the secondary band into the Medication Transfer Bin and locate the patient for medication administration.

F. **Step Six:** Using normal ID procedures, PLUS comparing the secondary ID band to the band on the patient, confirm identity and administer medications.

G. **Step Seven:** Immediately tap in. Sign off all medications that were administered. Return ID band to locked medication bin.

Attachments

Guidelines for Maintaining Standard Times.docx

IV Antibiotics and IVP Steroids.docx

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	2/17/2026
System P&T Committee	Cathi Cornelius: Clin Pharmacy Utilization Spec	2/13/2026
Document Owner	Heather Tolfree: Mgr Pharmacy - CPS	1/22/2026

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Area/ Department	Nursing
Applicability	Munson Healthcare Systemwide

Blood Transfusion Therapy & Transfusion Reaction

Purpose

To provide a process for safe and effective replacement of blood components as required by patient condition and best practice.

Scope

This policy applies to all locations within Munson Healthcare (MHC) where standard, non-emergent blood transfusion therapy occurs.

Definitions

The following definitions provide a brief description of blood components dispensed by Blood Bank.

1. **Red Blood Cells (RBC):** Red blood cells with most of the plasma removed and a preservative added. Administered to enhance the oxygen (O2) carrying capacity of the blood. Types of RBCs available include autologous, homologous/allogenic directed, leuko-reduced, irradiated, and incompatible.
2. **Irradiated Blood Products:** Blood products that have been exposed to a measured amount of radiation thereby rendering donor lymphocytes incapable of replication. Given to prevent transfusion graft versus host disease.
3. **Leuko-Reduced Red Blood Cells (RBC):** RBCs in which the leukocyte number has been reduced by centrifuge washing or filtration at the blood center. Given to prevent recurrence of febrile non-hemolytic transfusion reactions and transmission of Cytomegalovirus (CMV).
4. **Incompatible Red Blood Cells (RBC):** Blood containing RBCs which are agglutinated (clumped) or hemolyzed by the serum of the recipient in the crossmatch procedure. The blood types are incompatible. In these cases, the pathologist and the patient's physician have assessed the need for transfusion against the possible risks of transfusion and determined the patient's need for

transfusion to be greater than the risk. The pathologist has selected the best possible unit.

5. **Fresh Frozen Plasma (FFP):** Contains all the components of blood plasma (albumin, globulins, antibodies) including the clotting factors. FFP is beneficial to patients with demonstrated multiple coagulation deficiencies. It should not be used for volume expansion since it carries the risk of disease transmission.
6. **Platelets:** Obtained by separating the platelet-rich plasma from one unit of fresh whole blood. Platelets contain a phospholipid that enhances the conversion of prothrombin to thrombin. Types of platelets available are from a single donor by apheresis. Administered to control or prevent bleeding associated with deficiencies in platelet number or function.
7. **Cryoprecipitate:** Concentrate containing Fibrinogen; Factors VIII and XIII, vonWillebrand Factor (vWF) extracted from cold-thawed plasma.
8. **Rh Immune Globulin (RhIG):** Concentrate of IgG anti-D derived from plasma. Administered by intramuscular (IM) injection to Rh-negative individuals to prevent Rh alloimmunization after being exposed to Rh-positive cells through transfusion or pregnancy. The infusion is not subject to consent procedures associated with the administration of blood products above.

Policy

A. The following blood components are distributed by pharmacy and subject to the policies governing medication administration.
    1. Albumin
    2. Prothrombin Complex Concentrate and Anti-inhibitor Complex Concentrate
    3. C1 Esterase Inhibitor
    4. Antithrombin III
    5. Immune Globulin (intravenous [IV] and IM)

B. A Registered Nurse (RN) may administer blood components intravenously upon receipt of provider order entry (POE) by a practitioner privileged to do so.

C. Blood Transfusion Patient education sheet will be provided to patient prior to administration of blood products. Patient education should be provided again after ninety (90 days) or after discharge. Any patient questions will be addressed by provider.

D. In case of refusal a Confirmation of Choice to Refuse Designated Treatments Utilizing Blood Products (Adult) Form #318 must be signed. Refer to the Managing Refusal of Blood Transfusion policy.

E. On rare occasions it may not be possible for the Blood Bank to provide Red Blood Cells that are serologically compatible with the recipient. The Blood Bank will inform the patient's Physician/ Health Care Provider when an incompatibility is identified. In these cases, the pathologist and the patient's provider have assessed the need for transfusion against the possible risks of transfusion and determined need for transfusion to be greater than the risk.

F. Temperature, pulse, respirations, blood pressure (BP) and O2 saturation must be taken no more than one hour before beginning the transfusion. If temp 38.8°C or greater, notify ordering provider before obtaining blood component. An elevated temp is not a contraindication to the transfusion, but it may complicate assessment of a transfusion reaction.

G. Verify that patient has patent IV site with minimum of 24 gauge or larger prior to obtaining the

blood product.

H. Normal saline (0.9% NaCl) will be used as priming solution.

I. SURGICAL SERVICES ONLY: In the pre-op, intra-op or post-operative departments (while under the direction of the anesthesiologist), blood products may be co-administered with Normosol-R or Plasma-Lyte in place of Normal saline. (Normosol-R and Plasma-Lyte are isotonic solutions of balanced electrolytes in water that do not contain dextrose or calcium).

    1. Note: Dextrose solutions may cause hemolysis when in contact with RBCs. Lactated Ringers solutions contain calcium and may contribute to formation of micro-emboli.

J. When obtaining blood from the Blood Bank, personnel trained in the procedure and the lab technician checking out the component must check the following information and the product must not be issued, unless all information is identical:

    1. Patient name
    2. Medical record number
    3. Blood component
    4. Blood type of donor and recipient
    5. Rh factor of donor and recipient
    6. Blood unit number
    7. Expiration date

K. All information must again be checked by two staff qualified, in the presence of the recipient and trained to assist with blood administration before blood component is started. In the case of extracorporeal membrane oxygenation (ECMO) therapy a registered respiratory therapist may check the information along with the qualified staff. All information must be identical. Conscious patients should be asked to state their first and last name and date of birth in addition to checking ID band. Do not remove any patient identification bands during transfusion. The following verifications are required before the start of the transfusion:

    1. The transfusionist must verify that the recipient's name and MRN present on the patient armband match the information on the unit label.
    2. The unit number and donor ABO/Rh type on the blood component label must match the attached tag.
    3. The recipients ABO group (and Rh type if required) must be compatible with that of the unit. Interpretation of the crossmatch tests must also be verified.
    4. The transfusionist must verify that the component to be transfused matches the provider's order and that any special processing requests (ie. irradiation, blood warmer, washed, etc) was performed.
    5. The transfusion of the unit must start before the expiration date or time has passed.
    6. An active transfusion order must be validated at the bedside during the two person verification process.

L. If there are any discrepancies between the Crossmatch Transfusion Tag, blood bag, or patient identification band, the unit cannot be administered. Return the blood to the Blood Bank and complete a Safety Event Report. A blood component must be started within 30 minutes from the time of receipt, or it must be returned to the Blood Bank. Blood cannot be stored on the unit. The

exception is fresh frozen plasma which can be maintained up to 4 hours at 20-25°C (68-77°F).External pressure infusion devices designed specifically for blood administration that do not exceed 300-mmHg pressure, may be used to infuse blood.

M. Fluid warmers may be used for patients with cold agglutinins, massive or rapid transfusions, or exchange transfusions in the neonate.
    1. Note: Competency must be documented before use of this equipment is attempted.

N. If a blood component is not administered or is damaged it must be returned to the Blood Bank and document the reason.

O. A unit of blood and its associated filter/tubing should not hang for longer than four (4) hours. The frequency of tubing changes is dependent on the type of filter used and flow rate. If more than 30 minutes elapse between subsequent transfusions, discard the tubing.

P. An infusion pump may be used to administer blood.
    1. If the patient's clinical status dictates an extremely slow rate, contact the Blood Bank. They may divide the unit.
    2. Pediatrics and neonate patients do require the use of an infusion pump.

Q. No medication or IV solutions can be administered in the same line as a blood infusion.

R. RN spiking the blood bag must wear mask, goggles, and gloves. If a patient is transferred to another unit or department during transfusion, the Transfusion Record and a verbal report to the licensed clinician assuming care of the patient using hand-off guidelines (SBAR) is required.

S. Frequency of patient assessment and vital signs is based on patient clinical status and must be frequent enough to provide for assessment of physiologic status. The nurse should remain with the patient for the first fifteen (15) minutes after beginning the transfusion, at initial rate, to observe for signs of a transfusion reaction. See table for additional requirements.

Product	Volume	Rate	Vital Signs	Special Considerations
RBCs	Typically, 250-300 ml. Read unit bag for specific volume	First 15 minutes: 1-2 mL/min (60-120 mL/hr) After 15 minutes: as rapidly as tolerated (4 mL/min or 240 mL/hr). Faster or slower rates dictated by clinical condition.	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	All RBC products are leuko-reduced • **Observe patient constantly for first 15 minutes** • **Must not exceed 4 hours** A blood warmer may be indicated for use in: • Plasma exchange transfusion

Product	Volume	Rate	Vital Signs	Special Considerations
				• Surgery • Trauma • Cold agglutinin disease ***Pediatric Considerations:** • Dose: 10-20 mL/kg; NOT to exceed adult dose • Must be administered on a pump at a controlled rate; First 15 minutes at 25% of goal rate (goal is over 4 hours if patient is stable, or as indicated by provider order) ****Neonatal Considerations:** • ONLY O- RBCs will be administered • Dose: 10-20 mL/kg • CMV-, Leukoreduced, Irradiated • Comes in a syringe pre-filtered • Administered over time ordered by Provider

Product	Volume	Rate	Vital Signs	Special Considerations
Incompatible/ Least Incompatible RBCs	250-310	Start slowly at 1 mL/min for the first 15 minutes complete entire process for EACH unit of incompatible RBCs transfused. Not to exceed 4 hours	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Follow instructions that come with unit from Blood Bank • **Observe patient constantly for first 15 minutes** • If no symptoms of reaction after 30 minutes, proceed and monitor **Pediatric Considerations:** • Dose: 10-20 mL/kg; NOT to exceed adult dose • Must be administered on a pump at a controlled rate; See admin guidance above for initial rate **Neonatal Considerations:** • N/A, we never administer incompatible RBCs to a neonate
Cryoprecipitate	5 units per pool	Rapidly as tolerated	BP, temperature, pulse, respiratory and O2: • before • 15 minutes	Infuse as soon as possible after collection release of component. Always gravity flow cryoprecipitate. • Do not use

Product	Volume	Rate	Vital Signs	Special Considerations
			• 30 minutes • Completion of transfusion (more frequent if clinically indicated)	rapid infuser to administer cryoprecipitate • Special populations such as peds/ neonatal intensive care unit (NICU) may have alternate infusion procedures (see below) **Pediatric Considerations:** • Dose: 1 mL/kg NOT to exceed adult dose • Must be administered at a controlled rate • Syringe pump is acceptable for administration; NOT normal IV Pump • Administration usually over 30 minutes **Neonatal Considerations:** • Dose: 5-10 mL/kg • Comes in a syringe pre-filtered • Administered over time ordered by

Product	Volume	Rate	Vital Signs	Special Considerations
				Provider
FFP	Typically, 250-300 ml. Read unit bag for specific volume	First 15 minutes: 2-5 mL/min (120-300 mL/hr) After 15 minutes: as rapidly as tolerated, 300 mL/hr	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	**Pediatric Considerations:** • Dose: 10-15 mL/kg; NOT to exceed adult dose (MAX-500 mL or 2 Units) • Must be administered on a pump at a controlled rate, may use syringe pump if volume appropriate **Neonatal Considerations:** • Dose: 10 mL/kg • Administered over time ordered by Provider
Platelets	Varies. Read unit bag for specific volume	First 15 minutes: 2-5 mL/min (120-300 mL/hr) After 15 minutes: 300 mL/hr as tolerated	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Always gravity flow platelets to adult patients • Do not use rapid infuser to administer platelets • Human leukocyte antigens (HLA) Platelets - Special order. Panel-reactive antibody (PRA) & HLA

Product	Volume	Rate	Vital Signs	Special Considerations
				testing required • 1 unit apheresis equivalent to “5 Pack” (pooled unit) • Special populations such as peds/ NICU may have alternate infusion procedures (see below) ***Pediatric Considerations:** • Dose: 10 mL/ kg; NOT to exceed adult dose (MAX- 300 mL or one 5-pack) • Must be administered at a controlled rate • Syringe pump is acceptable for administration; NOT normal IV Pump • Administration usually over 30 minutes ****Neonatal Considerations:** • Dose: 10-15 mL/kg • Comes in a syringe pre-

Product	Volume	Rate	Vital Signs	Special Considerations
				filtered • Administered over time ordered by Provider
Whole Blood	Provider Discretion	As tolerated but not to exceed 4 hours. Faster or slower rates dictated by clinical condition.	BP, temperature, pulse, respiratory and O2: • before • 15 minutes • 30 minutes • Completion of transfusion (more frequent if clinically indicated)	Administration Inclusion Criteria: • Male: 15 years of age and OLDER • Female: 55 years of age and OLDER • At Trauma Surgeon discretion • Will primarily be administered in the ED at this time, and will arrive in a BLUE colored cooler

T. Symptoms of a Transfusion Reaction includes:

1. Temperature elevation (1.0°C during or within 2 hours of transfusion)
2. Chills, with or without rigors
3. Respiratory distress
4. Abdominal, chest, flank or back pain
5. Hypertension
6. Hypotension
7. Pain/oozing at the infusion site
8. Rash/hives/itching
9. Jaundice
10. Hemoglobinuria
11. Nausea/vomiting
12. Abnormal bleeding
13. Oliguria/anuria

U. Symptoms related to other health conditions to observe for include:
    1. Tachycardia
    2. Tachypnea
    3. Anxiety
    4. Headache
    5. Hematuria
    6. Cardiac arrest

V. If a transfusion reaction is suspected, immediately stop the transfusion by disconnecting the blood tubing from the IV and cap with a sterile cap. Convert the IV to an intermittent lock and begin an infusion of 0.9% normal saline until the situation can be assessed. Do not discontinue the IV.

W. Notify the primary physician and the Blood Bank. Complete the Reaction Transfusion Reaction Investigation Form #2874. Pending results, the Blood Bank will notify the nursing unit on how to proceed.

X. Upon completion of the transfusion, discard the bag and tubing in biohazard bin using Standard Precautions.

Y. Document patient education, response to therapy, vital signs, and blood unit information in the appropriate location of the medical record.

Procedure

A. See the on-line procedure manual for additional information, procedural steps, nursing considerations.
    1. Lippincott Procedures - Blood and Blood Product Transfusion
    2. Lippincott Procedures - Blood and Blood Product Transfusion, Pediatric
    3. Lippincott Procedures - Blood and Blood Product Transfusion, Neonatal

B. Consult product literature for specific instructions.

References

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4. "Use of Cryoprecipitate in Newborn Infants." *Newborn (Clarksville)*, vol. 2, no. 1, 2023, pp. 11–18. doi:10.5005/jp-journals-11002-0045.
5. Standards for Blood Banks and Transfusion Services, 33rd Edition, AABB, April 2022, pp 47-50
6. Technical Manual, 21st Edition, AABB, 2023, pp 557, 567-580

Keywords

blood, blood product, transfusion, blood components, red blood cells, RBC, fresh frozen plasma, FFP, cryoprecipitate, platelets, Rh Immune Globulin, RhIG, blood bank

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	12/10/2025
Executive Council	Jennifer Standfest: CNO	12/10/2025
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Lab Medical Directors	Steven Weindorf: PHYSICIAN	11/25/2025
Lab Medical Directors	Kyle Carr: PHYSICIAN	11/25/2025
Sys Dir Laboratory Services	Bonnie Torres: Sys Dir Laboratory Services	11/25/2025
Document Owner	Amber Bowers: Mgr Nursing Services	11/25/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

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Owner	Thomas Schermerhorn: Chief Medical Officer
Area/ Department	Medical Staff
Applicability	MMC
Tags	Policy

Chain of Command: Paging Response Time and Resolving Questions of Care or Safety

Purpose

To provide a policy for paging response time and resolving questions of care of safety for the chain of command.

Policy

A. It is the responsibility of all providers (or their designated cover) to answer a routine page within fifteen minutes of a message being received. If not answered, a second page will be initiated. A stat page should be answered immediately. If a page is not answered within this prescribed time frame, and circumstances warrant, the individual initiating the page will follow the chain of command outlined below until contact has been made with an appropriate staff member.

B. It is the responsibility of the unit manager or designee to be aware of the condition of every patient on the unit.

C. The attending/responsible physician shall be immediately notified of the following by the nurse:

1. Any marked deterioration of the patient's condition (Initiate MRT protocols as appropriate)
2. Any untoward drug reactions
3. Occurrence of life threatening medication errors
4. Critical test results

5. Any other incidents which significantly affect the patient's condition
6. Any other specific parameters ordered by the provider

D. The nurse shall immediately notify the coordinator or charge nurse/manager/administrative supervisor to implement the Medical Staff Chain of Command, if either of the following situations occurs:
    1. The attending/responsible physician fails to respond in a timely manner or is unavailable to address an urgent/emergent patient care situation.
    2. The quality or appropriateness of care being provided to a patient is in question and there is potential for patient injury.

E. The coordinator or charge nurse/manager/administrative supervisor shall notify the appropriate Medical Staff leadership to obtain assistance and provide for medical care of the patient in the following order: (Provision for medical care in this instance is considered an administrative responsibility and is indemnified and insured by the hospital.)
    1. Chief Medical Officer (CMO)
    2. Administrator on Call (if the CMO is not available)

F. Physicians who have the above concerns can contact the CMO for assistance.

G. For questions regarding scope of care and current privileges, the manager/supervisor or designee shall consult Munson Medical Center (MMC) Intranet-Physicians-Privileges or contact Medical Staff Services. If the scope is unclear or if the Medical Staff office is not available, the appropriate Medical Staff leadership shall be contacted as listed above.

H. The manager/supervisor shall notify the appropriate Director of Nursing and the Vice President of Patient Care Services of any cases where medical leadership has been contacted by nursing for assistance in resolving questions of care. Such incidents may be referred to Medical Staff leadership as a policy violation.

Document ID: 019.037

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	8/16/2022
Medical Executive Committee	Katryna Glettler: Sr Spec Lead, Med Staff Services	8/16/2022
Policy Owner	Walter Noble: Chief Medical Officer	8/16/2022

Applicability

Munson Medical Center

Standards

No standards are associated with this document

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Last Revised	3/18/2025
Next Review	3/18/2026
Owner	Jennifer Standfest: CNO
Area/ Department	Nursing
Applicability	MHC Hospital System w/KMHC (MMC, Cadillac, Charlevoix, Grayling, KMHC, Otsego, Manistee, POMH)

Nursing Documentation Guidelines

Purpose

To provide guidance for electronic inpatient and observation nursing documentation. Please refer to Hospital Nursing Documentation | Munson Healthcare for additional information and specific job aides. In addition to the specific procedures within this policy, all employees must adhere to general documentation guidelines within the Medical Record Entries policy.

Guidelines

General Documentation

A. All entries into the electronic document must be made under the individual's authorized log in. Information should be entered into the computer at time of collection to the extent possible.

B. All admission forms will be completed and documented within 24 hours of admission and according to unit standard, by a Registered Nurse (RN).

C. Nursing Assessment will be completed and documented at a minimum of every 8 hours, or more frequently per unit standards.

D. All patients are screened for pain at hospital admission and at a minimum of every shift to determine if pain is present. When present, assessment and reassessment will occur as appropriate per the Pain Management policy.

E. Medication administration: For a unit that uses barcoding for medications, including intravenous (IV) fluids, medications should be scanned prior to administration or upon transfer

from a non-electronic medication administration record (eMAR) unit.

1. For continuous or titratable drips, chart dose on IView in the IV Drips sections when changed or at least hourly for critical patients, and every 4 hours for non-critical patients. For all drips, enter zero when IV is temporarily stopped or permanently discontinued.
2. Patient-Controlled Analgesia (PCA): Document PCA every 4 hours.
3. Epidurals: Document Epidurals every 4 hours. Enter the 'Running Total'.

F. Intake and Output (I & O): Documentation of fluid volume required as ordered or according to unit standard. Document bowel movements on I & O, enter zero if none.

G. Activity/Ambulation/ADLs: Documentation required at least every shift and with care provided. Patient hygiene documented once every 24 hours.

H. Patient Education: Documented at least once per shift and more frequently, as occurs.

I. Plan of Care (POC): The nursing portion of the plan of care is initiated by the RN on admission and used throughout the hospital stay to document expected outcomes with goal timeframes, and interventions. The POC is reviewed and/or updated by the RN every shift and with any change in condition.

1. At discharge any unmet POC outcomes must be addressed in the comment field on the POC Overview Page. POC is available as a link on the Pre-Discharge Assessment Powerform.
2. The Event Summary may be updated as significant events occur.

J. Shift Summary: Documented at least once per shift.

1. Synopsis of shift activity.
2. Documentation of significant changes and interventions.
3. Document progress toward patient goals, related to POC.

K. Focus Notes should not replace other discrete documentation fields, but rather are used to supplement the record of events which cannot be adequately described by discrete fields alone.

L. All other documentation shall be based on patient specific needs and consistent with hospital or department standards of care. Documentation shall communicate pertinent information needed for clinical decision making and will demonstrate the interventions and level of care being provided.

M. Care which is declined by the patient is documented in the electronic health record (EHR).

Documentation of RN Supervision of Students, Non-Licensed & Licensed Personnel

A. Nursing Students:

1. For medications administered by nursing students, the RN instructor or RN preceptor observing the medication administration will cosign or note observation(s) in the

medical record.

2. For non-medication entries into the medical record, the nursing student's documentation will be reviewed, modified as needed, and noted by the RN preceptor in the medical record.

B. Nursing Assistants and/or Licensed Practical Nurse (LPN):

1. Will document data collected and/or delegated aspects of care in the medical record.
2. The RN will review and modify documentation as needed.

Keywords

electronic inpatient documentation, observation nursing documentation, electronic documentation

Approval Signatures

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System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	3/18/2025
Executive Council	Ashley Moeggenberg: Executive Assistant	3/17/2025
Document Owner	Jennifer Standfest: CNO	1/28/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

Status Active PolicyStat ID 13581095

MUNSON MEDICAL CENTER
MUNSON HEALTHCARE

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Last Revised	7/20/2023
Next Review	7/19/2026
Owner	Thomas Schermerhorn: Chief Medical Officer
Area/ Department	Medical Staff
Applicability	MMC
Tags	Procedure

Critical Results

Purpose

This policy is to define and specify the process for receiving and communicating critical result information to assure accurate communication between health care providers as well as timely treatment for the patient.

Munson Medical Center (MMC) is committed to patient safety. This commitment includes assuring accurate communication between health care providers. Verbal and telephone communication regarding critical results as defined in the attachments will be written down and read back by the person who is receiving the information on the result.

Definitions

1. C**ritical Result**: a value that is potentially life threatening and requires immediate communication and/or intervention. A listing of values considered critical at MMC is included in the attachments.
2. **Provider**: for the purpose of this policy is the Physician, Advanced Practice Provider (APP) (physician assistant [PA], nurse practitioner [NP], certified nurse midwife, certified nurse anesthetist [CNA], anesthesiologist assistant, or member of the Pharmacist-Managed Anti-Coagulation Team [PACT]) responsible for the patients care.
3. T**imely Response**: is completion within one hour of receipt of the critical results.
4. **Chronically Abnormal Critical Lab Values**: are lab values which are abnormal for at least 6 months.

Procedure

Critical Results Exemptions

A. For patients where response to critical results is guided by a protocol, the results are not required to be promptly called to the provider, but may be held until provider rounding.

B. The following critical results lab tests would be exempt in the presence of an active protocol:

1. Hypoglycemia with previously ordered Hypoglycemia Protocol.
2. Abnormal partial thromboplastin time (PTT) or Anti-Xa with previously ordered Heparin Protocol.
3. Abnormal electrolytes with previously ordered Electrolyte Replacement Protocol.

C. Also exempt are those situations in which the provider has specified parameters in an order for which they want to be notified of future/follow up results.

D. For patients who are monitored for chronically abnormal critical lab values, the results may be held until rounding if all the following criteria is met:

1. The critical value is expected with the condition or treatment.
2. The provider has documented in the medical record knowledge of these values prior.
3. Transfusion parameters for critical complete blood count (CBC) values are specified in an order.

Inpatient Procedures for Notification of Critical Results

A. Procedure for lab critical results being reported to a nursing unit or department

1. The lab will initiate a call to the patient's nurse or responsible party.
2. Validate the correct patient by using two identifiers. For both inpatient and outpatient, it is the patient's full name and date of birth and/or medical record number.
3. The nurse receiving the critical result information will write it down **and** read it back to the department completing the test. Staff providing the critical result(s) should always request the read back whenever communicating these results verbally.
4. Lab personnel will document details related to the receipt of the critical result information by the receiving Registered Nurse (RN).

B. Procedure for nurses or physicians (i.e. cardiologist) reporting a critical result to the attending provider:

1. Once a critical result is received, the nurse or responsible party is required to notify the provider responsible for the patient's care.
2. If the provider does not respond to the page, the page should be repeated once. If there is no response, the clinician should attempt to contact the provider's office, provider's practice on-call, the relevant section chief/department chair, Medical Staff President or the Chief Medical Officer (CMO), based on the urgency of the result and

the time of day.

3. For lab results, the nurse shall document in the medical record the critical value received, the time the provider was notified (except in circumstances listed in exemptions), and any actions taken to address the result.

Outpatient Procedures for Notification of Critical Results

A. The lab will initiate a call to the outpatient provider or responsible party, following the order as follows:

    1. Ordering provider's office or office staff (Note: Urgent Care is defined as Urgent Care desk).
    2. Ordering provider's pager or on-call designee.

B. In the event, the above parties are unable to be reached within 45 minutes and 3 or more attempts, the Clinical Pathology covering or on-call provider will be contacted with the following information:

    1. Patient name, medical record number, the critical result, the ordering provider, and the attempts at contacting.
    2. Patient contact information (phone number and physical address) will also be provided to the Pathologist for them to contact the patient directly, if clinically appropriate.
    3. If the pathologist if unable to contact the ordering provider or the patient, or otherwise deems further action necessary, the pathologist will initiate a welfare check by an emergency medical response crew.

C. When conveying results, validate the correct patient by using two identifiers. For both inpatient and outpatient, it is the patient's full name and date of birth and/or medical record number.

D. The office staff member or provider receiving the critical result information will write it down and read it back to the department completing the test. Staff providing the critical result(s) should always request the read back whenever communicating these results verbally.

E. Lab personnel will document details related to the receipt of the critical result information by the receiving party.

F. It is the responsibility of the outpatient office, clinic, or service to ensure a process exists for the results to be rapidly conveyed to a provider who can provide orders or make recommendations to the patient for care.

Special Instructions

A. For Munson Home Care patients, the ordering provider is the first contact for all critical results. In the event the ordering provider is unable to be reached, the provider's office or office staff shall be notified. Alternatively, the Home Care Triage Nurse may be paged to assist in notification process.

B. For patients of the Veterans Affairs (VA) Clinic, the ordering provider is the first contact for all

critical results, except the following circumstances:

1. For critical international normalized ratio (INR) during regular business hours, call 989-497-2500, extension 11731 (Anticoagulation Clinic at the Saginaw VA Center).
2. After hours, call 989-497-2500; ask for the medical officer on call.

Laboratory Critical Values

A. Use the following link for the Laboratory Critical Values list. Note: Adult and Pediatric values are on separate tabs.
   1. Laboratory/Point of Care Critical Values

Attachments

Critical Value Reporting Append B- CDS.docx

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	7/20/2023
Medical Executive Committee	Katryna Glettler: Sr Spec Lead, Med Staff Services SNE - Central Reg	7/20/2023
Policy Owner	Walter Noble: Chief Medical Officer	6/9/2023

Applicability

Munson Medical Center

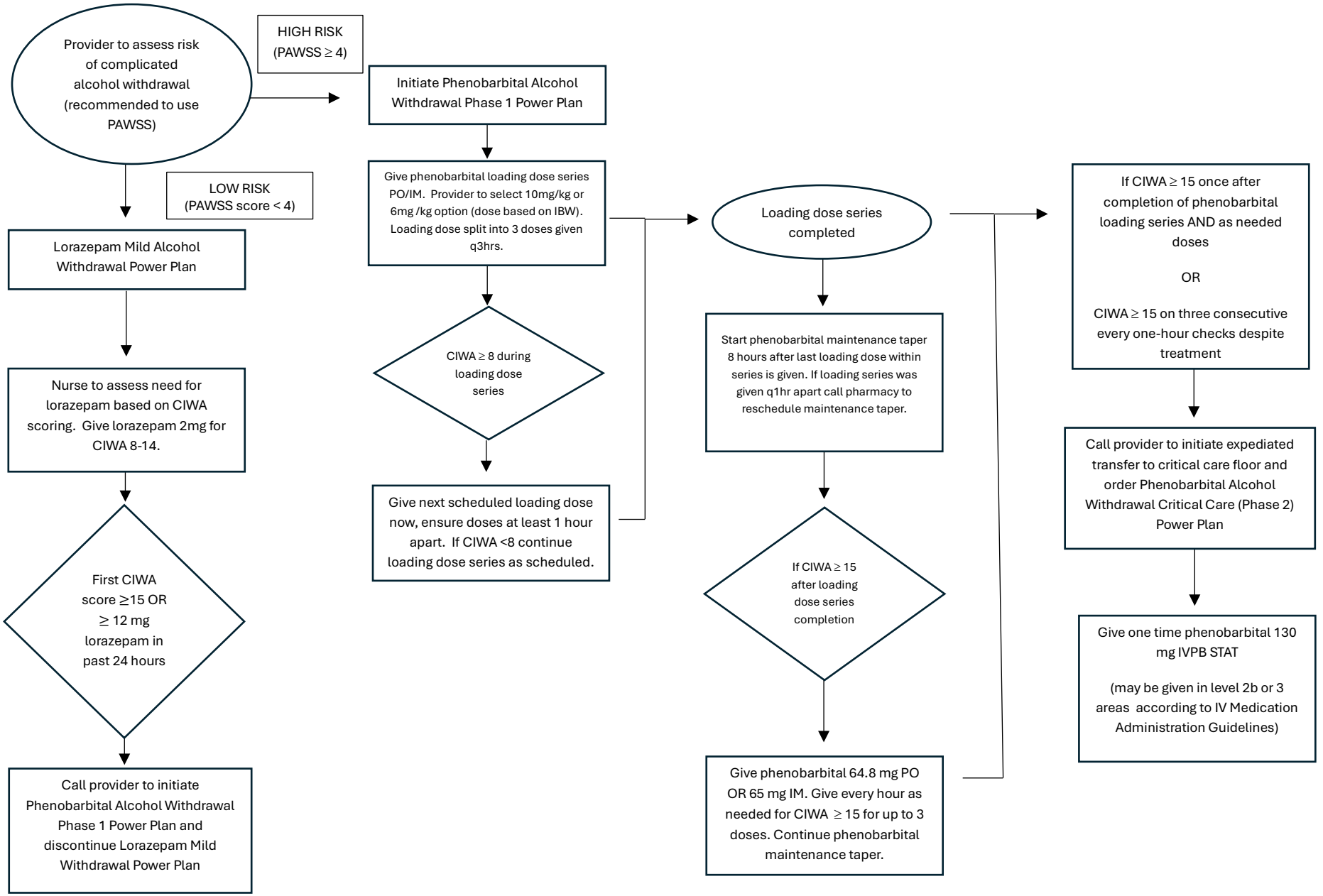
Standards

No standards are associated with this document

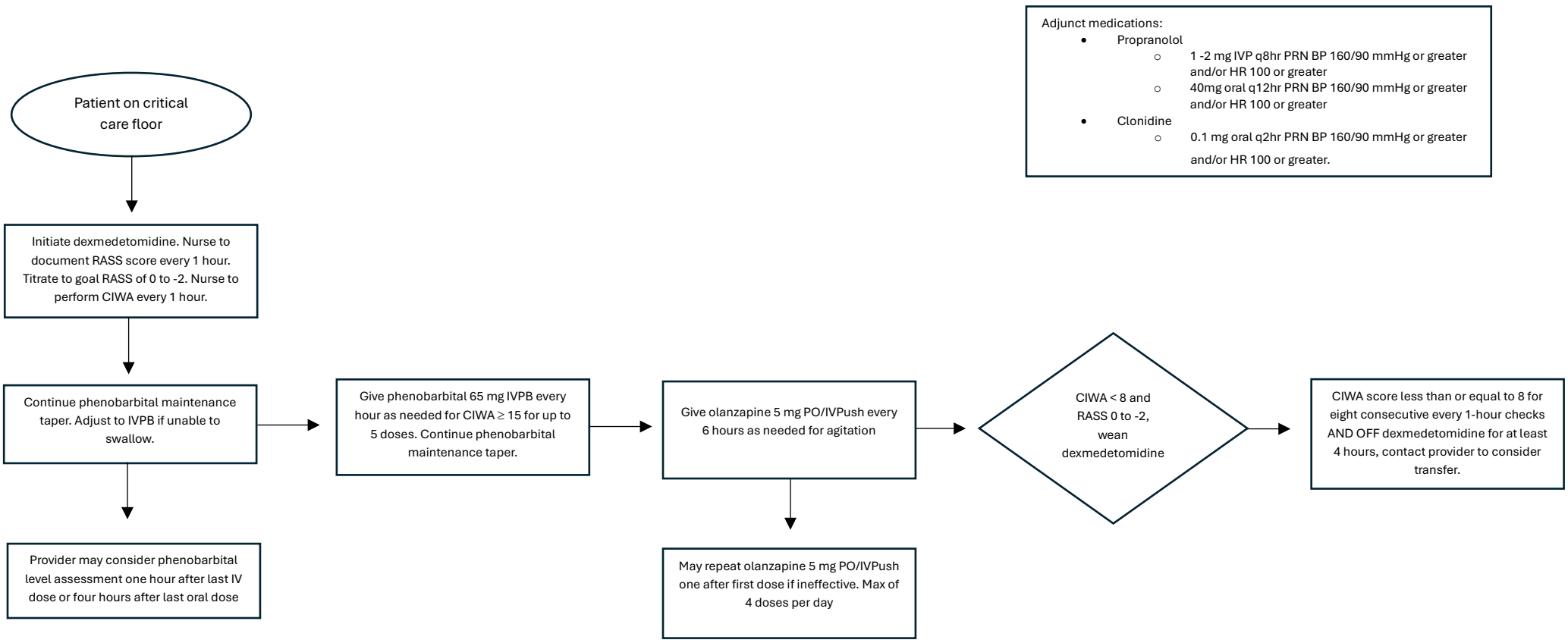
Phenobarbital Alcohol Withdrawal Phase 1

Adjunct medications:

- Propranolol
  - 1 -2 mg IVP q8hr PRN BP 160/90 mmHg or greater and/or HR 100 or greater
  - 40mg oral q12hr PRN BP 160/90 mmHg or greater and/or HR 100 or greater
- Clonidine
  - 0.1 mg oral q2hr PRN BP 160/90 mmHg or greater and/or HR 100 or greater.



Phenobarbital Alcohol Withdrawal Critical Care (Phase 2)



Restraints

Type of restraint/seclusion will be the least restrictive intervention to protect the patient, a staff member, or others from harm.

Non-violent restraints: used for non-self-destructive or non-violent behavior interfering with medical care, devices, tube/drains. The least restrictive device will be initiated to maintain the safety of the patient and staff.

Violent restraints: used only in situations where the patient's behavior becomes self-destructive, violent, aggressive, or assaultive and presents an immediate danger to the safety of the patient, other patients, or staff. The least restrictive device will be initiated to maintain the safety of the patient and staff.

Pearls

- Always use the least restrictive.
- Use of restraints is based on CURRENT patient behavior.
- Restraints must be discontinued at the earliest possible time.
- Restraints use should only be continued if the patient is still ACTIVELY exhibiting the behavior that led to restraints initiation, otherwise, the patient must be removed from restraints.
- Monitor the patient carefully for signs/symptoms of distress or injury.

Considerations

Risks of Restraints	Alternatives to Restraints
Entanglement in siderails or straps Choking, Suffocation, Death Weakness and Functional Decline Poor circulation, Skin Breakdown Aspiration, Pneumonia Rhabdomyolysis Infringement of rights Traumatization/re-traumatization Humiliation/Helplessness Agitation, Anger, Delerium	De-escalation Assess for and treat underlying causes (pain, delirium, hypoxia) Distraction Techniques Reduce stimulation (lights/sound) Evaluate needs for lines/tubes- secure/cover when present Implement "All About Me" form Ensure patient has necessary belongings (glasses, hearing aids, dentures)

Restraint Devices	Pearls
Mittens	Mitts are less restrictive (when not tied down) than soft restraints or hard restraints. May or may not be consider restraint. Considered a restraint if patient is unable to self-remove, significantly reduces the patient's ability to use hands, are used with wrist restraints.
Soft	Less restrictive than hard restraints. Always use a quick release knot. Can be used for both violent and non-violent criteria.
Hard	More restrictive than soft restraints. Does not require all four limbs to be secured. Can be used for both violent and non-violent criteria. Key required for removal.
Restraint Chair	Most restrictive. Used for violent patients only. **Only** used by ED, Behavioral Health, and designated Gray Team members with documented restraint char competency.
Spit Hood	Reduces staff exposure to a patient's oral or nasal secretions. **Only** used in situations where staff are unable to immediately access PPE. Monitor airway and respiratory status carefully while in use.

Restraint Requirements

Side Rails

A patient may have 2 or 3 side rails up so that they can control the movement of their bed or assist with positioning.

If 4 side rails are up with the intent to keep the patient from getting out of bed, this **is considered a restraint**.

Side rails are not considered a restraint when used for cribs, gurneys, patients covering from anesthesia, patients on seizure precautions (padded), or for certain specialty beds that require side rails to be up to prevent patient from falling out of bed.

Discontinuation

Discontinue restraints immediately when patient is no longer exhibiting the behavior that led to restraint initiation.

Document discontinuation in iView and inactivate dynamic group.

Temporary or trial removals are never allowed.

Once a restraint is discontinued, a new order must be obtained to reapply.

Changing Device

When changing a restraint device or number of points, document: “Change Device” in iView. This will discontinue restraint order and all associated tasking.

A new order for the new device or number of points will then need to be entered.

	Non-Violent	Violent
Reason for Restraint	Used for non-self-destructive or non-violent behavior interfering with medical care, devices, tube/drains.	Used only in situations where the patient’s behavior becomes self-destructive, violent, aggressive or assaultive and presents an immediate danger to the safety of the patient, other patients or staff.
Order Entry	Electronic order. Prior to application; however, in an emergent situation, a RN may initiate intervention. During or immediately after (within minutes) application of restraints, the provider must be notified, and orders obtained.	
Order Duration	Daily	Time-limited renewal order must occur in accordance with the following time frames for a maximum of 24 hours: • Every 4 hours for adults • Every 2 hours for 9-17 years of age • Every hour for children under 9 years of age
Provider Face to Face Assessment Requirement	No Face-to-Face Requirement	Within 1 hour of initial restraint application. After 24 hours, before entering a new order, a provider must see, assess, and document a face-to-face assessment.
Monitoring Documentation Requirements	RN will assess every 2 hours, document in the EHR.	RN will assess every 15 minutes, documenting in the EHR.

Resources

Policy:

Use of Restraints and Seclusion: Ordering, Monitoring and Documentation Requirements

Lippincott:

Restraints Application, Limb

Twice as Tough Physical Restraints (MHC)

Restraints Application, Mitts

EHR:

Non-Violent Restraints

Violent Restraints

Patient Rights

Informing patients of their rights is crucial for ethical and legal reasons, empowering them to make informed decisions about their healthcare and fostering a more trusting relationship with healthcare providers.
It also helps ensure patients receive respectful and dignified care, contributing to better health outcomes.

Patient Rights and Responsibilities

(see ***Patient Guide*** for more details)

Considerate and Respectful Care	• To receive ethical, high-quality, safe, and professional care. • To be treated with dignity, respect, and recognition of their individuality including the need for privacy in treatment.
Information Regarding Health Status and Care	• To be informed of their health status in terms that they can reasonably understand, and included in the development and implementation of their plan of care and treatment.
Ethical Decision Making and Notification	• To participate in health care decisions. • To choose a person to be their healthcare representative.
Access to Services	• To receive the free services of a translator/interpreter or other devices to facilitate communication. • Includes access to food, and safe, sanitary conditions.
Access to Medical Records	• To have all their medical records and protected health information kept confidential.
Protective Services	• Access to protective and advocacy services. • To expect emergency procedures to be carried out without unnecessary delay.
Payment and Administration	• To examine and receive an explanation of the patient's healthcare facility's bill, regardless of source of payment.
Additional Patient Rights	• Request opinion of another provider. • Request transfer to another unit/room.
Patient Responsibilities	• Provide accurate medical history. • Ask questions when you do not understand. • Report changes in your condition/pain/safety issues.
Visitation Rights	• To receive visitors, noting that guidelines may change based on factors such as environmental conditions.

Reminder

Patients are informed of their rights and responsibilities in the following ways:

- Patient rights are listed on the MHC website
- Patient rights are posted on the wall in main lobbies.
- At time of registration, patients are informed that they can request a printed copy of their rights.

Inpatients receive the ***Patient Guide*** upon admission, which contains their rights listed

Abuse and Neglect

Screening

Screening for abuse and neglect should be done at entry into the healthcare system and on an ongoing basis.

- When signs and symptoms are noted
- During routine health history
- Standard health assessment

Reporting

Per Michigan Child Protection Law report to centralized intake by phone or online. Within 72 hours of making an oral report the reporting person shall file a written report.

Adult Protective Services is an oral report, over the phone, via Central Intake.

With any assault it is the responsibility of all healthcare providers to report any person suffering from an injury inflicted by a weapon or form of violence to the appropriate police agency.

*Reporting Reminder

You are reporting the *suspicion* of abuse/neglect. Reporting in good faith frees the reporter from any liability, even if the report proves unfounded.

Types	• Intimate Partner Violence • Child Abuse/Neglect • Vulnerable Adult Abuse/Neglect
Signs and Symptoms *Listed are some possible signs and symptoms, but not an exhaustive list.	• Discomfort with questioning. • Presence of partner/caregiver/parent who controls the interview- may not leave pt alone with you or overly anxious/concerned. • Repeat visits with vague complaints. • Dehydration/Malnutrition • Bruising, Burns, Injuries • Wearing clothing inappropriate for the weather • Untreated medical conditions • Suicide attempts • Frequent UTIs/Vaginal Infections • Mixed feelings toward caregivers • Medication overdose or underdose
Actions	• Inform the pt of your support and availability. • Quote what is disclosed to you by those involved. • Michigan **mandates** reporting of suspected abuse/neglect with children and vulnerable adults. • Hospital staff will **NOT** do the child abuse/neglect investigation. It will be done by personnel from appropriate agencies that have undergone specialized training. • Communicate concerns of abuse/neglect with supervisor.

Documentation:

- Be objective and professional
- Use statements made by the victim/caregiver
- Include observed appearance and behavior of the victim
- Include name and relationship of the suspected abuser to the victim
- Describe event: date, time and location
- Be specific with details of injuries: number, size, location, degree of healing

Resources

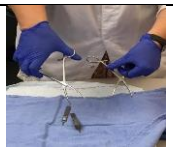
Centralized Intake (all suspected cases of abuse or neglect): (855) 444-3911

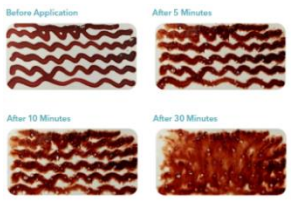
Form: Patient Guide: #12342
Actual or Suspected Child Abuse Report Form (DHS 3200)

Policy: Identifying and Reporting Abuse, Neglect, and/or Exploitation of a Vulnerable Adult
Abuse, Neglect, Exploitation, and Assault

Process Title: Proper Care of Instruments at the Point of Use V8 **Date created:** 28 April 2019
Author: Joanna Benchley **Staff Involved:** Clinical Staff, CPD or NMSA Courier **Last revision:** 14 August 2025
Purpose: Reduce the risk of infections associated with medical equipment, devices, & supplies
Scope: MHC ambulatory and hospital departments **Cadence:** For sending reusable instruments to CPD for reprocessing

2025-08-15 Proper Care of Instruments at the Point of Use – Ambulatory and Hospital Departments V8

Step	Who	Process Description: Key points and Reason Why	Example/Image	✓
		PRIOR TO START OF PROCEDURE		
1	Clinical Staff	**GATHER:** 1. Gather the following prior to procedure: a. Instruments b. Biohazard container ***WHY**: Preparing Ensures Quality at the Source*		☐
2	Clinical Staff	**PREPARE CONTAINER:** 1. Open the biohazard container ***WHY**: Decreases the chance of cross-contamination to the outside of the container*		☐
		POST PROCEDURE		
3	Clinical Staff	**DON PPE:** 1. Gown, when appropriate 2. Eye protection, when appropriate 3. Gloves ***WHY**: Prevents personal exposure to potentially infectious contaminants*		☐
4	Clinical Staff	**DISPOSE OF ITEMS:** (Perform at point of use) 1. Dispose of sharps into sharps container 2. Discard disposable items into trash container ***WHY:** Do this first to prevent sharps injury*		☐
5	Clinical Staff	**DISASSEMBLE:** (Perform at point of use) 1. If instruments can be disassembled, disassemble them 2. If instruments have hinges, fully open the hinges 3. If instruments are grossly soiled, remove soil with moistened gauze ***WHY**: Prepares instruments for removal of biofilm and effective disinfection*		☐
6	Clinical Staff	**LOAD CONTAINER:** (Perform at point of use) 1. Carefully place instruments in biohazard container, ensuring hinged instruments remain fully open 2. Do not overload the biohazard container (≤30 instruments for large container) ***WHY**: Limits instrument damage and allows for sufficient pre-treatment contact*		☐
7	Clinical Staff	**CLOSE CONTAINER:** (Perform at point of use) 1. Remove PPE 2. Perform hand hygiene 3. Secure lid on biohazard container ***WHY**: Reduces risk of cross contamination to door handles and other pieces of equipment*		☐
8	Clinical Staff	**TRANSPORT CONTAINER:** 1. Transport the closed biohazard container to the soiled utility room or other designated area ***WHY**: Ensures reprocessing is completed in a timely manner*		☐
9	Clinical Staff	**DON PPE:** 1. Gown, when appropriate 2. Eye protection, when appropriate 3. Gloves ***WHY**: Standard precautions prevent personal exposure to potentially infectious blood or bodily fluids*		☐

Step	Who	Process Description: Key points and Reason Why	Example/Image	✓
10	Clinical Staff	*** FOLLOW THIS STEP ONLY IF CONSOLIDATING INSTRUMENTS INTO A LARGER BIOHAZARD CONTAINER*** **TRANSFER INSTRUMENTS FROM SMALL TO LARGE BIOHAZARD CONTAINER:** 1. Open small container 2. Open the large container 3. Carefully place the instruments from the small container into the large biohazard container 4. Ensure hinged instruments remain open ***WHY**: Eliminates the need for large volumes of small biohazard containers and makes it easier for transport to CPD*		☐
11	Clinical Staff	**APPLY PRETREATMENT:** 1. Once all instruments are in the biohazard container, spray evenly with pretreatment product, at a distance of 4"- 8", so that all instruments are visibly covered 2. To prevent injury, avoid reaching into the biohazard container ***WHY**: Pretreatment product keeps bioburden from drying and creating biofilm, which is more difficult to remove by CPD*		☐
12	Clinical Staff	**CLOSE CONTAINER:** 1. Remove PPE 2. Perform hand hygiene 3. Secure lid on the biohazard container NOTE: If there is a desire to re-glove before securing the lid, once lid is secured, **gloves must be removed, and hand hygiene performed again** ***WHY:** Decrease the risk of cross contamination to door handles and other pieces of equipment*		☐
13	Clinical Staff	*** ONLY FOR DEPARTMENTS WHO FOLLOWED STEP 10 AND CONSOLIDATED INSTRUMENTS INTO A LARGER BIOHAZARD CONTAINER *** **DISINFECT SMALL BIOHAZARD CONTAINER:** 1. Don gloves 2. Disinfect the outside and inside of small biohazard container and lid using a hospital approved disinfectant wipes 3. Perform hand hygiene 4. Secure lid on the biohazard container 5. Return the biohazard container to clean storage ***WHY**: Disinfecting containers in between each use ensures they are safe for handling for the next patient*		☐
14	Clinical Staff	**PLACE CONTAINER IN CPD PICKUP AREA:** 1. Transport biohazard bin to the designated CPD pick up area and follow department specific process for pickup (E.g., place biohazard container in CPD case cart or place in larger CPD biohazard transport container) 2. Ecolab OptiPro gel and Steris PreKlenz will keep instruments moist in a closed container for 72 hours ***WHY**: Delaying processing allows for drying of organic soils and the formation of difficult to remove biofilm a*		☐
15	CPD or NMSA Courier	**CPD REPROCESS & RETURN BIN:** 1. CPD or NMSA Couriers round to pick up contaminated items at designated pickup times and locations ***WHY:** Grossly soiled instruments may be more difficult to clean if they are not cared for in an expedited fashion by CPD*		☐

Phone Numbers:	***Additional Notes:***
Central Processing Departments: MMC:231-935-6579 CAD:231-876-7383 MAN:231-398-1181 POMH:231-352-2250 GRY:989-348-0084 OMH:989-731-2457 CHX:231-547-8679 KMH:231-258-3632 **NMSA Courier Service:** 231-935-8233	• This process was reviewed and revised, by comparing AORN, AAMI, & OSHA standards, by the System Infection Prevention team **on 15 August 2025**. • Order information for the red biohazard containers: SST-283 RD LTCH, SST SYSTEM 18Lx12Wx3H-red with latches, 1= $123.03 NMSA# 81271 SST-2136 RD LTCH, SST SYSTEM 21Lx13Wx6H-red with latches, 1= $145.30 NMSA# 81272 SST-105 RD LTCH, SST System 10Lx7Wx6H-red with latches, 1 = $81.00 NMSA#81864

Munson Healthcare

Clinical Cleaning and Disinfecting Wipe Quick Reference Guide

Follow equipment manufacturer's instructions for use (IFUs) when choosing a wipe. Wear gloves when cleaning and disinfecting.

Product	Equipment	Dwell Time
Sani-Cloth AF3 Germicidal Wipes 	Bladder Scanners Bone Density (DXA) Cardiac Testing CPAP / BiPAP Machines Desktop Computers & Hardware Echocardiogram Glucometers Heated High Flow Oxygen Mechanical Lifts Rehab/Therapy Equipment PAPRs Pill Crushers (reusable) Pumps (Feeding & SCD) Suction Machines Telephones Thermometers Treadmills Ultrasound Probes and Machines Ventilators Vital Machines Weight Scales X-ray (fixed and portable) Use for General Disinfection of Work Surfaces	DISINFECTS IN 3 MINUTES
Sani-Cloth Bleach Germicidal Wipes 	Glucometers IV Pumps Laptops – not screens Mammography Phillips Monitors Posey Seizure Pads Spacelabs	DISINFECTS IN 4 MINUTES Kills C. Diff, C. Auris and Norovirus
Easy Screen Cleaning Wipes 	Computer and Laptop Screens Personal Digital Assistants (PDAs) Tablets and iPads Use to remove disinfectant residue from electronic equipment as needed Use for equipment requiring cleaning with 70% isopropyl alcohol	Wipe and Wait Until Surface are Dry

Cleaning and Disinfecting the Nova Stat Strip Glucometer

- Must be cleaned between patients with infection prevention approved wipe. Approved wipes include:
    - PDI Sani-Cloth Bleach Wipes
    - PDI Sani-Cloth AF3 Wipes

Gloves required when blood/other potentially infectious body fluids are present

- The wipe should be damp, but not dripping or saturated.
- No moisture or fluid should pool on the screen or enter the strip port, bar code scanner, or electrical connection.
- Inspect prior to use, clean if indicated.
- Clean and disinfect after each use, including QC checks.

To clean the meter:

- ☐ Remove fresh wipe from cannister, wipe the external surface thoroughly to remove any visible blood, protein, dust or debris.

To disinfect the meter:

- ☐ Remove another fresh germicidal wipe.
- ☐ Thoroughly wipe the top, bottom, left side and right side of the meter a minimum of **three times** vertically and **three times** horizontally.
- ☐ Gently wipe the surface of the test strip port, making sure no fluid enters the port.
- ☐ Ensure the meter stays wet for the required **dwell time**.
    - **Dwell time**, per EPA definition, is the amount of time that a sanitizer or disinfectant must be in contact with the surface, and remain wet, to achieve the product's advertised kill rate.

To clean the docking station:

- ☐ Remove fresh wipe from cannister, wipe the external surface thoroughly to remove any visible dust or debris.
- ☐ Wipe down docking stations daily. Don't forget the inner section where the glucometer attaches to the docking station.

ENSURE YOU CLOSE THE TOP OF THE WIPES CONTAINER

Updated by System IP 09/26/2025

MUNSON HEALTHCARE WASTE STREAM MANAGEMENT







HAZARDOUS PHARMACEUTICAL WASTE

All partially used or unadministered drugs and non-empty drug containers that are indicated in the EMR as BLK for a hazardous substance.

EXAMPLES:

- Insulins
- Oral and IV contrast
- Bulk chemotherapy medications
- All medication spill clean-up
- Warfarin and warfarin packaging
- Hazardous parenteral and oral products
- IV bags, tubing, and other containers with residual hazardous medication
- All nicotine products and packaging

NON-HAZARDOUS PHARMACEUTICAL WASTE

All partially used or unadministered drugs and non-empty drug containers that are not indicated as a hazardous or controlled substance.

- Non-empty containers of medication
- Unused medications: pills, tablets, powders, ointments and vials
- Non-empty IV bags and tubing containing residual medication
- Full or partial syringes of medication, with or without needles

INCOMPATIBLE HAZARDOUS WASTE

These wastes are to be returned to pharmacy as the DEQ requires segregation to comply with DOT, safety, and disposal facility requirements.

Follow hospital policy for disposal.

- Aerosols (Examples)
  - Aerosol inhalers such as Albuterol, Flovent, and Symbicort
  - Benzocaine spray
- Corrosives (Examples)
  - Acetic Acid
  - Hydrocortisone creams
- Oxidizers (Examples)
  - Used and unused silver nitrate sticks

CONTROLLED SUBSTANCES

Substances that are regulated and controlled under the Controlled Substances Act (CSA) in the United States.

All solid dosage forms, patches, and the remaining contents of vials, ampules, IV bags, epidural cassettes, PCAs, or any other form of controlled substances.

To be disposed of into the Secure a Drug container.

Empty bottles/vials should be placed in trash.

Full Secure A Drug containers should be placed into black bin labeled 0115.

MAINTENANCE IV SOLUTIONS & FEEDINGS NO MEDICATIONS

Open and pour down the drain.

Place empty plastic bag in trash.

- Feedings
- Maintenance IV Solutions Containing:
  - Potassium Chloride
  - Potassium Phosphate
  - Sodium Phosphate
  - Calcium
  - Sodium Bicarbonate
  - Dextrose
  - Saline
  - Magnesium
  - Lactated ringers
  - Electrolytes

TRACE CHEMOTHERAPY WASTE

Waste that is contaminated through contact with chemotherapeutic agents.

Containers deemed "RCRA Empty" with no more than 3% by weight of the container remaining.

- Tubing and empty bags
- Contaminated PPE (Includes gloves, gowns, masks, foot covers, hair cover, goggles)
- Needles and syringes

Containers containing over 3% by weight should be disposed of as hazardous.

SHARPS CONTAINERS

NO MEDICATIONS ALLOWED

Items that could cut or puncture human skin or a garbage bag.

- Scalpel blades
- Syringes with a needle
- Opened empty ampules
- Empty carpuject syringes
- Broken glass
- Glass vials
- Trocars
- Scissors
- Single-use instruments
- Glassware

MEDICAL WASTE

NO MEDICATIONS ALLOWED

Red container and/or a container with a red liner labeled with the words "biohazardous waste" or with the international biohazard symbol.

- Blood tubing/bags/ hemovacs/pleuravacs

Items soaked or saturated with blood/body fluids with potential to splash, splatter or drip

- Suction canisters or liners with bloody fluid or OPIM
- Chest tubes
- Glass/plastic specimen containers with body fluids (for the lab)

NOTE:
Feces, urine, sputum, vomit, sweat, and tears are not biohazardous unless there is visible blood.

PATHOLOGICAL WASTE

- Limbs
- Organs/Tissues

Packaging/Storage/ Labeling/Treatment

- Refrigerated until within 24 hours of pick-up
- If stored in Formalin, must be separated or managed accordingly
- Must be labeled with incineration sticker
- Treated through incineration

GENERAL TRASH NO MEDICATIONS

- All empty maintenance IVs and tubing
- Empty medication wrappers and packaging (except P-listed items)
- Non-contaminated PPE
- Empty antibiotic bags (unless labeled HW)
- Stained gauzes/ dressings
- Syringes without a needle

NOTE:
Feces, urine, sputum, vomit, sweat, and tears with no visible blood should be placed into the sewer and the containers disposed of as regular trash.

DISCLAIMER: This is a GUIDE ONLY and is intended to provide general information. Users of this guide are strongly encouraged to check applicable local, state and/or federal regulations

USN241160

Daniels
MAKING HEALTHCARE SAFER

Medication Management

It is the *responsibility of the nurse* to review the order details for completeness. Contact the provider if the current order does not meet the patient's assessed needs.

ANY departure from the medication orders without a documented reason supported in the order comments or a related policy, is outside the scope of the RN practice and licensure.

Seven Rights of Medication Administration

1. Patient
2. Medication
3. Dose
4. Route
5. Time
6. Indication
7. Documentation

Secure Medication

1. Pyxis Machine
2. Locked med room (no controlled substances)
3. Locked clean supply (IV fluids)
4. Locked nurse server (no controlled substances)
5. Meds under constant supervision until administered (not pockets)

Titrating Orders Components:

1. Medication name
2. Route
3. Initial rate of infusion (dose/unit of time)
4. Incremental units the dose can be increased or decreased
5. How often the dose can be increased or decreased
6. Maximum dose of the infusion
7. The objective clinical measure to be used to guide changes

PRN Order Reminders:

- Ensure the reason you are administering the medication matches the reason listed on the order.
- Ensure that it is administered in the timeframe and dosage it was ordered.
- If more than one medication is ordered for the same specific purpose the order(s) MUST be clarified.

Secure Medication Storage Requirements

- Medication storage areas including nurse servers must be **secured at all times.**
- Medications not securely locked must be under constant surveillance of an authorized personnel.
- Medications that are not secured may not be left unattended, even at the patient's bedside.
- Controlled substances **CANNOT** be stored in nurse servers.

Intravenous Tubing:

- IV tubing must be changed at the following intervals
  - **After each use:** Propofol, Intermittent lipids, Blood Products
  - **Every 24 hours:** Continuous lipids, Total nutrition additive (TPN), Intermittent infusions, Secondary lines that are disconnected from primary lines.
  - **Every 96 hours:** All other primary continuous infusions. All secondary lines that remain connected to the primary line, hemodynamic pressure lines.
- **Label tubing to indicate the day it needs to be changed**

Medication Titration

- Titrating orders include the progressive increase or decrease of dose in response to the patient's status.
- Assessment of the patient's clinical condition is confirmed and documented before titration per order (i.e. RASS, blood pressure, heart rate, MAP).
- Confirm parameters before adjusting the dose.
- If the ordered parameters are not meeting the patient's needs, you must contact the provider.
- Medication is scanned and dose changes are documented in the MAR concurrently with dose changes on the IV pump.

Additional Resources

Policy: High Alert Medications

Policy: Medication Administration

Policy: Ordering and Prescribing-General Requirements

Policy: Storage and Handling Requirements for Medications (Housewide)

Tips

Discuss with provider to consider scheduled non-opioid therapies (ex. Tylenol, Motrin, Toradol).

Consider chronic pain patients carefully.

Never administer PO and IV opioids at the same time.

Oral pain medications are the preferred route to help prepare patients for discharge and a home pain management regimen.

Clarify with provider inadequate response to therapy.

Peak Consideration

- PO peak effectiveness 60 min.
- IV peak effectiveness 30 min.

Non-Pharm Consideration

- Ice/Heat
- Repositioning/Elevation
- Distraction/Music/Imagery
- Breathing

Sedation Scales

The nurse may use sedation assessment scales to help balance pain management and risk of oversedation.
ie. RASS, SPAD or POSS

Pain Management

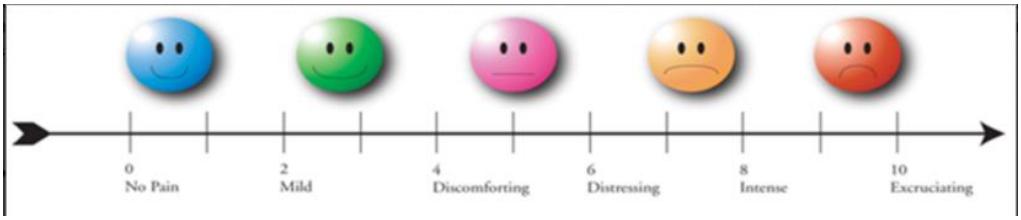
It is the responsibility of the provider to enter orders that clearly define when and how medications are to be administered.

- For PRN Pain Medication, the order must specify the level of pain for which the medication ordered is expected to be administered.

Assess the level of pain	• This will trigger the RN to administer a **specific** PRN pain medication.
Clear doses & medications for assessed level of pain	• Non-specific range orders or duplicate indicators for PRN medications are **NOT** allowed.
Clear and specific orders	• Any ambiguity in order details **must be clarified** with an ordering provider prior to administration.

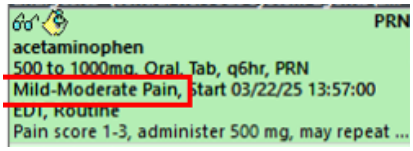
Pain Assessment

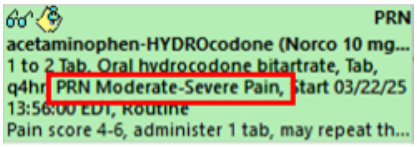
Assess pain **within 30 minutes prior** to administration of medication and reassessment of pain **within 60 minutes after** administration of pain medication.



Mild Pain (1-3)	Moderate Pain (4-6)	Severe Pain (7-10)
• Troublesome, not interfering with activities or sleep, may be intermittent. May require interventions.	• Distracting, may interfere with activity, sleep, and mood. Interventions may be indicated.	• Incapacitating, overwhelming and agonizing, activity and sleep are disturbed. Urgent interventions may be indicated.

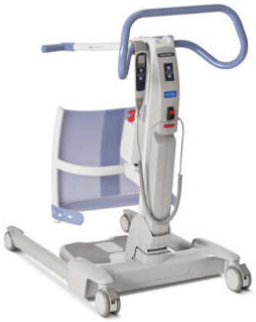
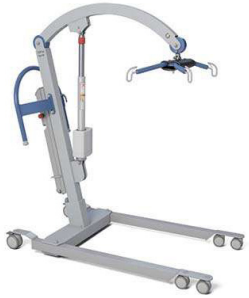
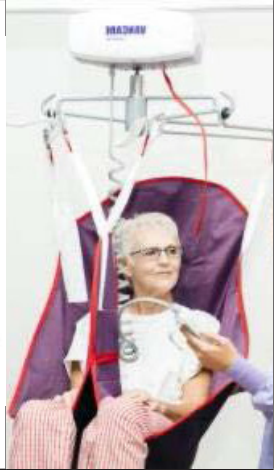
This is an example of a **therapeutic duplication** and must be clarified. Both orders have PRN indications for Moderate Pain.





MUNSON HEALTHCARE

GUIDE TO LIFTS

Device	Sara Stedy (ARJO)	Sara Flex (ARJO)	Sara Plus (ARJO) *(Only on A7 & rehab units)*	Maxi Move (ARJO)	Maxi Twin Compact (ARJO)	Tenor (ARJO)	Ceiling Lift (Van Care)
Weight Limit:	400 lbs	440 lbs	420 lbs	500 lbs	350 lbs	704 lbs	600 lbs
Used for:	Non-Powered Standing/Raising, Short Distance Patient Moving	Powered Standing/ Raising Device, Short Distance Patient Moving	Powered Standing/ Raising Device, Balance, Step, and Gait Training	Passive Lifting/ Transferring to chair or commode, can place the patient in an upright position with a click of a button, also can lift patients off the floor.	Passive Lifting/ Transferring into or Out of a Vehicle	Bariatric Passive Lifting/Transferring to chair or commode, also can lift patients off the floor	Passive Lifting/ Transferring to chair or commode
Patient Type:	Need **minimal** assist to stand &/or transfer, **NO lower extremity weight bearing restrictions**	Need **moderate** assist to stand &/or transfer, **NO lower extremity weight bearing restrictions**	Need **moderate** assist to stand or walk, **NO lower extremity weight bearing restrictions**	Need **max to total assist** to mobilize, patients with non weight bearing (NWB) lower extremities (LEs)	Need **max to total assist** to get **in & out of a vehicle**	Need **max to total assist** to mobilize, patients with non weight bearing (NWB) lower extremities (LEs)	Need **max to total assist** to mobilize, patients with non weight bearing (NWB) lower extremities (LEs)
Image:							

Hand-Off Communication

Hand-off communications occur in the following situations:

- Interdepartmental transfers (ex. shift change, or when care of patient is transferred to new provider).
- When patients leave their assigned unit and are transported to various areas of MMC for procedures, surgery, tests or therapies. (Ticket to Ride does not apply if nurse remains with the patient).
- When patient return to their assigned unit using Ticket to Ride.

Consider This for Verbal Handoff:

- Reason for Admission
- Pertinent Patient History
- Code Status
- Precautions/Isolation
- Mental Status/Level of Consciousness
- Vitals/Cardiac Rhythm
- Oxygen requirements
- Pertinent Assessment Findings
- IVs/Medications
- Fall Risk and Interventions
- Activity/Mobility Level

SBAR Communication

SBAR (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) is an effective communication, as it offers a clear and organized way to share information when care is transferred to a new nurse/provider. This structure enhances communication by ensuring essential details are conveyed accurately and efficiently, minimizing the chances of error or omissions.

When a provider must be paged for discussion, please include relevant data to address specific concerns:

Situation	• Concisely identify the current situation and reason for the call
Background	• Relevant history and current treatment plan
Assessment	• Vital signs (Temp, Pulse, RR, BP, SpO2), labs, pain, difficulty breathing, rhythm, level of consciousness
Recommentation	• What are you asking the provider to do? (ex. Can you come see the pt at bedside? I am not sure.)

If the appropriate provider is unable to be reached, or the provider's plan does not reflect the situation and/or best interest of the patient's safety, the nurse should follow the Chain of Command: Paging Response Time and Resolving Questions of Care or Safety policy.

Ticket to Ride

The ticket to ride is a standardized tool to communicate relevant medical history, important assessment findings and special safety concerns. Guidelines include:

- The bedside RN (in collaboration with the provider) determine if/when the patient is safe to transport and with what level of supervision/care.
- Patients will be accompanied by staff members trained in the appropriate care and monitoring required at the time of transport.
- Provider will determine whether the patient requires ECG monitor during transport.
- Any back-up/emergency equipment required by patient-specific conditions should always travel with the patient (ex. tracheostomy supplies).
- The primary RN will provide their contact information to ensure a direct line of communication.

Resources

Policy:

Transport and Hand-Off of Patients: SBAR and Ticket to Ride

Chain of Command: Paging Response Time and Resolving Questions of Care or Safety

Forms:

Ticket to Ride: #8890

SBAR: #8610

Ticket to Ride (ED): #11323

Plan of Care

Throughout the patient's hospitalization, there is a documented care plan to help guide the patient's treatment. Nurses play a key role in establishing and documenting the patient's progress to that Plan of Care.

Plan of Care includes:

- Nursing Plan of Care
- Progress/Consult Notes
- Order Sets and Pathways
- Standards of Care

Action

Each nurse participates in the care planning process. Each patient's Plan of Care contains goals and timeframes for achieving these goals.

Plan of Care Documentation

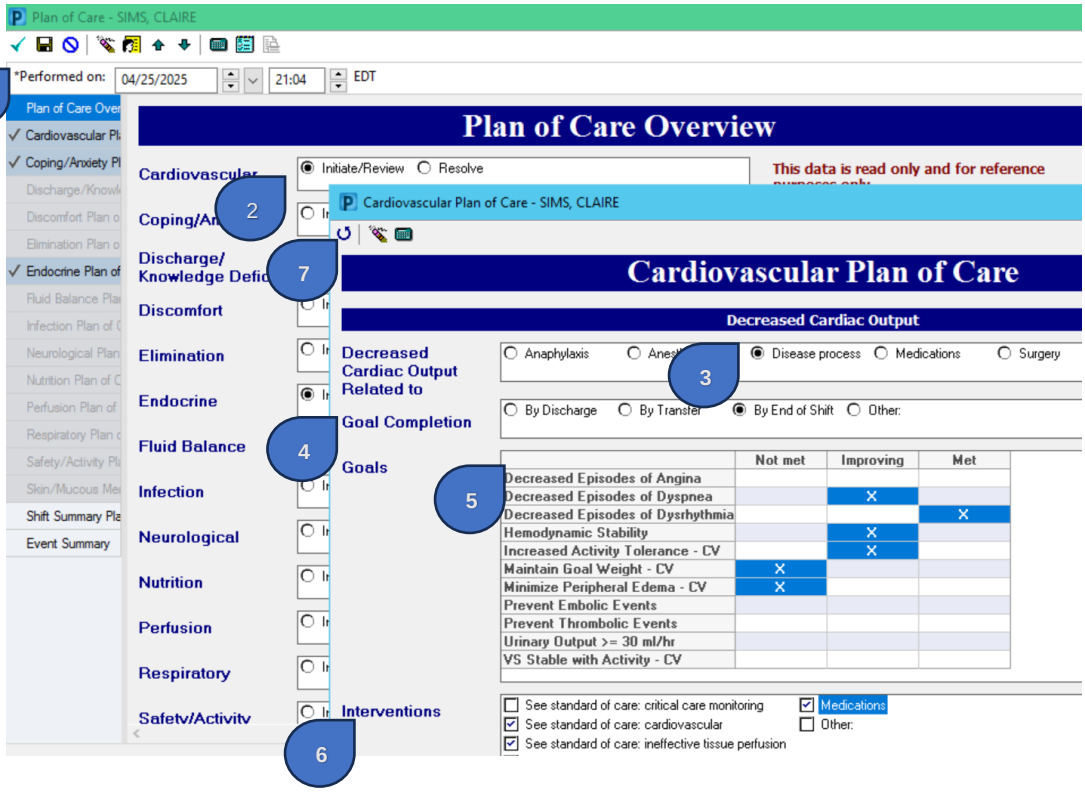
- Initiated by the RN on admission.
- Updated each shift (twice per day or via AdHoc).
- Include pt visit specific problems.
- Expected outcomes with goal timeframes.
- Interventions.

Timeframe/Goals can be found in:

- Nursing Plan of Care
- Established Pathways Order Sets (ex. total knee).
- Standards of Care (available as links within the nursing Plan of Care).
- Admission, Post-Surgical or Disease Specific PowerPlans (ex. Sepsis or Open Heart Surgery).
- Progress or Consultation Notes.

Discharge

If outcomes are not met at the time of discharge, document the reasons in the Comment field, found in the Nursing Plan of Care.



Documentation in Oracle

1. Ensure correct date and time under **Performed On**
2. **Initiate/Review** for Plan of Care Overview.
3. Complete all fields needed under selected problem.
4. Select timeframe for problem (should not all be at discharge).
5. Chart specific goals and progress toward goals every shift, update as needed.
6. Select interventions to help patient progress toward goals.
7. Return to Overview, select others as needed and Sign.

Resources:

EHR: Plan of Care, Hospital Nurses