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Saint John's Health Center
Providence

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Owner	Reena Manubag: Manager Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Code Ob

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Code OB

PURPOSE

To outline the Code Team response and process in the event of an antepartum/intrapartum obstetric emergency at Providence Saint John's Health Center, requiring emergent delivery of a fetus(es).

SCOPE

- Labor and Delivery and OB Staff, Providers, Anesthesiologists, Neonatologist, NICU RN, Respiratory Therapist, Emergency Department Providers and RN Staff

DEFINITIONS

Code OB: an overhead page and/or calls that are initiated when an antepartum/intrapartum patient at Providence Saint John's Health Center experiences an obstetric emergency requiring emergent delivery of their fetus(es).

Obstetric Emergency: a clinical event warranting timely intervention and delivery, which may include but is not limited to the following:

- Imminent or actual newborn delivery outside of Labor and Delivery
- Maternal cardiac or respiratory arrest anywhere in the hospital
- Additional Codes would be called as indicated

PROCEDURE/GUIDELINES

1. Code OB may be activated by any of the following personnel:

- Provider
- Labor & Delivery (L&D) and/or Emergency Department RNs

2. Code OB team members:

- Laborist
- L&D Anesthesiologist
- Labor and Delivery Charge RN or designee
- Neonatologist
- Neonatal Intensive Care Unit Charge RN or designee
- NICU Respiratory Therapist (RT)
- Security
- House Supervisor

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3. Mechanism for Code OB activation:

- Need for Code OB identified by Provider, L&D RN or Emergency Department RN
- Initiate Code OB by dialing "16" and requesting Code OB to location of emergent
- delivery
- The hospital operator will announce Code OB overhead and stat group page the Code OB team members to the emergency location
- Upon receiving the emergency page, all Code OB team members will respond to the designated location

4. Team Member Responsibilities:

A. First responder at emergent event:

- Initiate Code OB by dialing "16" and requesting Code OB to location of emergent delivery
- Provide maternal and/or fetal resuscitation measures as indicated
- Assess need for and activate Rapid Response Team if indicated
- Document events

B. Hospital operator:

- Initiates the overhead page for Code OB to emergency location
- Pages Code OB team members

C. Surgical tech (or 2nd RN)

- Call back-up anesthesia, if indicated by L&D charge nurse
- Call adult Respiratory Therapist (RT) if indicated
- Open OR or labor room as indicated, or delegate a staff member to do so if emergency occurs outside of L&D
- If RN, enters orders and prepares paperwork as indicated

D. L&D charge nurse or designee:

- Responds to Code OB events
- Directs staff
- Notifies patient's attending physician/obstetrician, or delegates a staff member to do so
- Provides additional help and assists with transfer, if necessary
- Brings Born out of Asepsis (BOA) kit to location off L&D unit
- Assess need for and activate Rapid Response Team if indicated
- Assess need for back-up anesthesia and delegates call to surgical tech/2nd RN

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E. Laborist:

- Responds to Code OB events
- Assists with intrauterine resuscitation and/or directs delivery
- Assess need for and activate Rapid Response Team if indicated

F. Anesthesiologist:

- Responds to Code OB events
- Assists with IV access as indicated
- Assists with airway management and/or anesthesia, as necessary

G. Neonatal team (Neonatologist & NICU Charge RN or designee):

- Responds to Code OB events
- Initiates care of the newborn

H. NICU Respiratory Therapist: (cell phone 310-382-1802)

- Responds to Code OB events
- Initiates care as indicated

I. Emergency Department RN (if outside of Labor and Delivery):

- Obtain BOA kit (located bottom draw of OB cart)

J. Security:

- Responds to Code OB events
- Assists with access and crowd control
- Supports unit as indicated

K. Additional team members and roles:

- House Clinical Coordinator to provide administrative help as needed
- OB surgical tech may provide additional clerical assistance

5. Documentation:

- Documentation of nursing care/interventions will be completed according to documentation standards in the area the obstetric emergency event occurs.

REFERENCES

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A. American College of Obstetricians and Gynecologists Committee on Ethics. (Reaffirmed 2018; 2014, March). Preparing for clinical emergencies in obstetrics and gynecology. ACOG Committee Opinion, (590).

B. Roth, C. K., Parfitt, S. E., Hering, S. L., & Dent, S. A. (2014, October/November). Developing protocols for obstetric emergencies. Nursing for Women's Health, 18(5), 378-390. doi:10.1111/1751-486X.12146

C. The Joint Commission. (2010, January). Preventing maternal death. Sentinel event alert.(44). Retrieved from www.jointcommission.org/sentinel_event_alert_issue_44_preventing_maternal_death/

Approval Signatures

Step Description	Approver	Date
Board of Directors	Siune Vartanian: Executive Assistant to CEO	08/2025
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	07/2025

Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	06/2025
PCSC	Jose Castro: Director Pharmacy	06/2025

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Infant Identification

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Policy Number: NB- 1

Effective Date: 2006

Review/Revise Date: 1/2009, 2/2012, 2/2015, 5/2018, 10/2024

I. PURPOSE

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Saint John's Health Center to provide guidelines for the nursing management of correct identification of the infant and mother at all times during hospitalization.

II. POLICY

A. Labor and Delivery Nursing staff will establish legal identity of the newborn by placing matching numbered identification band/bracelet on the infant's both ankles, and on mother's wrist.

B. Bands must be checked:

1. When assuming care of the infant
2. At the beginning of each shift
3. When transporting the infant to the mother
4. Whenever the infant is transported from the mother to the nursery
5. Before lab work or any invasive procedures or test

II. PROCEDURE

A. At birth maintain **infant security** by ensuring:

1. The delivery record and all 4 bands have the correct patient name
2. The delivery record and all 4 bands have the correct medical record number
3. All 4 bands have the same ID number and this corresponds to the number on the delivery record
4. Parent(s) participate in the verification
5. Apply ID bands to the infant's ankles, the mother's wrist and the significant other's wrist.
6. If there is no significant other present destroy the 4th band.

B. Attach electronic infant security tag to infants ankle, activate and enter into computer system

C. Maintain infant security at all times by:
    1. Verifying infants identification on admission to post partum or NICU
        a. The receiving nurse spells out loud the last name, medical record number and ID band number that is on the baby
        b. The transferring perinatal staff verifies this with the name, medical record number, and ID band number on the delivery record
        c. The significant other, if present, participates by verifying the data with his ID band
        d. Completion of this process is documented on the admission record
    2. Each time infant leaves the mother's room ID bands must be verified by perinatal staff and mother
    3. Only perinatal staff with approved ID badge may transport infant from the mother's room.
    4. Ensure each shift the electronic tag is activated and correct information is in the computer

D. Infant security at discharge:
    1. Remove one infant band and mother's band and attach them together to the chart copy of the discharge instructions.
    2. Have the mother sign the discharge sheet to validate her participation with the process
    3. Deactivate electronic tag
    4. Remove tag from the infant
    5. Remove the infant name from the electronic infant security computer system

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REFERENCES/RELATED POLICIES

Kilpatrick, Sarah J., Papile, Lu-Ann, and Macones, George A. (2017) *Guidelines for Perinatal Care, 8th Edition.* Elk Grove Village, Il: American Academy of Pediatrics; Washington, DC; The American College of Obstetricians and Gynecologists

Simpson, Kathleen R., and Creehan, Patricia A. (2014) *AWHONN's Perinatal Nursing, 5th Edition*. Lippincott Williams & Wilkins Philidelphia, PA

Newborn Care

Infant Security: Code Pink

Infant Security Plan

Approval Signatures

Step Description	Approver	Date
Board of Directors	Irma Castaneda: Executive Assistant	12/2024
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
PCSC	Jose Castro: Director Pharmacy	10/2024

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Saint John's Health Center
Providence

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Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Infant Safe Sleep

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POLICY

In keeping with the mission and values of Providence, it is the policy of Providence Saint John's Medical Center (PSJHC) to endorse the American Academy of Pediatrics (AAP) safe sleep recommendations from birth through the first year of life with the implementation and modeling of safe sleep practices whenever an infant is admitted and hospitalized in the Maternal Child Health (MCH) areas.

PURPOSE

The purpose of the policy is to outline nursing responsibilities related to and provide nurses with:

A. An evidence-based guideline for the purpose of providing a safe sleep environment for infants younger than 1 year,

B. Clarification on issues related to safe sleep, and

C. Recommendations on how to implement, endorse, and model safe sleep in their day-to-day practice in the MCH areas

D. The presence of this safe sleep policy provides a foundation for a culture of safety and is an effective intervention to improve safe sleep behaviors in the medical center environment, with strong leadership support ensuring implementation of this policy and demonstrating to staff that safe sleep is a medical center priority.

DEFINITIONS

A. Accidental asphyxiation or suffocation and strangulation in bed (ASSB) – An infant death as a result of suffocation or asphyxia while sleeping, terminology is used for vital statistical purposes.

B. Bed sharing – A sleep arrangement in which an infant sleeps on the same surface, such as a bed, couch, or chair, with another person

C. Co-sleeping – A sleep arrangement in which the parent (or another person) and infant sleep in close proximity (on the same surface or different surfaces) so as to be able to see, hear, and/or touch each other.

D. Developmental/therapeutic positioning devices – Positioning devices such as gel pillows, blanket rolls, and beanbags often are used to promote developmentally appropriate positioning for premature and critically ill infants.

E. Room sharing – A sleep arrangement in which an infant sleeps in the same room as parents or other adults, but on a separate sleep surface, such as a crib, bassinet, or play yard.

F. Sudden infant death syndrome (SIDS) – The unexpected death of an infant up to 1 year of age that is not explained by a careful review of the infant's medical history, an autopsy, and a death scene investigation.

G. Sudden unexpected infant death (SUID) – The newer terminology being used to describe infant deaths. It is an umbrella term used to classify any sudden unexpected infant death.

H. Sudden unexpected postnatal collapse (SUPC) – A new worldwide phenomenon occurring in obstetrical units related to the increase in breastfeeding and skin-to-skin care, occurs when an otherwise healthy newborn is found unresponsive with either temporary or permanent cessation of breathing and/or cardiorespiratory failure in the mother's bed, usually after breastfeeding or while performing skin-to-skin care while in the hospital.

I. Therapeutic positioning – Sleep positioning used for medical reasons (prone, side-lying, elevated head of bed); may include developmental positioners as recommended by occupational/physical therapy.

J. Tummy time – Providing infants who are placed primarily in the supine position with daily opportunities for awake, supervised prone positioning.

K. Undetermined – A generic term utilized when there is a lack of data or conflicting evidence for competing causes for the medical examiner or coroner to make a conclusion about the exact cause of death.

L. Unexplained – Refers to the lack of explanation for an infant's death following a rigorous investigation.

PROCEDURE/GENERAL INSTRUCTIONS

A. The AAP Safe Sleep Recommendations include the following:

1. Supine-only sleep position for healthy full-term infants
2. Stable preterm infants should be positioned supine per back to sleep recommendations by 32 weeks postmenstrual age (when medically stable).
3. Healthcare professionals should endorse and model safe sleep strategies, commencing at birth.

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4. Offer pacifier at sleep times. (Note: The AAP recommends for term infants that pacifier use be delayed until breastfeeding is well established; however, in preterm infants the benefits of pacifier use may outweigh the potential impact on breastfeeding).
5. Breastfeeding is recommended.
6. Stay up to date on infant's immunizations.
7. Firm sleep surface with a tight-fitting sheet.
8. Avoid soft surfaces and loose bedding in the infant's sleep environment. No extra bedding, soft objects, stuffed animals, etc. in the infant's sleep space.
9. Avoid bed sharing and co-sleeping.
10. Avoid overheating.
11. Separate but proximal sleep surface (i.e. in parents' room; not in parents' bed).
12. Encourage "tummy time" while infant is awake and being observed.
13. Avoid commercial products to maintain infant sleep position or reduce risk of SIDS (other that developmental positioners for preterm infants who are not cleared for back to sleep due to medical instability).
14. Avoid maternal and second-hand smoke exposure.
15. Gestating parent should receive regular prenatal care.
16. Breastfeeding parent should avoid alcohol and illicit drug use during pregnancy and after birth.
17. Do not use home monitoring device to reduce SIDS.

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B. Equipment
    1. Open cribs
    2. Bassinets
    3. Incubators
    4. Open warmers

C. Safe Sleep Environment
    1. Supine position (on back)
    2. Flat position (head of bed not inclined)
    3. Crib/bassinet/incubator/warmer empty of positioning devices
    4. Crib/bassinet/incubator/warmer empty of soft objects such as dolls or other toys, fluffy blankets, clothing, and/or other extra linen under face
    5. Crib empty of medical devices (bulb suctions, diapers, diaper wipes, facecloths, etc.)
    6. One thin sheet or blanket may be tucked around mattress to cover plastic surface

7. No hats once infant's temperature is stabilized.
8. Low swaddle or in a "Sleep Sack" when available
9. Safe Sleep Crib card on the crib/incubator.

D. Modeling Safe Sleep Behaviors

1. All MCH nurses caring for infants are to model a safe sleep environment beginning at birth (or as early as medically feasible) to effectively influence parents' and caregivers' safe sleep practices after discharge.
2. Do **not** model behaviors that conflict with the AAP recommendations, as parents may perceive that the recommendations are not actually important and instead mimic the unsafe behaviors they have observed.

E. **Labor and Delivery (L&D) and Mother-Baby Unit (MBU)**

1. Place all infants in a safe sleep environment upon admission per the AAP recommendations.
2. Do **not** allow infant to be placed for sleep in mother's bed or in chair unless the infant is being held by an awake, alert parent or caregiver.
3. If the infant is found in an unsafe sleep environment, place the infant in their bassinet and use that opportunity to reinforce safe sleep recommendations with the parent or caregiver.
4. Infants should be in a "low swaddle", i.e., no higher than the axillary or shoulder level; a "Sleep Sack" may be used. If temperature instability occurs, an additional layer of clothing can be used. Swaddling the baby with an additional blanket or wearable blanket is also acceptable.
5. Monitor the mother-infant dyad periodically and consider staying at the bedside or rounding more frequently whenever doing skin-to-skin care or breastfeeding with the infant in the MBU (Note: An alert and awake family member that has been educated on the signs of infant distress can be used as an alternative).
    a. Skin-to-skin care and breastfeeding cause the release of oxytocin from the mother and neonatal brain, causing relaxation and easement of stress, which leads to sleepiness in both the mother and infant.
    b. The labor process and/or medications given for pain increase the chance for SUPC to occur.
    c. Observing the mother-infant dyad during times of breastfeeding and skin-to-skin care helps to decrease the incidence of SUPC.
6. Reinforce with the parents the safe sleep recommendations upon admission to the MBU. Mothers who have just given birth are tired, likely in pain, and may be recovering from surgery and anesthesia; all of these factors increase the risk that a mother will fall asleep holding her infant.
7. Teach the mother that if she feels sleepy while holding her infant, she should

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put her infant down on a safe sleep surface or call for assistance.

8. Teach parents and visitors to observe the mother and be available to put the infant down safely if she falls asleep.
9. Consider implementation of a risk assessment for mothers who may be at increased risk for fatigue or sedation and monitor at-risk mother-infant dyads more closely.
    a. Use of a risk-assessment tool can help to identify mothers who are at increased risk of falling asleep with or dropping their infant.
    b. Assess each mother periodically for risk factors, including drowsiness, use of pain or sedative medications, lack of support person present, or language barrier, and determine level of risk (i.e., low risk, moderate risk, or high risk)
10. Based on the mother's risk level, implement interventions such as staying at the bedside during infant feedings or rounding more frequently.

F. **Neonatal Intensive Care Unit (NICU)**

1. In the NICU, transitioning premature and sick infants to a safe sleep environment is a complex issue. Current AAP recommendations state to transition an infant at 32 weeks gestation to a safe sleep environment based on the physiological maturity of their lungs. However, the timing of transitioning preterm infants from a non-supine to a supine sleep position can be complicated by the infants' stability and often not implemented at 32 weeks gestation.
2. Infants with medical contraindication to supine sleep position, i.e. congenital malformations, upper airway compromise, severe symptomatic GE reflex, are to have a physician's order stating the desired sleep position
3. **Criteria for eligibility for supine sleep positioning**
    a. Medical criteria must be met to safely transition a preterm infant to supine sleep positioning. Infants should be
        i. Clinically stable
        ii. Free of congenital or chromosomal abnormalities that prevent supine sleeping
        iii. Greater than or equal to 32 weeks corrected gestational age (CGA)
        iv. Weight ≥ 1500 grams
        v. Open crib or isolette
        vi. Sufficient neuromuscular development per Occupational Therapy (OT)/Physicial Therapy (PT) assessment
        vii. Oxygen requirement low flow nasal cannula < 1 liters per minute (LPM)
        viii. Not receiving IV fluids

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ix. Not receiving phototherapy

b. Prone Positioning in the NICU

i. Premature and critically ill infants may have improved oxygenation in the prone position.

ii. Teach parents/caregivers that therapeutic positioning of their infant (prone or side-lying) is for a medical purpose and will be moved to a supine position when stable.

c. Oxygen use alone should **not** prevent transition to supine positioning.

i. Place infant being discharged home on oxygen in supine positioning for a sufficiently long enough period of time before discharge to allow adjustment and monitoring for desaturation episodes and other complications.

ii. If the infant does not remain stable in the supine position, the medical team will discuss the best recommendations on an individual basis.

4. **Transitioning to supine positioning**

a. Move **medically stable** infants to supine positioning by 32 weeks CGA after consensus reached through interdisciplinary collaboration, including OT/PT evaluation for neurodevelopmental readiness

b. Infants are transitioned to supine positioning as soon as medically feasible and preferably long before discharge, with a goal of at least 3 days prior to anticipated discharge.

c. Ensure sufficient length of exists time before discharge to allow the infant to become accustomed to the supine position.

i. Allows both the infant and parent/caregiver to adjust to supine positioning in a safe, controlled environment.

ii. Allows sufficient time for safe sleep environment modeling and for reinforcement of safe sleep education.

5. Sleep on a flat surface: All infants who have transitioned to supine positioning are to sleep on a flat surface unless medically contraindicated.

a. Head-of-bed elevation may be appropriate for premature and critically ill infants, with Licensed Practitioner (LP) order.

6. Developmental/therapeutic positioning devices

a. Positioning devices are discontinued when the infant transitions to supine positioning.

b. Explain to parents/caregivers the medical reasons why positioning devices are used, reinforcing devices discontinued as soon as no

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longer needed by infant.

i. Nursing to be consistent in removal of positioning devices.

ii. If parents/caregivers continue to see positioning devices used as discharge approaches, they will be more likely to replicate at home.

iii. Positioning devices are not sent home with the infant.

7. Tummy time
    a. Provide infant with tummy time and appropriate developmental, social, and play experiences while awake.
    b. Prevent plagiocephaly, positional torticollis, decreased strength, aversion to prone posture and environmental developmental delay by providing infant with opportunities for muscle development and social interaction.
    c. Provide full-term infants with prone positioning for greater than an hour each day as it improves motor development at 4 months of age.

8. Non-patient infant siblings with parents/caregivers during NICU visitation
    a. If parents/caregivers of hospitalized infants request to bring in an infant sibling (twin or other multiple already discharged home) with them to visit in the NICU, follow safe sleep recommendations.
    b. If available, provide a safe sleep environment (crib or bassinet) for the infant.
    c. Do not permit infant siblings to sleep on a chair, patient bed, or any other unsafe sleep environment such as car seats or swings.
    d. If unsafe sleep behaviors are observed, reinforce to the parent/caregiver that those behaviors are unsafe and are not permitted in the hospital.

9. Crib cards
    a. Crib cards (Appendix A) are placed and crib audits (Appendix B) of a safe sleep environment performed on a routine basis on all infants <1 year of age who qualify for safe sleep to ensure that staff are following the AAP recommendations for a safe sleep environment.
    b. Crib cards serve as a reminder to nursing staff, parents, and other health care providers that the infant should be in a safe sleep environment.

10. Auditing Practice
    a. Auditing cribs has been shown to help with changing practice and to sustaining the change. A crib audit includes:

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i. Bed location that the infant is sleeping in
ii. Position the infant is sleeping in
iii. Condition of crib (e.g., looking for items such as blankets, toys, inappropriate developmental tools, and medical supplies)
iv. Whether the head of the bed is flat, and
v. Whether a pacifier is being used

G. **Parent/Caregiver Education**

1. Educate parents/caregivers about all safe sleep recommendations, starting at birth and admission and continuing through discharge and throughout the first year, if available.
    a. Start education as soon as possible after birth and admission.
    b. Include AAP Safe Sleep recommendations
    c. Provide education not only to parents but also to grandparents or others who may be caring for the infant, if available. Infants cared for by people other than the parents are less likely to be placed supine for sleep and more likely to have an unsafe sleep environment.
2. Provide clear, consistent education to parents and caregivers to increase parental implementation of safe sleep recommendations after discharge.
    a. Use standardized education materials to provide consistent education to parents and caregivers
    b. Follow unit-specific timing of safe sleep education to avoid confusion and inconsistent practices.
3. Address parent's and caregivers specific concerns and take into consideration their cultural background, socioeconomic status, and pre-existing beliefs with education.
    a. Parent and caregiver decisions about their infant's sleep environment are influenced by multiple factors other than advice given by health care providers, such as cultural background, advice given by family and friends, socioeconomic status, previous experience, and the media.
    b. Have an open, nonjudgmental discussion with parents and caregivers about their plans for their infant's sleep environment, their beliefs, and their concerns.
    c. Provide accurate, evidence-based information to encourage safe sleep behaviors and dispel myths or fears whenever risk factors are identified (e.g., intent to bed share, family members who smoke, or use of crib bumpers). Compliance with safe sleep recommendations is more likely if these topics are discussed.

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d. Ask specific questions on the following:
    i. Where will the infant sleep at home?
    ii. What position will the infant sleep in?
    iii. What bedding will be used in the sleep area?
    iv. Will anyone other than the parents care for the infant?
    v. Does anyone in the home smoke cigarettes?

4. Provide positive reinforcement when safe sleep recommendations are demonstrated by parents and caregivers.
    a. Praise parents/caregivers when they are observed following the safe sleep recommendations.
    b. Give positive feedback to increase parents/caregivers self-efficacy and confidence. This may make the parent/caregiver more likely to continue to demonstrate the same behaviors.

5. Post-discharge follow-up
    a. Post-discharge phone calls to parents/caregivers and follow-up breastfeeding discharge visits are opportunities to reinforce teaching, when these occur.
        i. Parents may leave the hospital intending to follow the safe sleep recommendations but decide to bed share or adopt other unsafe behaviors when they are home to cope with a fussy infant, to facilitate breastfeeding, or for any number of other reasons.
        ii. Post-discharge calls and follow-up breastfeeding visits can be used to help to reinforce safe sleep education and recommendations.

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H. **Documentation in the Electronic Health Record (EHR):**

1. Safe sleep positioning/environment in Safety Factors of the PCS Body Systems – Safety flow sheet.
2. Safe Sleep in Preterm or Newborn Education
3. Document all parental/caregiver teaching, level of understanding, and interactions related to sleep safe practices.

I. **Supporting Information**

1. Supportive Data: Infant mortality is used as a marker for a nation's health. The United States infant mortality rate of 5.8/1000 live is one of the highest in the world for industrialized nations, ranking 55 out of 224 nations. Sudden unexpected infant death (SUID) is the number 1 cause of deaths for infants from 1 month to 1 year of age in the United States. Safe Sleep Guideline, developed and published by the National Association of Neonatal Nurses (NANN), provides an evidence-based guideline for use by health care

providers to assist in the implementation of safe sleep for all hospitalized infants.

2. It is important that health care providers provide clear, consistent endorsement of the recommendations as parents may receive conflicting messages regarding safe sleep from family, friends, and the media. Parents and caregivers trust recommendations received from health care providers. When health care providers recommend supine sleep, parents are more likely to place their infants supine for sleep. This safe sleep policy for patients <1 year of age assists in the provision of patents' and caregivers' education on supine sleep, the implementation of safe sleep recommendations, and assists in changing nurses' beliefs and behaviors regarding safe sleep.
3. Successful implementation of safe sleep recommendations in the hospital environment requires a change in hospital culture. Personal, deep-held beliefs of nurses that conflict with the safe sleep recommendations must be identified and addressed with evidence-based education for behavior change to occur.
4. Nurses providing care for infants in the first year of life should have the same level of knowledge to maintain a consistently safe sleep environment. Maternal Child Health nurses' knowledge regarding the safe sleep recommendations is assessed and education provided upon hire and on an ongoing basis.
5. Accidental asphyxiation or suffocation and strangulation in bed (ASSB) – Examples of ASSB are suffocation from soft bedding or pillows blocking the infant's airway; overlay, when an adult, another child, or animal rolls on top of or up against an infant while sleeping and blocks the infant's airway; wedging or entrapment, where the infant becomes wedged or entrapped between two solid objects such as a bed and wall, bed and dresser, or an adult and the back or arm of a sofa, which blocks the infant's airway; and strangulation, when the infant's head or neck becomes entangled with an object such as a vertical blinds cord, bumper pads, or crib rails that are too far apart or not assembled correctly. A type of sudden unexpected infant death, most ASSB deaths are preventable deaths.
6. Sleeping with a baby in an adult bed increases the risk of suffocation and other sleep-related causes of infant death.
7. Co-sleeping arrangements can include room sharing or bed sharing. The terms "bed sharing" and "co-sleeping" are often used interchangeably, but they have different meanings.
8. The American Academy of Pediatrics (AAP) recommends that the infant's sleep surface be close to the parents' bed to aid in feeding, comforting, and monitoring of the infant. Room sharing is known to reduce the risk of SIDS and other sleep-related causes of infant death.
9. SIDS is a type of **s**udden unexpected infant death, not preventable because the cause of SIDS is unknown, although there are several theories regarding the cause of SIDS deaths.

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J. **Controversies Related to Safe Sleep**

1. **Bed sharing:** Cultural and societal influences often shape parental perceptions and decisions regarding safe sleep. The AAP advises consistent, clear, and universal messaging that infants should always sleep alone, on their backs, and in their own cribs. Among the potential physical dangers related to bed sharing, airway obstruction, strangulation, and suffocation are the most severe associated risks for SUIDs.
    a. In explaining the decision to share a bed with their infant, many mothers may cite family members and tradition to be more trustworthy sources of advice on the topic compared with healthcare providers. These views may reflect a lack of knowledge or exposure to AAP recommendations for safe sleep, often resulting in prone positioning, side positioning, and consistent bed sharing in the home environment, often for the purpose of breastfeeding, facilitating close infant monitoring, and comfort.
    b. The AAP does not recommend the use of infant beds attached to the adult bed (aka “bedside sleepers”) or products designed to facilitate safe sleep in the parent bed (aka “in-bed sleepers”).
    c. Parents are advised to avoid any products marketed for safe sleep, including crib bumpers, infant positioners, and home cardiorespiratory monitors because of insufficient evidence supporting their safety and use.
    d. Parents are advised to place infants alone in a crib, so they should not be placed to sleep with a sibling even in cases of infant multiples.
2. **Breastfeeding and Skin-To-Skin Care:** There has been an increase in breastfeeding and the use of skin-to-skin care for healthy term newborns as well as premature infants in L&D, MBU, and in NICU.
    a. The controversy with breastfeeding is that to promote breastfeeding, mothers often are instructed to feed in a side-lying or reclining position in an adult bed, especially in the early days after birth. This practice of bed sharing while breastfeeding can lead to a potential for compromised infant safety.
        i. The safety risk can occur because oxytocin, released during breastfeeding, not only helps with the “let down” of milk but also helps the mother feel calm, provides a sedative effect, reducing stress.
        ii. Additionally, a mother breastfeeding at night or while rocking the infant increases the chance that she will fall asleep during breastfeeding, especially in the early post-natal period when exhausted from the labor and delivery, and may have received pain medication.
    b. The skin-to-skin care controversy stems from the fact that mothers

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and infants become sleepy as a result of skin-to-skin care.

i. As soon as skin-to-skin care begins, oxytocin is released not only by the mother's brain but also the infant's brain. As stated earlier, oxytocin helps with reducing stress and provides a sedative effect, thus increasing the chances that the mother and infant drift off to sleep. The infant's airway can easily become blocked by embedding the nose into the breast or having the head slip below the breast tissue, or the infant could be dropped by the mother who has fallen asleep.

ii. After the mother and infant have fallen asleep, they are bed sharing, which goes against AAP recommendations. Advise parents to remove loose bedding and pillows from the adult bed prior to the initiation of feeding to mitigate known bed-sharing risk factors, promptly returning the infant to a separate and appropriate sleep space, and monitoring the infant when performing skin-to-skin care.

iii. Recommendations for skin-to-skin care, when the mother is awake and fully alert, to decrease the risk of SUPC include

a. Infant's face can be seen.
b. Infant's head is in the "sniffling" position.
c. Infant's nose and mouth is not covered.
d. Infant's head is turned to one side.
e. Infant's neck is straight, not bent.
f. Infant's shoulders and chest face the mother's.
g. Infant's legs are flexed.
h. Infant's back is covered with blanket.
i. Mother-infant dyad is monitored continuously by the staff in L&D, and regularly in the MBU.
j. When the mother wants to sleep, infant is placed in bassinet or with another support person who is awake and alert.

c. Caution mothers to be vigilant when breastfeeding, doing skin-to-skin care, and bed sharing because infant cardiopulmonary collapse may result from asphyxiation and airway obstruction.

3. **Vomiting, Choking, and Supine Position**

a. One of the most common arguments regarding placing an infant in the prone versus the recommended supine position is that parents, and other family members want to prevent choking and aspiration if

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the infant would happen to vomit or have gastroesophageal (GE) reflux.

b. Research studies have looked at the cause of death of infants and have not shown any increase in the incidence of aspiration.

   i. When an infant vomits or refluxes, the choking, gagging, or coughing is actually protecting the airway from the liquid in the esophagus.

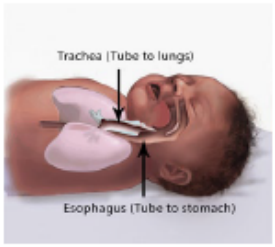
   ii. From an anatomical perspective, when an infant is lying supine, the trachea is anterior to the esophagus, decreasing the chance of aspiration (Figure 1, Picture 1).

   iii. When an infant is lying prone, the trachea is now posterior to the esophagus, increasing the chance of aspiration (Figure 1, Picture 2).

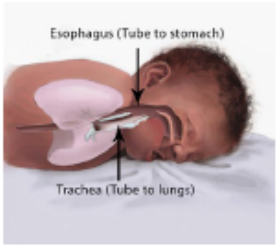
   iv.

Figure 1. Infant Airway Anatomy

PICTURE 1. An infant lying on their back



PICTURE 2. An infant lying on their stomach



(National Institute of Child and Human Development—Continuing Education of SIDS Risk Reduction, n.d.c.)

c. When placing an infant supine to sleep, gravity encourages any vomitus or reflux to return to the esophagus and not to the trachea, thus preventing aspiration.

4. **Head of Bed Elevation for Naso/Orogastric Feeds and/or GE Reflux**

   a. In many nurseries, the head of the bed traditionally was elevated to reduce GE reflux or when an infant is receiving tube feeds to increase gastric emptying. There currently is no evidence that shows elevating the head of an infant's bed will decrease the incidence of GE reflux or that infants being fed through a tube are at an increased risk of aspiration.

b. The North American Society for Pediatric Gastroenterology and Nutrition (NASPGN) states that the risk of SIDS far outweighs the risk of death from aspiration, so infants should be placed supine except in severe cases of upper airway anomalies.

c. In fact, elevating the head of an infant's bed can lead to the infant sliding down to the bottom of the bed and occluding their airway and ability to breathe and thus is not recommended.

5. **Medical Stability and Developmental Readiness in the NICU**

   a. Determining infant medical stability and developmental readiness for safe sleeping arrangements are additional areas of controversy.

      i. During acute illness, supine positioning may be avoided in favor of prone or side lying positioning to optimize infant breathing and development.

      ii. This is especially true in the premature infant population, where comorbidities related to early gestation abound, often requiring nonsupine positioning and the introduction of blanket barriers to maintain infant flexion and alignment (McMullen, 2013 [Level V]).

   b. The AAP recommends supine positioning when premature infants are 32 weeks corrected gestational age (GA) and medically stable; however, stability arrives at different points for individual infants.

      i. There is difficulty in uniformly requiring all NICU infants who have reached 32 weeks to be transitioned to supine positioning; illness and NICU admission prevent a universal time frame for back to sleep to be easily applied at a pre-set gestational age because of the interference of medical instability.

      ii. Diagnoses often dominate neonatal intensive care units and frequently extend beyond 32 weeks corrected gestational age (CGA). Exclusion criteria may include infants with: upper airway compromise, life threatening GE reflux, respiratory distress, a great degree of prematurity, bronchopulmonary dysplasia, cleft lip and palate or isolated cleft palate, necrotizing entercolitis, Pierre Robin Syndrome, congenital heart defect, myelomeningocele or encephalocele, perinatal asphyxia or hypoxic ischemic encephalopathy, greater than Grade II intraventricular hemorrhage or periventricular leukomalacia, chromosomal anomaly. These preterm and ill infants may benefit developmentally and physiologically from prone or side lying positioning until resolution of symptoms, and may be positioned in this manner when continuously monitored and observed.

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iii. Infants with Neonatal Abstinence Syndrome (NAS) with difficult to control symptoms may be placed in a prone position for brief periods of time.

c. The placement of NICU infants on their back to sleep should be done well before discharge to model safe sleep practices to their families

K. **Swings, bouncers, and other sitting devices**

1. Do not allow infants to **routinely** sleep in swings, bouncers, car seats, or other positioning devices such as lactation pillows.
    a. The AAP strongly recommends against the use of swings and other sitting devices for routine infant sleep, as infants placed in these devices, particularly infants with poor muscle tone and/or neck control, are at risk for positional asphyxia and increased reflux.
    b. Continuous monitoring in the NICU does not justify use of swings and sitting devices for routine sleep, particularly since parents/ caregivers will mimic the behaviors they see demonstrated in the NICU.
    c. Use swings, bouncers, and other sitting devices while infants are awake and supervised for soothing, to provide social interaction, and for age-appropriate developmental stimulation.
    d. It is acceptable to place a fussy infant in a device to help console them, then transfer to bassinet for sleeping.
    e. Infants with Neonatal Abstinence Syndrome (NAS):
2. Infants with NAS may benefit from the use of swings, rockers and/or other devices to console them.
    a. Use the devices while observation and monitoring the infant, and are terminate when symptoms resolve.
    b. At least 1 week prior to discharge, if not sooner, implement the safe sleep environment as appropriate related to the infant's condition and symptoms. Recommend that transition begins:
        i. When replacement therapy doses are able to be tapered to reflect a dose where discontinuing is possible within the next week.
        ii. Infant's average NAS score is < 6 in the 24-hours.
        iii. Infant's NAS score has not been >10 in the last 24-hours.
3. Car seat tolerance screening (CSTS):
4. An exception is during Car Seat Challenge, as it is important to ensure that the premature infant will be safe in the car seat after discharge. Advise parents/ caregivers that their infant should not routinely sleep in the car seat outside of the car. Refer to PSJHC policy Car Seat Challenge.

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"The care of patients is dependent on individual circumstances and no policy or procedure can detail or describe each circumstance. Thus, this policy is not a statement of the standard of care, and should not be interpreted as such. It is meant to be a guideline only, and should never be a substitute for the exercise of judgment."

REFERENCE(S)/RELATED POLICIES

American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome and The Committee on Fetus and Newborn. (2022). Sleep-related infant deather: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. *Pediatrics, 1*(150): e2022057990. doi: 10.1542/peds.2022-057990

Centers for Disease Control and Prevention. (2020, April 21). *Sudden unexpected infant death and sudden infant death syndrome*. Retrieved August 26, 2020 from https://www.cdc.gov/sids/data.htm

National Association of Neonatal Nurses. (2019). *Guideline Newborn Safe Sleep*. National Association of Neonatal Nurses.

National Institute of Child Health and Human Development. (n.d.). *Safe infant sleep basics: Common SIDS and SUID terms and definitions.* Retrieved March 13, 2023 from https://safetosleep.nichd.nih.gov/safesleepbasics/SIDS/Common

National Institute of Child Health and Human Development. (2022). What does a safe sleep environment look like? English and Spanish. Retrieved from: https://www.nichd.nih.gov/sites/default/files/2022-10/NICHD_STS_2022_Handout_Spanish508.pdf

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Attachments

	Appendix A - Safe Sleep Crib Card.pdf
	Appendix B - Safe Sleep Compliance Audit Tool.pdf
	Appendix C - What does a safe sleep environment look like - English.docx
	Appendix D - What does a safe sleep environment look like - Spanish.docx

Approval Signatures

Approver	Date
Irma Castaneda: Executive Assistant	02/2024
Peggy Mooney: Senior Manager Medical Staff Services	02/2024
Peggy Mooney: Senior Manager Medical Staff Services	02/2024
Jose Castro: Director Pharmacy	12/2023

Applicability

CA - Providence Saint John's Health Center

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Approval Signatures

Step Description	Approver	Date
Board of Directors	Irma Castaneda: Executive Assistant	02/2024
MEC	Peggy Mooney: Senior Manager Medical Staff Services	02/2024
Pediatrics	Peggy Mooney: Senior Manager Medical Staff Services	02/2024
PCSC	Jose Castro: Director Pharmacy	12/2023

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

Status Active PolicyStat ID 16901254

Saint John's Health Center
Providence

Origination	11/2015
Last Approved	12/2024
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Last Revised	12/2024
Next Review	12/2027
Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Infant Security: Code Pink

Policy Number: NB-18.1

Effective Date: 10/2009

Review/Revise Date: 11/2009, 2/2012, 2/2015, 5/2018, 7/2021, 10/2024

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I. PURPOSE

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Saint John's Health Center to provide guidelines to

A. Ensure that all hospital personnel and outside agencies are notified appropriately, with the goal being to locate and reunite the infant or child and his/her family as quickly as possible.

B. Provide effective crisis management, immediately following an infant or child abduction, requires close cooperation between physicians, nurses, administration, security, other hospital personnel, law enforcement personnel and the media.

C. And given the urgent nature of an infant or child abduction and time-critical decisions that must be made, this cooperation becomes vital.

II. POLICY

A. At no time during the early stages of an abduction should any person, without a valid need to know, be told that an infant or child is missing.

B. The law enforcement agency(ies) and Director, Public Relations will make that determination in conjunction with the administration of the hospital. No Health Center employee or volunteer is authorized to make a public statement concerning this incident or communicate with a member of the media without prior clearance from the Chief Adminstrative Officer, Public Relations Director or designee.

III. PROCEDURE

A. **Security**

1. Receiving an activation of the infant security alarm system:
    a. **A Code Pink alarm is automatically initiated by the Security Department.**
    b. The Desk Officer will immediately begin monitoring all areas of the Women's Health Services (WHS) using the camera surveillance system.
    c. The Desk Officer will immediately contact WHS to confirm if an infant abduction has occurred.
2. Code Pink initiated (Initiation of Internal Disaster)
    a. A Security Officer will be dispatched to the site of abduction.
    b. All Clinical Unit Charge Nurses in the CSS/Keck Building will assign staff to all elevators/stairwell exits.
    c. The Nursing Supervisor will notify the Administrator on Call.
    d. In the case of an attempted or actual abduction, the Security Desk Officer will notify the Santa Monica Police Department with Description of suspect(s) and Infant/ Mother demographics.
    e. The Security Desk Officer will issue a description of suspect(s) to all departments in the Keck/ CSS buildings and the Emergency Room entrances.
    f. The Security Desk Officer will notify the parking lot attendants to stop vehicles from entering or exiting the Health Center until the Code Pink is clear.
    g. A Security Officer will be assigned to check public transportation stops, stands, and adjacent parking areas.
3. The Security Officer arriving on scene of the abduction will initiate the following:
    a. Obtain a preliminary report from staff and family.
    b. Issue a description of the suspect(s) and infant to the Security Desk Officer
    c. Identify and secure the crime scene. If necessary, the mother will be moved to a different location.
    d. Identify and isolate witnesses.
    e. Coordinate a search of the WHS department including all likely areas an infant may be hidden, i.e. trash and linen chutes and containers.
    f. Confirm head count of remaining infants in the WHS department

B. **WHS Department**

1. When a staff member believes that an infant or child is missing or has been abducted, he/she will immediately:
    a. **Telephone** notification of appropriate staff by
        1. Dial emergency number 16
        2. Announce CODE PINK
        3. notify the Charge Nurse or department manager.
        4. Conduct a head count of remaining infants in the WHS department
        5. Search the unit for infant/child and secure the scene
    b. Obtain pertinent information and protect the potential crime scene until the Security Supervisor and/or law enforcement arrives

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1. Name of employee reporting the incident and the location
2. Last known location of the infant/child
3. Exit used to remove the infant/child from unit, if known
4. Description of the abductor, if known
5. Description of the infant

c. **Report** and reassign the mother/family to a different room for security purposes
    1. Once the abduction has been confirmed, the Department Director and the attending physician will notify the parents.
    2. The mother will be transferred to new room (without belongings) to further ensure her privacy. Security and nursing will secure belongings.
    3. The nurse assigned to the mother will accompany the family at all times.
    4. Contact other family members or chaplain per the family's request.
    5. Contact Social Services for family and staff assistance, as necessary.
    6. The Department Director should establish herself as the point of contact with the family for information. This is especially important if the family leaves the Health Center before the case is solved.

d. **Keep** all staff and visitors on the unit until law enforcement arrives. Law enforcement will release staff and visitors at their discretion.
    1. If the incident occurs during shift change, all personnel scheduled to leave will be requested to remain on the floor until released by law enforcement.
    2. Guests attempting to leave the unit will be asked to cooperate until law enforcement has arrived.
    3. The Admitting Department and the PBX Operator will initiate a "No Information" status for this patient.
    4. WHS Nursing Staff will request to place cord blood on hold in the Clinical Laboratory (if an infant was abducted).
    5. Locate and secure the following: Blood samples (if cord blood not available, Pictures, and Medical Record

C. Extended Follow-up Procedures:
    1. Administrator on Call (AOC) notified of status
    2. All media inquiries will be directed to the Director, Public Relations by the Administrator on Call (AOC).
    3. The Santa Monica Police Department and Security will conduct a search of the entire campus.
    4. If there has been an abduction, an internal disaster code will be initiated and the Incident Command Center activated
    5. Brief the Health Center spokesperson, Chief Adminstrative Officer and CNO of status.

D. The Director of Public Relations will:
    1. Contact local media, as appropriate, and request that they come to a designated media room.
    2. Provide the media with facts as accurately as possible about the incident. Ask for the assistance of the public in recovering the infant or child. Release only information that has been approved by law enforcement and the Chief Administrative Officer.

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3. Prepare a written response for inquiries about the incident.
4. Attempt to address the concerns of anxious parents who are planning on delivering their babies or currently have children admitted to the hospital

E. The Incident Command Center will:
1. Begin an event log and inform key persons of the incident.
2. Arrange for media briefing
3. Ensure that law enforcement personnel are being directed to the appropriate locations
4. Call the National Center for Missing and Exploited Children (NCMEC) at 1-800-THE-LOST (1-800-843-5678) for assistance in handling ongoing crisis.
5. Notify hospitals and outpatient clinics within the area of the incident. Provide complete description of infant or child and abductor if available.
6. Provide support for involved unit nursing staff and family as needed.
7. Prepare for visit from State Department of Health Services and/or The Joint Commission.

F. Health Center wide employee responsibilities include:
1. Be aware of all people carrying items that can hide an infant, including, but not limited to:
a. Suitcases
b. Bulky coats
c. Tote bags
d. Boxes
e. Blankets
f. Blankets

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G. Interdepartmental Support of a Code Pink
1. All Health Center staff, upon activation of **CODE PINK**, will immediately
a. Begin observation of their particular department/floor looking for suspicious persons, and alerting security as appropriate.
b. Charge Nurse/Supervisors will dispatch staff to all exterior exits on their floor observing personnel entering or exiting as listed below:

Garden Level Staff will cover the following exits						
Material Management (Keck)–	**Stairwell #4,**	**Receiving Docks B-1**	**Stairwell #7,**	**CSS/ Keck Staff Corridor**	**Elevator #14,**	**Elevator #13**
Radiation Therapy (Keck)	**Stairwell # 3**					
JWCI Clinic (Keck)	**Service Elevators #3 #4 # 5**	**Main Entrance**	**Breast Center (Keck)**	**Stairwell #5**	**Private Elevators #11 #12**	**Customer Waiting Area**
Kitchen (CSS)	**CSS/Keck Staff Corridor,**	**Service Elevators #3, 4, 5**				

Main Pharmacy (CSS)	Stairwell #2,	Breezeway Corridor Public Elevators #1, 2
Pathology (CSS)	Stairwell #1	

Level 1 Staff covers the following exits					
Emergency #1(Keck	Ambulance Bay Doors	Ambulance Bay Doors	Service Elevators #6 #7		Elevator #14
GI Lab (Keck	2 Exterior Doors to Healing Garden				
CDU (Keck)	CSS/Keck Staff Corridor				
Heart Institute/ Blood Donor (Keck	Stairwell #6,		Public Elevators #8 # 9 #10		
Admitting (Keck)	Breezeway Corridor from Atrium		Main Entrance		
Radiology/ Imaging/ Nuclear Medicine/MRI (Keck	Private Elevators #11 #12	Stairwell #3	Stairwell #4	Stairwell #5	Technology Docks Double Door
Medical/ Surgical Unit, North (CSS	Stairwell #1	Healing Garden Double Doors		Service Elevators #3 # 4 #5	
Medical/ Surgical Unit, South (CSS	Stairwell #2	Public Elevators #1 # 2		Breezeway Corridor	

Level 2 Staff covers the following exits					
Surgery (Keck)	Stairwell #4	Stairwell #7	Service Elevators #6 #7	Elevator #13	Elevator #14
Post Operative (Keck)	Private Elevators #11 #12		Stairwell #5		
Cath Lab (Keck)	Stairwell #3				
Pre Operative (Keck)	CSS/Keck Staff Corridor		CSS/Keck Breezeway Corridor		
Cafeteria (Keck)	Stairwell #6	Public Elevators #8 #9 #10		Breezeway Corridor	
Critical Care Center/PCCU (CSS)	Stairwell #1	Service Elevators #3 #4 #5	Stairwell #2	Public Elevators #1 #2	

Level 3 Staff covers the following exits						
Women's Health	Stairwell #3, 4, 5,	CSS/ Keck	Public Elevators	Private Elevators	Breezeway Corridor	Service Elevators

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Services (Keck)	**6, 7**	**Staff Corridor**	**#8 #9 #10**	**#11 #12**		**#6 #7**
Orthopedic (CSS)	**Stairwell #1**	**Service Elevators #3 #4 #5**	**CSS/Keck Breezeway Corridor**	**Stairwell #2**	**Public Elevators #1 #2**	

Level 4 Staff covers the following exits					
Patient Care Center (CSS)	**Stairwell #1**	**CSS/ Keck Staff Corridor**	**Service Elevators #3 #4 #5**	**Stairwell #7**	
Oncology (CSS)	**Stairwell #2,**	**Public Elevators #1 #2**	**CSS/Keck Breezeway Corridor**	**Breezeway Corridor/Public Elevators #8 #9 #10**	**Stairwell #6**

H. SUMMARY OF THE ELECTRONIC INFANT SECURITY SYSTEM

1. Tracks infants at all times on the 3rd floor of the Keck Building
2. Alarms if tag is removed from an infant (Zone Alarm, Security does not receive this alarm)
3. Alarms if infant remains close to an exit door in unit (loiter alarm) (Security does not receive this alarm)
4. Alarms if exit door opens and infant is near door (Egress Alarm, Security receives this alarm)
5. Alarms if infant is in exit corridor from Keck to CSS (CODE PINK is initiated) (Egress Alarm, Security receives this alarm)
6. The location of alarms is identified in the infant security computer system.
7. An infant security system monitor is located in the Security office to ensure immediate response from security staff for egress alarms.
8. All newborns have a security Tag placed on their wrist or ankle after birth in the labor and delivery department.
9. Refer to manufacturer's guidelines for tag placement, activation and deactivation procedures.
10. The room number, infant's name and tag number are entered into the infant security system computer.
11. The tag number is documented on the admission record
12. Verification of tag activation is verified every shift.
13. The tag is deactivated and removed by the discharging RN. The tag number is unassigned in the infant security computer system.
14. Tags are cleaned per manufacturer instructions.
15. Parents are educated about the system and the importance of not removing the tag.
16. Any time there is an audible egress alarm the Security Officer will call **CODE PINK** immediately.
17. In the event egress alarm is going off and code pink has not been annunciated , or infant is missing, WHS nursing staff will immediately **dial 16** and call **code Pink**

REFERENCES/RELATED POLICIES

Emergency Management Plan for Newborn Abduction, Journal of Obstetric, Gynecologic and Neonatal

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Nursing, 2002, May-June; 31(3) 340-6.

Turner, James T. Infant Abduction in Healthcare, *Journal of Police and Criminal Psychology*

The National Center for Missing and Exploited Children.

Infant Identification

Infant Security Plan

Approval Signatures

Step Description	Approver	Date
Board of Directors	Irma Castaneda: Executive Assistant	12/2024
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
PCSC	Jose Castro: Director Pharmacy	11/2024

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Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **16900810**

Saint John's Health Center
Providence

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Last Approved	12/2024
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Last Revised	12/2024
Next Review	12/2027
Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Infant Security Plan

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Policy Number: NB-4

Effective Date: 2006

Review/Revise Date: 1/2009, 2/2012, 2/2015, 5/2018, 10/2024

I. PURPOSE

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Saint John's Health Center to provide guidelines to:

A. To protect infants from removal by unauthorized persons

B. To ensure that, in the event an infant is missing, all hospital personnel and outside agencies are notified appropriately, with the goal being to locate and reunite the infant with his/her family in the most expedient manner possible.

II. POLICY

A. It is the policy of this hospital to provide a safe and secure environment for all patients. The security of patients is the responsibility of all hospital personnel. The procedures detailed in this document shall be strictly adhered to.

B. The components of an infant security system consist of:

1. Education of the personnel and parents/significant others
2. Access Control and Security Devices for areas where infants are admitted
3. Identification of the infant, parents/guardians, personnel and visitors

III. PROCEDURE

A. **IDENTIFICATION**:

1. Infants:

    a. Strict adherence to a newborn identification system minimizes threats associated with newborn abductions and inadvertent infant mix-ups or switching.

    b. Identification Bands:

        i. ID bands identifying mother and infant are to be attached to mother and infant at birth.

        ii. This band would display the same number as mother/baby.

        iii. On discharge from the hospital identification bands are verified with appropriate documentation and the infant is discharged to the mother, with the bands being included as part of the chart

        iv. Discharge of an infant to a person other than the parent requires special procedures and documentation such as 'RELEASE OF MINOR" form, prior to release from hospital.

    c. Name Alert:

        i. When two (2) or more patients have the same or similar last names, charts and the infant's crib cards will be labeled "NAME ALERT" and the mother's first name will be included on the chart and crib card.

        ii. When there are multiple births and charts, the infant's cribs shall be labeled with the infant's name (Last Name and Baby Boy or Baby Girl) followed by a letter of the alphabet (i.e., A, B, C, D).

    d. Personnel Identification:

        i. All personnel are to wear their photo IDs when they are in the Women's Health Services Unit of the hospital.

        ii. All Womens Health Services (WHS) personnel must have a specific photo ID

        iii. It is the responsibility of each regular womens health services employee to verify the identification and assignment of any personnel working in the unit on a temporary basis.

        iv. It is the responsibility of each WHS employee to monitor all visitors to the department

2. Infant/Mother Contact:

    a. Assure infant is only removed from mother's care (hospital room) by authorized mother/baby personnel.

    b. Mothers will be instructed on admission, regarding method of

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identification of mother/baby personnel utilizing photo ID badge.

i. Personnel without mother-baby photo badges (floats, students, outside registry) will wear temporary badges issued them by Staffing Office.

ii. At the end of each shift, all badges issued will be returned to the Staffing Office

c. Mothers will be instructed to only release their baby to personnel wearing appropriate identification during the admission to L&D and PP.

d. Babies will only be transferred in hall by bassinet. Anyone carrying a baby in hallway will be questioned by the WHS Unit personnel.

B. **ACCESS CONTROL AND SECURITY DEVICES**:

1. Emergency exits will not be used by visitors or staff and will have audible alarms and recorded video monitoring.
2. Doors will not be "propped" open for ventilation or to facilitate access or egress.
3. Security Devices:

a. The following mechanisms have been installed:

i. An infant protection band system has been installed in the hospital.

ii. This invisible, wireless system is designed to prevent an abduction attempt.

iii. The ankle band is attached to the infant's ankle upon admission and is tamper-resistant.

iv. Should the device be cut off or tampered with in any way, an alarm will sound.

b. The system offers:

i. A pulse emitting band that tracks the location of the infant through multi-pronged antennae in the ceiling.

ii. Alarm activation if an infant is taken through a protected doorway without the proper password authorization.

iii. When an alarm occurs at an exit, the system's computer displays the specific floor plan to the unit, showing which exit was used and the tag.

C. **EDUCATION**:

1. Personnel:

a. Security of patients is a responsibility of all hospital personnel.

b. Special attention is required for infants who are unable to protect themselves.

c. Any unusual activities, relating to infants being removed from this facility,

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shall be reported to the Security Department immediately.

d. Personnel assigned to the WHS Unit will receive the following training during their orientation period and annually thereafter.
    i. Infant vulnerability
    ii. Abductor profile information
    iii. Incident location profile
    iv. Disturbance ruses
    v. Suspicious activity response
    vi. Hospital safeguards
    vii. Access control mechanisms in place
    viii. Infant security devices
    ix. Employee photo identification badges
    x. Visitor identification
    xi. Instructions to mothers
    xii. Newborn identification bands
    xiii. Abduction attempts response plan
e. WHS unit personnel will be on the lookout for the following:
    a. Repeat visitors to the WHS Health Unit with extreme interest in babies
    b. Theft of personnel identification or uniforms
    c. Extensive questioning, regarding WHS Unit protocols or the babies
    d. Anyone carrying an infant instead of using a bassinet
    e. Anyone carrying bags, large packages or loosely wrapped bundles from the WHS Unit

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REFERENCES/RELATED POLICIES

Emergency Management Plan for Newborn Abduction, Journal of Obstetric, Gynecologic and Neonatal Nursing, 2002, May-June; 31(3) 340-6.

Turner, James T. Infant Abduction in Healthcare, *Journal of Police and Criminal Psychology*.

The National Center for Missing and Exploited Children

Infant Identification

Infant Security: Code Pink

Approval Signatures

Step Description	Approver	Date
Board of Directors	Irma Castaneda: Executive Assistant	12/2024
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	11/2024
PCSC	Jose Castro: Director Pharmacy	10/2024

Applicability

CA - Providence Saint John's Health Center

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Standards

No standards are associated with this document

Status **Active** PolicyStat ID **14186486**

Saint John's Health Center
Providence

Origination	11/2015
Last Approved	10/2023
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Next Review	10/2026
Owner	Jodene Strelley: Nurse Educator
Policy Area	Womens Health
Applicability	CA - Saint John's Health Center

Labor & Delivery/Postpartum Management of Neonatal Hypoglycemia

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PURPOSE

The purpose of this policy is to provide a guide for the screening and management of neonatal hypoglycemia, consistent with the recommendations of the American Academy of Pediatrics (2011) and the Pediatric Endocrine Society (2015).

POLICY

1. Routine screening and monitoring of blood glucose concentration is not needed in healthy term asymptomatic newborns after an entirely normal pregnancy and delivery.
2. The following infants are considered to be "at risk" for neonatal hypoglycemia, and will be managed with early feedings and test strip screening while asymptomatic:
    a. Small for gestational age (less than 10th percentile for weight)
    b. Large for gestational age (greater than 90th percentile for weight)
    c. Infants of diabetic mothers (including diet-controlled gestational diabetic mothers)
    d. Late-preterm infants (gestational age 34 0/7 - 36 6/7 weeks)
    e. Birth weight less than 2500 grams or greater than 4000 grams
3. Any infant who manifests clinical signs consistent with a low blood glucose concentration, e.g., symptomatic infant, will be screened with a test strip within minutes of the identification of the clinical signs, and the pediatrician will be notified. Clinical signs of neonatal hypoglycemia are not specific, but include:
    a. Jitteriness
    b. Irritability

c. Tremors
d. Exaggerated Moro reflex
e. Cyanosis
f. Seizures
g. Apneic episodes
h. Tachypnea
i. Weak or high-pitched cry
j. Floppiness or lethargy
k. Poor feeding
l. Eye-rolling
m. Temperature instability

4. Preprandial glucose screening for at-risk infants (see #2 under Policy) should occur at approximately 1, 3, 6, 12, and 24 hours of life.
    a. Babies that are SGA or late preterm are at higher risk of having missed hypoglycemia if glucose screening is discontinued before 24 hours of age. Continue routine glucose screening up to 24 hours of life, or longer if indicated.
    b. For all other at-risk infants, screening may be discontinued before 24 hours with 3 consecutive glucose levels ≥40 mg/dL.

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PROCEDURE

1. Review the maternal history and assess each newborn at delivery to identify infants at risk for neonatal hypoglycemia (see #2 under Policy). Consult with the Pediatrician or Neonatologist if there is a question about the infant's gestational age or intrauterine growth.
2. Skin area preparation for glucose measurement consists of:
    a. Alcohol wipe, lance of skin using neonatal heel incision device, discard 2-3 drops, sterile gauze wipe, and then acquire desired blood sample from next drops.
3. Screen any infant demonstrating clinical signs consistent with hypoglycemia (see #3 under Policy) immediately and notify the Pediatrician of the signs observed and the test strip result.
4. Institute early feeding for asymptomatic infants at risk for neonatal hypoglycemia:
    a. Feed the infant within one hour of delivery.
        i. Note options: Breastfeed, hand expressed milk, donor milk, or formula (5 mL/kg, up to 30 mL).
    b. Screen the infant via the blood glucose meter within 45-60 minutes after the start of the first feeding, or within 1 hour of life if no feeding occurs.
    c. If the initial glucose screen of the at-risk infant after the first feeding is <40 mg/dL,

even if the infant is asymptomatic:

i. Administer glucose 40% gel (see Glucose Gel order set).

ii. Feed the infant again (5 mL/kg, up to 30 mL). Recheck the glucose screen one (1) hour after the feeding. Monitor the neonate carefully for signs of hypoglycemia.

iii. Obtain 2 more pre-prandial blood glucose screenings (for a total of 3 post treatment) before returning to the blood glucose screen schedule (1, 3, 6, 12, and 24 hours of life).

5. Manage the infant according to the subsequent screening results (from #4c under Procedure) or when symptomatic (from #3 under Procedure):

    a. If the screening result is ever <25 mg/dL, treatment with intravenous glucose in the NICU is indicated.

        i. Administer glucose 40% gel (see Glucose Gel order set) if alert and respiratory status allows.

        ii. Notify the Pediatrician immediately and recommend transfer order to NICU.

            i. Communication of transfer should occur provider to provider so the Pediatrician is to notify of the Neonatologist of need of transfer to NICU.

        iii. Notify the charge nurse (L&D/Postpartum), NICU charge nurse, and the parents.

            • Physician to parent communication should also occur during transfer to NICU.

    b. If the screening result is 25 to 39 mg/dL (for infants under 24 hours of age), or 25 to 49 mg/dL (for infants 24-48 hours of age):

        i. Administer glucose 40% gel (see Glucose Gel order set) if alert and respiratory status allows.

        ii. Feed the infant again (5 mL/kg, up to 30 mL).

        iii. Recheck the glucose screen one (1) hour after the feeding. Monitor the neonate carefully for signs of hypoglycemia.

        iv. Obtain 2 more pre-prandial blood glucose screenings (for a total of 3 post treatment) before returning to the blood glucose screen schedule (1, 3, 6, 12, and 24 hours of life).

    c. The infant should not receive more than 3 doses of glucose gel. If 3rd dose of

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glucose gel is indicated, further evaluation of hypoglycemia in the NICU is warranted.

i. Administer 3rd dose of glucose 40% gel (see Glucose Gel order set) if alert and respiratory status allows.

ii. Notify the Pediatrician immediately and recommend transfer order to NICU.

- Communication of transfer should occur provider to provider so the Pediatrician is to notify of the Neonatologist of need of transfer to NICU.

iii. Notify the charge nurse (L&D/Postpartum), NICU charge nurse, and the parents.

- Physician to parent communication should also occur during transfer to NICU.

6. Continue feedings at least every two (2) to three (3) hours for the at-risk asymptomatic infant and perform preprandial glucose screening at approximately 1, 3, 6, 12, and 24 hours of life.
   a. Preterm and SGA infants should be screened through 24 hours of life.
   b. For all other at-risk infants, screening may be discontinued before 24 hours with 3 consecutive glucose levels ≥40 mg/dL.
      i. Target glucose range for infants less than 24 hours of age is ≥40 mg/dL.
      ii. Target glucose range for infants 24-48 hours of age is ≥50 mg/dL.
      iii. Target glucose range for infants >48 hours of age is ≥60 mg/dL.

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REFERENCES

Adamkin DH. Postnatal Glucose Homeostasis In Late-Preterm and Term Infants. ***Pediatrics***. 2011 Mar; 127(3):575-579.

Thompson-Branch A and Havranek T. Neonatal Hypoglycemia. ***Pediatrics in Review.*** 2017 Apr; 38(4):147-157.

Thorntin PS et al. Recommendations from the Pediatric Endocrine Society for Evaluation and Management of Persistent Hypoglycemia in Neonates, Infants, and Children. ***J Pediatr.*** 2015 Aug; 167(2):238-45.

Attachments

Neonatal Hypoglycemia Management ALGORITHM.pdf

Neonatal Hypoglycemia Worksheet.pdf

Approval Signatures

Step Description	Approver	Date
Board of Directors	Lori Higdon: Contracts Manager	10/2023
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	10/2023
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	10/2023
PCSC	Jose Castro: Director Pharmacy	09/2023

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Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Providence

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Owner	Reena Manubag: Manager Nursing
Policy Area	Womens Health
Applicability	CA - Saint John's Health Center

Neonatal Resuscitation Team Attendance at High Risk Deliveries

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PURPOSE

I. To provide optimal care for the newborn based on level of risk

II. To provide guidelines for conditions that may require notification of the NICU and/or Neonatologist before delivery of an infant.

POLICY

A. All individuals attending as caregivers must have completed and been certified in NRP
    1. Trainees not certified can be shadowed by senior mentor certified in NRP

B. Attendance by RRT and L&D delivery RN:
    1. Spontaneous vaginal delivery without complications
        a. Late preterm gestation 35-37 weeks
    2. Spontaneous vaginal delivery with low risk
        a. IUGR
        b. SGA/LGA infants
        c. Infants of diabetic mothers
        d. Maternal Antidepressant exposure
        e. Meconium presence
    3. Cesarean sections
        a. Scheduled/Repeat Scheduled

b. Repeat Unscheduled
c. Positional (i.e. Breech)

C. Attendance Neonatologist, RRT and NICU RN:
    1. All deliveries <35 weeks gestation
    2. Spontaneous vaginal deliveries >35 weeks with high risk
        a. Shoulder dystocia
        b. Cephalopelvic disproportion
        c. Non-reassuring fetal tracing
        d. Instrument use (Vacuum or Forceps)
        e. Cord Prolapse
    3. Cesarean sections urgent or emergent
        a. Failure to progress
        b. Non-reassuring fetal tracing

D. All deliveries ***with unexpected need for positive pressure respiratory support*** for the newborn should prompt need for neonatologist attendance.

E. All deliveries where there are obstetric team concerns, the full neonatal team support ***can and will be available*** with early notification.

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PROCEDURE

A. Primary RN of laboring mother notifies or delegates notification of an unexpected delivery needing the full neonatal team support to the NICU charge nurse.
    1. Include reason needed and location of delivery.

B. NICU charge nurse will call neonatologist and respiratory therapist to attend the delivery.

DOCUMENTATION

Documentation will include:

A. The names of the NICU team members present at the delivery

B. The time of notification of the neonatologist

C. Care provided by the team

D. The condition of the infant

E. Support provided during transfer

REFERENCES

National Institutes of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development. High-Risk Pregnancy *(https://www.nichd.nih.gov/health/topics/high-risk)*.

March of Dimes. Long-Term Health Effects of Premature Birth *(https://www.marchofdimes.org/complications/long-term-health-effects-of-premature-birth.aspx)*.

Neiger R. Long-Term Effects of Pregnancy Complications on Maternal Health: A Review. Journal of Clinical Medicine *(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5575578/)*. 2017 Aug;6(8):76.

Merck Manual. Risk Factors for High-Risk Pregnancy *(https://www.merckmanuals.com/home/women-s-health-issues/high-risk-pregnancy/risk-factors-for-high-risk-pregnancy)*.

Approval Signatures

Step Description	Approver	Date
Board of Directors	Irma Castaneda: Executive Assistant	03/2024
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	03/2024
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	03/2024
PCSC	Jose Castro: Director Pharmacy	02/2024

Applicability

CA - Providence Saint John's Health Center

Standards

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Saint John's Health Center
Providence

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Next Review	04/2028
Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Newborn Care

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Policy Number: NB-3

Effective Date: 2003

Review/Revise Date: 2/2012, 2/2015, 5/2018, 07/2021

I. PURPOSE

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Saint John's Health Center to provide guidelines for the nursing management of the newborn from birth to hospital discharge

II. POLICY

A. Follow the American Academy of pediatrics neonatal resuscitation guidelines for stabilization of the infant

B. A NRP certified nurse will be present at all deliveries to care for the newborn

C. The routine newborn admission will be completed in the LDR room with the parents present

D. Infants delivered by c/section will bond with parents in recovery room and initiate breastfeeding

E. The admission of c/section newborns will be completed in the nursery or recovery room

F. The father or significant other will be encouraged to be present in the nursery during the admission

G. Education of parents will be initiated from birth and throughout the hospital stay. Written education will be provided:

    1. Car seat safety which includes information on:

a. California car seat safety laws
b. Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system
c. Local child passenger restraint system programs

2. Jaundice
3. Infant security
4. Back to sleep-SIDS prevention
5. Newborn care
6. Breastfeeding

III. PROCEDURE

A. Preparation for birth

1. Assemble newborn supplies and check warmer and equipment in anticipation of the birth.
2. Receive an SBAR report from primary labor and delivery RN.

B. Birth

1. Assist mother with holding her newborn skin to skin immediately after birth
    a. MD will place newborn immediately on mother's chest
    b. C/section mothers will be assisted with skin to skin during surgery when both are stable
        i. Skin to skin contact will be initiated as soon as possible
2. Observe newborn immediately for the following criteria:
    a. Term gestation
    b. Clear amniotic fluid
    c. Breathing/ crying
    d. Good muscle tone.
3. Initiate routine care if all criteria met
4. Promote continuous skin to skin contact
5. Dry the infant on the mother's chest
6. Perform Apgar score at 1 and 5 minutes of age.
7. Transfer newborn to warmer if criteria not met and perform the following:
    a. Position
    b. Clear airway
    c. Dry
    d. Stimulate

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e. Follow NRP guidelines

C. Routine care
    1. Promote initiation of breastfeeding, assisting the mother as needed
    2. Assess temperature, heart rate, respirations, tone, and color within 15 minutes of birth
    3. Repeat temperature, heart rate, and respirations every 30 minutes for a minimum of 2 hrs or until stable
    4. Assess skin color, tone, and activity
    5. Complete assessment without separating mother and baby unless newborn or mother unstable
    6. Delay the following routine procedures to allow for uninterrupted bonding
        a. Bath
            i. May be delayed for up to 24 hrs
            ii. Ideally should be demonstrated with parents present
            iii. Should be performed when temperature is stable at ≥ 97.8° F
        b. Weight, length, complete physical assessment
            i. Complete within 2-3 hrs
        c. Lab work
        d. Medications
    7. Encourage parents to bond with their newborn
        a. Encourage parents to restrict their visitors during this initial bonding
        b. Collaborate with parents to ensure required observation and assessment are completed during bonding
        c. Combine assessment of newborn with teaching and assisting parents with breastfeeding and skin to skin contact

D. Medications
    1. Administer Erythromycin to infants eyes per standardized procedure within 2 hour of birth
    2. Administer vitamin K per standardized procedure
    3. Administer hepatitis vaccine and HBIG within 12 hrs of birth per standardized procedure if mother is positive HBsAG
    4. Administer hepatitis vaccine within 12 hrs of birth per standardized procedure if mother is unknown HBsAG status

E. Lab work
    1. Obtain glucose level per standardized procedure for diagnostic testing of the newborn

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a. SGA (*less than 10th percentile for weight*) or less than 2500 grams
b. LGA (*greater than 90th percentile for weight*) or greater than 4000 grams
    i. Using the Olson Growth Chart for term newborns
c. Late preterm (*gestational age 34 0/7 - 36 6/7 weeks)*
d. Infants of diabetic mothers

F. Infant security
    1. Maintain infant security by ensuring:
        a. The delivery record and all 4 bands have the correct patient name
        b. The delivery record and all 4 bands have the correct medical record number
        c. All 4 bands have the same ID number and this corresponds to the number on the delivery record
        d. The delivery RN and Baby RN verify bands together
        e. Parent(s) participate in the verification
        f. Apply ID bands to the infant's ankles, the mother's wrist and the significant other's wrist.
        g. If there is no significant other present destroy the 4th band
        h. Attach electronic infant security tag to infants ankle, activate and enter into computer system.
        i. Check ID bands with mother baby RN when transferring care

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G. Physical examination
    1. Complete a full physical assessment and document findings on the admission/ assessment form. Examine thoroughly :
        a. Skin intactness and presence of rash
        b. Head- fontanels , suture lines, caput, abrasions
        c. Ears
        d. Eyes
        e. Nose
        f. Mouth
        g. Chest
        h. Respirations and breath sounds
        i. Heart sounds
        j. Edema
        k. Abdomen
        l. Genitalia and rectum- may take temperature rectally to establish patent

anus if meconium not passed prior to exam

m. Back intactness
n. Extremities
o. Neurological- Reflexes

H. Communication

1. Admit newborn per standardized procedure for admission of the well newborn
2. Contact MD office/exchange to communicate admission details
3. Give a SBAR report to L/D RN when handing off care of the newborn
4. Give a SBAR report to the mother baby RN when newborn transferred to couplet level of care
5. Educate parents on the following:
    a. Infant security system
    b. Safe handling of the newborn
    c. Back to sleep positioning in crib
    d. Skin to skin positioning of the newborn
    e. Prevention of hypothermia
    f. Use of the bulb syringe
    g. Breastfeeding
        i. Positioning
        ii. Latch
        iii. Frequency of feeds – 8 or more in 24 hrs
    h. The need to call for assistance when rooming in but have concerns about newborn

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I. Documentation

1. Initiate the following during the admission process
    a. Physical assessment and vital signs
    b. Education in the EHR
    c. Plan of care in the EHR
    d. Infant security acknowledgement form (copy to parent)
    e. Car seat safety

J. Ongoing assessment

1. Repeat vital signs twice a shift with pain scale
2. Use the NIPS pain scale and manage any score > 0
    a. Swaddling, positioning change, diaper change, rocking, feeding are comfort measures that can be used for mild pain

b. A sucrose solution may be given for painful procedures such as lab draws per standardized procedure

3. Observe parent -infant interaction
4. Monitor parents ability to learn and care for infant
5. Teach every shift, reinforcing basic infant skills.
6. Bath infant and shampoo hair as needed.
7. Remove cord clamp after 24hrs
8. Observe cord for dryness every shift and clean with alcohol wipes if soiled
9. Assess for jaundice every shift. Obtain bilirubin levels per standardized procedure
10. Maintain intake and output by monitoring breast feeding, formula, voids and stools
11. Observe mother and infant during feeding a minimum of 2 times during a shift to ensure a correct latch and identify any problems
12. Obtain Newborn Screening within 12-48 hours of age
13. Ensure Hearing Screening is completed before discharge
14. Ensure oxygen saturation screening is performed after 24 hrs of age per policy
15. Ensure all procedures, lab work are completed before discharge
16. Perform a full physical assessment twice a shift and document findings
17. Examine thoroughly:
    a. Behavior
    b. Muscle tone
    c. Moro reflex
    d. Cry
    e. Skin
    f. Head
    g. Jaundice
    h. Fontanels
    i. Eyes
    j. Heart sounds
    k. Lung sounds
    l. Abdomen
    m. Nose
    n. Cord
    o. Circumcision site

K. Safety

1. Instruct parents not to sleep with baby in bed

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2. Review infant security with parents every shift
3. Check ID bands and electronic tag at the beginning of every shift and when assuming care of the infant
4. Check ID bands with mother when transferring infant back and forth to nursery
5. Check infant resuscitation equipment is in the room at all times
6. Maintain enough light in room that infant can be visualized easily
7. Maintain infant on back in crib
8. Give parents Safe Sleep handout
9. Reassess vital signs within 30 – 60 minutes if deviating from the normal range:
    a. Temperature range 97°F- 99.8° F
    b. HR 110-160 bpm
    c. Respirations 30-60 per minute
10. Report to MD
    a. Abnormal vital signs
    b. Heart murmur
    c. Abdominal distension
    d. Vomiting
    e. Blood sugar remaining <40 - 45
    f. High risk zone serum bilirubin
    g. Jaundice before 24 hrs of age
    h. No void within 24 hours of birth
    i. No stool or minimum stool within 48 hours of birth

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L. Documentation
1. Complete the following
    a. Assessments and vital signs
    b. Intake and output
    c. Education
    d. Care Plan
    e. Communication
    f. Discharge teaching (copy to parent) include pediatrician phone number, follow up appointment date and time

M. Discharge planning
1. Review discharge teaching instructions with parents, ensuring full understanding
2. Verify parents have written teaching/information
    a. Car seat safety

b. Newborn care
c. Jaundice
d. Back to sleep-SIDS prevention

3. Maintain infant security
    a. Deactivate and remove electronic tag immediately before discharge
    b. Remove one of the infant's ID bands and one of the parent's ID bands immediately prior to discharge.
    c. Attach the ID bands to the chart copy of the discharge instructions
    d. Have the parent(s) sign to validate their participation in this process
4. Verify with parents that the pediatrician has discussed with them about the first follow-up appointment in the office

REFERENCES/RELATED POLICIES

Kilpatrick, Sarah J., Papile, Lu-Ann, and Macones, George A. (2017) *Guidelines for Perinatal Care, 8th Edition.* Elk Grove Village, Il: American Academy of Pediatrics; Washington, DC; The American College of Obstetricians and Gynecologists

Simpson, Kathleen R., and Creehan, Patricia A. (2020) *AWHONN's Perinatal Nursing, 5th Edition*. Lippincott Williams & Wilkins Philidelphia, PA

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Standardized Procedure for admission of the Well Newborn

Standardized Procedure for Diagnostic Testing in the Newborn

Standardized Procedure for Prophylactic Medications in the Newborn

Standardized Procedure for Prophylactic Treatment of the Newborn of a HBsAG Positive Mother

Standardized Procedure for Administration of Sucrose for Discomfort/Pain Management

Standardized Procedure for Prevention of Hypoglycemia

Circumcision Care

Oxygen Saturation Screening

Approval Signatures

Step Description	Approver	Date
Board of Directors	Siune Vartanian: Executive Assistant to CEO	04/2025

Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	02/2025
Obstetrics and Gynecology	Peggy Mooney: Senior Manager Medical Staff Services	02/2025
PCSC	Jose Castro: Director Pharmacy	01/2025

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Providence

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Last Revised	04/2025
Next Review	04/2028
Owner	Reena Manubag: Manager Nursing
Policy Area	Neonatal Intensive Care Unit
Applicability	CA - Saint John's Health Center

Newborn Screening

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I. **POLICY:**

1. In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Saint John's Health Center that every Infant will have an accurate and timely newborn screening test performed prior to discharge

II. **GENERAL INSTRUCTIONS**

1. The Newborn Screen test will be performed on all newborns prior to discharge, **after 12 hours but no later than 48 hours of age** except:
    a. If the parent refuses to allow the specimen collection, the RN should notify the physician, physician should explain risk, benefits and alternatives.
        i. If parents still refuse:RN will have parent(s) sign the refusal section on the NBS form. NBS form will be completed and sent down to lab for collection. RN will document NBS refusal in EMR.
    b. Infants who were transported from another facility who have documented evidence that the Newborn Screen specimen has already been obtained.
    c. Infant is transferred to another health care facility for urgent reason. The RN should complete the NBS form and indicate transfer and name of receiving hospital, distribute copies to appropriate persons per the NBS and make a copy for the receiving hospital.
    d. Infant expired before newborn screen completed. The RN should complete the NBS form and indicate infant expired,distribute copies to appropriate persons.
    e. Newborn's condition is life threatening and NBS cannot be done safely. Physicians attending critically ill newborns who require special care may

postpone collection of a newborn screening specimen until the newborn's emergency condition is stabilized. The staff shall then collect the newborn screening specimen as soon as the newborn's condition is stabilized.

2. Repeat specimen will be obtained upon physician's order or after notification of inadequate specimen from NBS program.
3. Initial Newborn Screening specimen shall be obtained after 12 hours of age except when:
    a. An infant requires a blood transfusion (packed red blood cells only); the Newborn Screening test should be done prior to transfusion. A repeat NBS specimen will be obtained 24 hours after the last blood transfusion (PRBCs).
    b. If an infant is discharged prior to 24 hours of age, the specimen may be obtained prior to discharge. If test is done ≤12 hours of age, patient will need to be re-screened 48 hours after initial test.

III. **PROCEDURE**

1. Inform parents regarding need for testing, be sure they have received the information booklet regarding the Newborn Screen.
2. Gather equipment

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IV. **Instructions for collecting adequate dried blood spots appear on the Test Request Form**

1. CHECK THE EXPIRATION DATE ON THE FORM. The expiration information is in the lower right hand corner of the TRF: Example: LOT XXXXXX/XXXXX 12/31/2027.
    a. A specimen collected on an expired form will be deemed inadequate and the screen will need to be redone, thus delaying test results.
2. AVOID TOUCHING THE SPECIMEN COLLECTING AREA at any time with gloved or un-gloved hands. Oil, lotion, or powder from hands or gloves can prevent the blood from spreading evenly and thoroughly. Use un-powdered gloves.
3. Blood is to be collected from the heel. Do NOT collect blood from intravenous/intra-arterial lines, antecubital space or dorsal hand veins unless a heel stick is not possible.
4. Do not use capillary tubes for collecting the blood to spot on the card. It can damage the filter paper, resulting in an inadequate specimen.
5. Treat Neonate's pain with developmental positioning, swaddling or non-nutritive sucking to reduce stress and promote comfort.
6. Clean the skin with alcohol and allow to dry.
    a. Puncture the heel with a disposable lancet deep enough to reach the skin's primary blood supply, yet shallow enough to prevent heel or bone injury.
    b. Allow a large drop of blood to accumulate and wipe it away with a sterile gauze.
    c. Allow a large second drop of blood to accumulate, then apply the drop of

blood to the side of a circle on the NBS collection card.

d. Allow circles to fill by natural flow until the circle is completely filled when applying a large accumulated drop of blood to the specimen collection card. Repeat for each circle.

e. The circles should be filled completely when viewed from both sides. Fill all the circles. 

f. Avoid repeat applications of specimen collection card to the heel to fill any one circle.

g. Keep away from heat, lamps, direct sunlight and humidity.

h. Air-dry blood spots thoroughly at room temperature (for at least three hours) on a flat surface.

i. Specimens should not be placed in plastic bags or packaging.

j. Send specimens to the laboratory as soon as possible upon drying

k. Reminder: A detached white copy will be viewed as inadequate. If the white copy gets detached, write the baby's name and date of birth on the lines provided on the filter paper, and staple the filter paper to the bottom of the white copy. Collecting the specimen properly and keeping the form intact are crucial the keeping the specimen adequate.

l. An inadequate specimen will need to be redone.

V. **DOCUMENTATION**

1. RN to document completion of the newborn screen in the EMR and the newborn admission log book.

COPY

References:

California Department of Public Health (2022). *California laws and regulations on newborn screening*. Retrieved February 8, 2025, from https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/nbs/California-Laws-Pertaining-to-Newborn-Screening-.aspx#

California Department of Public Health (2025). *Newborn screening program*. Retrieved February 8, 2025, from https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/nbs/default.aspx

Kilpatrick, S. J., Papile, L., & Macones, G. A. (Eds.). (2017). *Guidelines for perinatal care* (8th ed.). American Academy of Pediatrics. https://doi.org/10.1542/9781610020886

Approval Signatures

Step Description	Approver	Date

Board of Directors	Siune Vartanian: Executive Assistant to CEO	04/2025
Medical Executive Committee	Peggy Mooney: Senior Manager Medical Staff Services	03/2025
Pediatrics	Peggy Mooney: Senior Manager Medical Staff Services	03/2025
PCSC	Jose Castro: Director Pharmacy	02/2025

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Status **Active** PolicyStat ID **17235362**

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Last Approved	04/2025
Effective	04/2025
Last Revised	04/2025
Next Review	04/2026
Owner	Teresa Claeson: Executive Director Nursing
Policy Area	Women's Services
Applicability	CA - Saint John's Health Center

Standardized Procedure for Admission of the Well Newborn

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Providence Saint John's Health Center Policy/ Procedure

I. **POLICY:**
To provide a standardized procedure for the admission process of the well newborn

A. Function: Registered Nurses can admit to the service of the attending physician, well newborns meeting the admission criteria for the newborn nursery. Well newborns do not require special monitoring or resuscitation and are admitted, stabilized and receive standard newborn care and initiation of feeding

B. Circumstances under which the RN may perform the function:

1. Setting: Labor and Delivery and Normal Newborn Nursery
2. Patient Population: Infants born at Saint John's Health Center or admitted to Newborn Nursery at Saint John's Health Center
3. Patient Conditions: Newborn
4. Contraindications: None
5. Supervision: None required

C. Newborn exclusions:

1. Weight less than 2200 grams
2. Newborn ≤ 34 6/7 weeks gestation

D. Patient Population:

1. Normal Newborns who are a minimum of 2200 grams and 35 weeks gestation

E. Nursing is responsible for the administration of medications and laboratory monitoring.

II. **PROCEDURE**

A. **Definition:**

1. This standard nursing practice addresses the management of normal newborns admitted in labor and delivery and the newborn nursery
2. Nurses may function independently in performance of general newborn assessment, gestational assessment, and newborn care management, initiation of emergency procedures, specific medication administration and laboratory monitoring

B. **PROCEDURE**

1. Assess maternal history, risk factors and gestation
2. Collaborate with pediatrician/neonatologist if infant's weight or status may require additional care and or possible transfer to the NICU
3. Verify the name of the pediatrician selected by the patient
4. Inform obstetrician if parents have not selected a pediatrician and assign as directed by obstetrician
5. At birth follow NRP (neonatal resuscitation provider)guidelines for assessment and stabilization
6. Administer oxygen as needed per NRP guidelines
7. Obtain vital signs at birth and every 30 minutes for a minimum of 2 hours or until stable
8. Obtain ongoing vital signs a minimum of every 6 hours
9. Obtain weight, head, and chest circumference
10. Complete a full physical assessment
11. Repeat full physical assessment a minimum of every 12 hours
12. Notify the Admitting Department of infant's birth in accordance with admissions procedure
13. Verify current privileges of selected pediatrician
14. Notify pediatrician's office or exchange of infant's birth and status
15. Assist mother with breastfeeding and promote breastfeeding when infant exhibits cues 8 or more times in 24 hours
16. Promote skin to skin contact and rooming in
17. Initiate formula feeding (if mother requests to formula feed infant) when infant exhibits cues 8 or more times in 24 hours
    a. Limit formula to 5 to 15 ml per feed during the first 24 hours
18. Initiate the Standardized Procedure for Administration of Prophylactic

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Medications to the Newborn

19. Initiate the Standardized Procedure for Diagnostic Testing in Newborns
20. Initiate the Standardized Procedure For Prophylactic Treatment Of The Newborn of a HBsAG Positive Mother Or An HBsAG Status Unknown Mother if indicated
21. Initiate the Standardized Procedure for Administration of Sucrose for Discomfort / Pain Management

C. **Documentation**

1. Complete the following
    a. Physical assessment and vital signs
    b. Education in EHR
    c. Care Plan in EHR

III. **REQUIREMENT FOR RN**

A. Education, Training and Experience:

1. Each RN performing standardized procedure functions must have:
    a. A current California RN license
    b. Completed the unit specific orientation,
    c. Current NRP certification
    d. Ongoing competency evaluated during the Annual Review.

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IV. **NOTIFICATION OF PHYSICIAN**

A. The RN must notify the physician when the following occur:

1. When there is any question about standardized lab tests or medication administration indicated for the individual infant
2. Mother had no prenatal care
3. Maternal history of drug abuse
4. Respiratory rate > 60 per minute
5. Heart rate >170 bpm
6. Temperature <97.5 F following warming measures, or >99.5F
7. Heart murmur
8. Abdominal distension
9. Vomiting
10. Blood sugar remaining <40
11. Jaundice before 24 hrs of age
12. No void within 24 hours of birth
13. Congenital abnormality

14. **Any other significant concerns**

V. **RNS AUTHORIZED TO PERFORM PROCEDURE**

A. All labor and delivery, mother baby, nursery and NICU RNs

B. List in Administration updated quarterly

VI. **RELATED POLICIES AND PROCEDURES**

A. Standardized Procedure for Administration of Prophylactic Medications to the Newborn

B. Standardized Procedure For Prophylactic Treatment Of The Newborn of a HBsAG Positive Mother or a HBsAG Status Unknown Mother

C. Standardized Procedure for Diagnostic Testing in Newborns

D. Standardized Procedure for Administration Of Sucrose for Discomfort / Pain Management

E. Newborn Care

F. Breastfeeding

VII. **REFERENCES**

A. Nursing Practice Act, Section 2725

B. Guidelines for Perinatal Care 8th edition American Academy of Pediatrics

VIII. **APPROVALS**

Interdisciplinary committee Date: ?/?/2018

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Approval Signatures

Step Description	Approver	Date
Board of Directors	Siune Vartanian: Executive Assistant to CEO	04/2025
Medical Executive Director	Peggy Mooney: Senior Manager Medical Staff Services	04/2025
Interdisciplinary Practice Committee	Peggy Mooney: Senior Manager Medical Staff Services	04/2025
PCSC	Jose Castro: Director Pharmacy	02/2025

Applicability

CA - Providence Saint John's Health Center

Standards

No standards are associated with this document

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Status **Active** PolicyStat ID **18463351**

Providence
Santa Rosa
Memorial Hospital

Origination	06/1977
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Last Revised	07/2025
Next Review	07/2027
Owner	Hiranya Abeysekara: Supervisor Clinical Laboratory
Area	Lab Services - Microbiology
Applicability	CA - Santa Rosa Memorial Hospital

Collection and Care of Urine Specimens

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PURPOSE/DEFINITION:

Collection of urine for laboratory examination is done to determine specific bacterial, cellular, or chemical properties to assist in diagnosis of disease entities. The amount of urine required and the time it is collected will vary according to the test to be performed.

POLICIES/GENERAL INSTRUCTIONS:

1. Urine supports rapid bacterial growth if left at room temperature; therefore, specimens should be taken to the laboratory within 15 minutes of collection for processing or refrigeration. If transport to the lab for is delayed, it can be refrigerated for up to two hours after which a new specimen must be obtained. If the specimen has been transferred into a grey top boric acid tube.
2. Urine tests that are sent to reference laboratory may require special handling and/or preservatives. Refer to the Reference Laboratory's collection information.
3. If patient is menstruating, the perineal area should be cleansed and a fresh vaginal tampon inserted before specimen is collected. The presence of RBC's will be detected on microscopic examination.
4. Label generated from the Laboratory Information System (LIS) must be affixed to each specimen container. During downtime, alternate labeling is acceptable.
5. Specimen must be placed in a biohazard bag, sealed, and transported to the lab.

6. Hazardous specimen should be clearly marked; ie red bagged or labeled with special sticker. If possible there should be three-day delay before collection of urine from Radiation Therapy.
7. For Urine Culture, clean-catch specimen, catheter aspiration, and pedi-bagged specimens are acceptable. Quantitative studies of organisms are done to determine the presence, type, and degree of pathogens in the urine . One (1) to five (5) milliliters of urine is required.
8. Routine Macroscopic Urinalysis includes a study of general appearance, pH, specific gravity, protein, glucose, ketones, occult blood, bilirubin. Routine Microscopic Urinalysis includes sediment analysis. Twelve (12) milliliters of urine is optimal.
9. Twelve or 24 hour Creatinine and Urea Clearance require urine and blood specimen. The blood is drawn during the collection period. It is part of the tests to determine the excretion rate.

EQUIPMENT FROM FLOOR SUPPLY:

1. A sterile urine container collection kit for Routine Urinalysis, Urine Culture, or Random chemistry test
2. Grey top BD Boric Acid tube for Culture and Sensitivity testing.
3. 24-hour urine collection bottle for timed urine tests
4. For Catheters, syringe with small gauge needle and prep pads
5. For babies or young children, plastic pedi-bag
6. Computer generated specimen identification label.
7. Clean urinal, appropriate container and graduated pitcher.
8. Electronic health record barcoded specimen label

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PROCEDURE:

1. Explain midstream clean catch procedure to patient.
2. Have patient wash hands!
3. Wash and glove your hands.
4. Midstream Collection:
    a. MALE: cleanse urethral meatus with three changes of castile soap towelettes, starting at the urethral orifice and cleansing away from the orifice (if foreskin is present, it must e retracted throughout the entire procedure). Initiate the stream of urine. Wait a few seconds, then collect the midstream specimen by passing the sterile collection cup into the stream of urine without stopping the flow. Optimal volume to collect 12 milliliters and no more than half full. Remove and close container securely. Wipe dry any excess urine on outside of container. Label properly.
    b. FEMALE: Retract labia minora with non-dominant hand. Cleanse vulvar area with three changes of castile soap towelettes beginning above the urethral orifice and moving downward posteriorly; ie front to back. Maintain hold on labia and initiate stream of urine. Wait for a single stream to be achieved. Collect the midstream specimen by passing the sterile collection cup into the stream of urine without

stopping the flow. Obtain at least 12 milliliters and no more than half full. Remove and close container securely. Wipe dry any excess urine on outside of container. Label properly.

5. Pedi-Bag collection: Before attaching bag, perform careful perineal prep and cleansing as noted above or as preferred by pediatrician. The bag containing the specimen is not to be sent to the laboratory, but rather use a 12 milliliter syringe to transfer this to a sterile specimen container. Indicate on the container that this is a "bagged" urine specimen. This assists the physician and Clinical Laboratory Scientist (CLS) to interpret any mixed growth with occurs with this type of collection when Urine Culture is performed.
6. Catheter Aspiration: Only to be done by RNs. Cleanse the surface of the collection port (just below the "Y" connection) with alcohol prep pad. Allow to air-dry thoroughly. Puncture the port with a small gauge needle and syringe and withdraw specimen. Aspiration of the catheter line tubing is contraindicated when a collection port is available. NEVER take urine from the collecting bag or lower portion of the collection tubing. NEVER disconnect catheter tubing for the purpose of obtaining a specimen . After obtaining the specimen, cap the syringe securely and label properly. Please note this was a "CATHETER" aspiration collection. The laboratory must know this so that the correct quantitative studies are done for Urine Culture. If desired, the urine specimen may be aseptically transferred to a sterile specimen container by removing the needle from the syringe and carefully expelling the urine into the sterile container.
7. Timed Urine Specimens: 12 hour, 24 hour collections (Creatinine, Urea Clearance, other timed Urine tests)
    a. Timed urine specimens are done to determine a specific function of the kidneys during a designated period of time. The length of study and type of collection bottle will vary according to the test ordered. Some will required preservatives.
    b. All timed urine specimens are started with an empty bladder and ended when the bladder is emptied for the final specimen. The exact time of starting and ending specimens should be indicated on label. If possible timed specimens should be scheduled to end at 0700.
    c. Explain the test and its duration to the patient to insure his/her cooperation in obtaining an accurate collection. Instruct the patient that he/she is to void into a suitable container or bedpan for the duration of the test procedure and to notify a nurse of each voiding so that it can be added to the specimen container. It is important that the patient be instructed to void in a separate container and to avoid any contamination of the urine with stool.
    d. Keep the urine specimen refrigerated during the collection period.
    e. At the end of the test period, have the patient empty his bladder again, add that specimen to the collection. Note the time of the last voiding on the specimen label. This ends the timed urine collection.
    f. For Creatinine and Urea Clearance, it is required to obtain blood Creatinine or Urea specimen during the urine collection time to determine excretion rate.
    g. Order the test in LIS and respond to the prompts if appropriate. On the LIS label, write the collection time/period and sign.
    h. Submit the specimen to the laboratory immediately.

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Approval Signatures

Step Description	Approver	Date
Laboratory Services Medical Director	Wanhua Yang: MD	07/2025
	Hiranya Abeysekara: Supervisor Clinical Laboratory	07/2025

Applicability

CA - Providence Santa Rosa Memorial Hospital

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Standards

No standards are associated with this document

Status **Active** PolicyStat ID **19033234**

Providence
Santa Rosa
Memorial Hospital

Origination	07/2025
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Last Revised	09/2025
Next Review	09/2028
Owner	Dalila Formato: Project Coordinator
Area	Infection Prevention Services
Applicability	CA - Santa Rosa Memorial Hospital

Prevention of Catheter Associated Urinary Tract Infection (CAUTI)

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Purpose

In keeping with the mission and values of Providence, Providence Santa Rosa Memorial Hospital (PSRMH) adopts the system policy titled " Catheter Associated Urinary Tract Infection (CAUTI) Prevention Viewing PSJH-CLIN-1210 Catheter Associated Urinary Tract Infection (CAUTI) Prevention **with the exception of the information below:**

Urine Culture Collection

Replacing the Foley catheter before collecting a urine sample for culture is essential to reduce the risk of contamination, which can lead to false positives indicating a urinary tract infection (UTI). False positives may result in misdiagnosis and inappropriate treatment. Therefore, it is crucial to follow proper procedures to ensure accurate diagnostic results.

For patients with a Foley catheter in place for **24 hours or more**, consult the attending healthcare provider before collecting a urine sample for microscopy or culture. Obtain an order to remove the existing catheter, and request an order for straight catheterization if obtaining a midstream specimen is challenging.

If the healthcare provider decides to continue using the urinary catheter, request an order to replace the catheter before collecting the urine sample to minimize contamination risks. Ensure the specimen is

promptly transferred to the laboratory, ideally within 15 minutes, to maintain its integrity for accurate testing and analysis.

Daily CHG Treatment

Daily CHG treatment will be performed on patients having a indwelling urinary catheter of any type, including those patients with catheters present on admit.

PSRMH Adult Acute Urinary Retention Pathway

Adhere to the attached **Santa Rosa Memorial Hospital Acute Urinary Retention Protocol (PSRMH Nursing Pathway for Adult Acute Urinary Retention)** when ordered.

Reference

PSJH-CLIN-1210 Catheter Associated Urinary Tract Infection (CAUTI) Prevention

Carlee Hoxworth MPH, CIC , Addressing [Urinary Tract Infection]. In: Dean R, Popescu S, eds. APIC Text. [Revised January 26, 2024]. Available at 34. Urinary Tract Infection | Prevention Measures for Healthcare-Associated Infections | Table of Contents | APIC. Accessed July 30, 2024.

Approvals

Infection Prevention Committee 09/2025
Medical Executive Committee 09/2025
Community Board 09/2025

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Attachments

PSRMH Nursing Pathway for Adult Acute Urinary Retention

Approval Signatures

Step Description	Approver	Date
	Dalila Formato: Project Coordinator	10/2025

Applicability

CA - Providence Santa Rosa Memorial Hospital

Standards

No standards are associated with this document

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