Physician Orientation and Ongoing Education Manual

Saint Joseph Health System

Part 2 of 2

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SAINT JOSEPH
Regional Medical Center

Organizational Integrity Program

As a member

of the Medical Staff of Saint Joseph Regional Medical Center, Inc. ("SJRMC"), you serve as a trusted partner in the delivery of health care services to the communities we serve. Our relationship is built upon mutual integrity and respect. SJRMC has implemented an Organizational Integrity Program ("OIP") to ensure our mission is fulfilled in a manner consistent with SJRMC's values and all applicable legal, ethical and professional standards.

This brochure will acquaint you with the beliefs, values and mission of SJRMC which serve as a foundation for the OIP. This brochure will also introduce you to certain aspects of the OIP, such as the Standards of Conduct, which have particular application to our relationship with you as a member of our devoted Medical Staff.

If you have any questions regarding this information, please contact SJRMC's Organizational Integrity Officer, Robert Sink at (574) 335-4654.

Our Beliefs

SJRMC represents a community of persons supporting right relationships to advance our healing mission. Integrity is another word for right relationships. Integrity fosters healthy relationships with those whom we serve, with ourselves as caregivers, and with the resources with which we are entrusted.

The OIP is an essential way that SJRMC promotes and seeks to ensure integrity – right relationships. Ethical, professional and legal behaviors are not only consistent with the mission of SJRMC, but also essential to the fulfillment of our mission. When we fulfill our ethical, professional and legal obligations, we foster the mission of SJRMC.

To put it briefly, SJRMC, the mission statement, and the core values all concern the right relationships and integrity.

Organizational Integrity Program ("OIP") "Doing the right thing"

Doing the right things for the right reasons means acting in a manner consistent with our ethical, professional and legal obligations. SJRMC's OIP has been designed to provide guidelines, education and tools to assist our employees and others who serve in partnership with us in "doing the right things." This includes assisting you in better understanding your responsibilities as a member of the Medical Staff of SJRMC.

The OIP is not concerned only with laws and regulations, but also emphasizes the responsible conduct of individuals and the organization. Basic principles such as treating others with respect and dignity, obeying the law and telling the truth, using good judgment, maintaining high ethical standards, and raising concerns when appropriate are the foundation upon which SJRMC's OIP is based.

SJRMC's Organizational Integrity Officer, Robert Sink., is a member of the senior management team. Mr. Sink is responsible for the development and operation of the OIP within SJRMC. You can contact Mr. Sink at (574) 335-4654.

Standards of Conduct

The Standards of Conduct provide guidance to assist our employees and others who serve in partnership with us in fulfilling their ethical, professional and legal responsibilities. Several areas addressed in the Standards of Conduct have particular applicability to you as a member of the Medical Staff of SJRMC.

Fraud and Abuse

It is the policy of SJRMC to comply in all respects with Medicare and Medicaid laws and regulations. These laws and regulations also are applicable to you and your practice. You should be aware that:

The offer or exchange of money, goods, services, below-market rates or any other thing in return for referral of patients to a healthcare provider is prohibited;

The same law also prohibits enticing patients or other customers to use or purchase an item or service that is paid for by Medicare or Medicaid by offering something of value to them (no matter how small the value may be).

Medicare laws and regulations prohibit the submission of inaccurate or misleading claims to any government or third-party payer. This includes claims for services not provided, claims that represent services differently than the service actually provided, or claims that do not meet other program requirements; and

Patient records, on which claims submitted are based, must be complete and accurate, and conform to accepted professional standards for the maintenance of such records.

Tax Matters

SJRMC is organized and operated exclusively for charitable purposes and to serve our community. As a result, SJRMC has both an ethical and legal obligation to operate in a manner consistent with our charitable purpose. You should be aware that:

Tax regulations prohibit the improper use of SJRMC's assets to benefit individuals, including Medical Staff members, in a position to exercise influence over the business activities of the organization; and

Financial transactions with Medical Staff members who refer patients to our facilities are subject to complex tax and fraud and abuse laws and regulations.

SJRMC has established certain policies and procedures to ensure all applicable laws and regulations are considered when conducting such transactions.

Conflicts of Interest

Conflicts of interest exist any time your activities or interest influence, or could appear to influence, your decision-making related to your Medical Staff membership with SJRMC. Appearances count when dealing with potential conflicts of interest.

Participation in activities that conflict with your duties and responsibilities as a Medical Staff member is not acceptable. Examples of potential conflicts of interest include:

Using your influence to recommend the selection of a vendor, contractor, product or supply with which you have a financial interest or other relationship without disclosure of such relationship to SJRMC;

The offering or acceptance of gifts, monetary or in-kind, from a vendor or contractor as an inducement for you to use your influence or position with SJRMC as a basis for entering into a business relationship with SJRMC.

If you have any doubt, treat the situation as if a conflict exists until you have properly disclosed and resolved the potential conflict through SJRMC's Organizational Integrity Officer or other appropriate channels within SJRMC.

Remember – you have an obligation to disclose actual or potential conflicts of interest to SJRMC.

Confidentiality of Information

It is the policy of SJRMC to adhere to all laws and regulation pertaining to the privacy and confidentiality of patient or any other sensitive information or records. Never disclose confidential information concerning a patient or other information to any person or organizations, including friends, family members, supplies, or others, without appropriate consent or authorization.

Excluded Providers

As a recipient of funds from Medicare and Medicaid programs, SJRMC is prohibited from submitting any claim for services ordered, prescribed or performed by individuals or organizations excluded from participation in state or federal health care programs. As a result, SJRMC has established a policy that prohibits the entering into or maintaining of a business relationship with any provider excluded or otherwise ineligible for participation in state or federally funded health care programs.

SJRMC routinely screens Medical Staff membership for exclusion purposes. However, if you are subsequently notified that you have been excluded from participation in state or federally funded health care programs, you have an obligation to notify your Medical Staff affairs office or SJRMC's Organizational Integrity Officer immediately.

Reporting Concerns: The Four-Step Process

Delivering health care services is complex, with ever-changing rules and requirements applying to our daily operations. SJRMC has established a Four-Step Process for the use of employees and others when seeking answers to questions or concerns, including possible violations of law, regulations or the Standards of Conduct. You may use any of the following steps at any time to seek answers to your questions or concerns;

Contact your Medical Staff Officer or Medical Staff Affairs Representative

If you are not comfortable seeking an answer from these individuals or are not satisfied with the answer received, contact a higher-level individual within SJRMC such as the CEO or COO.

Contact Robert Sink, the Organizational Integrity Officer, at (574) 335-4654.

The Integrity ALERTLINE

The Integrity ALERTLINE is staffed 24-hours a day, seven days a week by an outside organization professionally trained to handle such calls. The ALERTLINE does not trace calls or use Caller ID. Callers may report information anonymously if they so choose. However, callers may be asked if they are willing to identify themselves so that an issue can be followed up with the caller.

No one at SJRMC is allowed to retaliate in any form against an individual reporting a concern in good faith. Retaliation is subject to discipline, up to and including dismissal, on the first offense.

THANK YOU!

We appreciate your taking time to review this information
and your commitment to supporting the OIP at
Saint Joseph Regional Medical Center, Inc.
If you wish to obtain a complete Standards of Conduct booklet, please contact
Robert Sink, Vice President Finance/Organizational Integrity Officer
at (574) 335-4654 or by e-mail at sinkr@sjrmc.com.

MISSION STATEMENT

We serve together in Trinity Health,
in the spirit of the Gospel,
to heal body, mind and spirit,
to improve the health of our communities
and to steward the resources entrusted to us.

CORE VALUES

- Respect
- Social Justice
- Compassion
- Care of the Poor and Underserved
- Excellence

The False Claims Act

As a recipient of federal health care program funds, including Medicare and Medicaid, Trinity Health and Saint Joseph Regional Medical Center ("SJRMC") are required by law to include in its policies and provide to all associates, agents and contractors, detailed information regarding the federal False Claims Act and applicable state civil and criminal laws intended to prevent and detect fraud, waste and abuse in federal health care programs.

What is the False Claims Act?

The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program.

"Knowingly" includes having actual knowledge that a claim is false or acting with "reckless disregard" as to whether a claim is false. Examples of potential false claims include knowingly billing Medicare for services that were not provided, submitting inaccurate or misleading claims for actual services provided, or making false statements to obtain payment for services.

The False Claims Act contains provisions that allow individuals with original information concerning fraud involving government health care programs to file a lawsuit on behalf of the government and, if the lawsuit is successful, to receive a portion of recoveries received by the government.

State Laws

In most states it is a crime to obtain something (e.g., such as a Medicaid payment or benefit) based on false information. In addition to the federal law, several states in which Trinity Health operates (California, Indiana and Michigan) have adopted similar laws allowing individuals to file a lawsuit in state court for false claims that were filed with the state for payment, such as the Medicaid program.

Penalties for Violating the False Claims Act

There are significant penalties for violating the federal False Claims Act. Financial penalties to an organization that submits a false claim can total as much as three times the amount of the claim plus fines of $5,500 - $11,000 per claim. In addition to fines and penalties, the courts can impose criminal penalties against individuals and organizations for willful violations of the False Claims Act. The false claims laws adopted in the states of California, Indiana and Michigan also carry significant fines and penalties of $5,000 - $10,000 per claim.

Protections Under the False Claims Act

The federal False Claims Act protects anyone who files a lawsuit under the Act from being fired, demoted, threatened or harassed by his or her employer as a result of filing a False Claims Act lawsuit. Similar protections are also provided to individuals under the state False Claims Act laws adopted in California, Indiana and Michigan. Ohio also has specific laws providing protections.

Our Commitment to Integrity

Trinity Health and SJRMC are committed to fully complying with all laws and regulations that apply to our health care ministry. We have established the Organizational Integrity Program (OIP) as evidence of our commitment to operating with the highest degree of integrity. The OIP includes the Standards of Conduct, policies and procedures, training and education, auditing and monitoring, and mechanisms for individuals to raise issues and concerns without fear of retaliation.

Whether you are an associate, contract worker, volunteer, medical staff member, vendor or other business partner with Trinity Health and/or SJRMC, **you are reminded to:**

Act with honesty and integrity in all of your business activities

Follow all laws and regulations that apply to your work activities, including requirements of Medicare, Medicaid and other federal health care programs. These requirements generally include maintaining complete and accurate medical records, and submitting only complete and accurate claims for services provided

Contact one of the following resources available within Trinity Health or SJRMC if you have knowledge or concern regarding a potential false claim:

Your Local Integrity Officer – Robert Sink 574-335-4654
The Integrity Line – 1-866-477-4661. The Integrity Line is staffed 24 hours a day, seven days a week by an outside organization. You may choose to remain anonymous when filing a report.
You may also file a report online at www.mycompliancereport.com .
When prompted for an access ID, please use THO.

Trinity Health and SJRMC policies strictly prohibit retaliation, in any form, against an individual reporting an issue or concern in good faith. Retaliation is subject to discipline, up to and including dismissal from employment or termination of the business relationship with Trinity Health and/or SJRMC.

Please contact your Local Integrity Officer using the information above if you have any questions. Thank you for your commitment to operating with integrity and the highest standards of ethical behavior.

SAINT JOSEPH
HEALTH SYSTEM

Process to Identify and Manage Matters of Individual Physician Health Separate from the Medical Staff Disciplinary Function

Physician Orientation

A central obligation of the medical staff organization is to protect patients from harm. In this regard, the medical staff together with hospital leadership is responsible to consider and address physician health issues which might jeopardize hospital operations and/ or compromise quality of patient care.

The Centralized Well Being Committee of the medical staff (a group of knowledgeable, experienced, and seasoned physicians) is charged with overseeing the process of assistance and rehabilitation, rather than discipline, to aid medical staff members in retaining and regaining optimal professional functioning when physical, psychiatric, emotional illness or substance abuse is identified.

While education and prevention are paramount, physicians are not immune to disabling conditions. Confidential and systematic diagnosis, treatment, and rehabilitation of physicians suffering from potentially impairing conditions is maintained and supervised by the Centralized Well Being Committee.

Warnings which may signal existing or impending impairment include:

- Increased problems in quality
- Making rounds at odd or inappropriate times
- Inappropriate orders
- Unavailability or inappropriate responses to phone calls
- Social withdrawal
- Intoxication at social events
- Missing appointments
- Repeated "illnesses"
- Large weight gain or loss
- Disjointed thoughts
- Inappropriate levity

Although this issue is not a pleasant or popular topic of conversation for physicians, its importance goes well beyond compliance with regulatory bodies such as The Joint Commission. If we are serious about providing excellent healthcare to our patients and communities we must engage in taking care of ourselves and colleagues.

If you have concerns about a potentially impaired colleague, please approach your department chair or a member of the Centralized Well Being Committee.

SAINT JOSEPH
Regional Medical Center

Version #: 2

Title: Observed Behavior Suspected Impairment at Work

Document Owner: Dabney, RJ	PI Team: Leadership	Date Created: 10/01/07
Approver(s): Hofstra, Donna	Date Approved with no Changes: 08/25/2020	Date Approved: 06/29/2017 06/27/11
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Recruiting

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. To require safe, effective care, this policy is designed to assist in the identification, intervention and facilitation of care in situations of impaired performance.
2. SJRMC is committed to providing a safe working environment for all Employees, contractors, volunteers and medical staff. It is our responsibility to patients, fellow physicians, and the communities we serve to ensure our Employees, contractors, volunteers, and physicians are physically and mentally competent to meet the day-to-day responsibilities of their job. It is, therefore, our objective to recognize and address incidences of Employee, contractor, volunteer and physician job-related impairment and to facilitate evaluation and treatment where appropriate. This policy shall apply to issues of impairment due to drug (legal and illegal) abuse, alcohol abuse, and/or mental or physical illness of a significant magnitude that leads the observer to believe the individual's performance is impaired. There may be more specific policies and regulations that apply to certain Employees such as those positions requiring licensure (i.e. physicians, patient care). Those policies/regulations will apply when a conflict between the two policies/regulations exist.
3. This policy is intended to provide some overall guidance and direction on how to proceed when confronted with a potentially impaired professional or fellow Employee.

PROCEDURE:

A. **Reporting**

1) **Self-Reporting**: Impairment may be due to such things as the use of alcohol or other substances (legal or illegal) or medical and/or psychological conditions. SJRMC requires all individuals to immediately notify their supervisor and/or Employee Health when they are impaired and strongly encourages them to seek appropriate help either before or following an incident of impairment. It is hoped that Employees and physicians will make use of resources and programs that SJRMC offers to resolve potential problems long before such occurrences take place.

2) **Employee Reporting**: Employees, contractors, volunteers and physicians who observe or become aware of a potentially impaired physician, fellow Employee, volunteer or other persons, are required to report the incident to the individual's immediate supervisor, the House Supervisor, Risk Management or the Integrity Alert line just as quickly as possible. If a supervisor is unsure whether a situation is covered by this Policy, the Supervisor should call the Human Resources Department. Supervisors may consult Employee Health Services for situations that appear to be primarily medical in nature.

B. **Determination of Impairment**

1) **Determination by a Supervisor or Manager**: When a supervisor receives a report of or observes what appears to be impaired behavior, that supervisor is required to make a determination of possible impairment. Whenever possible, another supervisor should confirm the observations and accompany the supervisor as he/she talks to the individual. Ideally this person should be a supervisor at the same level or higher. The supervisor is asked to use the Observed Behavior Checklist to record his/her observations and/or discussions with the impaired person, as well as the report of impaired behavior received from another individual. In all cases of actual or possible impairment, the supervisor should contact Human Resources to determine if an EAP referral and/or disciplinary action, and/or a drug/alcohol screen are appropriate. In all cases, the Employee should be given a copy of the Observed Behavior Checklist if applicable. The supervisor should make reasonable efforts not to involve the Employee's co-workers in the conversations apart from the individual selected to be the observer.

2) **Determination by an Employee**: When an Employee suspects an individual is impaired, he/she shall notify his/her immediate supervisor. The Employee is not permitted to conduct the Determination of Impairment, but is only responsible to report it. If an Employee suspects his/her supervisor is impaired, he/she shall notify the supervisor's immediate supervisor. In either case, if the immediate supervisor is not available, the next higher-level supervisor shall be notified. An Employee reporting suspected impairment is protected from retaliation in accordance with SJRMC's policies/practices with reporting misconduct.

C. **Procedure Based on Perceived Level of Impairment**

1) An Employee, contractor, volunteer or physician whose words, behavior, appearance, or odor suggests impairment may be required to undergo drug/alcohol testing and/or may be suspended and sent home depending on the perceived level of impairment. If the individual is placed on leave and asked to leave the work site, the supervisors should NOT physically restrain the individual or interfere with the individual's free movement in any way. Supervisors shall take the actions described below in this Policy that are appropriate to the perceived level of impairment.

a) **Severely Impaired**: If individual is severely impaired (i.e. unconscious, staggering, or incoherent), the supervisor should:

For Hospital locations, follow emergency codes and process. Off-site locations call 911 immediately and request an ambulance.

(1) Have someone stay with the Employee until medical or emergency personnel arrive.

(2) Make sure the individual is safely in the custody of medical or emergency personnel.

(3) Document the incident in writing or by electronic reporting.

b) **Violent, Verbally Abusive, or Otherwise Threatening**: If an impaired individual is violent, verbally abusive, or otherwise threatening, the supervisor should:

(1) Call Security or local police for assistance in removing the individual from the property (or-911 for off-site or determined need).

(2) Do not attempt to physically restrain the individual or interfere with the individual's free movement in any way.

(3) Take reasonable efforts to protect yourself and others.

(4) Make certain the individual has been safely escorted off of the premises or is safely in the custody of public officials.

(5) Document the incident (in writing or electronic reporting).

D. **Safe Removal from the worksite**

1) An individual who is impaired may not remain at his/her work site because of the increased risk for accidents and other dangerous or hostile behavior. For the safety of the impaired individual and others at SJRMC, it is important that the impaired individual leave the work site immediately in a safe and orderly manner. From the options listed below, the supervisor shall find appropriate transportation for the impaired individual to either a medical facility or the individual's home. The supervisor should actively discourage the impaired individual from driving him/herself home, but the supervisor should not physically restrain the individual or interfere with the individual's free movement in any way. The supervisor shall inform an individual who refuses to accept alternative transportation that the supervisor is required to call the police if the individual chooses to drive any vehicles. The supervisor must call the police if the individual drives any vehicle. Supervisors or other Employees are discouraged from using their own vehicles to transport individuals showing signs of impairment. The supervisor should:

a) Ask the individual if he/she would accept a courtesy ride from SJRMC security

b) Ask the individual for a name and phone number of an individual who could provide a ride

c) Ask the employee if he/she would be willing to accept a taxicab ride paid for by SJRMC to either a medical facility (if other than the hospital setting) or the individual's home.

d) In all respects, the supervisor is asked to follow the Impaired Performance Instruction Sheet when removing an individual from the worksite**.**

E. **Return to Work**

1) The individual will not be allowed to return to work until the individual provides a statement from a licensed medical and/or mental health provider certifying that the individual is fit to return to work. The supervisor and Human Resources may extend an individual's leave from work for a designated period of time period of time to allow for an additional evaluation of the situation.

F. **Follow-Up Action**

1) The supervisor should consult Human Resources as soon as possible to discuss ways to facilitate treatment for the individual and to address any related employment issues. The supervisor should meet prior to or at the time of the individual's return to work to discuss the consequences of the individual's impaired actions and the possible need for further management of the condition prompting the individual’s impaired behavior. SJRMC expects the impaired behavior will cease in the workplace and that the individual will seek necessary assistance to prevent a reoccurrence. Depending on the circumstances and the cause of the suspected impairment, the individual may or may not be subject to disciplinary action. Further, an employee may be required to participate in rehabilitative or the Employee

Assistance Program services (i.e. Management referral program) as a condition of continued employment or work relationship.

Related Documents/Information:

- Observed Behavior Checklist

References/Standards:

- Substance Abuse / Drug Free Workplace Policy
- Drug/Alcohol Screening
- Impaired or Dysfunctional Physician Policy
- Impaired Performance Instruction Sheet
- Policy Reviewed: 06/11
- Policy Revised: 05/09

The Senior Management Team of SJRMC reserves the right to unilaterally change, modify, amend, add, delete, or rescind any or all policies, at any time, as it determines appropriate in its sole discretion. No employee or manager of SJRMC except the Chief Executive Officer or Chief Human Resource Officer has the authority to modify any Human Resources Policies or Procedures, and any such modification must be in writing.

SAINT JOSEPH
Regional Medical Center

Version #: 7

Title: Abbreviations Policy

Document Owner: Marjorie Gehrke	PI Team: Management of Information	Date Created: 07/01/94
Approver(s): LeAnn Springman	Date Approved with no Changes: 04/26/2021	Date Approved: Not approved
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Health Information Management (14030_78060)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. To ensure that all abbreviations and symbols used in patient records are standardized and approved for patient safety.
2. Abbreviations that are defined in Trinity's Health Abbreviation List may be used on patient medical records. For those abbreviations in which there are more than one use is listed, the context of the entry will reflect the designated use (i.e. BE used in a Radiology related entry would indicate Barium Enema and BE used in Blood Gas Report would be referring to Base excess).

PROCEDURE:

Individuals who work at SJHS may use any abbreviations, acronyms, symbols and dose designations if:

Listed standard abbreviation, acronym, or symbol that is not on the following Do Not Use abbreviation list.

A. Listed in the Trinity Health Services Approved Abbreviations: http://tdd.trinity-health.org/tdd/
B. Noted in a "key" on an approved form.
C. Listed on the Periodic Table
D. For printed forms, any abbreviations must be spelled out the first time used, or must be listed in a key on the form.
E. Abbreviations cannot be used on consent forms.

Do Not Use abbreviations deemed "dangerous" and subject to miscommunication per Joint Commission, may not be used. See Do Not Use Abbreviations List below.

The following table shows abbreviations that must never be used.

DO NOT USE Abbreviation	Preferred Term
U, u	unit
IU	international unit

Title: Abbreviations Policy

DO NOT USE Abbreviation	Preferred Term
Q.D., QD, q.d., qd Q.O.D., QOD, q.o.d., qod	daily or every day every other day
Trailing zero (X.0mg) Lack of leading zero (.X mg)	Never write a zero by itself after a decimal point, i.e. 5mg Always use a zero before a decimal point, i.e. 0.5mg
MS, MSO_4 $MgSO_4$	Morphine Sulfate Magnesium Sulfate

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

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

Development of the "Do Not Use" List
In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01

References/Standards: 6/19

- TJC IM 02.02.01

SAINT JOSEPH
Regional Medical Center

Version #: 1

Title: Abuse and Neglect and Violent Crime Policy

Document Owner: Elaine Flemming	PI Team:	Date Created: 06/05/2017
Approver(s): Loretta Schmidt	Date Approved with no changes: 03/08/2021	Date Approved: 06/15/2017
Location: Saint Joseph Health System (SJHS)		Department: Care Management (14030_78750), Nursing Admin (14030_10005)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be reluctant or unable to speak of the abuse. It may not be obvious to the casual observer. Hospital staff members need to know if the patient has been abused or neglected, as well as the extent and circumstances to provide appropriate care. The criteria focus on observable evidence, not allegations alone. Violent crimes must be reported to the appropriate law enforcement agency.
2. Staff members are expected to make appropriate referrals for victims of suspected or know abuse or neglect. The hospital maintains a list of available community resources to provide assistance to the victims.
3. Staff are educated on Abuse/Neglect through general and department specific orientation and competencies. With any policy/criteria revisions, staff is educated prior to implementation.
4. The purpose of this policy is to assure the identification, evaluation and referral of victims of suspected abuse or neglect.

PROCEDURE:

A. Indiana State law makes it mandatory for health care workers to report all suspected cases of abuse, neglect and violent crime including:
   1) Child abuse and neglect
   2) Abuse and/or neglect of an endangered adult including elder abuse.
   3) Gunshot wounds
   4) Stabbing
   5) Animal bites
   6) Beatings/Assaults
   7) Drowning
   8) Suicide attempt (Refer to suicide policy)

B. Reporting of suspected child abuse is to be reported to the Department of Child Services (DCS) and the reporting of suspected endangered adult abuse is to be reported to Adult Protective Services (APS).

C. Identification of Possible Child Abuse and/or Neglect – not all inclusive

The following is a list of potential physical and behavioral "indicators" of suspected abuse/neglect. It is not all inclusive. Indicators, as well as a history of suspicious injuries, child's age and child's verbal report should be considered when assessing for alleged abuse/neglect.

a) Signs of physical abuse

b) Unexplained bruises, welts or marks forming a pattern should be evaluated. Face, lips mouth, torso, back, buttocks and thighs are common abuse areas. Various states of healing, clustered markings or regular patterns reflecting a shape of an article used to inflict injury such as a belt buckle or other object.

c) Unexplained lacerations or abrasions.

d) Unexplained burns, cigarette burns, immersion burns or other suspicious burns.

e) Unexplained fractures or fractures in various stages of healing. Multiple long bone or spiral fractures. Injuries to the grown center of bone structure.

2) Behavioral Indicators of child physical abuse – Not all inclusive.

a) Wary of adult contact

b) Behavioral extremes

c) Overly aggressive, demanding, rageful

d) Overly compliant, passive, withdrawn

e) Frightened of caretaker

f) Cringes or jumps at sudden movement or sound

g) Developmental lags

h) Apprehensive when other children cry

i) Role reversal

j) Child acts adult-like

k) Wears long sleeve shirt/pants in hot weather

l) Overly eager to please

m) Verbally reports abuse/neglect

3) Caretaker behavioral indicators of physical abuse – not all inclusive

a) Verbalizes harsh discipline not appropriate for the child's age or behavior

b) Consistently describes the child's behavior as negative (bad, stupid, dumb)

c) Explains child's injuries that are not consistent with child's age, development stage or behavior

d) Becomes defensive or refusal to allow medical treatment to child

e) Attempts to conceal child's injuries

f) Apparent use of alcohol or drugs

4) Physical indicators of physical neglect of a child – not all inclusive

a) Lack of supervision – young children left unattended, children inadequately unsupervised for long periods of time, lack of meeting basic necessity of child care.

b) Nutrition – Lack of proper quantity of food intake. Children who fall three to four standard deviations below normal height/weight for age range.

c) Basic needs – lack of adequate clothing. Children dressed inappropriately for the weather. Consistently dressed dirty or inappropriate torn clothing. Severe diaper rash, lack of medical or dental care, unbathed.

5) Behavior indicators of physical neglect of a child – not all inclusive.
   a) Begging or stealing food, constantly complaining of hunger
   b) Constant fatigue
   c) Alcohol or drug abuse
   d) Delinquency, frequent absences from school
   e) Reports of being left alone or abandoned
6) Caretaker behavioral indicators of physical neglect – not all inclusive
   a) Misuse of alcohol or drugs
   b) Chaotic home life
   c) Expects child to care for self at inappropriate age
7) Physical Indicators of sexual abuse –not all inclusive
   a) Pregnancy in girl under 16 years of age
   b) Pelvic inflammatory disease in girl under 16 years of age
   c) Venereal disease of the throat, genitals or rectum
   d) Bruised or dilated genitals or rectum
   e) Foreign matter in bladder, rectum or vagina
   f) Recurrent urinary tract infection without a physiological basis
   g) Difficulty or pain in walking or sitting without a physiological basis
   h) Torn, stained or bloody underclothing
8) Behavioral indicators of sexual abuse of a child – not all inclusive
   a) Seductive behavior, advanced sexual knowledge for age, precocious sex play
   b) Drawing pictures of genitals
   c) Exhibiting extreme behaviors
   d) Sexually abusing another child
   e) Sleep disorders, nightmares
   f) Notable changes in behavior such as regressing, withdrawing, fear
   g) Taking frequent baths – particularly after seeing one specific person
   h) Reporting the abuse – expressing fear of a particular person or place
9) Caretaker Behavioral indicators of sexual abuse - not all inclusive
   a) Extremely protective or jealous of child and child's relationships
   b) Encouraging child to be involved in prostitution or sexual acts
   c) Misuse of alcohol or drugs
10) Behavioral indicators of Emotional Maltreatment of a child – not all inclusive
   a) Rocking, head-banging or thumb sucking in an older child
   b) Developmental lag
   c) Daytime anxiety and unrealistic fears
   d) Withdrawal or antisocial behavior
   e) Sleep disorders, nightmares
   f) Apathetic, indifferent, listless
   g) Extreme aggression or passiveness. Inappropriate adult or infantile behavior
   h) Defiant behavior
   i) Enjoyment out of hurting other children or animals
11) Caretaker Behavioral indicators of Emotional Maltreatment – not all inclusive

a) Rejecting or belittling the child.
b) Harsh Criticizing and not showing affection
c) Treating the child different than others in the family
d) Terrorizing the child. Blaming the child for things in which the child has no control. Threatening the child's safety and or possessions (toys, dolls, pets)
e) Isolation of the child from social experiences or friendships
f) Ignoring or having little interest in the child
g) Teaching the child socially deviant behavior

12) Abuse /Neglect of an endangered Adult – not all inclusive

An endangered adult is someone 18 years of age or older that is incapable of making their own decisions due to mental illness, challenged mental capacity, dementia, habitual drunkenness, excessive use of drugs, age, infirmity or other physical or mental incapacity – inability to care for self, make decisions or manage property or activities of daily living. Anyone who stands in a position of trust with an endangered adult is responsible to provide a safe environment.

a) Neglect – leaving the adult alone for extended periods of time without providing appropriate care.
b) Physical abuse
c) Misuse of the adults funds, personal property or services

13) Physical indicators of Endangered Adult physical abuse – not all inclusive

a) An injury that has not been properly cared for
b) An injury that does not match the history given by the caretaker
c) Unexplained bruises, welts or marks forming a pattern should be evaluated. Face, lips mouth, torso, back, buttocks and thighs are common abuse areas. Various states of healing, clustered markings or regular patterns reflecting a shape of an article used to inflict injury such as a belt buckle or other object
d) Cuts, lacerations or puncture wounds without explanation
e) Dehydration and or malnourishment without illness related cause
f) Extreme weight loss without illness related cause
g) Sunken eyes, cheeks without illness related cause
h) Evidence of inadequate or inappropriate medication administration
i) Signs of confinement (ligature marks on wrists, ankles, trunk)
j) Soiled, dirty, unbathed, fecal/urine smell
k) Rash, lice, sores
l) Animal infested living quarters
m) Poor skin hygiene
n) Unexplained burns, cigarette burns, immersion burns or other suspicious burns
o) Unexplained Injuries under the breasts or areas normally covered by clothing
p) Frequent use of the emergency department or "physician shopping"
q) Willful infliction of mental suffering
r) Abandonment

14) Behavioral indicators of Endangered Adult abuse – not all inclusive

a) Fear
b) Withdrawal and non-responsiveness
c) Depression without underlying illness
d) Agitation/anxiety
e) Implausible reasons for injuries or situations

f) Hesitant to speak openly
g) Anger not due to mental capacity
h) Ambivalence to injuries or situations
i) Making excuses for caretaker

15) Caretaker behavioral indicators of Endangered Adult abuse – not all inclusive
a) Caretaker not allowing the adult to speak for themselves
b) Absence of assistance, poor attitude or indifference toward the adult.
c) Blaming of the adult for the injuries or situation.
d) Aggressive behavior toward the adult, threats, insults, harassing
e) History of abuse to other endangered adults
f) Misuse of alcohol or drugs
g) Flirtation as indicator of possible inappropriate sexual relationship
h) Social isolation or restriction of activities
i) Conflicting accounts of situations by different family, supporters, caretakers
j) Unwilling to comply with safety plans for the adult
k) Withholding funds, property or other services that belong to the adult.
l) Indicators of financial abuse of the endangered adult – unusual or inappropriate banking
m) Power of attorney changes when the adult is incompetent of making the changes
n) Concerns by the caretaker of the money being taken away from the adult they are caring for
o) Unpaid bills, collections
p) Lack of necessary personal belonging for grooming, clothing, nutrition
q) Missing personal belongings, art, jewelry, items of value
r) Deliberate isolation from friends or family. Not allowing anyone to visit adult.

16) Rights of Endangered adults/Elders
a) The adult has the right to determine their affairs to the full extent of their ability
b) The adult has the right to receive protective services in the least restrictive environment
c) The adult has the right to make decisions regarding their care to the full extent of their ability

D. Child Abuse and Neglect Reporting/Examination.
1) Any SJHS employee who has reason to believe a child under the age of 18 is a victim of abuse or neglect (including non-accidental injury, sexual assault, physical neglect, emotional maltreatment and unexplained failure to thrive) is obligated to make a report with the Department of Child Services (DCS) and notify local law enforcement agencies.
2) The employee must also notify case management/social worker and the administrative supervisor.
3) Photographs of any visual trauma areas are to be taken. Consent not required by State Statute.
4) Radiological exanimations may be used if ordered by the physician.
5) All photographic and summaries related to the exam of the alleged abuse/neglect must be documented in the EMR.
6) DCS has the right to have a copy of the EMR, photographs and other relevant medical information according to law. No consent is necessary.

E. Reporting of Violent Crimes
a) Victims of violent accidents or crimes must be registered in the Emergency Department. The local police must be notified of the patient. No information is used to register the victim.

b) If a person is treated for the following, the police of jurisdiction must be notified: (Not all inclusive – if in doubt call the police)
- Bullet wound
- Gunshot wound
- Powder burn
- Any wound from a firearm or taser
- Stabbing – knife, ice pick, axe or any other sharp object that was used to inflict harm
- Dog bites – follow dog bite policy
- Suspicious burns inconsistent with reason stated for burn
- A burn that resulted from attempt at bodily injury
- Assaults – with or without weapons

F. Possible victims of Domestic Abuse
Certain types of injuries are typical of abusive relationships and the consideration of battery is to be reported when the explanation of how an injury occurs does not seem logical or possible.

G. Common types of Domestic Abuse injuries – not all inclusive
a) Contusions, abrasions, lacerations, fractures, strains and sprains – inconsistent with reporting method of injury
b) Injuries to head, breasts, neck or abdomen – inconsistent with reporting method of injury
c) Injuries during pregnancy – breast, abdomen or genital area
d) Poor nutrition or depression during pregnancy – miscarriage inconsistent with reporting
e) Multiple sites of injury, or same area injured multiple times
f) Inconsistent or suspicious reporting of headaches, difficulty sleeping, choking, abnormal breathing, frightened.
g) Appearing anxious with partner in room
h) Appearing shameful, helpless, evasive or social inapt
i) Fearful when questioned about injuries

SITE SPECIFIC:

1.

A.

Title: Abuse and Neglect and Violent Crime Policy

RELATED DOCUMENTS/INFORMATION:

-

DEFINITIONS:

-

REFERENCES/STANDARDS:

-

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: ADVANCE DIRECTIVES

Document Owner: Carole Langhauser	PI Team: POC. Ethics Committee	Date Created: 01/01/95
Approver(s): Genevieve Lankowicz, Jason Schultz, Loretta Schmidt, CNO, Laureen Painter, OSF (Ethics)	Date Approved with no Changes	Date Approved: 04/26/2019
Location: Saint Joseph Regional Medical Center (SJRMC) Mishawaka and Plymouth		Department: Legal - Integrity - HIPAA (14001_80700), Nursing Admin (14030_10005), Pastoral Care (14030_78660)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Saint Joseph Regional Medical Center (SJRMC), recognizes that competent patients have the right to make their own health care decisions and encourages patients to consider the importance of implementing their own Advance Directives. SJRMC will approach decisions regarding Advance Directives within the context of its mission, Ethical and Religious Directives for Catholic Health Care Services (ERDs), and the limits of the law.
2. Under federal law, adult/emancipated minor inpatients and observation patients must be offered written information about their rights under state law to formulate Advance Directives.
3. During the admission/registration process, A Guide to Patient Rights, Responsibilities and Advance Directives brochure will be available to adult/emancipated minor outpatients. The brochure refers patients for assistance with formulating Advance Directives upon request.
4. SJRMC staff will involve appropriate parties in considering a patient's Advance Directives. In the event of a perceived conflict between a patient's Advance Directive and the ERDs or state/federal laws, SJRMC staff will involve the Center for Spiritual Care and/or the Ethics Committee.
5. SJRMC will not discriminate against any patient for having or not having an Advance Directive. If appropriate, patients will be informed that nondiscriminatory medical and surgical care will be provided with or without the existence of written Advance Directives.
6. SJRMC staff will document the presence or absence of written Advance Directives in the medical record, and request a copy of the Advance Directives, if the patient has one or more, but did not supply a copy for his/her medical record.
7. The patient may review, modify or rescind the Advance Directives at any time. If a patient modifies/rescinds any part of or the entire document, such changes are to be noted in the patient's medical record

PROCEDURE:

A. Definition: Advance Directives is a document or documentation allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance Directives may include living wills, durable power of attorney for healthcare, health care representative, life-prolonging procedures, decisions regarding organ/tissue donation, Physician Orders for Scope of Treatment (POST) forms, or other similar documents expressing the individual's preference as specified in the Patient Self-Determination Act of 1990, 42 USC 1395cc(f)(3).

B. SJRMC will offer education to its staff and the community concerning Advance Directives. Informational brochures are available through points of registration, off-site facilities and community health information locations.

C. Upon preregistration/registration, SJRMC registration staff will ask all patients and/or the patient's representative if the patient has Advance Directives. The patient's or representative's reply will be entered into the electronic medical record (EMR).

D. Upon admission to an inpatient or pre-surgical unit (if the patient will be admitted following surgery), a registered nurse or chaplain will ask the patient if she/he has Advance Directives. Responses and actions taken are to be recorded in the patient's Medical Record.

E. If the patient does have a copy of his/her Advance Directives, the registered nurse or chaplain will:

1) Secure a copy of the original or print a copy that has been scanned from the EMR and place it in the medical record.

2) Verify that the Advance Directives have been signed and witnessed (or notarized if it is a durable power of attorney for healthcare).

3) Seek the assistance of the Center for Spiritual Care staff should an Advance Directive seem incongruent with the ERDs or state/federal law. A member of the Ethics Committee may also be consulted.

F. If the patient does have Advance Directives, **but does not have a copy available** with him/her, the registered nurse or chaplain will:

1) Request that the patient's family or significant other locate a copy of the Advance Directive(s) and bring it to the hospital as soon as possible so that it may be documented in the EMR.

2) Discuss with the patient (or representative) his/her wishes in terms of desired medical care should he/she become unable to communicate those wishes. The substance of this conversation is to be documented in the EMR in the Advance Directives/Health Care Decisions follow-up section. If the patient's wishes are incongruent with the ERDs, the nurse is to contact the Center for Spiritual Care and/or a member of the Clinical Ethics Committee.

3) Discuss the patient's wishes with the attending physician and/or physician consultants so that a verbal order for resuscitation/non-resuscitation can be updated.

4) If/when the written Advance Directive is received; it will be entered into the EMR. Until the patient's written Advance Directive is received, the verbal order that was written after the conversation with the patient/representative will be followed.

G. If the inpatient does not have Advance Directives, the registered nurse will make a referral to the Center for Spiritual Care or social work staff:

1) if the patient or patient's representative has questions, or

2) If the patient would like to formulate Advance Directives.

H. SJRMC staff will follow-up if a copy of the Advance Directives becomes available to ensure that it is placed in the EMR.

I. **Direct Admission to a Nursing Unit**:

1) The direct admit patient does not go through registration. Therefore, the admitting unit must ensure that the direct admission patient/patient representative receives a copy of the pamphlet

A Guide to Patient Rights, Responsibilities and Advance Directives. The admitting nurse will then follow procedure for the inpatient units above.

J. **Emergency Department, Emergent Patient**

1) In the event that the emergent patient is unable to speak for himself or herself and in the absence of a healthcare representative, the patient will be treated as having a full code status and no Advance Directives. Nursing staff will ask the patient or patient representative about the patient's Advance Directives as soon as the patient can speak for himself or herself or the patient representative is available. If the patient is unable to give or the patient representative is unavailable to obtain a response regarding Advance Directives, indicate this in the patient's EMR.

K. **Emergency Department, Non-emergent Patient**

1) Upon registration in the Emergency Department, SJRMC registration staff will ask the patient and/or patient representative if the patient has Advance Directives. The patient's response will be entered into the EMR.

2) Nursing staff will verify the Advance Directives status and indicate the appropriate information in the patient's EMR, as indicated below:

3) If patient is stable, the nurse will note that the patient is stable and this indicates that there is no immediate need to obtain the Advance Directives. The Advance Directives will be obtained by the admitting unit if the patient is admitted into the hospital as an inpatient.

L. **Inpatient and Outpatient Hospital Settings ---**

1) **Procedures requiring anesthesia/sedation**

a) For any patient who has been designated "Do Not Resuscitate" status preoperatively, it must be clearly stated in the DNR order that the patient falls into one of two categories:

(1) **Patient has agreed to the suspension of "Do Not Resuscitate" status.** The "Do Not Resuscitate" order which will be defined and documented in the patient's EMR is to be reinstated upon discharge from the perioperative setting.

(2) **Patient wishes "Do Not Resuscitate" status continued into the perioperative setting**. There must be a clear discussion and documentation of the interventions to be withheld and under what circumstances specifically they are to be withheld. Patients requesting anything but the total suspension of "Do Not Resuscitate" status shall have a preoperative discussion with all involved physicians. Both the surgeon(s) and the anesthesiologist(s) must agree to the circumstances under which the interventions are to be withheld. If the patient and involved physicians are not in agreement, the surgeon(s) and anesthesiologist(s) will work to identify providers that are comfortable to proceed with the patient's wishes.

(3) **Patient wishes are to be made part of the timeout pre-procedure.**

NOTE: **The above applies to any case involving an anesthesiologist or anyone providing conscious sedation at any anesthetizing site in the hospital setting including those outside the operating room (i.e. ICU, CCU, IR, Endoscopy, Radiology, etc.).**

2) **Procedures NOT requiring anesthesia/sedation**

a) Patient Advance Directives will be followed.

References/Standards:

- Ethical and Religious Directives for Catholic Health Care Services
- Patient-Self Determination Act, 42 USC 1395cc(f)
- Indiana Health Care Consent Act, Indiana Code 16-36-1 et seq.
- Indiana Living Wills and Life-Prolonging Procedures Act, Indiana Code 16-36-4-1 et seq.
- Indiana Out-of-Hospital Do Not Resuscitate Declarations, Indiana Code 16-36-5-1 et seq.
- Indiana Physician Orders for Scope of Treatment (POST) Act, Indiana Code 16-36-6-1 et seq.
- Indiana Uniform Anatomical Gift Act, Indiana Code 29-2-16.1 et seq.
- Indiana Powers of Attorney Act, Indiana Code 30-5-1 et seq.
- Indiana State Department of Health, Advance Directives: Your Right to Decide (November 1, 2018)
- "Do Not Resuscitate" in the Perioperative Period – policy of SJRMC
- Informed Consent – policy of SJRMC

Approved by the Mishawaka Medical Executive Committee on April 8, 2019

Approved by the Plymouth Medical Executive Committee on April 15, 2019

Approved by the Saint Joseph Physician Network Medical Executive Committee on April 25, 2019.

SAINT JOSEPH
Regional Medical Center

Version #: 3

Title: Computer Downtime

Document Owner: Marjorie Gehrke	PI Team: Management of Information	Date Created: June 2002
Approver(s): Elvira Burke, Nancy Bogol		Date Approved: 12/20/2016 May 18, 2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Health Information Management (14030_78060)

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POLICY:

1. The HIM Department will maintain procedures for downtime, allowing the impact to be minimal on the overall department and recovery to be efficient. Saint Joseph Regional Medical Center utilizes the Trinity Health Downtime and Recovery Procedure.

PROCEDURE:

A. Downtime Definition

1) Downtime is considered any time when an application or group of applications is unavailable for normal use whether it is because the application itself is down or an application that sends or receives data is down. There are 2 types of downtime, Scheduled and Unscheduled.

a) Scheduled downtime by definition is a downtime where you have advanced warning that it will occur or is a regularly scheduled event that you can plan for. It is usually done at a time to minimize patient care issues and inconvenience and allows for preparation to significantly lessen the impact of a system's unavailability. Typical examples of scheduled downtime are system unavailability during nightly processing, periodic preventative maintenance procedures and hardware or software upgrades.

b) Unscheduled downtime is that which occurs with no notice and may be due, for example, to an unplanned event such as a hardware failure, electricity outage or telephone/communication failure.

2) Any problem limited to a single workstation is not considered downtime. If that occurs, the Resolution Center should be contacted for correction. If multiple users' workstations are experiencing problems, notify the Resolution Center of the extent of the problem. Do not use downtime procedures unless a public address announcement or broadcast message advises that the downtime process is in effect.

3) There are degrees of downtime also depending on the application(s) that is interrupted and the amount of time you are expected to be down, from a few minutes to hours or days. Procedures may vary based on the length of time the downtime is expected.

B. Downtime Scenarios

1) Downtime can be experienced in the following situations.

a) All systems are down such that might occur in a power outage.

b) Cerner is down such that ProFile is not available therefore, patient deficiency analysis, coding and abstracting cannot be done; transcription results are not available for physicians in their In-box.

c) HealthQuest is down such that the patient information is not available

d) The interfaces into and out of Cerner and HealthQuest are down but those systems and all ancillary systems are up.

e) eScription is down such that transcription cannot load to Cerner.

C. Downtime Communications

1) Communication of a downtime will be announced and broadcasted, so that procedures may be uniformly initiated within the organization. The message will stipulate the application/system that is down, and advises on the impact to its functionality.

2) The Resolution Center will notify all pertinent departments when the problem is resolved and the system is available.

D. Downtime Reports

1) Anticipating that scheduled or unscheduled downtime will occasionally occur, the following on-line reports will be available and contain information from Cerner prior to the downtime.

a) Medication Administration Record (MAR)

b) Chart Summary

2) The MAR and Chart Summary are extracted every 30 minutes from Cerner and sent to pre-defined Quest downtime file folders. The Pharmacy Department will have access to the entire MAR while each Nursing Unit will only have access to the MAR and Chart Summary for patients in their unit. These reports will be available on any PC by logging into Quest and navigating to the appropriate downtime folder. They can be viewed on-line or printed.

3) Additionally, these reports will be sent to a local PC defined for each Nursing Unit and the Pharmacy Department in the event the network or Quest is down. Specific representatives in each department will have access to the reports on the local PC and be able to print them for the unit.

E. Back-up Databases

1) Cerner

a) A full copy of all Cerner modules is sent to the Disaster Recovery Database to be used as a back-up every 30 minutes. This can be used either as a read only or update database. The determination to switch over to the Disaster Recovery Database will be made by based on the Disaster Recovery Policy. It will take approximately 2 hours to get all the interfaces operational for both read and update capabilities to have the back-up available for use. The site will be notified when the back-up database is available. All patient data will be available except for the last 50 minutes just prior to downtime. In order to access the South Bend database, the user will need to double click the Continuity Site App Bar-Alpha icon located in the Novel-delivered application window. The log-in and passwords are the same as production.

b) Upon notification that the Novi production system is operational, the users will log out of the back-up system and revert to the normal icons for the production system.

Title: Computer Downtime

NOTE: If users attempt to log into the Disaster icons when we are not in Disaster mode, they will receive an error instructing them to contact the system administrator.

2) HealthQuest

a) A complete back-up of the HealthQuest system is performed every evening. If for any reason the database needed to be restored, it could be done from the back-up which would take 2 - 6 hours.

F. HealthQuest Patient Management (PM) Downtime Impact:

1) HealthQuest Patient Management has pre-defined scheduled downtimes, which may impact the ability to access patients in Cerner Profile, Power Chart or eScription. Patients registered or admitted PRIOR to the downtime should be available in Cerner Profile, Power Chart and eScription. Patients who are registered or admitted to the hospital DURING the Healthquest downtime will not be in other systems until:

a) HealthQuest if back up, and

b) Admissions/registrations from downtime have been entered and

c) The transactions have interfaced to other systems.

2) If a patient is admitted to the hospital during a HealthQuest downtime, he/she will arrive at the nursing unit or department with downtime forms and labels to be used for labeling downtime reqs, specimens, chart forms etc. Once recovery is performed on Healthquest, the proper face sheets and other forms will be delivered to the unit or department.

G. Cerner Clinical Documentation Downtime:

1) When Cerner downtime occurs, clinical staff will follow their specific downtime procedures. They will begin documenting on downtime forms per their procedure. These forms are a part of the paper based record and upon patient discharge will be filed into the record during the assembly process in the Health Information Management Department.

H. Downtime Process and Recovery Process

a) ProFile Down:

(1) If an urgent request is made for copies of medical records during downtime MHIN power chart may also be used to retrieve pertinent information,

2) If information is needed from PowerChart and the request is from inside the hospital, record the following information.

a) date requested

b) patient name

c) requestor name, phone and unit/dept

d) medical record number

e) admit and discharge dates

f) medical records requested

3) If the request is from outside (ROI), a written request must be received that includes the patient's signature authorizing release of information.

4) Advise the requestor the system is down and the approximate time to expect the information to be sent.

5) If a call is received to check the status of a request previously made, note the caller name, phone number, patient and date requested. Inform the caller the system is down, you will check the status and get back when the system comes up.

I. HealthQuest Downtime: Request for Records

1) If record is available in PowerChart, inform requester to use the on-line record because the paper portion of records post Go-Live contain limited clinical information

2) If record requested is for a date prior to Cerner, obtain the MRN, patient name, DOB and/or SSN initiate search for hard copy chart. Legacy would be accessed for STAR visit history.

3) If record request is for a current patient who was admitted during downtime, the record will not be available in Cerner until HQ is back up and registrations from downtime have been entered and transactions have interfaced to Cerner ProFile and other systems.

4) Follow ProFile downtime procedures.

a) ProFile Recovery:

(1) Follow up with requestors as necessary to keep them apprised of the status.

(2) Notify supervisor of continued significant backlog resulting from downtime.

5) Requests for records of patients who were admitted to the hospital during downtime will not be available in ProFile until HQ is back up and registrations from downtime have been entered and transactions have interfaced to ProFile. Requests in this scenario should follow the steps listed above for ProFile Downtime.

J. HealthQuest Recovery:

1) Once HQ is up, follow ProFile recovery.

2) Analysis and Reanalysis for Deficiencies.

K. HealthQuest Downtime: Analysis

1) No impact

2) ProFile Recovery:

a) Analysis can resume.

b) Notify supervisor of significant backlog resulting from downtime.

Use MNIN or eScription system to access critical information.

L. HealthQuest Downtime: Coding

1) No impact

2) ProFile Recovery:

a) The backlog of coding and abstracting can be done when ProFile is back up.

b) Notify supervisor of significant backlog resulting from downtime.

3) Cerner In-Box Downtime:

a) If physicians are trying to access In Box remotely and cannot, they may contact the HIM department. Inform them that the Cerner System is down. If the physician would like a call when Cerner comes back up note the following information:

(1) date and time of call

(2) physician name

(3) physician's phone/beeper Cerner In-Box Recovery:

b) Notify any physicians who requested the courtesy phone call when the system is available.

M. Transcription HealthQuest Downtime:

1) Transcription may not have access to demographics on patients who were admitted to the hospital during downtime. It will not be available until HQ is back up and registrations from downtime have been entered and transactions have interfaced to eScription and other systems.

2) If patient information is not available by calling into the department, place the report on HOLD.

3) Based on the expected duration of downtime, the HIM management will notify staff how to handle transcription with missing patient demographics. These options include:

a) Continue to hold report.

b) Release temporary report with missing demographics then complete when downtime is over.

N. HealthQuest Recovery:

1) Add demographic information to reports and remove reports from HOLD.

2) Add demographic information to reports that were released with missing information. This will allow the report to post to PowerChart for electronic signature.

3) Outsourced Transcription, HealthQuest Downtime:

a) Supervisor will notify outsource transcription company to stop transcribing until downtime is complete.

b) Call outsource Transcription Company to inform them when the system is up.

c) Interface Downtime:

(1) There are various interfaces to HealthQuest and Cerner applications:

(2) HealthQuest registration information

(3) Lab system

(4) Radiology system

(5) Pathology system

(6) EScription System

O. Any time an interface experiences downtime, there will be a delay in reports posting to Cerner. The interfaces will resume sending information to systems when they are up.

P. Other sources that can be used for reference are:

Title: Computer Downtime

1) MHIN Power chart, Trinity Power chart, Health Quest, Legacy STAR, Meditech, eMon, Vista and Initiate Enterprise

16. Diabetes Care in the Hospital: *Standards of Medical Care in Diabetes—2022*

*American Diabetes Association Professional Practice Committee**

Diabetes Care 2022;45(Suppl. 1):S244–S253 | https://doi.org/10.2337/dc22-S016

The American Diabetes Association (ADA) "Standards of Medical Care in Diabetes" includes the ADA's current clinical practice recommendations and is intended to provide the components of diabetes care, general treatment goals and guidelines, and tools to evaluate quality of care. Members of the ADA Professional Practice Committee, a multidisciplinary expert committee (https://doi.org/10.2337/dc22-SPPC), are responsible for updating the Standards of Care annually, or more frequently as warranted. For a detailed description of ADA standards, statements, and reports, as well as the evidence-grading system for ADA's clinical practice recommendations, please refer to the Standards of Care Introduction (https://doi.org/10.2337/dc22-SINT). Readers who wish to comment on the Standards of Care are invited to do so at professional.diabetes.org/SOC.

Among hospitalized patients, hyperglycemia, hypoglycemia, and glucose variability are associated with adverse outcomes, including death (1–3). Therefore, careful management of inpatients with diabetes has direct and immediate benefits. Hospital management of diabetes is facilitated by preadmission treatment of hyperglycemia in patients having elective procedures, a dedicated inpatient diabetes service applying well-developed standards, and careful transition out of the hospital to prearranged outpatient management. These steps can shorten hospital stays and reduce the need for readmission, as well as improve patient outcomes. Some in-depth reviews of hospital care for patients with diabetes have been published (3–5). For older hospitalized patients or for patients in the long-term care facilities, please see Section 13, "Older Adults" (https://doi.org/10.2337/dc22-S013).

HOSPITAL CARE DELIVERY STANDARDS

Recommendations

16.1 Perform an A1C test on all patients with diabetes or hyperglycemia (blood glucose >140 mg/dL [7.8 mmol/L]) admitted to the hospital if not performed in the prior 3 months. **B**

16.2 Insulin should be administered using validated written or computerized protocols that allow for predefined adjustments in the insulin dosage based on glycemic fluctuations. **B**

Considerations on Admission

High-quality hospital care for diabetes requires standards for care delivery, which are best implemented using structured order sets, and quality assurance for process improvement. Unfortunately, "best practice" protocols, reviews, and guidelines (2–4) are inconsistently implemented within hospitals. To correct this, medical centers striving for optimal inpatient diabetes treatment should establish protocols and structured order sets, which include computerized physician order entry (CPOE).

**A complete list of members of the American Diabetes Association Professional Practice Committee can be found at https://doi.org/10.2337/dc22-SPPC.*

Suggested citation: American Diabetes Association Professional Practice Committee. 16. Diabetes care in the hospital: Standards of Medical Care in Diabetes—2022. *Diabetes Care 2022;45(Suppl. 1):S244–S253*

Initial orders should state the type of diabetes (i.e., type 1, type 2, gestational diabetes mellitus, pancreatic diabetes) when it is known. Because inpatient treatment and discharge planning are more effective if based on preadmission glycemia, an A1C should be measured for all patients with diabetes or hyperglycemia admitted to the hospital if the test has not been performed in the previous 3 months (6–9). In addition, diabetes self-management knowledge and behaviors should be assessed on admission and diabetes self-management education provided, if appropriate. Diabetes self-management education should include appropriate skills needed after discharge, such as medication dosing and administration, glucose monitoring, and recognition and treatment of hypoglycemia (2,3). There is evidence to support preadmission treatment of hyperglycemia in patients scheduled for elective surgery as an effective means of reducing adverse outcomes (10–13).

The National Academy of Medicine recommends CPOE to prevent medication-related errors and to increase efficiency in medication administration (14). A Cochrane review of randomized controlled trials using computerized advice to improve glucose control in the hospital found significant improvement in the percentage of time patients spent in the target glucose range, lower mean blood glucose levels, and no increase in hypoglycemia (15). Thus, where feasible, there should be structured order sets that provide computerized advice for glucose control. Electronic insulin order templates also improve mean glucose levels without increasing hypoglycemia in patients with type 2 diabetes, so structured insulin order sets should be incorporated into the CPOE (16,17).

Diabetes Care Providers in the Hospital

Recommendation

16.3 When caring for hospitalized patients with diabetes, consult with a specialized diabetes or glucose management team when possible. **C**

Appropriately trained specialists or specialty teams may reduce the length of stay, improve glycemic control, and improve outcomes (10,18,19). In addition, the greater risk of 30-day readmission following hospitalization that has been attributed to diabetes can be reduced and costs saved when inpatient care is provided by a specialized diabetes management team (20,21). In a cross-sectional comparison of usual care to management by specialists who reviewed cases and made recommendations solely through the electronic medical record, rates of both hyper- and hypoglycemia were reduced 30–40% by electronic "virtual care" (22). Details of team formation are available in the Joint Commission standards for programs and from the Society of Hospital Medicine (23,24).

Even the best orders may not be carried out in a way that improves quality, nor are they automatically updated when new evidence arises. To this end, the Joint Commission has an accreditation program for the hospital care of diabetes (23), and the Society of Hospital Medicine has a workbook for program development (24).

GLYCEMIC TARGETS IN HOSPITALIZED PATIENTS

Recommendations

16.4 Insulin therapy should be initiated for treatment of persistent hyperglycemia starting at a threshold ≥180 mg/dL (10.0 mmol/L) (checked on two occasions). Once insulin therapy is started, a target glucose range of 140–180 mg/dL (7.8–10.0 mmol/L) is recommended for the majority of critically ill and noncritically ill patients. **A**

16.5 More stringent goals, such as 110–140 mg/dL (6.1–7.8 mmol/L), may be appropriate for selected patients if they can be achieved without significant hypoglycemia. **C**

Standard Definitions of Glucose Abnormalities

Hyperglycemia in hospitalized patients is defined as blood glucose levels >140 mg/dL (7.8 mmol/L) (2,3,25). Blood glucose levels persistently above this level should prompt conservative interventions, such as alterations in diet or changes to medications that cause hyperglycemia. An admission A1C value ≥6.5% (48 mmol/mol) suggests that the onset of diabetes preceded hospitalization (see Section 2, "Classification and Diagnosis of Diabetes," https://doi.org/10.2337/dc22-S002) (2,25). Hypoglycemia in hospitalized patients is categorized by blood glucose concentration and clinical correlates (**Table 6.4**) (26): Level 1 hypoglycemia is a glucose concentration 54–70 mg/dL (3.0–3.9 mmol/L). Level 2 hypoglycemia is a blood glucose concentration <54 mg/dL (3.0 mmol/L), which is typically the threshold for neuroglycopenic symptoms. Level 3 hypoglycemia is a clinical event characterized by altered mental and/or physical functioning that requires assistance from another person for recovery. Levels 2 and 3 require immediate correction of low blood glucose.

Glycemic Targets

In a landmark clinical trial, Van den Berghe et al. (27) demonstrated that an intensive intravenous insulin regimen to reach a target glycemic range of 80–110 mg/dL (4.4–6.1 mmol/L) reduced mortality by 40% compared with a standard approach targeting blood glucose of 180–215 mg/dL (10–12 mmol/L) in critically ill patients with recent surgery. This study provided robust evidence that active treatment to lower blood glucose in hospitalized patients had immediate benefits. However, a large, multicenter follow-up study, the Normoglycemia in Intensive Care Evaluation and Survival Using Glucose Algorithm Regulation (NICE-SUGAR) trial (28), led to a reconsideration of the optimal target range for glucose lowering in critical illness. In this trial, critically ill patients randomized to intensive glycemic control (80–110 mg/dL) derived no significant treatment advantage compared with a group with more moderate glycemic targets (140–180 mg/dL [7.8–10.0 mmol/L]) and, in fact, had slightly but significantly higher mortality (27.5% vs. 25%). The intensively treated group had 10- to 15-fold greater rates of hypoglycemia, which may have contributed to the adverse outcomes noted. The findings from NICE-SUGAR are supported by several meta-analyses, some of which suggest that tight glycemic control increases mortality compared with

more moderate glycemic targets and generally causes higher rates of hypoglycemia (29–31). Based on these results, insulin therapy should be initiated for treatment of persistent hyperglycemia ≥180 mg/dL (10.0 mmol/L) and targeted to a glucose range of 140–180 mg/dL (7.8–10.0 mmol/L) for the majority of critically ill patients. Although not as well supported by data from randomized controlled trials, these recommendations have been extended to hospitalized patients without critical illness. More stringent goals, such as 110–140 mg/dL (6.1–7.8 mmol/L), may be appropriate for selected patients (e.g., critically ill postsurgical patients or patients with cardiac surgery), as long as they can be achieved without significant hypoglycemia (32,33). On the other hand, glucose concentrations between 180 mg/dL and 250 mg/dL (10–13.9 mmol/L) may be acceptable in patients with severe comorbidities and in inpatient care settings where frequent glucose monitoring or close nursing supervision is not feasible. Glycemic levels above 250 mg/dL (13.9 mmol/L) may be acceptable in terminally ill patients with short life expectancy. In these patients, less aggressive insulin regimens to minimize glucosuria, dehydration, and electrolyte disturbances are often more appropriate. Clinical judgment combined with ongoing assessment of clinical status, including changes in the trajectory of glucose measures, illness severity, nutritional status, or concomitant medications that might affect glucose levels (e.g., glucocorticoids), should be incorporated into the day-to-day decisions regarding insulin dosing (34).

BEDSIDE BLOOD GLUCOSE MONITORING

In hospitalized patients with diabetes who are eating, bedside glucose monitoring should be performed before meals; in those not eating, glucose monitoring is advised every 4–6 h (2). More frequent bedside blood glucose testing ranging from every 30 min to every 2 h is the required standard for safe use of intravenous insulin. Safety standards for blood glucose monitoring that prohibit the sharing of lancets, other testing materials, and needles are mandatory (35).

The vast majority of hospital glucose monitoring is performed using standard glucose monitors and capillary blood taken from fingersticks, similar to the process used by outpatients for home glucose monitoring (36). Point-of-care (POC) meters are not as accurate or as precise as laboratory glucose analyzers, and capillary blood glucose readings are subject to artifact due to perfusion, edema, anemia/erythrocytosis, and several medications commonly used in the hospital (37). The U.S. Food and Drug Administration (FDA) has established standards for capillary (fingerstick) blood glucose meters used in the ambulatory setting, as well as standards to be applied for POC measures in the hospital (37). The balance between analytic requirements (e.g., accuracy, precision, interference) and clinical requirements (rapidity, simplicity, point of care) has not been uniformly resolved (36,38), and most hospitals/medical centers have arrived at their own policies to balance these parameters. It is critically important that devices selected for in-hospital use, and the workflow through which they are applied, have careful analysis of performance and reliability and ongoing quality assessments. Recent studies indicate that POC measures provide adequate information for usual practice, with only rare instances where care has been compromised (39,40). Good practice dictates that any glucose result that does not correlate with the patient's clinical status should be confirmed through measurement of a serum sample in the clinical laboratory.

Continuous Glucose Monitoring

Real-time continuous glucose monitoring (CGM) provides frequent measurements of interstitial glucose levels as well as the direction and magnitude of glucose trends. Even though CGM has theoretical advantages over POC glucose testing in detecting and reducing the incidence of hypoglycemia, it has not been approved by the FDA for inpatient use. Some hospitals with established glucose management teams allow the use of CGM in selected patients on an individual basis, provided both the patients and the glucose management team are well educated in the use of this technology. CGM is not approved for intensive care unit use.

During the COVID-19 pandemic, several institutions used CGM to minimize contact between health care providers and patients, especially those in the intensive care unit (41–49). This approach seems to be helpful in that regard, as well as helping to minimize the use of personal protective equipment. Unfortunately, the data about the use of CGM to improve either glycemic control or hospitalization outcomes are not yet available. Preliminary data that are already at hand suggest that CGM can offer significant improvement to both glycemic control and outcomes of hospitalization.

For more information on CGM, see Section 7, "Diabetes Technology" (https://doi.org/10.2337/dc22-S007).

GLUCOSE-LOWERING TREATMENT IN HOSPITALIZED PATIENTS

Recommendations

16.6 Basal insulin or a basal plus bolus correction insulin regimen is the preferred treatment for non–critically ill hospitalized patients with poor oral intake or those who are taking nothing by mouth. **A**

16.7 An insulin regimen with basal, prandial, and correction components is the preferred treatment for non–critically ill hospitalized patients with good nutritional intake. **A**

16.8 Use of only a sliding scale insulin regimen in the inpatient hospital setting is strongly discouraged. **A**

Insulin Therapy

Critical Care Setting

In the critical care setting, continuous intravenous insulin infusion is the most effective method for achieving glycemic targets. Intravenous insulin infusions should be administered based on validated written or computerized protocols that allow for predefined adjustments in the infusion rate, accounting for glycemic fluctuations and insulin dose (3).

Noncritical Care Setting

In most instances, insulin is the preferred treatment for hyperglycemia in hospitalized patients. However, in certain circumstances, it may be appropriate to continue home regimens, including oral

glucose-lowering medications (50). If oral medications are held in the hospital, there should be a protocol for resuming them 1–2 days before discharge. For patients using insulin, recent reports indicate that inpatient use of insulin pens is safe and may be associated with improved nurse satisfaction compared with the use of insulin vials and syringes (51–53). Insulin pens have been the subject of an FDA warning because of potential blood-borne diseases; the warning "For single patient use only" should be rigorously followed (54).

Outside of critical care units, scheduled insulin regimens are recommended to manage hyperglycemia in patients with diabetes. Regimens using insulin analogs and human insulin result in similar glycemic control in the hospital setting (55). The use of subcutaneous rapid- or short-acting insulin before meals, or every 4–6 h if no meals are given or if the patient is receiving continuous enteral/parenteral nutrition, is indicated to correct hyperglycemia. Basal insulin, or a basal plus bolus correction regimen, is the preferred treatment for noncritically ill hospitalized patients with poor oral intake or those who are restricted from oral intake. An insulin regimen with basal, prandial, and correction components is the preferred treatment for noncritically ill hospitalized patients with good nutritional intake.

For patients who are eating, insulin injections should align with meals. In such instances, POC glucose testing should be performed immediately before meals. If oral intake is poor, a safer procedure is to administer prandial insulin immediately after the patient eats, with the dose adjusted to be appropriate for the amount ingested (55).

A randomized controlled trial has shown that basal-bolus treatment improved glycemic control and reduced hospital complications compared with reactive, or sliding scale, insulin regimens (i.e., dosing given in response to elevated glucose rather than preemptively) in general surgery patients with type 2 diabetes (56). Prolonged use of sliding scale insulin regimens as the sole treatment of hyperglycemic inpatients is strongly discouraged (19,57).

While there is evidence for using premixed insulin formulations in the outpatient setting (58), a recent inpatient study of 70/30 NPH/regular insulin versus basal-bolus therapy showed comparable glycemic control but significantly increased hypoglycemia in the group receiving premixed insulin (59). Therefore, premixed insulin regimens are not routinely recommended for in-hospital use.

Type 1 Diabetes

For patients with type 1 diabetes, dosing insulin based solely on premeal glucose levels does not account for basal insulin requirements or caloric intake, increasing the risk of both hypoglycemia and hyperglycemia. Typically, basal insulin dosing schemes are based on body weight, with some evidence that patients with renal insufficiency should be treated with lower doses (60,61). An insulin regimen with basal and correction components is necessary for all hospitalized patients with type 1 diabetes, with the addition of prandial insulin if the patient is eating. Most importantly, patients with type 1 diabetes should always be treated with insulin.

Transitioning Intravenous to Subcutaneous Insulin

When discontinuing intravenous insulin, a transition protocol is associated with less morbidity and lower costs of care (62,63) and is therefore recommended. A patient with type 1 or type 2 diabetes being transitioned to a subcutaneous regimen should receive a dose of subcutaneous basal insulin 2 h before the intravenous infusion is discontinued. The dose of basal insulin is best calculated on the basis of the insulin infusion rate during the last 6 h when stable glycemic goals were achieved (64). For patients transitioning to regimens with concentrated insulin (U-200, U-300, or U-500) in the inpatient setting, it is important to ensure correct dosing by utilizing an individual pen and cartridge for each patient and by meticulous supervision of the dose administered (64,65).

Noninsulin Therapies

The safety and efficacy of noninsulin glucose-lowering therapies in the hospital setting is an area of active research (66,67). Several recent randomized trials have demonstrated the potential effectiveness of glucagon-like peptide 1 (GLP-1) receptor agonists and dipeptidyl peptidase 4 inhibitors in specific groups of hospitalized patients (68–71). However, an FDA bulletin states that providers should consider discontinuing saxagliptin and alogliptin in people who develop heart failure (72).

Sodium–glucose cotransporter 2 (SGLT2) inhibitors should be avoided in cases of severe illness, in patients with ketonemia or ketonuria, and during prolonged fasting and surgical procedures (4). Until safety and effectiveness are established, SGLT2 inhibitors are not recommended for routine in-hospital use. Furthermore, the FDA has recently warned that SGLT2 inhibitors should be stopped 3 days before scheduled surgeries (4 days in the case of ertugliflozin).

HYPOGLYCEMIA

Recommendations

16.9 A hypoglycemia management protocol should be adopted and implemented by each hospital or hospital system. A plan for preventing and treating hypoglycemia should be established for each patient. Episodes of hypoglycemia in the hospital should be documented in the medical record and tracked for quality improvement/quality assessment. **E**

16.10 For individual patients, treatment regimens should be reviewed and changed as necessary to prevent further hypoglycemia when a blood glucose value of $<$70 mg/dL (3.9 mmol/L) is documented. **C**

Patients with or without diabetes may experience hypoglycemia in the hospital setting. While hypoglycemia is associated with increased mortality (73), in many cases it is a marker of underlying disease rather than the cause of fatality. However, hypoglycemia is a severe consequence of dysregulated metabolism and/or diabetes treatment, and it is imperative that it be minimized in hospitalized patients. Many episodes of hypoglycemia among inpatients are preventable. Therefore, a hypoglycemia prevention and management protocol should be adopted and implemented by each hospital or hospital system. A standardized hospital-wide, nurse-initiated hypogly-

cemia treatment protocol should be in place to immediately address blood glucose levels of <70 mg/dL (3.9 mmol/L). In addition, individualized plans for preventing and treating hypoglycemia for each patient should also be developed. An American Diabetes Association consensus statement recommends that a patient's treatment regimen be reviewed any time a blood glucose value of <70 mg/dL (3.9 mmol/L) occurs, as such readings often predict subsequent level 3 hypoglycemia (2). Episodes of hypoglycemia in the hospital should be documented in the medical record and tracked (3).

Triggering Events and Prevention of Hypoglycemia

Insulin is one of the most common drugs causing adverse events in hospitalized patients, and errors in insulin dosing and/or administration occur relatively frequently (73–75). Beyond insulin dosing errors, common preventable sources of iatrogenic hypoglycemia are improper prescribing of other glucose-lowering medications, inappropriate management of the first episode of hypoglycemia, and nutrition-insulin mismatch, often related to an unexpected interruption of nutrition. A recent study describes acute kidney injury as an important risk factor for hypoglycemia in the hospital (76), possibly as a result of decreased insulin clearance. Studies of "bundled" preventive therapies, including proactive surveillance of glycemic outliers and an interdisciplinary data-driven approach to glycemic management, showed that hypoglycemic episodes in the hospital could be prevented. Compared with baseline, two such studies found that hypoglycemic events fell by 56–80% (77,78). The Joint Commission recommends that all hypoglycemic episodes be evaluated for a root cause and the episodes be aggregated and reviewed to address systemic issues (23).

In addition to errors with insulin treatment, iatrogenic hypoglycemia may be induced by a sudden reduction of corticosteroid dose, reduced oral intake, emesis, inappropriate timing of short- or rapid-acting insulin in relation to meals, reduced infusion rate of intravenous dextrose, unexpected interruption of enteral or parenteral feedings, delayed or missed blood glucose checks, and altered ability of the patient to report symptoms (5).

Predictors of Hypoglycemia

In ambulatory patients with diabetes, it is well established that an episode of severe hypoglycemia increases the risk for a subsequent event, in part because of impaired counterregulation (79,80). This relationship also holds for inpatients. For example, in a study of hospitalized patients treated for hyperglycemia, 84% who had an episode of "severe hypoglycemia" (defined as <40 mg/dL [2.2 mmol/L]) had a preceding episode of hypoglycemia (<70 mg/dL [3.9 mmol/L]) during the same admission (81). In another study of hypoglycemic episodes (defined as <50 mg/dL [2.8 mmol/L]), 78% of patients were using basal insulin, with the incidence of hypoglycemia peaking between midnight and 6:00 A.M. Despite recognition of hypoglycemia, 75% of patients did not have their dose of basal insulin changed before the next insulin administration (82).

Recently, several groups have developed algorithms to predict episodes of hypoglycemia among inpatients (83,84). Models such as these are potentially important and, once validated for general use, could provide a valuable tool to reduce rates of hypoglycemia in hospitalized patients.

MEDICAL NUTRITION THERAPY IN THE HOSPITAL

The goals of medical nutrition therapy in the hospital are to provide adequate calories to meet metabolic demands, optimize glycemic control, address personal food preferences, and facilitate the creation of a discharge plan. The American Diabetes Association does not endorse any single meal plan or specified percentages of macronutrients. Current nutrition recommendations advise individualization based on treatment goals, physiological parameters, and medication use. Consistent carbohydrate meal plans are preferred by many hospitals as they facilitate matching the prandial insulin dose to the amount of carbohydrate consumed (85).

Orders should also indicate that the meal delivery and nutritional insulin coverage should be coordinated, as their variability often creates the possibility of hyperglycemic and hypoglycemic events.

Many hospitals offer "meals on demand," allowing patients to order meals from the menu at any time of the day. This option improves patient satisfaction but complicates meal–insulin coordination. Finally, if carbohydrate counting is provided by the hospital kitchen, this option should be used in patients counting carbohydrates at home (86).

SELF-MANAGEMENT IN THE HOSPITAL

Diabetes self-management in the hospital may be appropriate for specific patients (87,88). Candidates include both adolescent and adult patients who successfully conduct self-management of diabetes at home and whose cognitive and physical skills needed to successfully self-administer insulin and perform self-monitoring of blood glucose are not compromised. In addition, they should have adequate oral intake, be proficient in carbohydrate estimation, use multiple daily insulin injections or continuous subcutaneous insulin infusion (CSII), have stable insulin requirements, and understand sick-day management. If self-management is to be used, a protocol should include a requirement that the patient, nursing staff, and physician agree that patient self-management is appropriate. If CSII or CGM is to be used, hospital policy and procedures delineating guidelines for CSII therapy, including the changing of infusion sites, are advised (89,90). As outlined in Recommendation 7.29, patients using diabetes devices should be allowed to use them in an inpatient setting when proper supervision is available.

STANDARDS FOR SPECIAL SITUATIONS

Enteral/Parenteral Feedings

For patients receiving enteral or parenteral feedings who require insulin, the regimen should include coverage of basal, prandial, and correctional needs (91,92). It is particularly important that patients with type 1 diabetes continue to receive basal insulin even if feedings are discontinued.

Most patients receiving basal insulin should continue with their basal dose,

while the dose of insulin for the total daily nutritional component may be calculated as 1 unit of insulin for every 10–15 g carbohydrate in the formula. Commercially available cans of enteral nutrition contain variable amounts of carbohydrate and may be infused at different rates. All of this must be taken into consideration while calculating insulin doses to cover the nutritional component of enteral nutrition (86). Most specialists recommend using NPH insulin twice or three times daily (every 8 or 12 h) to cover patient needs. Adjustments in insulin doses must be made frequently. Correctional insulin should also be administered subcutaneously every 6 h using human regular insulin or every 4 h using a rapid-acting insulin. If enteral nutrition is interrupted, a 10% dextrose infusion must be started immediately to prevent hypoglycemia and to allow time to select more appropriate insulin doses.

For patients receiving enteral bolus feedings, approximately 1 unit of regular human insulin or rapid-acting insulin per 10–15 g carbohydrate should be given subcutaneously before each feeding. Correctional insulin coverage should be added as needed before each feeding.

In patients receiving nocturnal tube feeding, NPH insulin administered with the initiation of feeding represents a reasonable approach to cover this nutritional load.

For patients receiving continuous peripheral or central parenteral nutrition, human regular insulin may be added to the solution, particularly if >20 units of correctional insulin have been required in the past 24 h. A starting dose of 1 unit of human regular insulin for every 10 g dextrose has been recommended (93) and should be adjusted daily in the solution. Adding insulin to the parenteral nutrition bag is the safest way to prevent hypoglycemia if the parenteral nutrition is stopped or interrupted. Correctional insulin should be administered subcutaneously. For full enteral/parenteral feeding guidance, please refer to review articles detailing this topic (91,94).

Because continuous enteral or parenteral nutrition results in a continuous postprandial state, any attempt to bring blood glucose levels to below 140 mg/dL (7.8 mmol/L) substantially increases the risk of hypoglycemia in these patients.

Glucocorticoid Therapy

The prevalence of glucocorticoid therapy in hospitalized patients can approach 10%, and these medications can induce hyperglycemia in patients with and without antecedent diabetes (95). Glucocorticoid type and duration of action must be considered in determining insulin treatment regimens. Daily-ingested short-acting glucocorticoids such as prednisone reach peak plasma levels in 4–6 h (96) but have pharmacologic actions that last through the day. Patients on morning steroid regimens have disproportionate hyperglycemia during the day, but they frequently reach normal blood glucose levels overnight regardless of treatment (95). In subjects on once- or twice-daily steroids, administration of intermediate-acting (NPH) insulin is a standard approach. NPH is usually administered in addition to daily basal-bolus insulin or in addition to oral antidiabetes medications. Because NPH action peaks at 4–6 h after administration, it is best to give it concomitantly with steroids (97). For long-acting glucocorticoids such as dexamethasone and multidose or continuous glucocorticoid use, long-acting insulin may be required to control fasting blood glucose (50,98). For higher doses of glucocorticoids, increasing doses of prandial and correctional insulin, sometimes in extraordinary amounts, are often needed in addition to basal insulin (99,100). Whatever orders are started, adjustments based on anticipated changes in glucocorticoid dosing and POC glucose test results are critical.

Perioperative Care

Many standards for perioperative care lack a robust evidence base. However, the following approach (101–103) may be considered:

1. The target range for blood glucose in the perioperative period should be 80–180 mg/dL (4.4–10.0 mmol/L).
2. A preoperative risk assessment should be performed for patients with diabetes who are at high risk for ischemic heart disease and those with autonomic neuropathy or renal failure.
3. Metformin should be withheld on the day of surgery.
4. SGLT2 inhibitors must be discontinued 3–4 days before surgery.
5. Withhold any other oral glucose-lowering agents the morning of surgery or procedure and give half of NPH dose or 75–80% doses of long-acting analog or pump basal insulin.
6. Monitor blood glucose at least every 2–4 h while the patient is taking nothing by mouth and dose with short- or rapid-acting insulin as needed.
7. There are no data on the use and/or influence of GLP-1 receptor agonists or ultra-long-acting insulin analogs upon glycemia in perioperative care.

A recent review concluded that perioperative glycemic control tighter than 80–180 mg/dL (4.4–10.0 mmol/L) did not improve outcomes and was associated with more hypoglycemia (102); therefore, in general, tighter glycemic targets are not advised. Evidence from a recent study indicates that compared with usual dosing, a reduction of insulin given the evening before surgery by ~25% was more likely to achieve perioperative blood glucose levels in the target range with a lower risk for hypoglycemia (104).

In noncardiac general surgery patients, basal insulin plus premeal short- or rapid-acting insulin (basal-bolus) coverage has been associated with improved glycemic control and lower rates of perioperative complications compared with the reactive, sliding scale regimens (short- or rapid-acting insulin coverage only with no basal insulin dosing) (56,105).

Diabetic Ketoacidosis and Hyperosmolar Hyperglycemic State

There is considerable variability in the presentation of diabetic ketoacidosis (DKA) and hyperosmolar hyperglycemic states, ranging from euglycemia or mild hyperglycemia and acidosis to severe hyperglycemia, dehydration, and coma; therefore, individualization of treatment based on a careful clinical and laboratory assessment is needed (106–109).

Management goals include restoration of circulatory volume and tissue perfusion, resolution of hyperglycemia, and

correction of electrolyte imbalance and acidosis. It is also important to treat any correctable underlying cause of DKA, such as sepsis, myocardial infarction, or stroke. In critically ill and mentally obtunded patients with DKA or hyperosmolar hyperglycemia, continuous intravenous insulin is the standard of care. Successful transition of patients from intravenous to subcutaneous insulin requires administration of basal insulin 2–4 h prior to the intravenous insulin being stopped to prevent recurrence of ketoacidosis and rebound hyperglycemia (108). There is no significant difference in outcomes for intravenous human regular insulin versus subcutaneous rapid-acting analogs when combined with aggressive fluid management for treating mild or moderate DKA (110). Patients with uncomplicated DKA may sometimes be treated with subcutaneous insulin in the emergency department or step-down units (111), an approach that may be safer and more cost-effective than treatment with intravenous insulin. If subcutaneous insulin administration is used, it is important to provide an adequate fluid replacement, frequent bedside testing, appropriate treatment of any concurrent infections, and appropriate follow-up to avoid recurrent DKA. Several studies have shown that the use of bicarbonate in patients with DKA made no difference in resolution of acidosis or time to discharge, and its use is generally not recommended. For further information regarding treatment, refer to recent in-depth reviews (4).

TRANSITION FROM THE HOSPITAL TO THE AMBULATORY SETTING

Recommendation

16.11 There should be a structured discharge plan tailored to the individual patient with diabetes. **B**

A structured discharge plan tailored to the individual patient may reduce the length of hospital stay and readmission rates and increase patient satisfaction (112). Discharge planning should begin at admission and be updated as patient needs change.

The transition from the acute care setting presents risks for all patients. Inpatients may be discharged to varied settings, including home (with or without visiting nurse services), assisted living, rehabilitation, or skilled nursing facilities. For the patient who is discharged to home or to assisted living, the optimal program will need to consider diabetes type and severity, effects of the patient's illness on blood glucose levels, and the patient's capacities and preferences. See Section 13, "Older Adults" (https://doi.org/10.2337/dc22-S013), for more information.

An outpatient follow-up visit with the primary care provider, endocrinologist, or diabetes care and education specialist within 1 month of discharge is advised for all patients experiencing hyperglycemia in the hospital. If glycemic medications are changed, or if glucose control is not optimal at discharge, an earlier appointment (in 1–2 weeks) is preferred, and frequent contact may be needed to avoid hyperglycemia and hypoglycemia. A recently described discharge algorithm for glycemic medication adjustment based on admission A1C was found useful to guide treatment decisions and significantly improved A1C after discharge (7). Therefore, if an A1C from the prior 3 months is unavailable, measuring the A1C in all patients with diabetes or hyperglycemia admitted to the hospital is recommended.

Clear communication with outpatient providers either directly or via hospital discharge summaries facilitates safe transitions to outpatient care. Providing information regarding the cause of hyperglycemia (or the plan for determining the cause), related complications and comorbidities, and recommended treatments can assist outpatient providers as they assume ongoing care.

The Agency for Healthcare Research and Quality recommends that, at a minimum, discharge plans include the following (113):

Medication Reconciliation

- The patient's medications must be cross-checked to ensure that no chronic medications were stopped and to ensure the safety of new prescriptions.
- Prescriptions for new or changed medication should be filled and reviewed with the patient and family at or before discharge.

Structured Discharge Communication

- Information on medication changes, pending tests and studies, and follow-up needs must be accurately and promptly communicated to outpatient physicians.
- Discharge summaries should be transmitted to the primary care provider as soon as possible after discharge.
- Scheduling follow-up appointments prior to discharge increases the likelihood that patients will attend.

It is recommended that the following areas of knowledge be reviewed and addressed prior to hospital discharge:

- Identification of the health care provider who will provide diabetes care after discharge.
- Level of understanding related to the diabetes diagnosis, self-monitoring of blood glucose, home blood glucose goals, and when to call the provider.
- Definition, recognition, treatment, and prevention of hyperglycemia and hypoglycemia.
- Information on making healthy food choices at home and referral to an outpatient registered dietitian nutritionist to guide individualization of the meal plan, if needed.
- If relevant, when and how to take blood glucose–lowering medications, including insulin administration.
- Sick-day management.
- Proper use and disposal of needles and syringes.

It is important that patients be provided with appropriate durable medical equipment, medications, supplies (e.g., blood glucose test strips), and prescriptions, along with appropriate education at the time of discharge in order to avoid a potentially dangerous hiatus in care.

PREVENTING ADMISSIONS AND READMISSIONS

In patients with diabetes, the hospital readmission rate is between 14% and 20%, nearly twice that in patients without diabetes (114,115). This reflects increased disease burden for patients and has important financial implications. Of patients with diabetes who are hospitalized, 30% have two or more hospital

stays, and these admissions account for over 50% of inpatient costs for diabetes (116). Factors contributing to readmission include male sex, longer duration of prior hospitalization, number of previous hospitalizations, number and severity of comorbidities, and lower socioeconomic and/or educational status; scheduled home health visits and timely outpatient follow-up reduce rates of readmission (114,115). While there is no standard to prevent readmissions, several successful strategies have been reported (115). These include targeting ketosis-prone patients with type 1 diabetes (117), insulin treatment of patients with admission A1C >9% (75 mmol/mol) (118), and use of a transitional care model (119). For people with diabetic kidney disease, collaborative patient-centered medical homes may decrease risk-adjusted readmission rates (120). A recently published algorithm based on patient demographic and clinical characteristics had only moderate predictive power but identifies a promising future strategy (121).

Age is also an important risk factor in hospitalization and readmission among patients with diabetes (refer to Section 13, "Older Adults," https://doi.org/10.2337/dc22-S013, for detailed criteria).

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SAINT JOSEPH
Regional Medical Center

Version #: 2

Title: DNR/Allow Natural Death/Decisions to Limit Life Saving Treatment

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Location: Saint Joseph Regional Medical Center (SJRMC)		Department: St Joe's Regional Medical ctr-Mishawaka/Plymouth

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POLICY:

1. Saint Joseph Regional Medical Center is committed to preserving life and limiting pain and suffering, especially at the end of life. Decisions to forego life-sustaining treatments are made through a medically responsible, ethical, and sensitive process that protects the rights of patients and ensures that there is adequate communication among patients/significant others and care givers. SJRMC recognizes the patient's or decision maker's right to participate in and make decisions about treatment and to be provided with adequate information regarding treatment options and withdrawing and withholding of treatment, including resuscitation. Care necessary to meet emotional, spiritual, and comfort needs including adequate pain relief, is to be provided without regard to decisions to limit treatment.
2. At all times, SJRMC strives to provide health care in a holistic and appropriate manner for the condition of the patient, within the context of our mission statement and in accordance with the Ethical and Religious Directives (ERDs) for Catholic Health Care Services.
3. Respect for each person's cultural and personal beliefs and wishes motivate the care given to patients at all stages of the treatment process regardless of prognosis. In this regard, patients' rights must always be respected in relation to the scope and kind of treatment that is delivered or withheld.
4. Good decision-making about life-sustaining treatments depends on the process of shared decision-making. The ethically sound process is one that enables competent and informed patients and their family members to reach voluntary decisions about care. In those cases where the patient is unable to make decisions, the individual properly delegated to do so should likewise participate in the shared decision-making process.
5. In recognition of the sensitive issues involved with the requirements and the nature of Do Not Resuscitate (DNR) or Allow a Natural Death (AND) orders and orders to provide, withhold or withdraw life-sustaining treatments, it is the policy of SJRMC that specific procedures will be followed when decisions are made to limit life-sustaining treatment.
6. There may be certain situations regarding the forgoing of life sustaining treatment in which the patient's wishes conflict with the Catholic nature of Saint Joseph Regional Medical Center. *ERD 24: The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored." [Note: Directive 58 and the hydration/nutrition of patients in specific medical conditions.]* In such cases, it may be appropriate to help the patient transfer to another facility that is willing to comply with his or her request. The refusal to honor certain requests stems from our understanding of human dignity and what is appropriate health care.

Title: DNR/Allow Natural Death/Decisions to Limit Life Saving Treatment

PRINCIPLES:

The following principles are guidelines for health care providers for implementing decisions to limit treatment.

1. The patient or decision maker has the right to refuse or limit treatment that he or she has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community. The responsible physician and other health care providers are obligated to honor this decision made in compliance with this policy. The patient or decision-maker has the right to refuse resuscitation and the responsible physician is obligated to honor this decision or transfer care for the patient to the service of another physician.
2. Patients with a DNR or AND order will continue to receive appropriate/expected treatment therapies without discrimination, including admission to the Critical Care Units when indicated.
3. The responsible physician will discuss risks, benefits, and alternatives of treatments with the patient or decision-maker.
4. There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.
5. Life-sustaining treatment cannot be withheld or withdrawn from a pregnant patient as long as it is probable that the fetus has the potential to be viable outside the uterus.
6. This policy identifies and describes the responsibilities and procedures for making and implementing decisions to limit life-sustaining treatment, withdrawing or withholding of treatment including resuscitation, as well as for resolving disagreements related to such decisions.

PROCEDURE: Implementation of treatment limitation/DNR

A. Discussion of treatment limitations/DNR-Allowing Natural Death or AND – Allow a Natural Death.

B. Discussion regarding treatment limitations or DNR or AND is appropriate, but not limited to the following:
   1) The patient initiates a request to limit treatment or not be resuscitated
   2) The patient has a life-threatening condition.
   3) The patient has an Advance Directive and/or there exists a decision-maker who requests to limit treatment or no resuscitation.
   4) In the responsible physician's judgment, treatment would be medically ineffective.

C. An Advance Directive, and/or the use of a decision-maker, becomes effective only upon determination that the patient lacks decision-making capacity. For the purposes of limiting treatment, an Advance Directive, and/or use of a decision-maker, become effective only when the patient lacks decision-making capacity and is either permanently unconscious or in a terminal condition

D. The responsible physician will have a full and sufficient discussion with the patient/decision-maker concerning the nature of the illness, the prognosis, and the options for treatment including palliative/supportive care and recommendations regarding treatment.

E. When the patient is competent, decisions will be reached by agreement between the patient and the physician. When the patient is incompetent, this decision will be reached through consensus by the appropriate legal representative (i.e., Health Care Representative, Durable Power of Attorney), or in the absence of such, family member(s), (spouse, children, parents) or significant others and the physician.

F. Documentation of Treatment Limitations/DNR/AND

1) The responsible physician should record the patient's current medical condition and prognosis in the medical record.

G. The responsible physician should document the basis for decisions regarding life-sustaining treatments, and all other relevant considerations in the progress notes of the medical record. This documentation should include the physician's judgment of the patient's capability and his/her evaluation describing how the patient meets the medical criteria for such judgment. The physician should also include a summary of his/her discussion with the patient, patient representative, family members, or guardian, and indicate their wishes.

H. When an Advance Directive is considered in patient care decisions, it will be interpreted in light of the ERDs. Advanced Directives do not apply as long as the patient has decision-making capacity.

1) In the absence of an Advance Directive, the patient representative, next-of-kin or a guardian must provide informed consent for incapable patients or minors regarding DNR or life-sustaining treatments.

2) If no patient representative, next-of-kin or guardian exists, referring the case to the Ethics Committee is strongly encouraged.

3) Orders to withhold or withdraw life-sustaining treatment cannot be written for pregnant patients as long as it is probable that the fetus has the potential to be viable outside of the uterus.

I. Communication of Treatment Limitations/DNR/AND Orders

1) If the patient has an order for "Do Not Resuscitate ", the chart must be identified with a blue strip of tape on the lower front cover as well as the vertical end of the chart.

2) The Attending physician will educate the patient and/or family or legal representative regarding the meaning and implications of the "Do Not Resuscitate status", as well as the possible results or outcome of non-treatment, together with any significant alternatives. Notations in the physicians' progress notes will reflect the discussions related to the DNR orders held with the patient and/ or legal representative.

3) The Attending Physician will communicate to the nurse caring for the patient that an order to limit treatment has been written. The responsible physician and/or nurse caring for the patient should inform other involved medical personnel that a DNR or other order has been written to limit treatment.

4) If the patient has an Advance Directive, it should be placed in the patient's medical record.

5) Verbal (non-written) DNR orders are acceptable only in emergency or extraordinary circumstances. Such verbal orders are automatically discontinued after 24 hours unless they

are converted into formal written orders by the primary physician's signature. If the order is not signed after 24 hours, the Registered nurse will contact the physician to clarify the status.

6) DNR/Treatment Limitation orders must be reviewed and reordered with each hospital admission and/or transfer from one nursing unit to another.
7) DNR order does not preclude the patient from receiving all other appropriate care.
8) A physician order is required when any medical treatments, procedures, therapies, etc. are to be discontinued.
9) In order to assure that each patient receives optimal care, the nurse will notify the appropriate physician with any significant change in the patient's status or physical condition unless a physician's order instructs otherwise.
10) The Registered Nurse will review the DNR order and contact the physician with any questions for clarification.
11) The Registered Nurse will communicate status to other caregivers and staff as appropriate.

Amending for the Operating Room and Post Anesthesia Care Unit:

A. The physician performing the procedure and/or anesthesiologist will review treatment limitations and any existing DNR order with the patient or decision-maker prior to the operative procedure.
B. The physician performing the procedure and/or anesthesiologist will document the discussion and any changes applicable only to the Operating Room and Post Anesthesia Care Unit with a notation in the Progress Note.
C. Upon returning to the floor/unit, the Treatment Limitation/DNR order will be resumed.
D. **If the patient chooses surgery with a Treatment Limitations/DNR order**, this decision shall be honored. If the surgeon or anesthesiologist does not agree, the care of the patient shall be transferred to another physician who will agree to honor this agreement.

DNR-Allow Natural Death Orders in the Emergency department:

A. Patients without decision-making capacity arriving in the Emergency Department will be resuscitated as medically indicated.
B. If an Advance Directive or other evidence of a patient's preference not to be resuscitated is produced, it will be honored after the document has been reviewed and found applicable to the clinical situation.
C. Patients with decision-making capacity will have their treatment preferences honored.

Review, Revision, and Revocation:

A. Treatment Limitation/DNR orders can be revoked or revised at any time by the patient with decision-making capacity. Treatment Limitation/DNR orders can be revoked or revised by the decision-maker/legal representative as long as such revocation or revision is not contrary to the patient's prior stated wishes.

Title: DNR/Allow Natural Death/Decisions to Limit Life Saving Treatment

References/Standards:

- Ethical and Religious Directives for Catholic Health Care Services, "Part Five: Issues in Care for the Dying," p. 21 ff.
- Development of Church Teaching on Prolonging Life, by Kevin D. O'Rourke, O, JCD.

SAINT JOSEPH
Regional Medical Center

Version #: 3

Title: Donation of Human Organs and Tissues (Anatomical Gifts)

Document Owner: Maranda Renaud	PI Team: Provision of Care	Date Created: 01/2014
Approver(s): Carole Langhauser, LeAnn Springman, Loretta Schmidt		Date Approved: 06/2016
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Admin (14030_10005), Nursing Admin (14035_10005)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

In accordance with the Trinity Health Core Values of Respect, Social Justice, Compassion, Care of the Poor and Underserved, and Excellence and in compliance with the Ethical and Religious Directives for Catholic Health Care Services (ERD), Saint Joseph Regional Medical Center (SJRMC) believes that each person is created in the image and likeness of God and has been endowed with unique human dignity, rights and responsibilities. SJRMC believes that the dignity and rights of each person must be promoted with utmost care, from the moment of conception, throughout life, in death, and throughout the pre-procurement and procurement process.

With this philosophical base, we approach the subject of donation of human organs and tissues with the following provisions:

1. That the life of each patient be considered sacred and at all times be provided appropriate medical care, without regard to whether an anatomical gift is under consideration.
2. That, given life-saving and health-enhancing potential of organ transplantation and tissue transplantation procedures, utmost consideration be given to the securing of suitable anatomical gifts when all hope of recovery is gone and the death of the patient is imminent or has occurred. (See ERD #63)
3. That in securing of permission to obtain anatomical gifts, utmost consideration and sensitivity will be shown for family members and friends of the patient (decedent). This includes not mentioning any type of donation to the family by anyone other than a Designated Requestor at the appropriate time in the process.
4. That every patient near imminent death or already deceased must be evaluated for the suitability to donate.
5. That collaboration among multi-disciplinary caregivers is essential to providing quality care and to promoting positive donation outcomes.
6. That the patient and family be given care, respect and spiritual support throughout the dying process and after the patient's death.
7. That the quality and integrity of the Donation of Organs-Tissues Policy will be monitored by the Donor Council. Improvements will be recommended as necessary.

PROCEDURE:

A. REFERRALS:

1) Possible Organ Donors: Call on EVERY patient meeting clinical triggers.

a) As soon as possible after a vented patient with a heartbeat meets the clinical triggers, the patient's nurse or designated person calls the **Vital Link Donation Center (VLDC)** , Indiana Donor Information Line (DIL) 1-800-356-7757, and records the time of that call, responder's name, referral number, and the caller's signature on the Vented Patient As Possible Donor Early Referral form (6871) and also in the EMR. Inform DIL if this is a coroner's case.

b) **Clinical Triggers:**

(1) Vented patient with a Glasgow Coma Scale (GCS) of 5 or less

(2) Before any withdrawal of vent or support medications

(3) First mention of withdrawing support or donation questions by physician or family

c) Indiana Donor Network (IDN) will return the call and obtain patient's medical information. Nurse records time the call is returned on the Vented Patient as Possible Donor Early Referral form (6871) and also in the Electronic Medical Record (EMR) in Nurse Progress Notes.

d) The patient's eligibility or ineligibility as a possible donor is also recorded in both places.

e) If the patient remains a possible organ donor, IDN will monitor the patient's medical status (usually by sending a representative to the hospital) and will coordinate any donation requests.

f) IDN will inform the attending physician of the rationale for suitability for donation.

g) If the patient becomes both an organ and tissue donor, IDN will coordinate the procurement schedule between agencies. Nurse updates patient information on both the Vented Patient (6871) form and in the EMR as contact with IDN proceeds.

h) If the patient becomes ineligible for organ donation, record that on the Vented Patient (6871) form and in the EMR and follow the Possible Tissue-Eye Donor procedures at the time of the patient's cardiac death.

2) **Possible Tissue-Eye Donors: Call on EVERY cardiac death.**

a) As soon as possible after the patient's cardiac death, the patient's nurse or designated person calls the **Vital Link Donation Center (VLDC),** 1-800-356-7757, and records the time of that call, the responder's name, referral number, and the caller's signature on the Release to Funeral Home (6365) form and in the Electronic Medical Record (EMR). Inform DIL if this is a coroner's case.

b) The appropriate Agency returns the call to obtain patient's medical information and evaluates eligibility. Nurse records time the call is returned on the Release form.

c) The nurse notifies the attending physician of eligibility or ineligibility. Indiana Donor Network will proceed with the authorization/disclosure process if eligible.

d) If the patient has been previously evaluated for organ donation, the call is still made again at cardiac death (give prior referral number).

e) If the decedent is unsuitable for donation, the donation process stops. The family is not asked about donation. Preparation is made for transporting the body to the morgue and releasing to the body to the funeral home.

3) Possible Whole Body Donors:

a) The patient or family has usually made arrangements with the program where this donation will be made. Nurse notifies the 800# (DIL) of this when calling at the cardiac time of death.

b) Family, nurse, or designated person calls the desired program to assure the body donation will still be accepted.

c) If the family has not made prior arrangements, but expresses interest, family can be given program contact information by Designated Requestor.

B. CONSENT:

1) Possible Tissue-Eye Donors After Circulatory Cardiac Death

a) If the decedent is deemed medically suitable for donation, the family is given time to de-couple before any approach for consent is made.

b) Permission to proceed has been given by the Coroner, if a Coroner's case.

c) At the appropriate time, the Indiana Donor Network or Vision First coordinates the approach to the family/legal representative to request consent or to confirm the decedent's intent. See Attachment #1 - Order for Decision-making Authority.

(1) Only Indiana Donor Network and/or Vision First will approach/mention donation to the family.

d) If the Decision-maker is not at the hospital or is not yet ready for a request to be made at the hospital (not yet de-coupled), a representative from the Donor Agency may contact the patient's representative by telephone for consent. Hospital provides that number to the Donor Agency.

e) The conversation should be in a private area away from the decedent, if possible, and primarily with the Decision-maker, but may include others as desired.

f) If consent is given, Indiana Donor Network completes the Organ, Tissue, and Eye Donation Authorization Form (6364) with the decision-maker and completes the medical-social history.

g) Support continues for the Decision-maker and other family members regardless of the consent decision.

h) The hospital personnel completes the donation box on the Release to Funeral Home and Authorization to Embalm form (6365), indicating consent or non-consent.

i) If the decedent will be a donor, the nurse notifies the Nurse Administrative Supervisor. Supervisor gathers or coordinates printing of needed medical records and forms and becomes the liaison with the Donor agency in the procurement process.

j) If there will be a significant delay in any part of the process before the consent request, and the family is not present, transport of the body to the morgue for refrigeration should be done as soon as possible in order to preserve the donation possibility.

2) Possible Organ Donors:

a) IDN representative is informed of test results and plans for doctor to speak with family about test results.

b) Permission has been given by Coroner to proceed if this is a Coroner's case.

c) **Possible Organ Donor After Brain Death (DBD):**

(1) Doctor informs the patient's family that the patient is brain dead.

(2) Family is given time to absorb the reality of the patient's death (de-couple).

d) **Possible Organ Donor After Circulatory Cardiac Death (DCD):**

(1) Doctor informs the patient's family of the patient's severe medical condition (neurological illness or injury of known cause with no hope for survival or meaningful functional status, but who does not meet brain death criteria and the probability that the patient will die within 90 minutes after the removal of ventilation.)

(2) Family is given time to absorb the reality of the patient's medical condition.

(3) Family decides to discontinue life-support measures <u>prior to and independent</u> of any consideration of donation.

e) IDN representative confirm the decedent's intent or coordinates the request for consent from the decision-maker and any members of the multidisciplinary team who should be involved. Any needed permission from the Coroner should have been completed.

f) The conversation should be primarily with the Decision-maker, but may include others. **(See Attachment #1 - Order for Decision-Making Authority)**

g) The approach for consent should be conducted in a private space away from the patient.

h) The consent process should include an approximate time line for evaluation, allocation and recovery, the benefits that could be provided to the recipients, the fact of no cost for donation-related procedures, and that a normal funeral viewing should not be affected by donation.

i) **Additionally for DCD:** A full description of the process that includes that the death will occur in the OR, a physician will pronounce the death, a few family members can be with the patient during the terminal wean, the family will leave the OR after the physician pronouncement of death so that procurement will begin immediately, and an explanation of the timing and reason for the use of heparin or other anticoagulant medications. Most family members, except those going to the OR are encouraged to say "good-bye" in the ICU or at the funeral home. If a

viewing after procurement is desired arrangements will be made for that. In the event that the patient does not die within 90 minutes after the terminal wean, the donation process will cease. The patient will be moved to an appropriate room where comfort measures will still continue.

j) If consent is received:

(1) Organ, Tissue and Eye Donation Authorization Form (6364) is completed with the Decision-Maker.

(2) IDN representative conducts a thorough medical/behavioral history interview.

(3) Nurse notifies inpatient registration to set up a new donor account (new MRN, new registration number, first name will be donor and placed in overflow bed as outpatient.)

(4) IDN and Designated Requestor will coordinate time to discuss the Release (6365) form completion with the Decision-maker.

(5) Nurse Administrative Supervisor will be notified of plan for organ donation and will work with the IDN representative for needed medical documentation and hospital coordination.

(6) Family will be provided as much time with the patient as possible.

(7) **Additionally for DCD:**

(a) Nurse will notify Administrator On Call and the Ethics Consult On Call (Switchboard will be aware of ethics call schedule.)

(b) IDN Donor After Circulatory Death Consent Form is completed with the Decision-maker. Timing and use of heparin or anticoagulants is specified in the consent.

(8) Most of the family's farewell to the patient will occur in the ICU with appropriate support personnel (chaplain, Donor Agency coordinator, etc.) A few family members may choose to accompany the patient to the Operating Room where the terminal wean will occur. They must understand the need to leave the OR with support personnel when death is pronounced. The family should be encouraged to further view and mourn the deceased at the funeral home. If the family wants a viewing at the hospital after organ/tissue recovery, however, arrangements should be made for a suitable room and appropriate support personnel.

(9) In the event that the patient does not expire within ninety minutes (90) after discontinuation of support and does not demonstrate a significant progression towards death, the organ donation process will cease. The patient will be moved to an appropriate room where comfort measures will still continue.

k) If patient is not donor designated and consent is not given:

IDN representative and hospital staff will support the family's decision.

l) Documentation of consent/non-consent is noted by:

(1)) the nurse in the electronic medical record nurse progress notes.

(2) the Designated Requestor on the paper Release form (6365)

3) Possible Whole Body Donors:

a) If arranged prior to death, person has signed all consents required by the program.

b) If arranged after a death, Decision-maker signs all consents required by the program.

C. **PROCUREMENT PROCESS:**

1) Tissue-Eye Procurement Process

a) DIL notifies the Donor Agency that consent has been given.

b) Donor Agency verifies any needed medical/social history information.

c) The Donor Agency calls the Hospital with any necessary details and provides an estimated time of arrival.

d) **For cornea donors:** The decedent's eyes are closed and covered with 4x4s dampened with saline and/or a very light pack with water and a small amount of ice. (Too much ice can freeze the corneas, making them unusable for transplant)

e) The nurse moves the decedent to morgue for refrigeration. [Mishawaka: Release to Funeral Home (6365), Consent (6364) and Expiration Checklist (7170.32) with refrigeration temperature completed are taken to Nurse Administrative Supervisor's office.]

f) The Nursing Unit (Mishawaka} or Nurse Administrative Supervisor (Plymouth) will make the decedent's chart and all pertinent forms available for the Donor Agency's review.

g) The Donor Agency is given access to the hospital and to the decedent for procurement. The team from the Donor Agency will enter the Hospital through the Emergency Department and ask the ED Registration staff to notify the designated Hospital Contact (Nurse supervisor and/or Security) for access to the morgue.

h) The Donor Agency verifies medical records and consent.

i) The Donor Agency recovers the consented tissues.

j) The Donor Agency notifies the designated Hospital contact, Nurse Administrative Supervisor, when the procurement is complete.

2) **Organ Procurement Process for Donation After Brain Death (DBD**):

a) IDN will oversee the maintenance of the donor.

b) IDN representative will arrange for the operating room suite with administrative nursing supervisor to coordinate the arrival of the organ recovery team.

c) IDN representative will arrange for the donor to be moved to the OR.

d) IDN recovery team will manage the recovery of organs in the operating room.

e) IDN representative notifies the Nurse Administrative Supervisor when the procurement is complete.

f) If the family desires viewing after the procurement, the decedent is prepared and taken to a suitable room. Appropriate support will be available for the family.

g) The decedent will be taken to the morgue after surgery or after the family viewing.

3) **Organ Procurement Process for Donation After Circulatory Cardiac Death (DCD):**

a) **Donor Maintenance for DCD**

(1) The responsible physician will retain full responsibility for the patient until such time as the patient's death is pronounced.

(2) The responsible physician for the patient will make a clinical judgment on the advisability of administering medications for comfort measures.

(3) The administration of clinically appropriate medications in appropriate doses to provide comfort is acceptable and encouraged.

(4) The use of paralytics is prohibited.

(5) Interventions to preserve organ function but which may cause patient discomfort or hasten death are prohibited, i.e. no defibrillation. (Refer to catastrophic Brain Injury Protocol/ Guidelines)

b) **Preparation for DCD**

(1) IDN coordinates the Recovery team's arrival and schedules the OR.

(2) IDN notifies OR of need for additional scrubs and sizes.

(3) IDN notifies Chaplain of OR time so that scheduling can be done for one chaplain with the family, one chaplain to stay in the OR with the medical team, and at least one chaplain covering call.

(4) IDN will coordinate with physician who will pronounce so that physician will be present and will not have pager responsibilities during this time.

(5) IDN will coordinate with time in the OR with other medical staff needed: ICU nurse, respiratory therapist to monitor vent, OR staff (at least 1 nurse).

(6) IDN will provide prior training to the staff, as well as an "at the time" walk through.

c) **Terminal wean in the OR process for DCD**

(1) The Organ Recovery Team will be in the Hospital and available prior to moving the patient to the OR.

(2) OR staff with input from IDN will prepare the OR suite prior to the patient being brought into the room. This will include the covering of windows, dimming of lights, no or appropriate music, etc.

(3) When all aspects are coordinated, the OR team transports the patient to the OR accompanied by: Physician who will pronounce (a resident can pronounce death), ICU nurse, Respiratory therapist, family members going into the OR.

(4) Organ Recovery Team and OR staff will prepare and drape the patient and complete other pre-surgery arrangements. Draping of patient should include leaving a hand exposed for family to hold. Draping should leave patient looking as much like they are "in bed" as possible.

(5) Leads for monitoring devices are placed on the back of the patient, when possible.

(6) The Organ Recovery Team will leave the OR after preparation and will not be with the patient during the withdrawal of support or the certification of death.

(7) Standard protocols for comfort care during the withdrawal of support will be followed. Medications for support will be brought by ICU nurse or other designated personnel. The following procedure will also be utilized:

(a) Heparin 300 units/kg IV push will be administered (by or under direction of pronouncing physician)

(b) Ventilator support will be withdrawn and intravenous infusions excluding medications for comfort measures will be discontinued. Cardiac monitoring and invasive blood pressure monitoring will be maintained.

(8) Family may be with patient after prepped and draped and support has been withdrawn until respirations have ceased (RHC). Emotional and spiritual support will be provided by hospital personnel and IDN personnel. This support will continue throughout the process.

d) **Certification of Death for DCD**

(1) For certification of death, the prompt and accurate diagnosis of cardiac arrest is extremely important.

(2) Recovery of organs cannot take place until the patient meets the cardiopulmonary criteria for death.

(3) Under no circumstances will an incision, for the purpose of organ recovery, be made until death is pronounced.

(4) Under no circumstances will cold perfusion catheters be inserted until after death has been pronounced.

(5) For the purposes of pronouncing death prior to organ recovery, the following will be confirmed.

(a) Correct cardiac electrode placement

(b) Absence of pulse waveform on arterial line or absence of palpable pulse by exam or doppler flow

(c) Apnea via auscultation of breath sounds

(d) Completely unresponsive to stimuli

(e) Five (5) minutes of any of the following electrocardiographic rhythms, confirmed in two (2) different leads:

(f) Electrical asystole

(g) Ventricular fibrillation

(h) Pulseless electrical activity

(i) Pulselessness via auscultation of heart sounds

(j) Pupils fixed and dilated

(6) Under no circumstances will chest compressions be performed after the declaration of death.

(7) The physician declaring death will document the date and time of death in the patient's hospital record and will complete the certificate of death.

(8) If the patient does not deteriorate to death within the designated time of ninety (90) minutes and does not demonstrate a significant deterioration towards death, the donation process will cease and comfort measures will be maintained. The patient will be moved to a patient room that has been previously designated for the continuation of comfort measures. Support to the family will also continue.

e) **Recovery Organs for DCD**

(1) Recovery of organs will proceed after the certification of death.

(2) The recovery surgeon will be informed of the warm ischemic time.

(3) For the purpose of this protocol, warm ischemic time will be defined as the time from pulselessness until the organs have been initially cooled and flushed.

(4) IDN notifies the Nurse Administrative Supervisor when the procurement is complete.

(5) The family will be given the option to see their loved one after organ recovery has been completed if they have chosen to do so. The IDN Coordinator, chaplain and other appropriate people will accompany the family to a designated place for this viewing.

(6) The decedent will be taken to the morgue when surgery is completed or when the family has left after the viewing.

D. **RELEASE OF BODY TO FUNERAL HOME**

1) Decedent's body is secured in the morgue cooler after donation is completed.

2) Nurse Administrative Supervisor completes the Expiration Form in the patient's EMR and enters the correct time of death. Supervisor also takes responsibility for Release (6365), the County Health Department Provisional Notification of Death-Burial Transit Permit, and any other forms that will eventually be sent to Health Information Services.

3) The Funeral Home is notified by: Security (Mishawaka), Nurse Administrative Supervisor (Plymouth)

4) The Funeral Home enters the Hospital through the: Dock/Morgue area (Mishawaka), Emergency Department (Plymouth)

5) Access to the Morgue is provided by: Security (Mishawaka); Nurse Administrative Supervisor (Plymouth)

6) The identity of the decedent is verified by: Security (Mishawaka); Nurse Administrative Supervisor (Plymouth)

7) Hospital personnel releasing the body signs the Release (6365) and the County Provisional Notification of Death-Burial Transit forms

8) The Funeral Home signs the Release (6365) and the County Provisional Notification of Death-Burial Transit Form

9) The Funeral Home takes the appropriate copies and the other copies are directed as indicated on the forms.

E. **POST DONATION PROCESS**

1) **Donation of Tissue, Corneas, Organs from a donor after brain death (DBD)**

The Donor Agencies and the Donor Council will work together to evaluate and to improve the donation process.

2) **Donation of Organs from a donor after Circulatory Cardiac Death (DCD)**

a) Post Donation Conference: Initially, every DCD case will be reviewed, ideally within 72 hours, by a committee composed of: Medical Director ICU, Director ICU / OR, Staff involved from ICU / OR, Staff involved from IDN, Chaplains, Others as invited

b) IDN Coordinator will organize and conduct the meeting

c) The purpose of this review is to:

(1) assure compliance with the policy and procedure

(2) identify problems and complications, potential or actual, and recommended solutions

(3) protect the interests of the donor, donor family, hospital, recipients, health care providers and IDN

Definitions:

- Anatomical Gift: the giving of the body or parts of the human body after death for the medical benefit of another person or for the advancement of medical studies or research.
- Organ Donation: the gift of solid human organs such as, but not limited to, kidneys, heart, lung, pancreas, liver, and intestines for primarily transplantation or, when specified, research.
- Tissue Donation: the gift of human body tissue such as, but not limited to, corneas, eyes, bone, skin, veins, arteries, and fascia for primarily transplantation or, when specified, research.
- Whole Body Donation: the gift of the entire human body or specific body parts for Education, Research, or the Advancement of Medical Science or Dental Science.
- Imminent Death: vented patient with a heartbeat who has an injury or medical condition that patient is not expected to survive.
- Brain Death: cessation of brain activity according to standard brain death definition.

- Cardiac Death: cessation of heart activity.
- Donor Agency: organization contracted by the hospital for organ or tissue procurement. Currently:

  Indiana Donor Network (IDN) for organs

  New Life Generation (NLG) for tissue

  Donor Services of Indiana (DSI) for cord blood/placenta and some research tissue or whole body for research

  Indiana Lions Eye and Tissue Transplant Bank for cornea and eye tissue
- Donor Designation: driver's license, donor card or other written documentation that states that the patient/decedent wanted to be a donor. Agencies can check state records.
- Designated Requestor: a person from the Donor Agency who has been trained and certified to work with family members and decision-makers concerning donation.
- Decision-maker: person with the legal authority to make decisions about donation.
- De-coupling time: sufficient time between the delivery of the news of a grave prognosis or death and a discussion about donation with the decision-maker.
- Electronic Medical Record: EMR

References/Standards:

- Potential Organ Donor-Support Protocol Physician Orders [SPP.436]

Related Documents:

- Order for Decision-Making Authority (Attachment #1)
- Whole Body Donation Information (Attachment #2)

Attachment #1:

Order for Decision-making Authority

According to the Indiana Uniform Anatomical Gift Act (UAGA)

A. Donor Designation: Under Indiana's UAGA, if a person is medically suitable for donation and knowledge of the donor's legal declaration of an anatomical gift is known, Indiana law considers this declaration authorization to proceed with donation. If the decedent has made a donor designation, the conversation with the Decision-Maker verifies the decedent's intent. Evidence of a declaration of gift may include, but not be limited to:

1) a government issued driver's license or identification card (A driver's license that is suspended, revoked or expired does not change the validity of the declaration of gift);

2) documentation from an appropriate anatomical gift registry;

3) The individual him/herself (patient) gives consent, provided that the consent was made while the patient was of sound mind, and is evidenced by a signed, written consent that has not since been revoked;

4) If the patient is terminally ill, and unable to write, he/she may make an oral consent (or refusal) to donate.

Upon determination by Indiana Donor Network that a declaration of gift is valid, no further approval is required from the patient, patient's next of kin, agent or POA in order to proceed with the donation of organs and/or tissue. In the absence of donor designation, an Indiana Donor Network Coordinator may seek consent from a Durable Power of Attorney or other Decision Maker.

B. A Durable Power of Attorney, given general authority as to health care powers, may consent to an anatomical gift, request an autopsy, and provide for the disposition of the patient's remains. The execution of a Durable Power of Attorney is considered to be the act of the patient him/herself and takes priority under law over other decision-makers. This is true unless a valid Will is presented with statements to the contrary.

C. Decision-Maker: If the individual or the individual's Durable Power of Attorney, if applicable, has not made a decision for or against anatomical donation, other decision-makers may be consulted. However, opposition to anatomical donation on the part of any member of the same or higher priority class than the person who is consenting to anatomical donation will nullify the consent. Donor Agencies should be notified of any expressed opposition to donation in order to determine if the consent process should continue. In descending order of priority these Decision-makers are:

a) spouse
b) son or daughter over age 18 or emancipated
c) either parent
d) grandparent
e) brother or sister over age 18 or emancipated
f) guardian of the person of the decedent (patient) at the time of his/her death

Attachment #2:

WHOLE BODY DONATION INFORMATION:

A. Donation of the entire body or specific body parts may be made.

B. Ideally, donation arrangements are made by the person prior to their death.

C. If no prior arrangements have been made or the selected place for donation has refused to take the body at the time of death, the family is responsible for contacting a suitable program. Hospital personnel may assist the family in reasonable ways.

D. Total body donation precludes any organ or tissue donation except possibly cornea/eye donation.

E. Screening criteria and acceptance of this gift must be made prior to transportation of the body.

F. Generally decedents with open sores, non-healed surgical wounds, or blood-borne communicable diseases are not accepted for donation.

G. The protocol provided by the selected program will be followed for any accepted whole body donors.

H. Possible Programs:

1) Anatomical Education Program

Indiana University School of Medicine
Room 5035
Medical Science Building
635 Barnhill Dr.
Indianapolis, IN 46202-5120
1-317-274-7450

2) Use a web search engine to locate Anatomical Education Programs in other states or other research programs by entering "whole body donation" into the search.

SAINT JOSEPH
Regional Medical
Center

Version #: 2

Title: Equal Employment Opportunity / ADA / Reasonable Accommodation

Document Owner: Dabney, RJ	PI Team: Leadership	Date Created: 03/94
Approver(s): Hofstra, Donna		Date Approved: 06/27/11 06/29/2017
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Recruiting

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY TITLE:

Equal Employment Opportunity/Non-Discrimination, Protection Against Retaliation, and Reasonable Accommodation For Disabilities and Religious Beliefs, Observations and Practices

POLICY:

It is the Policy of SJRMC to provide equal employment opportunities in all aspects of employer/employee relations according to federal, state, and local laws, ordinances, and executive orders. Accordingly, SJRMC will not discriminate against employees or applicants based on the following legally protected characteristics: race, color, religion, sex (including sexual orientation and gender identity), pregnancy (including childbirth, lactation and related medical conditions), national origin, ancestry, age, physical or mental disability, genetic information (including testing and characteristics), veteran status, uniformed servicemember status, or other status protected by applicable local, state or federal law.

This Policy applies to all employment actions including but not limited to: recruitment, hiring, promotion, transfer, job assignment, working conditions, pay practices, salary increases, benefits, training, discipline and separation from employment. This policy prohibits unlawful discrimination by any employee, including supervisors and co-workers.

Any employee who believes that he/she has been the subjected to discrimination is strongly encouraged to report the alleged discriminatory act to Human Resources, his/her supervisor, a higher-level manager, the Department of Inclusion and Collaboration, the Integrity and Compliance Officer, or by contacting the Integrity and Compliance Line, 866-477-4661 or www.mycompliancereport.com (access ID = THO), as soon as possible after the incident.

Any manager who receives a complaint is required to respond timely and appropriately and immediately report the complaint to Human Resources. Any employee who engages in illegal discrimination, harassment, or retaliation in violation of this Policy will be subject to discipline up to and including termination, at the sole discretion of SJRMC. No Employee will be retaliated against for making a complaint under this Policy.

Protection Against Relations

Retaliation is prohibited against any person by another employee or by SJRMC for using this complaint procedure, reporting proscribed discrimination or harassment, or for filing, testifying, assisting or participating in any manner in any investigation, proceeding or hearing conducted by a governmental enforcement agency. Prohibited retaliation includes, but is not limited to, termination, demotion,

suspension, failure to hire or consider for hire, failure to give equal consideration in making employment decisions, failure to make employment recommendations impartially, adversely affecting working conditions, responding to an employee engaged in protected activity by taking adverse action against his/her family member who is also a SJRMC employee, or otherwise denying any employment benefit.

An employee should report any retaliation prohibited by this Policy to Human Resources, his/her supervisor, a higher-level manager, the Department of Inclusion and Collaboration, the Integrity and Compliance Officer, or by contacting the Integrity and Compliance Line, 866-477-4661 or www.mycompliancereport.com (access ID = THO, as soon as possible after the incident.

Any report of retaliatory conduct will be investigated in a thorough and objective manner. If a report of retaliation is substantiated, appropriate disciplinary action, up to and including termination of employment, will be taken at the sole discretion of SJRMC.

Reasonable Accommodations For Disabilities and Religious Beliefs, Observances and Practices

With respect to qualified individuals with physical or mental disabilities, SJRMC complies with federal and state laws, which require employers to provide a reasonable accommodation for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee, unless undue hardship and/or a direct threat to the health and/or safety of the individual or others would result.

SJRMC will provide reasonable accommodation for an employee's religious beliefs, observances, and practices when a need for such accommodation is identified and a reasonable accommodation is available. A reasonable accommodation is one that eliminates the conflict between an employee's religious beliefs, observances, or practices and the employee's job requirements, without causing undue hardship to SJRMC.

SJRMC will not retaliate against any employee for obtaining an accommodation or requesting an accommodation under the provisions of this Policy. Anyone who retaliates against an employee in violation of this Policy will be subject to discipline, up to and including termination, at the sole discretion of SJRMC.

References/Standards:

- The policy replaces the policies formerly known as Equal Employment Opportunity and Americans with Disabilities Act (archived for reference)
- Harassment Prevention & Offensive Behavior Policy
- At – Will Employment Policy
- Managing Staff Requests Policy
- Policy Reviewed: 08/07; 06/11

- Policy Revised: 11/99

The Senior Management Team of SJRMC reserves the right to unilaterally change, modify, amend, add, delete, or rescind any or all policies, at any time, as it determines appropriate in its sole discretion. No employee or manager of SJRMC except the Chief Executive Officer or Chief Human Resources Officer has the authority to modify any Human Resources Policies or Procedures, and any such modification must be in writing.

SAINT JOSEPH
Regional Medical Center

Version #: 1

Title: Fall Risk Assessment and Prevention

Document Owner: Janelle Johnson	PI Team: POC/Team 3	Date Created: 08/06/2014
Approver(s): Amy Murray, Carol Walker, Christina Kaufman, Debra Versaw, Elizabeth Kloska-Kearney, Jennifer Byall, Loretta Schmidt, Merita Allsop-Borton	Date Approved with no changes: 06/18/2019	Date Approved: 06/18/2019
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Admin (14030_10005), Nursing Admin (14035_10005)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. The purpose of this policy is to guide decisions regarding the management of patients at risk for a fall and achieve a reduction in the number of patient falls.
2. **Universal Fall Precautions** will be implemented for all patients served by Saint Joseph Health System (SJHS).
   A. **Universal Newborn Fall Precautions** will be implemented for all newborn patients
   B. **Universal Pediatric Fall Precautions** will be implemented for all pediatric patients.
   C. **Adult inpatients** entering SJHS will be considered at risk for falls and appropriate prevention measures will be implemented.
   D. **Adult outpatients** entering SJHS will be considered to be at risk for falls and appropriate prevention measures will be implemented.
3. Additional **Fall Risk Precautions** will be implemented along with the Universal Fall Precautions for patients with a Morse Fall score of 45 or greater or at the discretion of the nurse or provider.

PROCEDURE:

A. Adult inpatient Fall Risk Assessment will be completed on all patients using the Morse Fall Scale and will be completed as part of the initial nursing assessment within four (4) hours of admission to the unit.
   1) Morse Fall Scale
      a) Patient has a history of falling
      b) Patient has a history of a secondary diagnosis
      c) Patient uses ambulatory aids
      d) Patient has IV therapy or saline lock
      e) Patient's Gait
         (1) Normal gait – walking with head erect, arms swing freely at the side and stride without hesitation
         (2) Weak gait – stoops but is able to lift head while walking without losing balance. Steps are short and may be shuffling. Support is only featherweight touch for reassurance, rather than grabbing to remain upright.

(3) Impaired gait – difficult rising from chair, attempting to get up by pushing on the arms of the chair or bouncing. Head is down, balance poor, grasps onto furniture, person or walking aid and cannot walk without assistance.

(4) If patient is in a wheelchair, score according to the gait used when transferring to/from the wheelchair.

f) Patient's Mental Status

2) If the Morse Fall score is 45 or greater, the patient is considered high at risk for falling. **Universal Fall Precautions and Fall Risk Precautions** will be implemented.

B. **Universal Fall Precautions**: Precautions to be implemented for all adult patients admitted to SJHS

1) Orient patient to surroundings
2) Ensure patient footwear is adequate; if no footwear is available, provide non-skid socks
3) Keep bed in low position and locked
4) Lock all wheels on all wheelchairs, beds, commodes, and stretchers.
5) Ensure adequate lighting, patient room is free of clutter and trip hazards.
6) Call light is within easy reach of the patient
7) Keep telephone and patient personal items within reach of the patient.
8) Perform purposeful hourly rounding with extra focus surrounding the following times:
   a) Upon awakening
   b) One hour after diuretics
   c) Before analgesics
   d) After meals
   e) Before bedtime
9) Standardized patient/family education has been completed utilizing the Patient Safety through Fall Prevention trifold.
   a) Provide patient/family with age-appropriate education on ways to prevent a fall from occurring such as: use of eye glasses, appropriate footwear, hearing aids and any personal assistive devices as needed
   b) Call for assistance to transfer, ambulate, toilet or retrieve hard to reach items.
   c) Inform the nurse of any symptoms (i.e. dizziness or lightheadedness) with postural changes.

C. **Fall Risk Precautions** will be implemented for patients identified as high risk for falling

1) Place a yellow wrist band on patient
2) Initiate yellow light indicating fall risk within Hill Rom call system
3) Place yellow, double treaded socks on the patient
4) Bed alarm activated
5) Consider requesting family to stay with patient

6) Re-orient to environment, time, person, place, as frequently as needed and/or use behavior management techniques.
7) Utilize safety tools and technology as needed (i.e. gait belt, chair alarm, other assistive walking/lifting/transferring devices). Consider the use of Tele Sitter or 1:1 Patient Safety Attendant.
8) Notify Physician or designee that the patient is at high risk for falls by:
    a) Documenting in patient's nursing assessment or progress note
    b) Discussing and initiating a Fall Integrated Plan of Care (IPOC) which addresses:
        (1) Medications (pain, antidepressants, anti-epileptics, diuretics, anti-psychotics, sedatives/hypnotics, and/or opiates/narcotics)
        (2) Cognitive function
        (3) Gait and/or balance
        (4) Other issues that may be contributing to patient's risk for falls
    c) Recommend/suggest referral or consults to address individually assessed problems (i.e. physical therapy, occupational therapy, pharmacy, speech, social worker, pain management)
9) Ensure supervision and assistance with elimination, transfer and ambulation activities.
10) Patients who are at high risk for falls *and* who meet one or more of the following criteria will be considered as **'Stay with Me'** patients. Colleagues will remain within arm's reach (approximately 3 feet) of the patient during toileting to help prevent falling.
    a) 24 hours post-operative
    b) On anticoagulant therapy
    c) Diagnosed with osteoporosis
    d) On high risk for fall medications - pain, antidepressants, anti-epileptics, diuretics, anti-psychotics, sedatives/hypnotics, and/or opiates/narcotics.
    e) Impulsive
    f) Age 85 or older

D. Fall risk re-assessment will be done:
    a) Twice daily (once per shift)
    b) Upon transfer to a new unit.
    c) Post fall
    d) Change of status; defined to include:
        (1) Surgery
        (2) Anesthesia
        (3) Procedure
        (4) Change in patient condition warranting a call to the physician

E. Post Fall Assessment and Follow-up

1) Nurse will immediately assess patient who has sustained a fall. They physician will be notified immediately after the initial assessment. The patient's physician, physician on-call for the practice or the Emergency Department physician will assess the patient within two (2) hours of the occurrence based on the nature and severity of any injuries to determine the need for additional interventions.
2) The family will be notified of the fall as soon as possible.
3) A Post Fall Assessment ad hoc form will be documented in PowerChart immediately following the event.
4) A Fall Huddle will convene following the assessment. The team members are to include (depending on availability) nurses, physicians, PCPs, rehabilitation, nursing management, risk management, administrative supervisor. The Patient Fall Event Report will be completed and sent to the unit manager and risk manager.
5) A Significant Event form will be completed within PowerChart.
6) A VOICE report will be submitted
7) A twenty-four hour post fall assessment form will be completed in PowerChart.

F. **Adult Outpatients**

1) Associates will demonstrate an awareness of the patient's status and communicate any concerns to the clinical staff.
2) Associates will assess the patient's ability to ambulate to the treatment area or exam room and provide appropriate assistive devices/assistance as needed.
3) Colleagues will assess the patient's ability to sit, stand, lie and participate in the various positions needed for treatment.
4) If a patient is determined to be at high risk for falls, the patient should remain visible to colleagues during the outpatient visit.

G. **Universal Newborn Fall Precautions**: Precautions implemented for patient birth to age 28 days. Reference Neonatal Safe Sleep and Fall Prevention Policy for more in-depth information

1) Newborns are at fall risk all the time.
2) Infants are in a crib, warmer or isolette when not being held by caregiver, volunteer, or family member. Other approved devices can be used provided the infant is supervised.
3) Cribs or warmers are used for transporting infants from place to place. Head of the bed is flat during transport.
4) Crib rails are up when infant is unattended. Warmer sides are up when infant is unattended. Isolette doors are closed when infant is unattended.
5) Ensure that children are closely supervised while weighing or conducting procedures.
6) Mother needs to call for assistance when handling infant until the mother is ambulatory.
7) Infant should not sleep in bed with mother.
8) When mother is breastfeeding in bed, bed rails x2 should be up and pillows use for propping infant.

9) An adult must supervise young siblings who are allowed to hold the infant at all times.
10) Family will be educated on fall prevention strategies as stated above.

H. **Universal Pediatric Fall Precautions**: Precautions implemented for pediatric patients. This list of fall precautions will be used as age and developmentally appropriate for pediatric patients in addition to the Universal Fall Precautions for adult patients.
1) Determine appropriate bed type and position. Typically children age 3 and under will use a crib but will depend on patient size and developmental status.
2) Keep objects and toys away from latches on cribs to make sure they are locked.
3) Use bubble tops on cribs for children who can pull to a standing position.
4) Keep bed/crib rails up and isolette doors closed when child is unattended.
5) Keep the floors and hallways clutter/obstacle free.
6) Ensure the children are closely supervised while weighing or conducting procedures.
7) All infants and developmentally young children are transported in the appropriate device (i.e. crib, wagon, isolette)
8) Family will be educated on fall prevention strategies as stated in above precautions.

SITE SPECIFIC:

1. This policy covers the Rehabilitation Institute with the following addendum:
A. Patient's that are progressing to discharge may still be a 45 on the Morse Fall Scale. Upon assessment by therapy with appropriate documentation in being deemed safe to perform certain tasks (i.e. activities of daily living, toileting, etc.) a physician order will be written for modified independent.

DEFINITIONS:

- **Fall**: A sudden change in body positon in a downward direction, which may or may not result in a physical injury. A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. This will include all assisted falls and exclude near falls.
- **Assisted Fall**: When a colleague attempts to minimize the impact of a fall.
- **Near Fall**: A slip, trip, or quick loss of balance but the patient was able to regain control with or without assistance.
- **Witnessed/Unwitnessed Fall**: It is assumed the patient has fallen when a patient is found on the ground regardless if there was a witness.
- **Level of Injury**
  - 0 – No apparent injury
  - 1 – Minor injury (abrasion, bruise, minor laceration requiring application of a dressing, ice, cleaning of the wound, limb elevation, or topical medication)
  - 2 – Moderate injury (laceration requiring stitches/steri-strips, fracture that does not require surgery, casting, or traction, or may be splinted)

- 3- Major injury (resulted in surgery, casting, traction, required neurological consultation {e.g. basilar skull fracture or small subdural hematoma} or internal injury {e.g. rib fracture, small liver laceration} or patient with any type of fracture regardless of treatment or patients who have coagulopathy who receive blood products as a result of a fall)
- 4-Death (Patient died as a result of injuries sustained from the fall, not from physiological events causing the fall)

- **Patient Safety Attendant**: Colleague who provides 1:1 monitoring of patient.
- **Tele Sitter**: Continuous virtual monitoring (CVM) via the AvaSys robot.

REFERENCES/STANDARDS:

- Patient Fall Event Report (#7170.190) available on daily dose under clinical forms.

SAINT JOSEPH
Regional Medical
Center

Version #: 2

Title: Harassment Prevention and Offensive Behavior

Document Owner: Dabney, RJ	PI Team: Leadership	Date Created: 11/99
Approver(s): Hofstra, Donna		Date Approved: 06/27/11 06/17/2015
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Recruiting

POLICY:

1. To provide a work environment respectful of all persons (employees, patients, physicians, interns, contractors and volunteers) that is free from offensive behavior and illegal discrimination, including, but not limited to, Sexual Harassment and Harassment that is based on an individual's gender, disability, race, national origin, age, religion, marital status or other protected status under federal, state or local law. It is also SJRMC's intention to provide and identify the complaint procedure available to employees who have been subjected to, witness, or learn of a violation of this Policy.
2. Conduct, whether intentional or unintentional, that is offensive or that results in discriminatory harassment by or against employees because of their sex (whether or not sexual in nature) or other factors, including race, religion, national origin, age, disability, marital status or any other characteristic protected by applicable law is considered misconduct and will not be tolerated by SJRMC. SJRMC expects all employees, physicians, interns, contractors, volunteers and other third parties to maintain a place of employment that is free of harassing, abusive, disorderly, disruptive and illegal conduct. Further, conduct prohibited by this policy is not only unacceptable in the workplace, but also in any work-related setting outside the workplace such as business trips, in business meetings, and at business-related social events.

PROCEDURE:

A. **Harassment/Offensive Behavior:**

1) Consistent with this Policy, SJRMC prohibits any member of management, employees, physicians, interns, volunteers, contractors, and other third parties from engaging in conduct or communications which has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

2) Other harassing conduct in the workplace, whether committed by supervisors or non-supervisory personnel, is also prohibited. Such conduct includes, but is not limited to:

a) Verbal "kidding" or abuse based on or because of a protected status;

b) Offensive or derogatory statements, comments, slurs or gestures based on or because of protected status;

c) The display in the workplace of derogatory objects, pictures or jokes;

d) Inappropriate e-mails, blogs, the transmittal or accessing of any message or data that could be construed to be disparaging of others based on protected status;

e) Physical conduct intended to or which intimidates or creates a hostile environment; and

f) Unreasonably interfering with work performance or creating an offensive or intimidating working environment because of a person's protected status.

B. **Sexual Harassment**:

1) Consistent with this Policy, SJRMC prohibits any member of management, employees, physicians, interns, volunteers, contractors, and other third parties from making sexual advances of a verbal or physical nature toward another employee or applicant for employment, from making employment decisions based on the individual's submission to or rejection of such advances, or from creating a hostile work environment that interferes with an employee's ability to perform his/her job.

2) Examples of Sexual Harassment: Sexual harassment comes in many forms. The following are some examples of sexual harassment:

a) Sexual harassment refers to unwelcome sexual advances, requests for sexual favors and other verbal and/or physical conduct of a sexual nature when:

(1) Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment.

(2) Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual.

(3) Such conduct has the purpose or effect of substantially interfering with an individual's work performance, or creating an intimidating, hostile or offensive working environment.

b) Sexual harassment also refers to other sexual harassing conduct in the workplace that creates a hostile work environment, whether committed by supervisors or non-supervisory personnel such as:

(1) Unwelcome sexual flirtation, advances or propositions;

(2) Sexually oriented verbal "kidding" or abuse;

(3) Sexual comments about an individual's body;

(4) Sexually degrading words used to describe an individual;

(5) Display in the workplace of sexually suggestive objects or pictures;

(6) Subtle pressure for sexual activity, flirtation, sexual advances, propositions and other verbal or physical conduct of a sexual nature;

(7) Physical contact such as patting, pinching or brushing against another's body; and

(8) Demands for sexual favors, accompanied by implied or overt promises of preferential treatment or threats concerning an individual's employment status.

C. **Employee Responsibility**:

1) Each member of management has a duty to maintain his/her workplace/department free of offensive behavior, illegal harassment, and illegal sexual harassment. Likewise, all employees have an obligation to follow this Policy fully, to report any violations of this Policy, and to cooperate in an investigation of an alleged violation of this Policy.

D. **Consequences:**

1) Employees who fail to follow this Policy and/or to cooperate in an investigation on matters involving this Policy may be subject to disciplinary action, up to and including immediate

termination from employment. Corrective or disciplinary action will be designed to stop the harassment or offensive behavior, correct the effects on the victim, and ensure that further harassment or offensive behavior does not occur. Remedial action taken against the offender may not necessarily be the action requested by the victim, as long as SJRMC deems it an effective response.

E. **Complaint Process:**

1) Early reporting and intervention are the most effective methods for resolving actual or perceived incidents of discrimination, harassment or retaliation. Therefore, any individual, male or female, who believes he/she has been the subject of offensive behavior, harassment and/or sexual harassment, shall report the alleged act immediately to one or more of the following sources:

   a) to the Chief Human Resource Officer,

   b) the Human Resources Department, or

   c) the Integrity Officer

2) Additionally, any individual, who has observed or learns of conduct s/he believes is contrary to this Policy, has an obligation to take advantage of this complaint procedure. Failure to fulfill this obligation could affect the individual's rights in pursuing legal action. SJRMC's reporting and investigative process does not extend any time period that an individual may have by law to file a complaint with the Equal Employment Opportunity Commission or the Indiana Civil Rights Commission, which may be as short as six months after prohibited conduct has occurred.

3) If any member of management learns of or receives a complaint of offensive behavior, harassment or sexual harassment, regardless of the degree of misconduct, he/she shall forward the complaint immediately to Human Resources for investigation. Failure to report an alleged violation under this Policy will subject the member of management to disciplinary action up to and including immediate termination from employment. All reports of discriminatory harassment will be promptly, fully and fairly investigated by Human Resources.

F. **Prohibition Against Retaliation:**

1) It is strictly prohibited to retaliate against any employee, physician, intern, contractor, volunteer or other third party who: (a) files a complaint under this Policy, (b) assists or participates in an investigation, proceeding or hearing regarding a violation of this Policy, or (c) opposes language or conduct that violates this Policy. Retaliation is a serious violation of this Policy, and any offender will be subject to disciplinary action, up to and including immediate termination from employment. If an individual feels that s/he has been retaliated against in violation of this Policy, s/he shall follow the complaint process described above.

G. **Questions Concerning This Policy:**

1) Any questions or concerns about this Policy should be directed to the Human Resources Department. Directing concerns or questions about this Policy to Human Resources does not, however, relieve an individual of his/her obligation to report any actual, suspected or known violations of this Policy.

Title: Harassment Prevention and Offensive Behavior

References/Standards:

- Equal Employment Opportunity Policy
- At – Will Employment Policy
- Corrective Action and Counseling Policy
- Standards of Behavior
- Policy Reviewed: 08/07; 05/09; 06/11
- Policy Revised: 11/01

The Senior Management Team of SJRMC reserves the right to unilaterally change, modify, amend, add, delete, or rescind any or all policies, at any time, as it determines appropriate in its sole discretion. No employee or manager of SJRMC except the Chief Executive Officer or Chief Human Resources Officer has the authority to modify any Human Resources Policies or Procedures, and any such modification must be in writing.

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: Pain Management

Document Owner: Michael Poulsen	PI Team: POC		Date Created: 07/01/08
Approver(s): Loretta Schmidt		Date Approved with no Changes: 08/10/2020	Date Approved: 08/10/2020
Location: Saint Joseph Regional Medical Center (SJRMC)			Department: Faculty Practice (14030_86035), Family Medicine Center (14030_86030), Nursing Admin (14030_10005), Sports Medicine Fellowship (14030_23910)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Patients in all settings will be assessed/screened for presence, absence and history of pain at point of service.
2. Assessment of pain (Pain Scales):
    A. Patient's self-report is the primary indicator of pain reporting:
        1) Verbal (0 – 10) Pain Scale with 0 being no pain and 10 being worst pain.
            a) Mild (1-3), Moderate (4-6), Severe (7-10)
        2) Adults and Children who can understand number concept
            a) Faces Scale: Children (age 3 and older) and Adults
            b) Other self-reporting methods include; Visual Analog Scale (VAS); Categorical Scales: patient rates pain using verbal or visual descriptor (mild, unbearable, crushing, etc.)
3. Assessment of Pain in Patients with Barriers to Communication
    A. Infants and children
    B. Individuals with advanced age (e.g. older than 85 years)
    C. Adults with emotional or cognitive disturbances
    D. Patients with cultural, educational, or language barriers to communication
    E. Intubated patients
    F. Patients who are seriously ill
4. General Approach to Pain Assessment of Patients with Barriers to Communication
    A. Allow sufficient time for the assessment
    B. Allow opportunity to use a rating scale or other tool appropriate for that population (i.e. intubated patient may nod, point to a number on a scale, etc)
    C. Use of Hierarchy of Pain Assessment:
        1) Self-report whenever possible
        2) Search for Potential Causes of Pain –Pathologic Conditions (e.g. surgery, wound care, rehab activities, positioning/turning, blood draws, heel sticks, history of persistent or chronic pain)
        3) Observe Patient Behaviors that may indicate pain such as grimacing, crying, agitation.
        4) Use of behavioral pain assessment scales
            a) FLACC (non-verbal pain scale based on five sub-scores of face, legs, activity, cry, consolability) Scale for Pediatrics (2 months to 7 years of age),
            b) CRIES is the pain assessment tool for neonates

c) CPOT (Critical Care Pain Observation Tool)
d) Checklist of Nonverbal Pain Indicators (tested in adults in acute and long-term care settings for acute and chronic pain)
e) Pain intensity using objective judgment may not be an accurate reflection of the severity of pain in these patients. A multifaceted approach is recommended (observation, family/caregiver and evaluation of response to treatment).
5) Surrogate Reporting (family members, parents, caregivers)
6) Attempt an Analgesic Trial based on estimated pain intensity (mild, moderate, severe), patient's pathology and analgesic history.

5. Initial patient history will include: Screening question about pain based on patient self-report.
6. When self-report is not obtainable the nurse will utilize Hierarchy of Pain Assessment as above. A positive finding for pain on admission will initiate further questioning, which includes, but is not limited to the following:

A. Description
B. Intensity
C. Location
D. Aggravating and alleviating factors
E. Associated signs and symptoms
F. Impact on functional ability
G. Methods of pain management (current and past regimens and effectiveness)
H. Patient's personal goal for pain relief
I. Physical exam/observation of the pain site

7. Initial assessment of learning includes pain management and becomes a part of the plan of care.
8. Pain assessment (intensity and/or pain relief) will be assessed/screened and documented at a minimum:

A. On admission/presentation to Emergency Department
B. Routine: based on assessment/reassessment policy, physician orders, and patients' status.
C. After any known pain producing event
D. With each new report or behavioral indication of pain
E. After each pain intervention once sufficient time has lapsed for the treatment to reach peak effect (pharmacologic and nonpharmacologic).
1) Within 30 Minutes for IV Medications
2) Within 60 Minutes for PO Medications or other Non-Pharmacologic interventions
3) Intensity (reported verbal pain level 0-10 or corresponding pain level if objective pain scale utilized) of pain should be document at time of Intervention and post intervention as above.
a) If verbal rating scale utilized and patient resting or cannot rate intensity of pain at minimum document the following
(1) Pain relieved with Medication? Yes or No (If unable to determine – i.e. patient sleeping then complete is pain level acceptable?
(2) Is pain level acceptable? Yes, No, Unable to Determine, or Other. If Unable to determine or other (add comment – i.e. sleeping).

9. Parents/legal guardians will be involved in pain management decisions regarding their child
10. Methods to decrease pain in neonates, infants, and children include but are not limited to:

A. Providing information and preparing the parent and child.

B. Involving the parent.
C. Maintaining a quiet, calm environment.
D. Allowing comfort items such as favorite stuffed animals or blankets.
E. Giving the child choices to increase the perception of control.
F. Planning ahead and drawing all blood samples at once if possible.
G. Sucrose Pacifier

11. All terminally ill patients will be kept as comfortable as possible to allow them to die comfortably and with dignity. It is understood that medications may be given to the dying patient, even if this therapy may indirectly shorten patient's life, as long as the intent is not to hasten death.

PROCEDURE:

Pain Assessment

A. Admitting nurse questions patient for current pain and a history of pain. If patient complains of pain or behavioral indicators are present, appropriate approved scale should be used for intensity and the remainder of comfort section completed.

B. Process of interventions should be initiated and documented with modifications based on patient self-report and ongoing assessments. Patient preferences for pain management strategies (pharmacologic and/or nonpharmacologic) should be utilized when possible. Personal, cultural, spiritual, and/or ethnic beliefs will be considered in decisions regarding pain management.

C. Prescribed analgesics should be administered in a timely, logical, and coordinated manner.

D. There are certain circumstances when an LIP may write PRN medication orders that allow variation in administration based on patient preference.

1) A patient may request to receive a medication ordered for a lesser pain scale. It is NEVER acceptable to administer a medication intended for a higher pain scale based on patient preference.

a) For example, if a patient has on their profile Tylenol 650 mg every 4-6 hours PRN for Mild Pain and Norco-5 1 tablet every 4-6 hours PRN for Moderate pain then:

1. If the patient reports their pain is Mild, they can receive the Tylenol because it is indicated for Mild Pain
2. If the patient reports their pain as Moderate, they can receive the Norco for Moderate pain or the Tylenol because it is ordered for a lesser pain scale
3. If the patient reports their pain as Mild, they can NEVER receive the Norco, as it is intended for a higher pain scale

2) The medical record must accurately reflect that the medication used for a lesser pain scale was based on patient preference.

E. As an adjunct to analgesia, nonpharmacologic approaches may be utilized (e.g. distraction therapy, positioning).

F. If a patient continues to complain of unrelieved pain following interventions, the physician should be contacted. Additionally, new pain, change in location, quality or intensity, and side effects should be documented and reported.

G. Patient and family education should include rights and responsibilities, information to allay fears and correct misconceptions about pain medications, pain treatment, and expected response.

H. A proactive approach should be utilized re: anticipated pain-producing events, e.g. exercise, wound care, diagnostic/therapeutic procedures.

11. Pain management should be included in the discharge planning process.

12. Staff education regarding pain management should be provided, and staff competency should be evaluated during orientation and on an on-going basis.
13. Pain management issues will be included in topics for discussions during interdisciplinary care planning/conferences.
14. Patient's preference for pain rating scale will be determined at first report of pain, and will be utilized for subsequent pain assessments. Change in the patients' condition may require utilization of a different pain scale or method.

Related Documents/Information:

- **See Range Order policy for medication administration requirements based on patient pain rating (mild, moderate, severe) and rules regarding patient preference when requesting medication ordered for lower rating.**

References/Standards:

- Herr K., Coyne P. J., Manworren R., et al: Pain Assessment in the Nonverbal Patient: Position Statement with Clinical Practice Recommendations
- Gelinas C., Fillion L., Puntillo K., et al: Validation of the Critical Care Pain Observation Tool (CPOT) in adult patients, Presented at the IASP 11th World Congress on Pain, Sydney Australia, August 12, 2005
- Krechel S W, Bildner J: CRIES: a new neonatal postoperative pain measurement score, Initial testing and validity and reliability. Paediatric Anaesthesiology, 5(1), 53-61
- Manworren, R. C. B., & Hynan, L.S. (2003). Clinical validation of FLACC: preverbal patient pain scale. Pediatric Nursing, 29(2), 140-146
- Feldt, K. S. (2000a). The Checklist of Nonverbal Pain Indicators (CNPI). Pain Management Nursing, 1(1), 13-21.
- Feldt, K. S., (2000b). Improving assessment and treatment of pain in cognitively impaired nursing home residents. Annals of Long Term Care, 8(9), 36-42.

SAINT JOSEPH
Regional Medical Center

Version #: 4

Title: Rapid Response Team (RRT) (Adult and Pediatric)

Document Owner: Elaine Flemming	PI Team: Provision of Care	Date Created: 05/29/2018
Approver(s):Loretta Schmidt	Date Approved with no Changes: 03/15/2021	Date Approved: 03/15/2021
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Admin (14030_10005), Nursing Admin (14035_10005)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. A rapid response is a team of multidisciplinary health care providers that responds to patient scenarios with early signs of clinical deterioration to prevent respiratory or cardiac arrest. The goal is to provide early intervention to affect more timely transfers to a higher level of care, to reduce patient intubations and reduce risk and number of hospital deaths. To promote the highest level of patient safety, it is always the primary goal for the attending physician to be notified prior to the patient experiencing a significant decline in patient condition.
2. To provide, within minutes, a multidisciplinary assessment team or Rapid Response Team (RRT), to assess, and treat a patient whose condition is declining or deteriorating
3. A chaplain will respond if available.
4. The RRT will provide 24 hour coverage, seven days a week.
5. The RRT will respond to calls involving patients in all patient treatment areas.
6. The Attending physician will also be called immediately for any deterioration in patient condition

PROCEDURE:

A. The Multidisciplinary assessment team provides clinical expertise, advanced respiratory assessment, airway management, immediate oxygen therapy, treatments, and interventions as necessary.

B. Criteria for staff to call the RRT is as follows:

   1) Patient, family member or anyone having concerns regarding the patient condition may request the nurse to call the RRT.

   2) Staff member assesses emergent changes in one or more patient condition (s) as follows:

   3) Acute change in:
      a) Heart Rate, (<40 or >130)Systolic Blood Pressure or circulatory status;
      b) Acute change in systolic blood pressure (<90mmHg)
      c) Acute change in respiratory rate (<8 or >28) airway compromise or increased work of breathing, and/or threatened airway
      d) Acute change in oxygen saturation by pulse oximeter or ABG (<90% despite O2 being utilized)
      e) Level of Consciousness
      f) Significant bleeding
      g) New onset, repeated, or prolonged seizures
      h) Failure to respond to treatment for an acute problem/symptom

i) New onset chest pain
j) Nurse or family is concerned about the patient.
k) Inability to reach attending/specialty physician and/or attending physician unresponsive to escalating concerns. The medical staff chain of command will always be utilized as appropriate.

SITE SPECIFIC:
Mishawaka:

1. When the nurse assesses that a patient needs more immediate intervention, call RRT 5-5555 and a multidisciplinary team will be activated.
   A. The multidisciplinary medical team will include a PCU/ICU Nurse, Resident Physician and a Respiratory Therapist, to assess and treat a patient, whose condition is deteriorating.
   B. A chaplain and nursing supervisor will respond if available.
   C. The RRT will provide 24 hour coverage, seven days per week.
   D. The RRT will respond to calls involving patients in all patient treatment areas. (NICU excluded).
   E. At all off sites, the attending physician will be called immediately for any deterioration in patient condition.
   F. **Pediatric RRT**
      1) An additional team member will include an ED nurse with training in emergency pediatric response
         a) The PCU/ICU will send a PALS certified nurse if available
         b) PEDIATRIC RRT CALLS: Also call 5-1110 to notify the ED nurse. Once page is received, the RRT will simultaneously go to that room. If an extension is used, individual team members will call for location of the patient.
         c) PEDIATRIC RRT CALLS: The ICU nurse will provide a backup call to notify the ED nurse when they arrive at the scene of a pediatric patient
   G. **Primary Nurse Responsibilities:**
      1) Activate RRT
      2) Bring code cart to patient room
      3) Provide report to the RRT using SBAR communication
      4) Have electronic medical record available
      5) Remain with the patient and assist with interventions as required
   H. **PCU/ICU Nurse Responsibilities**
      1) Consults primary nurse for history of emergent situation, background and reason for hospitalization.
      2) Assist with further assessment of the patient
      3) Assist with interventions as required

4) Speak with the family/patient about the patient's condition.
5) Assist /facilitate with transfer to higher level of care if indicated
6) Primary responsibility for completion of the RRT documentation form
7) Support team during pediatric RRT calls as necessary
8) Bring RRT equipment box from ICU

I. **Resident Physician Responsibilities:**

1) Assess the patient and prescribe treatment as indicated.
2) Communicate with attending physician
3) Sign Documentation

J. **Respiratory Therapist Responsibilities:**

1) Assess and provide treatment after consultation with Resident Physician
2) Provide emergency interventions

K. **Emergency Department Nurse Responsibilities:** (PEDIATRIC RRT CALLS ONLY):

1) Advanced pediatric assessment
2) Assist with interventions as required

L. The anesthetist on call may be consulted by the RRT as required.

M. A member of the team will either continue to stay with the patient until they are stable or assist with transfer to a higher level of care

N. **Documentation:**

1) Document in the electronic medical record (Significant Event)
2) The RRT event form is completed and signed by the RRT members [RN, Physician, Respiratory Therapist, ED RN (pediatric calls)]. The original copy is placed in the chart.
3) White Copy of the RRT Record is scanned by the Primary Nurse or designee and sent to designated confidential email in HIM; then yellow copy sent to Critical Care unit manager following the initial RRT call.
4) RRT data will be entered into Get with the Guidelines (GWTG)
5) This data will be sent to the Safety Committee.
6) Follow-up is completed within 24 hours following the RRT call by the ICU manager or delegate.

Title: Rapid Response Team (RRT) (Adult and Pediatric)

Plymouth:

2. When the nurse assesses that an inpatient needs more immediate interventions:

Call RRT 8-888 and a multidisciplinary team will be activated.

A. The multidisciplinary medical team will include the Primary nurse, CCU nurse, Hospitalist/On call covering Provider. Nursing Administrative Supervisor, Respiratory Therapist, to assess and treat a patient, whose condition is deteriorating.

B. A chaplain will respond if available.

C. The RRT will provide 24 hour coverage, seven days per week.

D. The RRT will responds to calls involving **inpatients** in all treatment areas.

E. Pediatric RRT

1) An additional team member will include an ED nurses with training in emergency pediatric response/PALS certified. An ED Physician will respond in lieu of hospitalist.

a) The Primary Nurse will call 8-8888. Instruct the registrar to announce a "Pediatric Rapid Response" overhead.

b) The Pediatric Attending Physician will be notified

F. Primary RN Responsibilities:

1) Activate RRT

2) Bring code cart to patient room. (If I/P is having testing in an O/P area, then CCU nurses will bring the code cart)

3) Provide report to the RRT using SBAR communication

4) Have electronic record available

5) Remain with the patient and assist with interventions as required

G. CCU RN Responsibilities:

1) Consults primary RN for history of emergent situations, background and reason for hospitalization

2) Assist with further assessment of the patient

3) Primary responsibility for completion of the RRT documentation form

4) Support team during a pediatric RRT as necessary

H. Hospitalist/Attending/OnCall covering Provider Responsibilities:

1) Assess the patient and provide treatment as indicated

2) Communicate and handoff with the the Attending/Specialty/Intensivist Physician

I. Respiratory Therapist Responsibilities;

1) Assess and provide treatment after consultation with the team

2) Provide emergency interventions

J. Emergency Department Nurse Responsibilities: (PEDIATRIC RRT CALLS ONLY)

1) Advanced pediatric assessment

2) Provide with interventions as required

K. Intensivist, Emergency Department Physician, Anesthesia Provider:

May be contacted by the RRT after assessment and as appropriate. The Physician/Provider may be asked to participate in circumstances requiring additional Physician/Provider support or when circumstance of a code blue appears imminent.

L. Nursing Administrative Supervisor

1) Support and assist team as needed.

2) Assist /facilitate with transfer to higher level of care if indicated.

M. A member of the team will either continue to stay with the patient until they are stable or assist with a transfer to a higher level of care

N. Documentation:

1) Complete RRT Form and document in the electronic medical record (Significant Event). CCU RN or Nursing Administrative Supervisor will ensure that documentation is complete.

2) VOICE Entry of the Event will be made to ensure the Performance Improvement department is notified of the event to prompt a review.

3) RRT data will be reviewed byt the Provision of Patient Care PI Team.

1. **Hospitalist/Attending/On Call Covering Provider Responsibilities:**
   A. Assess the patient and provide treatment as indicated
   B. Communicate and handoff with the Attending/Specialty/intensivist Physician
2. **Respiratory Therapist Responsibilities: (**
   A. Assess and provide treatment after consultation with the team
   B. Provide emergency interventions
3. **Emergency Department Nurse Responsibility (Pediatric RRT only)** The CCU RN or Administrative Supervisor will provide a backup call to notify the ED nurse upon arrival to scene and discovery of pediatric circumstance.
   A. Advanced pediatric assessment

B. Assist with interventions as required

4. **The** Intensivist, Emergency Department Physician or the Anesthesia Provider may be contacted by the RRT after assessment and as appropriate. The Physician/Provider may be asked to participate in circumstances requiring additional Physician/provider support or when circumstance of code blue appear imminent.

REFERENCES/STANDARDS:

- Institute for Clinical Systems Improvement. (2011). "Health care protocol: Rapid response team (4th ed.)" [Online]. Accessed December 2016 via the Web at https://www.icsi.org/_asset/8snj28/RRT.pdf

- The Joint Commission. (2016). Standard NPSG.01.01.01. *Comprehensive accreditation manual for hospitals.* Oakbrook Terrace, IL: The Joint Commission. (2016). Standard NPSG.01.01.01. *Comprehensive accreditation manual for hospitals.* Oakbrook Terrace, IL: The Joint Commission.

SAINT JOSEPH
Regional Medical Center

Version #: 2

Title: Responding Justly

Document Owner: Maggie Chipman	PI Team: PI Leadership		Date Created: April 2006
Approver(s): Christopher Karam, Loretta Schmidt		Date Approved with No Changes: 07/17/2020	Date Approved: 05/09/2017, July 22, 2011
Location: Saint Joseph Regional Medical Center (SJRMC)			Department: QA-PI Medical Staff

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POLICY:

1. Saint Joseph Regional Medical Center supports the rights of patients through the following policy statements and actions:
   - A. Patients or their surrogates are the ultimate decision-makers about their healthcare.
   - B. Patients will be provided with sufficient information necessary to make an informed decision about treatment.
   - C. A patient is presumed to have decision-making capacity (See Definitions, page1.).
   - D. Patients and designated family members/surrogate decision-makers will be informed promptly about adverse outcomes.
   - E. Having a legal guardian does not exempt a health care professional from communicating with a conscious patient after an adverse outcome.
   - F. It is the responsibility of all employees and physicians to report any adverse outcome immediately to their immediate supervisor and the facility Risk Manager, and/or designee.
   - G. Information received and any subsequent evaluation of the facts will be conducted in a non-punitive manner while appropriate action is taken to ensure compliance with facility policies and procedures.

PROCEDURE:

A. Discovery/Reporting

1) The individual discovering the adverse outcome will take the following steps:
   - a) Take all necessary action to mitigate the extent of the harm to the patient that may be caused by the adverse outcome.
   - b) Immediately notify the patient's treating Physician, the Nurse Manager, facility Risk Manager, and/or designee and other personnel as appropriate.
   - c) Complete an unusual occurrence (event/incident) report per hospital policy for all adverse outcomes.
   - d) Upon request, participate in any investigation to identify the cause of the outcome and determine actions that may prevent future like occurrences, as appropriate.

2) The patient's treating Physician, the Nurse Manager and facility Risk Manager and/or designee will take the following steps upon notification an adverse outcome has occurred:
   - a) Identify appropriate individuals to investigate the cause of the outcome and determine actions that may prevent future like occurrences, as appropriate.

b) Identify an individual who will coordinate the disclosure process.

c) Offer a referral to spiritual care and Employee Assistance Program to involved employees, if appropriate.

B. Disclosure

1) Once it has been determined that an adverse outcome has occurred, disclosure is necessary. The treating Physician, Risk Manager, and/or designee and Nurse Manager will identify the most appropriate time and manner for disclosure. The treating physician and appropriate hospital representatives should participate in the disclosure process.

2) The treating physician has the responsibility for disclosure of all adverse outcomes. In those cases where the adverse outcome is associated with non-physician staff, the disclosure will be delegated to those who are responsible for this staff and have the most thorough knowledge of the outcome. The attending physician will be made aware of the disclosure prior to meeting with patient and designated family members/surrogate decision-makers, as appropriate, and will be offered the opportunity to participate. Depending upon the severity of the adverse event, senior management is informed.

3) If there is disagreement or uncertainty on either the method of disclosure or need for disclosure, the issue will be immediately referred to the ethics consult team for recommendation. The hospital administration will be advised of the ethics consult team's recommendation. The hospital administration and an ethics consult team representative will jointly develop a decision about disclosure. The Director of Ethics and Vice President of Insurance and Risk Management are available to assist achieving consensus in the decision-making process. Resolution of a disagreement regarding disclosure must be timely and facilitate disclosure within 24 hours of identifying an adverse outcome.

4) Disclosure should be conducted in accordance with the following guidelines:

a) The treating physician and others shall meet with the patient and designated family members/surrogate decision-makers as appropriate, as soon as possible given the patient's clinical condition. The disclosure will take place within 24 hours of identifying an adverse outcome.

b) Present the nature, severity, and cause (if known) of the adverse outcome in a straightforward and nonjudgmental manner.

c) Avoid attributing blame, as events are rarely attributable to a single action or individual.

d) Offer an apology to the patient and designated family members/ surrogate decision-makers. An apology or expression of sorrow is not an admission of guilt.

e) View disclosure as an ongoing process. Avoid speculation, focus on what is known at the time of discussion, and answer all questions to the best of one's ability at the time but advise that additional information may change the conclusion.

f) Identify a contact person for the patient and family to ensure prompt follow-up and communication on all unanswered questions.

g) Disclose whether and what type of medical attention is required. When appropriate, offer a second opinion and transfer of care to another practitioner.

h) Offer a referral to spiritual care, if appropriate.

5) The disclosure process is not an acceptance of liability and does not involve attribution of fault or other actions that may be inappropriate given the status of the investigation.

C. Documentation: Documentation within the medical record of disclosure of adverse outcomes shall be done by the individual(s) who provided the disclosure and shall include the following elements:

1) A full description of the facts of the outcome without conjecture/opinion as to the cause or attribution of fault.

2) The substance of the disclosure discussions with the patient and designated family members/surrogate decision-makers, as appropriate, about the outcome, including dates, times, and the names and relationships of those present.

3) The patient's and designated family members'/surrogate decision-makers' decision to decline disclosure.

4) The identity of the contact person for the patient and family who will ensure prompt follow-up and communication on all unanswered questions.

5) The identity of any interpreter whose services may have been used.

6) The reason for any decision to withhold some or all of the information about the outcome.

7) Any follow-up discussions with the patient and designated family members/surrogate decision-makers.

8) Offers, referrals or requests for a spiritual care.

D. An unusual occurrence (event/incident) report will be completed in accordance with Saint Joseph Regional Medical Center's policy or Occurrence Reporting System (MIDAS) by the individual discovering the adverse outcome and maintained by the hospital's Risk Manager, and/or designee. The report is not to be filed in the medical record. Only the facts of the outcome will be recorded in the medical record.

Related Documents:

- MIDAS Online Occurrence Report
- Pathway for Disclosure Flowchart
- **Related Policies**:
  - Sentinel Event Policy
  - Serious Adverse Event Reporting Policy
  - Complaint/Grievance Resolution Policy
  - Patient Rights and Responsibilities Policy
  - Chain of Command Policy

Definitions:

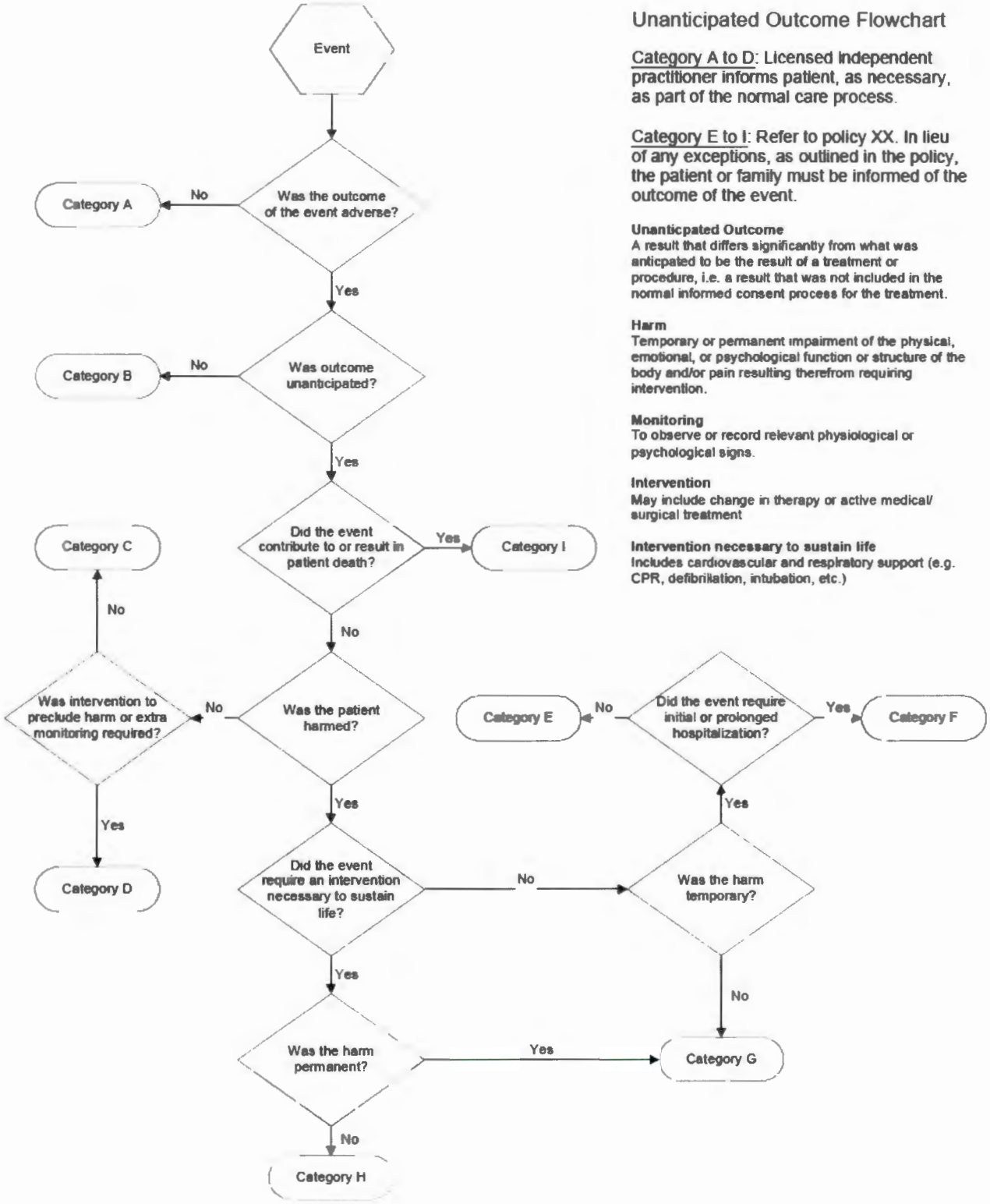
- **Disclosure:** Communication of information regarding an adverse outcome to the patient and designated family members/surrogate decision-makers stemming from the provision of or omission of medical care, treatment, diagnostic test, surgical intervention or procedure. Such communication is not considered an admission of liability.

- **Adverse Outcome:** A negative outcome stemming from the provision of or omission of medical care, treatment, diagnostic test, surgical intervention or procedure differs significantly from what is anticipated.
- **Harm:** Temporary or permanent impairment of the physical, emotional or psychological function or structure of the body and/or pain requiring medical intervention.
- **Decision-making capacity:** A patient is presumed to have decision-making capacity. A patient does not lack decision-making capacity with regard to medical treatment decisions because he/she is confused about other aspects of life such as the date, events of the day, the identity of people or because he/she makes a medical treatment choice that others do not agree with. Patient has decisional capacity if he/she can understand:
  - The nature of his/her medical condition.
  - The medical treatment options the physician has offered him/her.
  - The general implications of his/her choice among these medical options.
- **Surrogate decision-maker:** A person designated to make decisions on behalf of a person who is incapable of making decisions. A surrogate decision-maker may be selected in advance of a person becoming incapable of making decisions or may be selected after a patient has become incapable of making decisions.
- **Treating Physician:** The physician primarily responsible for treating the patient when an adverse outcome occurs.
- **Attending Physician:** Physician on record, who may or may not be involved in the patient's treatment when an adverse outcome occurs.

References/Standards:

- Trinity Health's Responding Justly to Adverse Outcomes Philosophy

Title: Responding Justly



SAINT JOSEPH
Regional Medical Center

Version #: 10

Title: Restraints and Seclusion

Document Owner: Gregor Staniszewski	PI Team: POC	Date Created: 06/01/08
Approver(s): Loretta Schmidt	Date Approved with no Changes: 03/21/2021	Date Approved: 03/21/2021
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Admin (14030_10005)

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POLICY:

POLICY STATEMENT

Use of restraint and seclusion is limited to situations in which it is necessary to ensure the immediate physical safety of the patient, staff members, or others. Restraint and seclusion are used only with appropriate and adequate clinical justification when less restrictive interventions are ineffective and the least restrictive means of restraint or seclusion to ensure safety is applied. It is not used as a means of coercion, discipline, convenience, or staff retaliation. Discontinuation of restraint and seclusion occurs as soon as possible, based on an individualized patient assessment and reevaluation, regardless of the scheduled expiration of the order.

PURPOSE

To establish standardized decision-making criteria and practical procedures for the use and discontinuation of restraint and seclusion to protect the patient's health and safety and the safety of others, as well as to preserve the patient's dignity, rights, and well-being.

SCOPE

Applies to staff members who provide patient care, who may assist with the application of restraints, and who monitor patients in restraints and/or during seclusion.

DEFINITIONS

Authorized physician or other licensed independent practitioner – An individual primarily responsible for the patient's ongoing care who is legally authorized to practice by the state in which this organization is located and who is acting within the scope of his or her license when he or she orders restraint or seclusion.

Restraint – 1. Any method (chemical or physical) of restricting an individual's freedom of movement, including seclusion, physical activity, or normal access to his or her body that

(1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented,

(2) is not indicated to treat the individual's medical condition or symptoms, or

(3) does not promote the individual's independent functioning.

2. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

3. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Seclusion – Seclusion occurs on the Plymouth campus only in the ED safe room.

1. The involuntary confinement of an individual in a room alone, for any period of time, from which the individual is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as the confinement of a person who is facing serious criminal charges or who is serving a criminal sentence. Forensic patients require the presence of law enforcement.

RESPONSIBILITIES

Ordering restraint and/or seclusion is the responsibility of a physician or another licensed independent practitioner primarily responsible for the patient's ongoing care.

Restraints Non-Violent (Non-Violent or Non-Self-Destructive)	**Restraints Violent (Violent or Self-Destructive)**
Physical restraints used to limit the mobility of a patient related to a medical/post-surgical need. The reason for use is to directly support medical healing by preventing interference with treatment or unsafe behavior by the patient.	Physical restraint used in **emergency** situations where the patient's behavior is violent, aggressive, or assaultive, and the least restrictive measure that will assure the patient or others safety is a restraint or seclusion. This is behavior that presents an immediate and serious danger to the safety of the patient, other patients, or staff. Medications used for behavior management are medications used in addition to or in replacement of the patient's regular drug regimen to control extreme behavior during an emergency.

PROCEDURE:

Only an authorized physician or another licensed independent practitioner does the following:

1. Orders the use of restraint or seclusion when determined to be clinically necessary.
   - Determines that all alternative interventions have been considered or have failed.
   - Assesses the risks and benefits of restraint or seclusion use.
2. Includes the following details in all orders for restraint or seclusion:
   - Type of restraint or seclusion
   - Start time of restraint initiation
   - Anticipated ending time as soon as possible, based on an individualized patient assessment and reevaluation

- All non-violent restraints are ordered daily; violent restraints are to be reordered
- Indications and reasons for use
- Behavioral criteria for release

Emergency Situations Without an Available, Authorized Physician, or Licensed Independent Practitioner

A registered nurse (RN) who is competent in restraint or seclusion usage does the following:

1. Directs that the patient be restrained or secluded.
2. Notifies the authorized physician, or licensed independent practitioner immediately and obtains an order. Immediately, either during the restraint application or after restraints applied, ideally 15 minutes or less.
3. For Violent restraints/seclusion the patient is under constant supervision until the physician, or licensed independent practitioner arrives. The physician /LIP completes the face-to-face assessment either before or within an hour after the application of the violent restraint/seclusion.
4. Documents the following:
   - Name of the authorized physician or licensed independent practitioner who was notified
   - Time the physician, clinical psychologist, or licensed independent practitioner was notified
   - Alternative measures that were considered or attempted
   - Rationale for the restraint or seclusion method used
   - Steps taken to ensure that the patient's needs, comfort, and safety were appropriately considered

The notified physician or licensed independent practitioner will do the following:

1. Write an order for the restraint during the emergency application of the restraint or seclusion.

OR

2. Write an order for the restraint immediately after the restraint or seclusion is applied, if it is not possible to write the order during the emergency application of the restraint or seclusion.
3. Will evaluate the patient within one hour of Violent restraint application if not present during the application.

Applying the Restraint or Initiating Seclusion

Staff members do the following:

1. Use the least restrictive device.
2. Apply the restraint or initiate seclusion in a manner that respects the patient's rights, confidentiality, dignity, privacy, and individuality.
3. As needed, gather staff to safely apply the restraint or initiate seclusion and explain why the restraint/seclusion is being initiated and any comorbidities of the patient.
4. Explain the following to the patient and/or his or her family, as appropriate:
   - Procedure to be used
   - Reason for procedure
   - Criteria for release
   - Notify family if not present and document in EMR
5. Allow the patient and/or family to participate in the patient's care, as appropriate.
6. Maintain the patient's modesty at all times.
7. Maintain a clean, safe, and comfortable environment.

Monitoring:

1. Provide a means of communication with the patient at all times
2. Evaluate the patient for safety and comfort at the initiation of restraint or seclusion. The evaluation includes any of the following, as appropriate to the patient and the type of restraint or seclusion:
    - The type of restraint applied
    - Nutrition and hydration
    - Circulation and range of motion in the extremities (unless the patient is asleep)
    - Vital signs
    - Hygiene and elimination
    - Physical and psychological status and comfort
    - Readiness for discontinuation of restraint or seclusion
3. Take and record vital signs, as ordered or per Assessment/Re-Assessment policy

Continued Use of Restraint or Seclusion

Only an authorized physician or another licensed independent practitioner does the following:

1. Determines the clinical justification for continued use of restraint or seclusion at the time of the order's renewal.
2. Issues a new order of restraint only when clinically justified.
3. A physician's order is required daily for the continued use of non-violent restraint.
4. For violent/self-destructive behavior, renewal of the order is within the following limits,
    - 4 hours for adults 18 years of age or older and emancipated minors
    - 2 hours for children and adolescents 9 to 17 years of age
    - 1 hour for children under 9 years of age

Release from Restraint or Seclusion

RN does the following:

1. Assesses the patient for readiness to discontinue restraint or seclusion at regular intervals that ensure the patient's safety.
2. Documents the restraint assessments in the patient's medical record.
3. Uses the criteria for discontinuation included in the order of restraint or seclusion to determine the patient's readiness for release.
4. Prohibits the use of PRN ("as needed") orders for restraints.
5. Restraints may be removed during providing care to a patient as long as nurse remains at the bedside.
6. If a restraint is removed for any duration or a lesser restraint is appropriate the nurse will need to obtain a new order from for restraining the patient.

Title: Restraints and Seclusion

Restrain ordering process:

Restraints: **Non-Violent Restraint** (Non-Violent or Non-Self-Destructive)	Restraints: **Violent Restraint** (Violent or Self-Destructive)
a) For patients who are exhibiting behavior that is interfering with patient care such as the patient is attempting to pull out tubes. b) EMR fires task to the nurse to renew order in 20 hours Restraint Order Review Pending ii) After review of need for renewal, complete on Activities/Interventions c) EMR fires tasks for the **Nonviolent Restraint Form q** 2 hours i. Initiation – must be completed when initiating restraint(s) ii. Subsequent assessments: complete the assessment iii. Discontinue – complete when restraint no longer needed iv. Must ad hoc the first form (the EMR will fire the task on the next even hour from the time the restraint was ordered) d) An order must be obtained as restraints are being placed or within minutes of being applied. e) A physician's order is required daily for the continued use of restraints f) Orders must include: i. Date and time of order ii. Less restrictive alternated tried iii. Clinical justification/Indication for restraint iv. Type of restraint v. End restraint when no longer needed vi. Physician's signature **PRN orders are not permitted**	a) For aggressive, violent patient who present immediate and serious danger to self or others b) EMR does not fire tasks c) Document on **Violent Restraint Form** d) Restraints are used to control assaultive, combative behavior e) The order must be obtained prior to application or as restraints are being applied or within minutes of the application. Physician must complete a face-to-face assessment either before or within one hour of application of the restraints. f) The initial order cannot exceed four hours for adults, two hours for adolescents (age 9-17) or one hour for children under 9. The order may be renewed every four hours (for adults) by phone if necessary, for a total of 24 hours. Orders for adolescents and children cannot be renewed without a face-to-face and reassessment by the physician. g) Orders must include: i. Date and time of order ii. Less restrictive alternated tried iii. Clinical justification/Indication for restraint iv. Type of restraint v. End restraint when no longer required vi. Physician's signature **PRN orders are not permitted**

A. Re-assessment (Nursing)

Restraints Non-Violent Restraint Form (Non-Violent or Non-Self-Destructive)	**Restraints Violent Restraint Form (Violent or Self-Destructive)**
1) RN reassesses every two hours for: a) Behavior indicating continued need b) Appropriate application c) Least restrictive method used d) Physical and emotional well-being e) Rights, dignity and safety maintained 2) Observation routine rounding schedule 3) Vital signs every 4 hours if clinically indicated 4) Circulation and skin check every 2 hours 5) Release of restraint, range of motion and repositioning every 2 hours 6) Offering fluids and toileting every 2 hours 7) Provision for nutrition 8) Provision for regular hygiene and personal care 9) Documentation is recorded in EMR Restraint form every 2 hours	1) At the end of the initial 4-hour order if the continued use of restraint to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, another order is required. 2) Prior to the expiration of the original order the RN, must contact a physician or other LIP, report the results of his/her most recent assessment and request that the original order be renewed, if restraints are still indicated. 3) The original restraint order maybe renewed within the limits for up to a total of 24 hours. The physician/LIP must assess the patient at the end of the 24-hour period to renew the restraints 4) Whether or not an onsite assessment is necessary prior to renewing the order is left at the discretion of the physician or LIP in conjunction with the discussion with the RN who is overseeing the care of the patient. 5) RN reassesses at least every 15 minutes for: a) Behavior indicating continued need b) Appropriate application c) Least restrictive method used d) Physical and emotional well-being e) Rights, dignity and safety maintained f) Effects of medication if used as restraint 6) Continuous observation by caregiver and complete observation records every 15 minutes 7) Vital signs as dependent upon the patient's needs and situational factors 8) Circulation and skin check every 15 minutes 9) Release of restraint, range of motion and repositioning every 2 hours/prn 10) Provision for nutrition 11) Provisions for regular hygiene and personal care 12) Documentation is recorded in EMR Restraint forms every 15 minutes

1. Education/Training of Associates/LIPs

A. Education regarding use of restraints will be included in orientation as appropriate for patient care associates, prior to participating in the application of restraints, the monitoring, assessment, or care of a patient in restraints.

B. Additional competencies will be provided for appropriate patient care associate, based on the associate's needs, changes in policy, and trends in restraint data.

C. Physician/LIP - Upon orientation and based on the Physician/LIP needs, changes in policy, and trends in restraint data.

2. Reporting of Deaths Related to Restraint/Seclusion Usage

A. The hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:

a. Each death that occurs while a patient is in restraint or seclusion.
b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
c. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation….
d. The staff must document in the patient's medical record the date and time the death.

B. The hospital must report to its CMS Regional Office each death that occurs, the only exception is when no seclusion has been used and the only restraint used was a soft, cloth-like two-point wrist restraints;

• Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, two-point wrist restraint; or,

• Within 1 week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time.

- "Reasonable to assume" applies only to those deaths that occur on days 2-7 after restraint or seclusion has been discontinued.
- This criterion applies regardless of the type of restraint that was used on the patient. In other words, it applies to all uses of restraint or seclusion where the patient has died on days 2-7 after the restraint or seclusion was discontinued, and it is reasonable to assume the use of the restraint or seclusion contributed to the patient's death.
- In a case where only two-point soft wrist restraints were used and there was no seclusion, it may reasonably be presumed that the patient's death was not caused by the use of restraints.
- In cases involving death within one week after use of restraint or seclusion where the intervention may have contributed to the patient's death it is possible that the patient's death might occur outside the hospital and that the hospital might not

learn of the patient's death, or that there might be a delay in the hospital's learning of the patient's death.

Risk Management will document in the patient's medical record the date and time the death was reported to CMS.

D. When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, Risk Management must record in an internal log the following information:

(i) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

E.Document in the patient's medical record the date and time the death was recorded in the internal log for deaths

F. For deaths entered in to the log must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient.

(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient medical record number, and primary diagnosis(es).

(iii) The log information must be made available in either written or electronic form to CMS immediately upon request.

G.Hospitals must maintain an internal log or other type of tracking system for recording information on each death that occurs:

- While a patient is in only 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and
- Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion.

H. Use of the log is limited only to patient deaths meeting one of these two criteria. Examples of patient deaths associated with restraints that must still be reported to CMS include:

• Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device or with seclusion; or

• Deaths associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints.

I.These cases would not be included in this internal log or tracking system and would require reporting the death to CMS using telephone, fax, or electronically.

J.The two-point soft wrist restraint death report must be entered into the internal log or tracking system within 7 days of the patient's death.

K.The death report log or tracking system entry must include:

• The patient's name;
• Patient's date of birth;
• Patient's date of death;

• Name of the attending physician or other licensed practitioner who is responsible for the care or the patient;

• Patient's medical record number; and

- Primary diagnosis(es).cause of death (preliminary, in case a final, official cause of death is not yet available),
- types of restraint of seclusion used.

L.There is a CMS form used by Risk Management to complete and submit to CMS
M. The information must be made available in either written or electronic form to CMS immediately upon request.
N. The Indiana State Department of Health regulations require any patient death or serious disability associated with the use of restraints or bed rails while being cared for in the hospital must be reported. The report must be submitted to the State Department of Health no later than 15 working days after the reportable event is determined to have occurred by the hospital; and a potential reportable event once identified by the hospital must be submitted no later than 4 months to the State Department of Health. Any "serious injury" or death must be reported to the State Office of Protection and Advocacy for Persons with Disabilities. The System CNO is responsible for reporting the incident in cooperation with the risk manager.

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O. The hosptial must report to the Food and Drug Administration (FDA), and to the device manufacturer—if the manufacturer's identity is known—within 10 working days of becoming aware of information that reasonably suggests that a device has caused or may have caused or contributed to a death. A "user facility" must report to the manufacturer within 10 working days of becoming aware of information that reasonably suggests that a device has caused or may have caused or contributed to a serious injury. Such reports shall be submitted to the FDA if the device manufacturer is not known. The System CNO or designee is responsible for reporting the incident in cooperation with the risk manager and the safety officer

References/Standards:

- **TJC RESTRAINT/SECLUSION STANDARDS.**
- **CMS RESTRAINT REGULATIONS**

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

Document Owner: Maggie Chipman	PI Team: PI Leadership	Date Created: 08/13/2019 May 1998
Approver(s): Christopher Karam, Genevieve Lankowicz, LeAnn Springman, Loretta Schmidt	Date Approved with no Changes: 07/17/2020	Date Approved: 07/17/2020; July 6 2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: QA-PI Medical Staff

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Saint Joseph Regional Medical Center (SJRMC) is committed to providing quality care to all patients and preventing undesired patient outcomes or occurrences.
2. As part of the SJRMC's commitment to quality care and patient safety, appropriate steps will be taken to prevent the occurrence of these events. The purpose of this policy is to provide a procedure to identity, investigate and manage Serious Reportable Events as reportable to Trinity Health (SRE), Sentinel Events as defined by The Joint Commission and Indiana Medical Error Reporting System (Indiana State Department of Health), as well as near misses and unexpected outcomes. This policy provides the procedure in place for the management of these events.
3. Attention will be focused on understanding the factors that contributed to the event as well as changing the hospital's culture, systems and processes to reduce the probability of such an event in the future.

PROCEDURE:

A. All parties involved in the identification and reporting processes and activities will exercise confidentiality.

B. When a SJRMC associate or Medical Staff member becomes aware of an event, they will notify the Department Director or Supervisor. If Department Director /Supervisor are unavailable, a voicemail may be left and the Administrative Supervisor must be notified.

C. When an reportable event occurs the following should happen:
   1) Take action to protect patients and to prevent similar events from occurring
   2) Sequester any medical equipment or records necessary to conduct an investigation
   3) Notify the Department Director/Supervisor or Administrative Supervisor (if not already aware)
   4) The Administrative Supervisor will Notify the Administrator On-Call
   5) The Administrator On-Call will determine if the COO/CMO/CNO and the Risk Manager/Patient Safety Officer or others need to be notified
   6) A VOICE incident report or MIDAS incident report must be completed.

D. Within 24 hours the Department Director and Senior Leadership will conduct an initial investigation to determine if the event meets the definition of a Reportable Event. this team may include:
   1) Risk Manager/Patient Safety Officer
   2) Department Director/Manager
   3) Director of Performance Improvement

4) The designee of any of the above.
5) If necessary, other people with relevant functional expertise, i.e. Pharmacy, Lab or Radiology
6) President of Medical Staff
7) General Counsel
8) Chief Nurse Officer
9) Chief Medical Officer
10) Vice President of Medical Affairs
11) President

E. Trinity Health Reportable Events

1) Serious Reportable Events:
   a) The Risk Manager or designee will submit a report to the Trinity Home Office within five (5) business days of discovery thru STARS. Events that result in death or permanent harm should be reported in STARS immediately but no later than one (1) business day after the discovery of the event.
   b) When a RHM reports a SRE to Trinity Home Office that results in death or permanent harm the RHM CEO will call either the Executive Vice-President Chief Clinical Officer, or the Senior Vice President Chief Quality and Patient Safety or the Senior Vice President System Chief Nursing Officer no later than one (1) business day after discovery of the Event. When the CEO is unavailable to place the call, the executive next in line shall make the call. The CEO/RHM executive will be expected to discuss the facts of the event, investigation conducted to date, status of the Root Cause Analysis (RCA), risk manager involvement, status of disclosure to patient and/or family, staff support provided, 3rd party inquiry (i.e. press, local government authorities) and any response or needs the RHM may have related to the event. Questions about whether an event should be called to the EVP or SVP can be directed to a Loss Control Director in Insurance and Risk Management Services.
2) Adverse Clinical Events:
   a) It is an unexpected adverse clinical event that does not meet the definition of a Serious Reportable Event. The RHM CEO will call either the Executive Vice President Chief Clinical Officer, or the Senior Vice President Chief Quality and Patient Safety, or the Senior Vice President System Chief Nursing Officer no later than one (1) business day after discovery of an adverse clinical event when that event,
      (1) Results in death or permanent harm or
      (2) Could reasonably be expected to lead to reputational harm or
      (3) Could reasonably be expected to result in a review by a licensing or accrediting agency or
      (4) Requires securing non Trinity Health resources for advice, or consultation during the investigation state.
      (5) Could reasonably affect multiple patients

b) When the CEO is unavailable to place the call, the RHM executive next in line shall make the call. The CEO/RHM executive will be expected to discuss the facts of the event, investigation conducted to date, status of the RCA, risk manager involvement, status to patient and /or family, staff support provided, 3rd party inquiry (i.e. press, local government authorities), and any response, could reasonably affect multiple patients, and any needs the RHM may have related to the event.

F. ISDH procedure for reporting a reportable event is as follows:

1) The report shall:

a) Be made to the Indiana State Department of Health

b) Be submitted not later than 15 working days after the reportable event is determined to have occurred by the hospital

c) Be submitted not later than 4 months after the potential reportable event is brought to the hospital's attention; and

d) Identify the reportable event, the quarter of the occurrence, and the hospital, but shall not include any identifying information for any patient, for any licensed individual or any hospital employee involved, or any other information.

2) A potential reportable event may be identified by a hospital that:

a) Receives a patient as a transfer, or

b) Admits a patient subsequent to discharge, from another health care facility subject to a reportable requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility.

3) The report, and any documents permitted under this section to accompany the report, shall be submitted electronically to the Indiana State Department of Health.

G. The Joint Commission requirements for reporting:

1) Self-reporting of a sentinel event (SE) to the Joint Commission is not required. However, the expectation is to identify and respond appropriately to all sentinel events. A thorough and credible comprehensive systematic analysis and action plan is to be completed within 45 business days of the event or of becoming aware of the event. This includes a timely, thorough, and credible root cause analysis; developing an action plan to implement improvement to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements. Under the direction of Trinity Health, we do not report to TJC.

H. Root Cause Analysis (RCA) will be conducted for each SRE, SE and Indiana Medical Error as required.

1) A RCA team, including SJRMC associates and/or medical staff members involved in the event will be organized by the Risk Management/PI department to investigate identified events. The team will include associates at all levels closest to the issue and also those with decision-making authority. The team will clearly define the issues and be responsible for finding an opportunity for improvement.

2) If the event is a fall, a fall huddle form may replace the RCA unless the fall results in death or permanent loss of function as a direct result of the injuries sustained.
3) The RHM will complete a Root Cause Analysis (RCA) within three (3) weeks of discovery as required by Trinity Health. RCA for events that result in death or permanent harm should commence immediately or within 3 business days after discovery.
4) All Hospital acquired Stage 3, 4 and unstageable pressure ulcers require an intensive review. Discussions about the need for an RCA should be done in collaboration with the wound care specialist and the Risk Manager. The intensive review or RCA will be reported to the System Office within (3) weeks of discovery.
5) The RCA team will develop a corrective action plan which includes; action to be taken, implementation of the action plan and development of education to implement the action plan.

REALTED DOCUMENTS/INFORMATION:

- List of Reportable Events (attached above- Attachment A)

Definitions:

- Sentinel Event: A patient safety event(not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in any of the following:
  - Death, permanent harm or severe temporary harm. A listing of TJC Sentinel Events are in attachment A
- TJC - An *adverse event* is a patient safety event that resulted in harm to a patient
- TJC - A *no-harm event* is a patient safety event that reaches the patient but does not cause harm
- TJC - A *close call* (or " near miss" or "good catch") is a patient safety event that did not reach the patient
- TJC - A *hazardous* (or "unsafe") *condition*(s) is a circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event.
- SRE's (see attachment A link at top of document (paperclip)
- Root Cause Analysis (RCA): A process for identifying the most basic or causal factors that underlies variation in performance including the occurrence of a reportable event or near miss. The root cause analysis identifies potential improvements that could be made in systems and processes that would improve the level of performance and reduce further risk.
- Permanent Harm: A serious reportable event resulting in harm with no expected change in clinical condition; includes events resulting in permanent loss of organ, limb, physiologic or neurologic function
- Severe Temporary Harm: Critical potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

- Adverse Clinical Event is defined and listed as an event that would require a call to a System Office Senior Leader
  - Results in death or permanent harm or
  - Could reasonably be expected to lead to reputational harm or
  - Could reasonably be expected to result in a review by a licensing or accrediting agency or
  - Requires securing non Trinity Health resources for advice, or consultation during the investigation
  - Could reasonably affect multiple patients

References:

- Indiana Medical Error Reporting System
- The Joint Commission Sentinel Events Chapter
- Trinity SRE Policy

Type of Event	Trinity SRE Reportable-Description	ISDH Reportable-Description	Joint Commission Reportable-Sentinel Event Description
1. Surgical or Invasive Procedure Events			
Wrong site/body part	Surgery or other invasive procedure performed on the wrong site	Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (A) that occur in the course of surgery; or (B) whose exigency precludes obtaining informed consent; or both.	Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
Wrong Patient	Surgery or other invasive procedure performed on the wrong patient	Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.	Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
Wrong procedure	Wrong surgical or other invasive procedure performed on a patient	Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (A) that occur in the course of surgery; or (B) whose exigency precludes obtaining informed consent; or both.	Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
Retention of foreign object	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (A) Objects intentionally implanted as part of a planned intervention. (B) Objects present before surgery that were intentionally retained. (C) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.	Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
Intraop or post-op Death	Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient	Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.	

Type of Event	Trinity SRE Reportable-Description	ISDH Reportable-Description	Joint Commission Reportable-Sentinel Event Description
2. Products or Device Events			
Contaminated drugs, devices	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility. Included are generally detectable contaminants in drugs, devices or biologics regardless of the source of contamination or product.	
Device related incidents	Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended.	Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (A) Catheters (B) Drains and other specialized tubes. (C) Infusion pumps. (D) Ventilators.	
Intravascular Air Embolism	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the facility. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.	
3. Patient Protection Events			
Discharge or release	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	Infant discharged to the wrong person.	Discharge of an infant to the wrong family
Elopement	Patient death or a serious injury associated with patient elopement (disappearance)	Patient death or serious disability associated with patient elopement.	Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
Suicide	Patient suicide, attempted suicide, or self-harm that results in serious injury. while being cared for in a healthcare setting.	Patient suicide or attempted suicide resulting in serious disability, while being cared for in the facility, defined as events that result from patient actions after admission to the facility. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the facility.	Suicide of any patient receiving care, treatment, and services in a staffed around-the clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)

Type of Event	Trinity SRE Reportable-Description	ISDH Reportable-Description	Joint Commission Reportable-Sentinel Event Description
4. Care Management Events			
Medication Errors	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (A) drug; (B) dose; (C) patient; (D) time; (E) rate; (F) preparation; or (G) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has known allergy and drug-drug interactions for which there is known potential for death or serious disability	
Administration of Blood Products	Patient death or serious injury associated with unsafe administration of blood products	Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.	Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
Maternal Death or Serious Injury	Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the facility. Included are events that occur within forty-two (42) days post-delivery. Excluded are deaths from any of the following: (A) Pulmonary or amniotic fluid embolism. (B) Acute fatty liver of pregnancy (C) Cardiomyopathy.	Any intrapartum (related to the birth process) maternal death. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.
Hypoglycemia		Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the facility.	
Full Term Infant Death	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy		Unanticipated death of a full-term infant
Hyperbilirubinemia in Neonates		Death or serious disability (kernicterus) associated with hyperbilirubinemia in neonates.	Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

Type of Event	Trinity SRE Reportable-Description	ISDH Reportable-Description	Joint Commission Reportable-Sentinel Event Description
Pressure ulcers/Injuries	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting	Stage 3 or 4 pressure ulcers acquired after admission to the facility. Excluded is progression from State 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.	
Loss of Specimen	Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen		
Communication of results	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results		
Joint Movement Therapy		Patient death or serious disability resulting from joint movement therapy performed in the facility.	
5. Environmental Events			
Electric Shock	Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	Patient death or serious disability associated with an electric shock while being cared for in the facility. Excludes events involving planned treatment, such as electrical counter shock or elective cardioversion.	
Oxygen or other gas line	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	Any incident in which a line designated for oxygen or another gas to be delivered to a patient: (A) contains the wrong gas: or (B) is contaminated by toxic substances.	
Burn	Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	Patient death or serious disability associated with a burn incurred from any source while being cared for in the facility.	
Fall	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	Patient death or serious disability associated with a fall while being cared for in the facility.	
Restraints	Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting	Patient death or serious disability associated with the use of restraints or bed rails while being cared for in the facility.	
Fire, flame, smoke etc.			Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

Type of Event	Trinity SRE Reportable-Description	ISDH Reportable-Description	Joint Commission Reportable-Sentinel Event Description
6. Radiologic Events	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area		Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
7. Potential Criminal Events			
Impersonation of healthcare team member	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.	
Abduction	Abduction of a patient/resident of any age	Abduction of a patient of any age.	Abduction of any patient receiving care, treatment, and services
Sexual Assault	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	Sexual assault on a patient within or on the grounds of the facility.	**Patient:** Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital **Staff Member:** Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
Physical Assault	Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.	Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the facility.	**Patient:** Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital **Staff Member:** Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital

Incident Reporting Process:
Midas – Voice – UAIR

- **Midas** is used to report all events involving physician / provider quality or behavior issues.
- **Voice** is used to report other events – for example – falls, medication errors, equipment issues, privacy or HIPAA issues as well as complaints, grievances and compliments.
- **UAIR** (Unified Associate Incident Reporting) is to be used to report all SJHS associate injuries.
- Each of these systems are located as an icon on every desktop in the Saint Joseph Health System.
- Contact your Risk Manager or Department Director/Manager for assistance or further information.

Stroke/TIA patient feedback

Name:_____ Room number:_____ Discharge date: _____

Saint Joseph Health System Stroke team strives for unsurpassed care for patients and their families. It is important for us to know your perception of the stroke care you received while you were a patient. To help us improve our services and care, please complete the survey below. Family members are encouraged to complete the form if the patient is unable to do so.

Thank you so much for helping us improve our stroke care at Saint Joseph Health System.

	Yes	No
I received the stroke education booklet.		
I received information about the warning signs of stroke.		
I know what BEFAST is.		
I know what type of stroke I had.		
I was instructed to dial 9-1-1 if I have stroke symptoms in the future.		
I received information on my personal risk factors for stroke.		
I received printed/verbal information about my prescribed medications.		
I have all the medications that have been prescribed or have received prescriptions for the new medications.		
The results of my tests were explained to me.		
I received information that helped me understand my diagnosis.		
I was satisfied with the Physical Therapy services I received.		
I was satisfied with the Occupational Therapy services I received.		
I was satisfied with the Speech Therapy services I received.		
I have made or will arrange for a follow up appointment.		
Has anyone talked with you about a sleep apnea test?		
Are you scheduled for an outpatient sleep apnea test after discharge?		

Survey completed by(circle all that apply) Patient Family Other

Use the space below for any comments, suggestions or ideas you have for improvement.

Please return this to your nurse at discharge or during rounding.

STROKE CORE MEASURE DOCUMENTATION

Checklist initiated on Presentation. Review item list and initial and date when each initiative met.

Discharge nurse responsible to ensure completion of form.

Patient arrival time:_____ Activation time:_____ Last known well time: _____

- ❑ Call "Code stroke"
- ❑ Consider TPA- for last known well time of 3.5 hours document exclusions
- ❑ CT scan completed within 25 mins and results within the following 20 mins.
  - ❑ Direct to CT without delay for labs, EKG, ect.
- ❑ PT, INR, Blood Glucose, and CBC completed and results within 45 min. To be completed upon arrival to pt room from CT.
- ❑ EKG and chest x-ray (if ordered) complete within 45 mins ED physician evaluates pt and reads results.
- ❑ Stroke symptom power plan initiated in ED.
- ❑ Dysphagia screening prior to any oral intake- including aspirin
  - ❑ RN to complete bedside screening tool.
- ❑ NIH Stroke scale assessment completed within 30 mins of arrival by stroke certified RN.
- ❑ Contact Loyola and request neurologist o/c for stroke team/stroke robot activation to initiate robot if appropriate. Phone number 1-800-727-5862
- ❑ If pt is to be transferred to Loyola:
  - ❑ Transfer options include:
  - ❑ Air: Parkview Samaritan dispatch: 1-800-727-6911
  - ❑ Med flight: 866-262-4247
  - ❑ The Loyola neurologist will determine whether 1) weather pt should be transferred to Loyola or Mishawaka and 2) tPA should be initiated before pt transfer.
  - ❑ Paper work to send: transfer forms (SJRMC form and Tri-county/Samaritan form) EKG strips, and any other forms that are not on the computer. If pt transfers via flight, make copy for flight crew. Inform CT Scan to electronically send relevant imaging, and also burn a CD for flight crew.

INPATIENT PHASE

- ❑ An NIHSS should be done in ER prior to admission or transfer.
- ❑ Q2H Vital signs and complete Nero checks for 24 hours
- ❑ VTE/DVT Prophylaxis – prior to end of day 2. If pt is ambulatory and the doctor isn't going to order any prophylaxis, the doctor must state, " Pt is ambulatory and doesn't require VTE prophylaxis".
- ❑ Antithrombotic medication prior to end of day 2.
- ❑ Lipid panel (all ischemic strokes) Or documentation exclusions.
- ❑ Statin (all ischemic strokes) Or documentation exclusions.
- ❑ Rehabilitation consult (Assessment and therapies ordered)
- ❑ Stroke education (All five required elements addressed-see below)
- ❑ Tobacco counseling

DISCHARGE PHASE AND/OR DISCHARGE TO REHAB

- ❑ Discharge on Antithrombotic and anticoagulation (if Atrial fibrillation or atrial flutter)
- ❑ Discharge on statin medication (all ischemic strokes) Or document exclusions
- ❑ Discharge with sleep study referral (if at risk for sleep apnea: with BMI >30 and/or snoring)
- ❑ Discharge with event Monitor Referral (If at risk for cardiac arrhythmias)
- ❑ Discharge instructions and completion of stroke education 5 must haves:
  - ❑ Activation of EMS (When to call 911)
  - ❑ Follow up after discharge
  - ❑ Medications prescribed
  - ❑ Stroke personal risk factors
  - ❑ Stroke signs and symptoms

Saint Joseph Regional Medical Center

STROKE CORE MEASURE DOCUMENTATION

Checklist initiated on **presentation**. Review items listed and initial and date when each initiative met.
Discharge nurse responsible to ensure completion of form.

Date & initials	ER/Admission
☐ -_____	**Consider TPA – for last known well time of 3.5 hours document exclusions**
☐ -_____	CT Scan completed within 25 mins and resulted within the following 20 mins
☐ -_____	PT, INR, Blood Glucose, and CBC completed and resulted within 45 mins
☐ -_____	EKG completed within 45 mins
☐ -_____	Chest x-ray completed within 45 mins
☐ -_____	Stroke Symptoms Power Plan initiated in ED
☐ -_____	Dysphagia Screening prior to any oral intake – Including Aspirin (RN to complete bedside screening tool).
☐ -_____	NIH Stroke Scale assessment Completed within 30 minutes of Arrival by stroke certified RN

Date & initials	Inpatient Phase
☐ -_____	**Stroke/Ischemic Stroke/TIA Admit Power Plan (Thrombolytic or Non-Thrombolytic)**
☐ -_____	**IPOC: Tissue Perfusion, Cerebral; Alteration or Risk of IPOC**
☐ -_____	**NIH Stroke Scale** assessment **Completed Daily** by stroke certified RN
☐ -_____	**Q2H Vital Signs and Complete Neuro Checks for 8 hours**
☐ -_____	**VTE Prophylaxis** – prior to end of **day 2**. If the patient is ambulatory and the doctor isn't going to order any prophylaxis, the doctor must state "The patient is ambulatory and doesn't require VTE prophylaxis." (SCD's are suitable for those who have anticoagulant contraindications)
☐ -_____	**Antithrombotic** medication prior to end of hospital **day 2**
☐ -_____	**Anticoagulation** therapy for patients with **atrial fibrillation/atrial flutter**
☐ -_____	**Lipid Panel** (All ischemic strokes) **Or document exclusions**
☐ -_____	**Statin** (All ischemic strokes) **Or document exclusions**
☐ -_____	**Speech Therapy**
☐ -_____	**Rehabilitation Consult** (Assessment and Therapies ordered)
☐ -_____	**Stroke Education** (All five required elements addressed – see below)
☐ -_____	**Tobacco counseling**

Date & initials	Discharge Phase and/or Discharge to Rehab
☐ -_____	Discharge on Antithrombotic and Anticoagulant (if atrial fibrillation or atrial flutter)
☐ -_____	Discharge on Statin medication (all ischemic strokes) Or document exclusions
☐ -_____	Discharge with Sleep Study Referral (if at risk for sleep apnea; with BMI > 30 and/or snoring)
☐ -_____	Discharge with Event Monitor Referral (if at risk for cardiac arrhythmias)
☐ -_____	Discharge instruction and completion of Stroke Education 5 Must Haves:

- **Activation of EMS (when to call 911)**
- **Follow-up after discharge**
- **Medications prescribed**
- **Stroke personal risk factors**
- **Stroke signs & symptoms**

STROKE/TIA patient feedback

Saint Joseph Health System Stroke Team strives for unsurpassed care for patients and their families. It is important for us to know your perception of the stroke care you received while you were a patient. To help us improve our services and care, please complete the survey below. Family members are encouraged to complete the form if the patient is unable to do so.

Thank you so much for helping us improve our stroke care at Saint Joseph Health System.

	Yes	No	RN Initials and Comments
I received the stroke education booklet.			
I received information about the warning signs of stroke.			
I know what BEFAST is.			
I know what type of stroke I had.			
I was instructed to dial 9-1-1 if I have stroke symptoms in the future.			
I received information on my personal risk factors for stroke.			
I received printed/verbal information about my prescribed medications.			
I have all the medications that have been prescribed or have received prescriptions for the new medications.			
The results of my tests were explained to me.			
I received information that helped me understand my diagnosis.			
I was satisfied with the Physical Therapy services I received.			
I was satisfied with the Occupational Therapy services I received.			
I was satisfied with the Speech Therapy services I received.			
I have made or will arrange for a follow up appointment.			

Survey completed by (circle all that apply) Patient Family Other

Use the space below for any comments, suggestions or ideas you have for improvement.

RN Signature:_____

Please return this to your nurse at discharge or during rounding.

SAINT JOSEPH
HEALTH SYSTEM
MISHAWAKA
MEDICAL CENTER

Elkhart
Mishawaka
Plymouth
South Bend

sjmed.com

193827-SJHS-CED-Stroke

/dkl:F/ (10/9/19)

888888-2

Code Stroke 914 Activation
Complete on any potential tPA patient

Do not attach Face Sheet

Patient Name:

DOB: You may use patient sticker

MRN:

Patient Arrival Date:_____Time: _____ Mode of arrival _____
Use EMS dept. name if by ambulance

Who identified the stroke EMS Triage Registration MD (Circle one Please)

Time of 914 Activation:_____ Last known well time (LKWT) _____

Nurse_____ Phone #_____ ED Physician_____ Phone #_____
Time:

If Patient is given tPA or Transferred to Loyola.
Contact Dr. Zimmerman on Doc Halo with Name, DOB, and MRN and say if tPA only or Transfer.

Also Contact Gregor so he can do immediate follow up.

Initial contact for 914	Time	Who
Call CT Tech at 51160		
Call Pharmacy at 53109		
Call Lab at 57154		

Once patient is registered

- ☐ Page Code Stroke overhead in ED
- ☐ Place 914 on tracking board
- ☐ Call Loyola for tPA candidate 800-888-5862
- ☐ Enter patient information into StrokeRESPOND
- ☐ Fax Face Sheet to Loyola 708-216-6181
- ☐ Call House Supervisor

Physician/Loyola Notification

Notifications	Time Paged	Return Page
Call to Loyola - Dr._____		
Doc Halo to Dr. Zimmerman		
Other:		

Kerry's Data (Do Not Use)

Complaint:				
EMS Dispotisiton:				
Other:				
Radiology Data				
	Order	Complete	Read	Radiologist
CT				
CTA				
CXR				
Pharmacy Data				
Call	Order	Deliver	Given	Pharmacist
Bolus:		Drip:		Wgt:
Laboratory Data				
NIHSS:		Test	Complete	Result
MEND/CSS:		PT/INR		
		Gluc		

Reason 914 is cancelled_____

Secretary Signature _____

Place in the Stroke folder

CONSENT FOR TPA PROCEDURE

Alternative to Procedure: The only alternative is aspirin with routine stroke care.

Prognosis if No Treatment: I have been informed of the prognosis if no tPA is provided, as follows:

Prognostic value of NIHSS score in patients **not** treated with tPA

NIHSS score	Prognosis
Greater than 20 plus age greater than 75 yr	Mortality rate 45% (Mortality rate 48% with tPA)*
Greater than 17 plus atrial fibrillation	Positive predictive value for poor outcome 96% (MRS greater than 3)
Greater than or equal to16	High probability of death or severe disability
Greater than 7	Only 2.5% of patients functionally normal at 48 h
Less than or equal to 7	45% of patients functionally normal at 48 h
Less than or equal to 6	Good spontaneous recovery
Note: MRS = Modified Rankin Scale.	

My physician has explained to me the general nature of my condition, the proposed procedure, and the expected outcome, material risks and reasonable alternatives of the proposed procedure.

I also understand that during the course of the procedure unforeseen conditions may become apparent that require an extension of the original procedure or a different procedure from that described by my physician. I therefore authorize my physician, his/her associates or assistants to perform such procedures as they, in the exercise of their professional judgement, deem reasonable, necessary and desirable. The main additional procedure would be a neurosurgical consultation for possible blood clot removal from the brain.

I have had the opportunity to obtain answers to all questions I have regarding the procedure.

By signing this consent form you or your family member acknowledge understanding of the potential benefits of less disability with tPA balanced by the risk of causing bleeding in the brain which could lead to death or a more serious stroke.

_____ _____ _____

Patient Signature *Date and Time* *Witness*

The patient is unable to consent because _____
I therefore consent for the patient.

_____ _____ _____ _____

Signature *Date and Time* *Relationship to Patient* *Witness*

I have personally explained the above information to the patient or the patient representative.

_____ _____

Physician Signature *Date and Time*

CONSENT FOR TPA PROCEDURE

I hereby authorize Doctor _____ his/her associates _____
(Physician name) (Physician Name)
_____, to perform upon _____ the following
(Physician name) (Name of patient)
procedure:

Administer tissue plasminogen activator (tPA) per FDA guidelines for the treatment of stroke.

Material Risks: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the tPA procedure planned for me. I realize that common to tPA procedures is the potential for bleeding which could lead to death.

Stroke severity is measured by several scales. One of the scales is called the National Institutes of Health Stroke Scale (NIHSS). The following table details the risk of bleeding complications based on a patients NIHSS score.

Pretreatment variable	Risk of symptomatic intracranial hemorrhage
NIHSS score	
> 20 (most severe)	17%
11-20	4-5%
< 10 (least severe)	2-3%
Edema or mass effect on CT	
Present	31%
Absent	6%

Because the risk of bleeding into the brain is so much higher in patients with a NIHSS score greater than 20 or who have swelling on a CT scan of the brain, tPA is often not recommended for these patients.

Your doctor has determined that your NIHSS score is: _____

Potential benefits of tPA: In a large study using tPA, patients who received tPA had a 31% chance of complete recovery vs. only a 20% chance in patients who did not receive tPA. Patients receiving tPA had a 50% chance of nearly complete recovery vs. only a 38% chance in patients who did not receive tPA.

The risk of bleeding into the brain was 6% in patients who received tPA and about 1% in patients who did not receive tPA. Most of the patients who had a bleeding complication died. Despite this, the number of patients who died in the study were the same between the tPA and untreated groups.

Another way to look at the risk/benefit ratio is to look at the number of patients who would be helped or hurt in a group of 100 patients.

	Received tPA	No tPA
Excellent Outcome	37	25
Moderate Disability	19	25
Severe Impact	25	31
Death	19	19

Thus if tPA is given 12 more patients out of 100 will do well, 6 fewer patients out of 100 will have moderate disability and 6 fewer patients out of 100 will have total disability. The number of patients dying would be the same with or without tPA.

Emergency Medicine - Stroke Symptoms [1600000558]

General

Diet - NPO

☐ Diet - NPO
Diet effective now, Starting today
Location:

Precautions - Seizure

☐ Seizure precautions
Details

Nursing

Vital Signs

☐ Vital Signs (specify frequency)
Once
Includes: Temperature, Pulse, Respirations and Blood Pressure

Vital Signs - Pulse Oximetry

☐ Pulse oximetry, continuous
Until discontinued, Starting today

Cardiac Monitoring - Other Indication

☐ Cardiac monitoring while in ED
Until discontinued, Starting today For Until specified

Nursing Assessments - NIH Stroke Scale Assessment

☐ NIH Stroke Scale assessment
Until discontinued, Starting today
Every 15 minutes X (occurrences): 8
Every 30 minutes X (occurrences): 12
Every 1 hour X (occurrences): 16
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:
NIHSS as needed for new neurological changes

☐ Modified NIH Stroke Scale Assessment
Until discontinued, Starting today
Every 15 minutes X (occurrences): 8
Every 30 minutes X (occurrences): 12
Every 1 hour X (occurrences): 16
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:
NIHSS as needed for new neurological changes

Nursing Assessments - Swallow Screen

☐ Nursing swallow screen
Once

Nursing Assessments - Neuro Checks (Single Response)

○ Neuro checks - Q15 Min
Every 15 min For Until specified
Every 15 minutes X (occurrences):
Every 30 minutes X (occurrences):
Every 1 hour X (occurrences):
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:

○ Neuro checks - Q1H
Every 1 hour For Until specified
Every 15 minutes X (occurrences):
Every 30 minutes X (occurrences):
Every 1 hour X (occurrences):
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:

Nursing Interventions - Insert IV

☐ Insert and Maintain IV
"And" Linked Panel

- ☐ Insert peripheral IV
  STAT, Once For 1 Occurrences
  Saline lock:
- ☐ Saline lock IV
  Routine, Once For 1 Occurrences
- ☐ sodium chloride 0.9 % flush
  10 mL, intravenous, As needed, line care

Respiratory Interventions - Oxygen Therapy PRN

- ☐ Oxygen Therapy, Adult — STAT, As needed; Device:; Keep O2 Sat Above: 90%

Labs

ED Labs - Stroke Symptoms

- ☐ Basic metabolic panel — STAT For 1 Occurrences, Blood
- ☐ Complete blood count — STAT For 1 Occurrences, Blood
- ☐ POCT Glucose, blood — STAT, Once, Blood
- ☐ POC glucose manually resulted — STAT, Once, Blood
- ☐ Prothrombin time with INR — STAT For 1 Occurrences, Blood
- ☐ Activated partial thromboplastin time — STAT For 1 Occurrences, Blood
- ☐ POCT Protime-INR — STAT, Once, Blood
- ☐ POCT Creatinine, blood — STAT, Once, Blood
- ☐ Magnesium — STAT For 1 Occurrences, Blood
- ☐ Troponin (Single Response)
  - ○ Troponin I (first draw NOW and then in 3 hours) — Now then every 3 hours For 2 Occurrences, Blood
  - ○ Troponin I (6 hours after initial draw) — Once, Starting H+6 Hours For 1 Occurrences, Repeat evaluations beyond 3 hours should be reserved for patients with an intermediate or high suspicion for ACS, Blood
- ☐ Troponin POCT
  - ☐ POCT troponin — STAT, Once For 1 Occurrences, Blood
  - ☐ POCT troponin manually resulted — STAT, Once For 1 Occurrences, Blood
- ☐ Pregnancy
  - ☐ POCT pregnancy, urine manually resulted — STAT, Once, Urine
  - ☐ POCT pregnancy, urine auto resulted — STAT, Once, Urine
  - ☐ HCG qualitative, urine — STAT For 1 Occurrences, Urine
  - ☐ HCG, serum, qualitative — STAT For 1 Occurrences, Blood
- ☐ Urinalysis with reflex microscopic — STAT For 1 Occurrences, Urine
- ☐ Drug abuse screen, urine — STAT For 1 Occurrences, Urine

Imaging

ED Imaging - Chest X-Ray

- ☐ XR Chest 1 View — STAT, Once For 1 Occurrences; Is the patient pregnant?; Portable?
- ☐ XR Chest 2 Views — STAT, Once For 1 Occurrences; Portable?; Is the patient pregnant?

ED Imaging - CT/CTA Head and Neck

- ☐ CT Head wo Contrast — STAT, Once For 1 Occurrences; Is the patient pregnant?; What is the patient's sedation requirement?
- ☐ CT Angio Head wo and/or w Contrast — STAT, Once For 1 Occurrences; Is the patient pregnant?; What is the patient's sedation requirement?
- ☐ CT Angio Neck wo and/or w Contrast — STAT, Once For 1 Occurrences; Is the patient pregnant?; What is the patient's sedation requirement?
- ☐ CT Cerebral Perfusion w Contrast — STAT, Once For 1 Occurrences; Is the patient pregnant?; What is the patient's sedation requirement?

ED Imaging - MRI Head

- ☐ MR Brain wo Contrast — STAT, Once For 1 Occurrences; Is the patient pregnant?; What is the patient's sedation requirement?

Other Tests

Cardiac Test - ECG

☐ Electrocardiogram, 12 lead	STAT, Once For 1 Occurrences Reason for Exam:

IV Fluids

IV Fluid Boluses

☐ sodium chloride 0.9 % (NS) 500 mL bolus	500 mL, intravenous, Once, For 1 Doses
☐ sodium chloride 0.9 % (NS) 1000 mL bolus	1,000 mL, intravenous, Once, For 1 Doses

IV Fluid Infusions

☐ sodium chloride 0.9 % infusion	150 mL/hr, intravenous, Continuous

Emergency Medicine - Ischemic Stroke Non-Thrombolytic [1600000556]

Advisory: This order set is intended for use in the patient who has been determined NOT to be a thrombolytic candidate.

General

Diet - NPO

- ☐ Diet - NPO — Diet effective now, Starting today; Location:

Precautions - Aspiration

- ☐ Aspiration precautions — Details

Precautions - Seizure

- ☐ Seizure precautions — Details

Nursing

Vital Signs - Pulse Oximetry

- ☐ Pulse oximetry, continuous — Until discontinued, Starting today

Cardiac Monitoring - Other Indication

- ☐ Cardiac monitoring while in ED — Until discontinued, Starting today For Until specified

Nursing Assessments - Ischemic Stroke

- ☐ NIH Stroke Scale assessment — Until discontinued, Starting today; Every 15 minutes X (occurrences): 8; Every 30 minutes X (occurrences): 12; Every 1 hour X (occurrences): 16; Every 2 hours X (occurrences):; Every 4 hours X (occurrences): Until discharge; Every 8 hours X (occurrences):; Then:; NIHSS as needed for new neurological changes.
- ☑ Modified NIH Stroke Scale Assessment — Until discontinued, Starting today; Every 15 minutes X (occurrences): 8; Every 30 minutes X (occurrences): 12; Every 1 hour X (occurrences): 16; Every 2 hours X (occurrences):; Every 4 hours X (occurrences): Until discharge; Every 8 hours X (occurrences):; Then:; NIHSS as needed for new neurological changes.
- ☐ Weigh patient — Daily
- ☐ POCT Glucose, blood — STAT, Once For 1 Occurrences, Blood

Nursing Assessments - Swallow Screen

- ☐ Nursing swallow screen — Once

Nursing Interventions - Stroke Patient Education

- ☑ Provide and document stroke education — Until discontinued, Starting today

Nursing Interventions - Straight Catheter

- ☐ Straight catheter — Once For 1 Occurrences

Nursing Interventions - Insert IV

- ☐ Insert and Maintain IV — **"And" Linked Panel**
  - ☐ Insert peripheral IV — STAT, Once For 1 Occurrences; Saline lock:
  - ☐ Saline lock IV — Routine, Once For 1 Occurrences
  - ☐ sodium chloride 0.9 % flush — 10 mL, intravenous, As needed, line care

Respiratory Interventions - Oxygen Therapy

- ☐ Oxygen therapy, non-rebreather - STAT — STAT, Continuous; Device:; Keep O2 Sat Above: 90%
- ☐ Oxygen therapy, nasal cannula — Routine, Continuous; Device:; Keep O2 Sat Above: 90%
- ☐ End tidal CO2 monitor — Routine, Once

Cannula

Consults

Ancillary Consult - SLP

- [ ] SLP eval and treat
  - STAT, Once For 1 Occurrences
  - Reasons for treatment:
  - Can patient sit upright?
  - Does patient have a tracheostomy?

Physician Consult - Neurology

- [ ] Inpatient consult to Neurology
  - Reason for Consult?
  - Level of Consultation:
  - Did you contact the consultant?
  - Routine

Physician Consult - Neurosurgery

- [ ] Consult to Neurosurgery
  - Reason for Consult?
  - Routine

Labs

ED Labs

- [ ] Comprehensive metabolic panel — STAT For 1 Occurrences, Blood
- [ ] Basic metabolic panel — STAT For 1 Occurrences, Blood
- [ ] Complete blood count — STAT For 1 Occurrences, Blood
- [ ] Troponin (Single Response)
  - ○ Troponin I (first draw NOW and then in 3 hours) — Now then every 3 hours For 2 Occurrences, Blood
  - ○ Troponin I (6 hours after initial draw) — Once, Starting H+6 Hours For 1 Occurrences, Repeat evaluations beyond 3 hours should be reserved for patients with an intermediate or high suspicion for ACS, Blood
- [ ] Troponin POCT
  - [ ] POCT troponin — STAT, Once For 1 Occurrences, Blood
  - [ ] POCT troponin manually resulted — STAT, Once For 1 Occurrences, Blood
- [ ] Lipid panel — STAT For 1 Occurrences, Blood
- [ ] Prothrombin time with INR — STAT For 1 Occurrences, Blood
- [ ] Activated partial thromboplastin time — STAT For 1 Occurrences, Blood
- [ ] POCT Protime-INR — STAT, Once, Blood
- [ ] POCT Creatinine, blood — STAT, Once, Blood
- [ ] Blood gas, arterial — STAT For 1 Occurrences, Blood
- [ ] Blood gas, venous — STAT For 1 Occurrences, Blood
- [ ] Urinalysis
  - [ ] POC Urine Non-Auto W/O Micro — STAT, Once For 1 Occurrences, Urine
  - [ ] POCT urinalysis auto resulted — STAT, Once For 1 Occurrences, Urine
  - [ ] Urinalysis with microscopic — STAT For 1 Occurrences, Urine
  - [ ] Urinalysis chem only — STAT For 1 Occurrences, Urine
  - [ ] Urinalysis with reflex microscopic — STAT For 1 Occurrences, Urine
  - [ ] Urinalysis microscopic only — STAT For 1 Occurrences, Urine

Imaging

ED Imaging - Chest X-Ray

- [ ] XR Chest 1 View
  - STAT, Once For 1 Occurrences
  - Is the patient pregnant?
  - Portable?
- [ ] XR Chest 2 Views
  - STAT, Once For 1 Occurrences
  - Portable?
  - Is the patient pregnant?

ED Imaging - MRI Head

- [ ] MR Brain wo Contrast
  - STAT, Once For 1 Occurrences
  - Is the patient pregnant?
  - What is the patient's sedation requirement?

ED Imaging - MRA Neck

- [ ] MR Angio Neck wo Contrast
  - STAT, Once For 1 Occurrences
  - Is the patient pregnant?
  - What is the patient's sedation requirement?

ED Imaging - CT/CTA Head and Neck

☐ CT Head wo Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Head wo and/or w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Neck wo and/or w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Cerebral Perfusion w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?

ED Imaging - US Head and Neck

☐ Vascular US duplex carotid bilateral	Routine, Once

Other Tests

Cardiac Test - ECG

☐ Electrocardiogram, 12 lead	STAT, Once For 1 Occurrences Reason for Exam:

Fluid and Electrolytes

IV Boluses (Single Response)

○ lactated ringers (LR) bolus	intravenous, Once, For 1 Doses
○ sodium chloride 0.9 % (NS) bolus	intravenous, Once, For 1 Doses

IV Fluids (Single Response)

○ lactated ringers infusion	intravenous, Continuous
○ sodium chloride 0.9% (NS) infusion	intravenous, Continuous

Medications

Aspirin (Single Response)

○ aspirin tablet	325 mg, oral, Once, For 1 Doses Indication:
○ aspirin tablet	325 mg, nasogastric tube, Once, For 1 Doses Indication:
○ aspirin suppository	300 mg, rectal, Once, For 1 Doses

Antihypertensives (Single Response)

During initial 24 hours post-stroke, **recommended to not lower blood pressure unless:**
-SBP **GREATER** than 220 mmHg
OR
-DBP **GREATER** than 120 mmHg

○ IV Antihypertensives for SBP GREATER than 220 mmHg or DBP GREATER than 120 mmHg (Single Response)

○ labetalol (NORMODYNE,TRANDATE) loading and maintenance doses

☐ labetalol (NORMODYNE) - bolus	10 mg, intravenous, for 1-2 Minutes, Once as needed, high blood pressure, blood pressure higher than 220/120, For 1 Doses Administer if SBP is above 220 mmHg or DBP is above 120 mmHg.
☐ labetalol (NORMODYNE) - infusion	0.5-8 mg/min, intravenous, Continuous GOAL EFFECT: SBP 180 - 220 mmHg STARTING RATE: 2 mg/min TITRATION DOSE: 1 mg/min TITRATION FREQUENCY: 20 min CONTACT PRESCRIBER: SBP outside of goal range; HR less than 60 or greater than 120 BPM; maximum total daily dose of 300 mg Individual cases may require deviation from parameters
○ niCARdipine (CARDENE) - infusion	2.5-15 mg/hr, intravenous, Continuous GOAL EFFECT: SBP 180 - 220 mmHg STARTING RATE: 5 mg/hr TITRATION DOSE: 2.5 mg/hr TITRATION FREQUENCY: 5 min CONTACT PRESCRIBER: SBP outside of goal range

Individual cases may require deviation from parameters

Antiemetic (Single Response)

○ ondansetron (ZOFRAN-ODT) disintegrating tablet	4 mg, oral, Once, For 1 Doses
○ ondansetron (ZOFRAN) injection	4 mg, intravenous, Once, For 1 Doses

Reason For Not Administering IV Thrombolytic (Selection Required)

☐ Reason for not initiating IV thrombolytic: Time last known well to arrival in the ED greater than 4.5 hrs	Reason for not initiatiing IV Thrombolytic?
☐ Reason for not initiating IV thrombolytic: Patient received IV or IA t-PA at transferring hospital	Reason for not initiatiing IV Thrombolytic? Patient received IV or IA t-PA at a transferring hospital
☐ Reason for not initiating IV thrombolytic: Patient has a NIHSS score of zero	Reason for not initiatiing IV Thrombolytic? Patient has a NIHSS score of zero
☐ Reason for not initiating IV thrombolytic: Patient/family refused	Reason for not initiatiing IV Thrombolytic? Patient/family refused
☐ Reason for not initiating IV thrombolytic: Other (please provide additional details)	Reason for not initiatiing IV Thrombolytic?

Emergency Medicine - Ischemic Stroke Thrombolytic [1600000557]

General

Diet - NPO

- [ ] Diet - NPO — Diet effective now, Starting today
  Location:

Precautions - Aspiration

- [ ] Aspiration precautions — Details

Precautions - Bleeding

- [ ] Bleeding precautions —
  - Monitor the patient closely for hemorrhage. Observe secretions for gross evidence of blood
  - Monitor coagulation studies, including prothrombin time, partial thromboplastin time, fibrinogen, fibrin degradation/split products, and platelet counts), as appropriate
  - Monitor orthostatic vital signs, including blood pressure lying, sitting, standing if appropriate
  - Maintain bedrest during active bleeding
  -Avoid injections (IV, IM, SQ), as appropriate
  -Use soft toothbrush or toothettes for oral care
  - Use electric razor, instead of straight-edge, for shaving
  - Avoid constipation (e.g., encourage fluids intake and stool softeners), as appropriate
  - Note hemoglobin/hematocrit levels before and after blood loss, as indicated

Precautions - Seizure

- [ ] Seizure precautions — Details

Nursing

Cardiac Monitoring - Other Indication

- [ ] Cardiac monitoring while in ED — Until discontinued, Starting today For Until specified

Vital Signs - Pulse Oximetry

- [ ] Pulse oximetry, continuous — Until discontinued, Starting today

Nursing Assessments - Ischemic Stroke

- [ ] NIH Stroke Scale assessment — Until discontinued, Starting today
  Every 15 minutes X (occurrences): 8
  Every 30 minutes X (occurrences): 12
  Every 1 hour X (occurrences): 16
  Every 2 hours X (occurrences):
  Every 4 hours X (occurrences): Until discharge
  Every 8 hours X (occurrences):
  Then:
  NIHSS as needed for new neurological changes.
- [x] Modified NIH Stroke Scale Assessment — Until discontinued, Starting today
  Every 15 minutes X (occurrences): 8
  Every 30 minutes X (occurrences): 12
  Every 1 hour X (occurrences): 16
  Every 2 hours X (occurrences):
  Every 4 hours X (occurrences): Until discharge
  Every 8 hours X (occurrences):
  Then:
  NIHSS as needed for new neurological changes.
- [ ] Weigh patient — Daily
- [ ] POCT Glucose, blood — STAT, Once For 1 Occurrences, Blood

Nursing Assessments - Swallow Screen

- [ ] Nursing swallow screen — Once

Nursing Interventions - Insert IV

- [ ] Insert and Maintain IV — **"And" Linked Panel**
  - [ ] Insert peripheral IV — STAT, Once For 1 Occurrences
    Saline lock:
  - [ ] Saline lock IV — Routine, Once For 1 Occurrences
  - [ ] sodium chloride 0.9 % flush — 10 mL, intravenous, As needed, line care

☐ Sodium chloride 0.9 % flush — 10 mL, Intravenous, As needed, line care

Nursing Interventions - Stroke Patient Education

☑ Provide and document stroke education — Until discontinued, Starting today

Respiratory Interventions - Oxygen Therapy PRN

☐ Oxygen Therapy, Adult — STAT, As needed
Device:
Keep O2 Sat Above: 90%

Consults

Ancillary Consult - SLP

☐ SLP eval and treat — STAT, Once For 1 Occurrences
Reasons for treatment:
Can patient sit upright?
Does patient have a tracheostomy?

Physician Consult - Neurology

☐ Inpatient consult to Neurology — Reason for Consult?
Level of Consultation:
Did you contact the consultant?
Routine

Physician Consult - Neurosurgery

☐ Consult to Neurosurgery — Reason for Consult?
Routine

Labs

ED Labs - Ischemic Stroke Thrombolytic

☐ Comprehensive metabolic panel — STAT For 1 Occurrences, Blood

☐ Basic metabolic panel — STAT For 1 Occurrences, Blood

☐ Complete blood count — STAT For 1 Occurrences, Blood

☐ Troponin (Single Response)

- ○ Troponin I (first draw NOW and then in 3 hours) — Now then every 3 hours For 2 Occurrences, Blood
- ○ Troponin I (6 hours after initial draw) — Once, Starting H+6 Hours For 1 Occurrences, Repeat evaluations beyond 3 hours should be reserved for patients with an intermediate or high suspicion for ACS, Blood

☐ Troponin POCT

- ☐ POCT troponin — STAT, Once For 1 Occurrences, Blood
- ☐ POCT troponin manually resulted — STAT, Once For 1 Occurrences, Blood

☐ Prothrombin time with INR — STAT For 1 Occurrences, Blood

☐ Activated partial thromboplastin time — STAT For 1 Occurrences, Blood

☐ POCT Protime-INR — STAT, Once, Blood

☐ POCT Creatinine, blood — STAT, Once, Blood

☐ POCT Glucose, blood — STAT, Once For 1 Occurrences, Blood

☐ Pregnancy

- ☐ POCT pregnancy, urine manually resulted — STAT, Once, Urine
- ☐ POCT pregnancy, urine auto resulted — STAT, Once, Urine
- ☐ HCG qualitative, urine — STAT For 1 Occurrences, Urine
- ☐ HCG, serum, qualitative — STAT For 1 Occurrences, Blood

☐ Urinalysis

- ☐ POC Urine Non-Auto W/O Micro — STAT, Once For 1 Occurrences, Urine
- ☐ POCT urinalysis auto resulted — STAT, Once For 1 Occurrences, Urine
- ☐ Urinalysis with microscopic — STAT For 1 Occurrences, Urine
- ☐ Urinalysis chem only — STAT For 1 Occurrences, Urine
- ☐ Urinalysis with reflex microscopic — STAT For 1 Occurrences, Urine
- ☐ Urinalysis microscopic only — STAT For 1 Occurrences, Urine

Imaging

ED Imaging - Chest X-Ray

☐ XR Chest 1 View — STAT, Once For 1 Occurrences
Is the patient pregnant?

	Is the patient pregnant? Portable?
☐ XR Chest 2 Views	STAT, Once For 1 Occurrences Portable? Is the patient pregnant?
ED Imaging - MRI Head	
☐ MR Brain wo Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
ED Imaging - CT/CTA Head and Neck	
☐ CT Head wo Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Head wo and/or w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Neck wo and/or w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Cerebral Perfusion w Contrast	STAT, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
ED Imaging - US Head and Neck	
☐ Vascular US duplex carotid bilateral	Routine, Once
Cardiac Test - ECG	
☐ Electrocardiogram, 12 lead	STAT, Once For 1 Occurrences Reason for Exam:

Fluid and Electrolytes

IV Boluses (Single Response)

○ lactated ringers (LR) bolus	intravenous, Once, For 1 Doses
○ sodium chloride 0.9 % (NS) bolus	intravenous, Once, For 1 Doses

Medications

Alteplase for Thrombolysis (Selection Required)

If this patient **should not receive a thrombolytic**, use alternative order set for **Ischemic Stroke (No Thrombolytic).**

☐ alteplase (ACTIVASE) bolus and infusion for ischemic stroke - patient weight LESS than 100 kg	**"Followed by" Linked Panel**
☐ alteplase IV bolus	0.09 mg/kg, intravenous, for 1 Minutes, Once, For 1 Doses Alteplase Indication: Ischemic Stroke/CVA
☐ alteplase infusion	0.81 mg/kg, intravenous, for 60 Minutes, Once, Starting H+1 Minutes, For 1 Doses Alteplase Indication: Ischemic Stroke/CVA
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, Starting H+1 Hours, For 1 Doses Infuse at same rate as alteplase after alteplase infused to ensure complete dose is delivered
☐ alteplase (ACTIVASE) bolus and infusion for ischemic stroke - patient weight GREATER than OR equal to 100 kg (Selection Required)	**"Followed by" Linked Panel**
☐ alteplase IV bolus	9 mg, intravenous, for 1 Minutes, Once, For 1 Doses Alteplase Indication: Ischemic Stroke/CVA
☐ alteplase IV infusion	81 mg, intravenous, for 60 Minutes, Once, Starting H+1 Minutes, For 1 Doses Alteplase Indication: Ischemic Stroke/CVA
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, Starting H+1 Hours, For 1 Doses Infuse at same rate as alteplase after alteplase infused to ensure complete dose is delivered
☑ No Anticoagulants for 24 Hours	Until discontinued, Starting today For 24 Hours, Oral anticoagulants include: warfarin (Coumadin), dabigatran (Pradaxa), apixaban (Eliquis), rivaroxaban (Xarelto), edoxaban (Savaysa), and betrixaban (Bevyxxa). Injectable anticoagulants include: heparin, enoxaparin

(Lovenox), dalteparin (Fragmin), tinzaparin (Innohep), fondaparinux (Arixtra), bivalirudin (Angiomax), argatroban, desirudin (Iprivask), danaparoid (Orgaran), and nadroparin (Fraxiparine).

☑ No Antiplatelets for 24 Hours — Until discontinued, Starting today For 24 Hours, Oral antiplatelet medications include: aspirin, ibuprofen, naproxen, clopidogrel (Plavix), prasugrel (Effient), ticagrelor (Brilinta), cilostazol (Pletal), anagrelide (Agrylin), aspirin-dipyridamole (Aggrenox), vorapaxar (Zontivity), and ticlopidine.

IV antiplatelet medications include: eptifibatide (Integrilin), abciximab (Reopro), cangrelor (Kengreal), tirofiban (Aggrastat), and defibrotide (Defitelio).

Antihypertensives PRE-Alteplase Administration (if BP greater than 185/110 mmHg) (Single Response)

○ labetalol IV injection — 10-20 mg, intravenous, for 1-2 Minutes, Every 10 min PRN, high blood pressure, BP greater than 185/110 mmHg in patient otherwise eligible for alteplase, For 2 Doses

○ niCARdipine IV infusion — 2.5-15 mg/hr, intravenous, Continuous
ONLY if SBP GREATER than 185 or DBP GREATER than 110 PRIOR to alteplase

GOAL EFFECT: BP LESS than 185/110 *Adjust to maintain proper BP limits*
INITIAL RATE: 5 mg/hr
USUAL DOSE RANGE: 2.5-15 mg/hr
TITRATION DOSE: 2.5 mg/hr
TITRATION FREQUENCY: 5 min

Individual cases may require deviation from parameters (with prescriber approval)

Antihypertensives Post-Alteplase Administration (Single Response)

For 24 hours following alteplase:
-Keep SBP **LESS** than **OR** equal to 180 mmHg
AND
-Keep DBP **LESS** than **OR** equal to 105 mmHg to avoid hemorrhagic conversion

○ IV Antihypertensives During and After Alteplase Administration (BP GREATER than 180/105 mmHg) (Single Response)

○ labetalol (NORMODYNE) bolus and infusion

☐ labetalol (NORMODYNE) - bolus — 10 mg, intravenous, Once as needed, high blood pressure, SBP above 180 or DBP above 105 during or after alteplase administration., For 1 Doses
Bolus - to be given prior to initiating continuous labetalol infusion.

☐ labetalol (NORMODYNE) - infusion — 0.5-8 mg/min, intravenous, Continuous
GOAL EFFECT: SBP 180 mmHg or less and DBP 105 mmHg or less
STARTING RATE: 2 mg/min
TITRATION DOSE: 1 mg/min
TITRATION FREQUENCY: 20 min
CONTACT PRESCRIBER: HR less than 60 or greater than 120 BPM; SBP less than 90 or greater than 180 mmHg; maximum total daily dose of 300 mg; unable to maintain BP goals at maximum rate
Individual cases may require deviation from parameters

○ niCARdipine (CARDENE) - infusion — 5-15 mg/hr, intravenous, Continuous
GOAL EFFECT: SBP 180 mmHg or less and DBP 105 mmHg or less
STARTING RATE: 5 mg/hr
TITRATION DOSE: 2.5 mg/hr
TITRATION FREQUENCY: 5 min
CONTACT PRESCRIBER: SBP less than 90 or greater than 180 mmHg; unable to maintain BP goals at maximum rate
Individual cases may require deviation from parameters

Emergent Reversal of Alteplase

☐ Emergent Reversal of alteplase (ACTIVASE), tenecteplase (TNKase), or reteplase (RETAVase)

Consider reversing only if patient has received a dose within the last 24 hours

Recommended **first line** therapy is 10 units of cryoprecipitate

If blood products are required, use:
General - IP Blood and Blood Component Transfusion Therapy orderset to place orders

tranexamic acid (CYKLOKAPRON) is recommended **if cryoprecipitate is not available in a timely manner**

☐ tranexamic acid (CYKLOKAPRON): ONLY if cryoprecipitate is NOT available	1,000 mg, intravenous, for 20 Minutes, Once, For 1 Doses Tranexamic Acid Indication:

PRN Medications

Antiemetics

☐ ondansetron (ZOFRAN) injection	4 mg, intravenous, Once, For 1 Doses

Emergency Medicine - Hemorrhagic Stroke [1600000512]

General

Activity - Bedrest

☐ Bed rest

Until discontinued, Starting today
Type of activity:
Assistance Needed:
Assistive Device Needed:
Activity Instructions (Free Text):
Type of Restriction: Strict Bedrest
Bedrest Instructions:

Precautions - Seizure

☐ Seizure precautions

Details

Nursing

Cardiac Monitoring - Other Indication

☐ Cardiac monitoring while in ED

Until discontinued, Starting today For Until specified

Nursing Assessments - Neuro Checks (Single Response)

○ Neuro checks - Q15 Min

Every 15 min For Until specified
Every 15 minutes X (occurrences):
Every 30 minutes X (occurrences):
Every 1 hour X (occurrences):
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:

○ Neuro checks - Q1H

Every 1 hour For Until specified
Every 15 minutes X (occurrences):
Every 30 minutes X (occurrences):
Every 1 hour X (occurrences):
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:

Nursing Assessments - NIH Stroke Scale Assessment

☐ NIH Stroke Scale assessment

Until discontinued, Starting today
Every 15 minutes X (occurrences): 8
Every 30 minutes X (occurrences): 12
Every 1 hour X (occurrences): 16
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:
NIHSS as needed for new neurological changes

☐ Modified NIH Stroke Scale Assessment

Until discontinued, Starting today
Every 15 minutes X (occurrences): 8
Every 30 minutes X (occurrences): 12
Every 1 hour X (occurrences): 16
Every 2 hours X (occurrences):
Every 4 hours X (occurrences): Until discharge
Every 8 hours X (occurrences):
Then:
NIHSS as needed for new neurological changes

Nursing Assessments - Swallow Screen

☐ Nursing swallow screen

Once

Nursing Interventions - Head of Bed

☐ Head of bed 45 degrees

Until discontinued, Starting today
Head of bed adjustment:

Nursing Interventions - Insert IV

☐ Insert and Maintain IV

"And" Linked Panel

☐ Insert peripheral IV

STAT, Once For 1 Occurrences
Saline lock:

☐ Saline lock IV

Routine, Once For 1 Occurrences

- [ ] sodium chloride 0.9 % flush — 10 mL, intravenous, As needed, line care

Respiratory Interventions - Oxygen Therapy PRN

- [ ] Oxygen Therapy, Adult — STAT, As needed
  Device:
  Keep O2 Sat Above: 90%

Consults

Physician Consult - Neurology

- [ ] Inpatient consult to Neurology — Reason for Consult?
  Level of Consultation:
  Did you contact the consultant?
  Routine

Physician Consult - Neurosurgery

- [ ] Consult to Neurosurgery — Reason for Consult?
  Routine

Labs

ED Labs - Hemorrhagic Stroke

- [ ] Basic metabolic panel — STAT For 1 Occurrences, Blood
- [ ] Comprehensive metabolic panel — STAT For 1 Occurrences, Blood
- [ ] Magnesium — STAT For 1 Occurrences, Blood
- [ ] CBC and differential — STAT For 1 Occurrences, Blood
- [ ] Activated partial thromboplastin time — STAT For 1 Occurrences, Blood
- [ ] Prothrombin time with INR — STAT For 1 Occurrences, Blood
- [ ] Type and screen — Once, Blood
- [ ] POCT Protime-INR — STAT, Once, Blood
- [ ] POC glucose manually resulted — STAT, Once, Blood
- [ ] POCT Glucose, blood — STAT, Once, Blood
- [ ] Troponin (Single Response)
  - ○ Troponin I (first draw NOW and then in 3 hours) — Now then every 3 hours For 2 Occurrences, Blood
  - ○ Troponin I (6 hours after initial draw) — Once, Starting H+6 Hours For 1 Occurrences, Repeat evaluations beyond 3 hours should be reserved for patients with an intermediate or high suspicion for ACS, Blood
- [ ] Troponin POCT
  - [ ] POCT troponin — STAT, Once For 1 Occurrences, Blood
  - [ ] POCT troponin manually resulted — STAT, Once For 1 Occurrences, Blood
- [ ] Pregnancy
  - [ ] POCT pregnancy, urine manually resulted — STAT, Once, Urine
  - [ ] POCT pregnancy, urine auto resulted — STAT, Once, Urine
  - [ ] HCG qualitative, urine — STAT For 1 Occurrences, Urine
  - [ ] HCG, serum, qualitative — STAT For 1 Occurrences, Blood
- [ ] Drug abuse screen, urine — STAT For 1 Occurrences, Urine

Imaging

ED Imaging - CT/CTA Head and Neck

- [ ] CT Head wo Contrast — STAT, Once For 1 Occurrences
  Is the patient pregnant?
  What is the patient's sedation requirement?
- [ ] CT Angio Head wo and/or w Contrast — STAT, Once For 1 Occurrences
  Is the patient pregnant?
  What is the patient's sedation requirement?
- [ ] CT Angio Neck wo and/or w Contrast — STAT, Once For 1 Occurrences
  Is the patient pregnant?
  What is the patient's sedation requirement?
- [ ] CT Cerebral Perfusion w Contrast — STAT, Once For 1 Occurrences
  Is the patient pregnant?
  What is the patient's sedation requirement?

Other Tests

Cardiac Test - ECG

☐ Electrocardiogram, 12 lead — STAT, Once For 1 Occurrences
Reason for Exam:

Disease Specific Medications

IV Fluids

☐ sodium chloride 0.9 % bolus — 1,000 mL, intravenous, Once, For 1 Doses

☐ sodium chloride 0.9 % infusion — 100 mL/hr, intravenous, Continuous

IV Antihypertensives (Single Response)

○ labetalol (NORMODYNE) bolus and infusion

☐ labetalol (NORMODYNE) - bolus (Single Response)

○ labetalol (NORMODYNE) injection — 10 mg, intravenous, Every 15 min PRN, high blood pressure, SBP greater than 140 or MAP greater than 130, For 2 Doses
May repeat 1 time in ED only.

○ labetalol (NORMODYNE) injection — 20 mg, intravenous, Every 15 min PRN, high blood pressure, SBP greater than 140 or MAP greater than 130, For 2 Doses
May repeat 1 time in ED only.

☐ labetalol (NORMODYNE) - infusion — 0.5-8 mg/min, intravenous, Continuous
GOAL EFFECT: SBP less than 140 mmHg or MAP less than 110 mmHg
TITRATION DOSE: 1 mg/min
TITRATION FREQUENCY: 20 min
CONTACT PRESCRIBER: HR less than 60 or greater than 120 BPM; SBP less than 90 or greater than 180 mmHg; maximum total daily dose of 300 mg
HOLD INFUSION: SBP less than 90
Individual cases may require deviation from parameters

○ niCARdipine (CARDENE) infusion — 2.5-15 mg/hr, intravenous, Titrated
GOAL EFFECT: SBP less than 140 mmHg
TITRATION DOSE: 2.5 mg/hr
TITRATION FREQUENCY: 5 min
CONTACT PRESCRIBER: SBP less than 90 or greater than 180 mmHg
HOLD INFUSION: SBP less than 90
Individual cases may require deviation from parameters

niMODipine (Single Response)

For Subarachnoid Hemorrhage

○ niMODipine (NIMOTOP;NYMALIZE) — 60 mg, oral, Once, For 1 Doses

○ niMODipine (NIMOTOP;NYMALIZE) — 60 mg, g-tube, Once, For 1 Doses

Anticoagulant Reversal Agents (Single Response)

If blood products are required, use **General - IP Blood and Blood Component Transfusion Therapy** orderset to place orders

○ Emergent Reversal of warfarin (COUMADIN) for:
Life-Threatening Bleed OR Need for Emergent Life-saving Procedure

For emergent full reversal of warfarin (COUMADIN) therapy in patients with:

- A life-threatening bleed
- The need for emergent life-saving surgery/procedure

*Consider reversing only if **INR greater than or equal to 1.4***

☐ Prothrombin time with INR — Once For 1 Occurrences, Blood

☐ phytonadione (VITAMIN K) IVPB for Administration with 4-Factor PCC (Single Response)

○ phytonadione (VITAMIN K) IVPB — 10 mg, intravenous, for 30 Minutes, Once, For 1 Doses
Indication for IVPB phytonadione (VITAMIN K)?

○ phytonadione (VITAMIN K) IVPB — 5 mg, intravenous, for 30 Minutes, Once, For 1 Doses
Indication for IVPB phytonadione (VITAMIN K)?

☐ Four-Factor Prothrombin Complex Concentrate (KCENTRA) (Single Response)

4-Factor Prothrombin Complex Concentrate (4F-PCC) [KCENTRA] product is **contraindicated in HIT**:

- Use a non-heparin containing 4F-PCC or Fresh Frozen Plasma (FFP)

○ Four-Factor Prothrombin Complex Concentrate

○ Four-Factor Prothrombin Complex Concentrate (KCENTRA): Fixed Dosing (Single Response)

For severe life-threatening bleeding due to warfarin therapy:

- Provide **initial** fixed dose of **1500 units**
- Patients with a **weight greater than 100 kg** consider **increasing dose to 2000 units**
- Patients with a ***baseline*** **INR greater than 7.5** consider **increasing dose to 2000 units**

If necessary, repeat dosing to achieve goal INR:

- Provide dose of **500 units** if INR **5 or LESS**
- Provide dose of **1000 units** if INR **GREATER than 5**

○ four-factor prothrombin complex concentrate (KCENTRA): Initial Dosing (Single Response)

○ four-factor PCC (KCENTRA) infusion: initial fixed dose — **"Followed by" Linked Panel**

☐ four-factor PCC (KCENTRA) infusion	1,500 Units, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: weight greater than 100 kg — **"Followed by" Linked Panel**

☐ four-factor PCC (KCENTRA) infusion	2,000 Units, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: baseline INR greater than 7.5 — **"Followed by" Linked Panel**

☐ four-factor PCC (KCENTRA) infusion	2,000 Units, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor prothrombin complex concentrate (KCENTRA): Repeat Dosing (Single Response)

○ four-factor PCC (KCENTRA) infusion: repeat dose for an INR 1.5 to 5 — **"Followed by" Linked Panel**

☐ four-factor PCC (KCENTRA) infusion	500 Units, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: repeat dose for an INR greater than 5 — **"Followed by" Linked Panel**

☐ four-factor PCC (KCENTRA) infusion	1,000 Units, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ Four-Factor Prothrombin Complex Concentrate (KCENTRA): Weight Based Dosing (Single Response)

○ INR 1.4 to 3.9: four-factor prothrombin complex — **"Followed by" Linked Panel**

concentrate (KCENTRA)

- ☐ four-factor PCC (KCENTRA) infusion — 25 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ INR 4.0 to 6.0: four-factor prothrombin complex concentrate (KCENTRA) — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 35 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ INR 6.1 and Above: four-factor prothrombin complex concentrate (KCENTRA) — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 50 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ Four-Factor Prothrombin Complex Concentrate (KCENTRA): INR Pending and Known Warfarin Use — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 25 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ Emergent Reversal of heparin (UFH)

Consider Reversing only if patient has received:

- IV heparin dose within 6 hours
- SQ **Therapeutic** heparin dose within 12 hours

Dosing instructions to reverse continuous infusion heparin:

- 0-30 minutes since heparin stopped: prescribe 1 mg of protamine for **each 100 units of heparin administered**
- 30-60 minutes since heparin stopped: prescribe 0.5 mg of protamine for **each 100 units of heparin administered**
- 60-120 minutes since heparin stopped: prescribe 0.375 mg of protamine for **each 100 units of heparin administered**
- 2-6 hours since heparin stopped: prescribe 0.25 mg of protamine for **each 100 units of heparin administered**

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once, then prescribe 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

No single protamine dose should exceed 50 mg administered over 10 minutes due to hypotension with rapid administration

- ☐ Protamine — intravenous, for 10 Minutes, Once, For 1 Doses
  -Administer over at least 10 minutes, IV Push
  -Maximum 50 mg per dose

☐ Protamine second dose if needed-see dosing instructions — intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses
If total dose needed is greater than 50 mg, prescribe BALANCE of total dose
-Start 10 minutes after first dose is completely administered
-Administer over at least 10 minutes, IV Push
-Maximum 50 mg per dose

☐ Protamine third dose if needed-see dosing instructions — intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses
If total dose needed is greater than 100 mg, prescribe BALANCE of total dose
-Start 20 minutes after first dose is completely administered
-Administer over at least 10 minutes, IV Push
-Maximum 50 mg per dose

○ Emergent Reversal of Select Antiplatelet Agents: clopidogrel (PLAVIX), prasugrel (EFFIENT), ticagrelor (BRILLINTA)

Medication Advisories:

- **clopidogrel (PLAVIX) ADVISORY**: Consider reversing only if patient has **received a dose within 5 days**
- **prasugrel (EFFIENT) ADVISORY**: Consider reversing only if patient has **received a dose within 9 days**
- **ticagrelor (BRILINTA) ADVISORY**: Consider reversing only if patient has **received a dose within 3 days**

No antidote available, consider **desmopressin (DDAVP)** for:

- Intracranial hemorrhage
- Renal failure patients

Consider **platelet transfusion** for **surgical candidates:**
Transfuse STAT 2 x 5 pack of pooled random donor platelets if patient will undergo surgery

If blood products are required, use:
General - IP Blood and Blood Component Transfusion Therapy orderset to place orders

☐ desmopressin (DDAVP) for Reversal of Select Antiplatelet Agents — 0.4 mcg/kg, intravenous, for 30 Minutes, Once, For 1 Doses

○ Emergent Reversal of LMWH enoxaparin (LOVENOX) and LMWH dalteparin (FRAGMIN) (Single Response)

○ Emergent Reversal of LMWH enoxaparin (LOVENOX)

Dosing instructions to reverse LMWH enoxaparin (LOVENOX):

- If 8 hours or less since last dose: prescribe 1 mg of protamine for **each 1 mg** of enoxaparin administered
- If 8 to 12 hours since last dose: prescribe 0.5 mg of protamine for **each 1 mg** of enoxaparin administered

If life threatening LMWH bleeding persists **OR** significant renal impairment is present:

- A repeat dose of 0.5 mg protamine for each 1 mg of enoxaparin administered **can be considered** if anti-factor **Xa activity remains elevated after 2 to 4 hours**

* Protamine only **partially neutralizes (60%)** of the effects of low molecular weight heparins (LMWH)*

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once, then prescribe 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

***No single protamine dose should exceed 50 mg administered over 10 minutes due to**

hypotension with rapid administration*

☐ Protamine	intravenous, for 10 Minutes, Once, For 1 Doses -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine second dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses If total dose needed is greater than 50 mg, prescribe BALANCE of total dose -Start 10 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine third dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses If total dose needed is greater than 100 mg, prescribe BALANCE of total dose -Start 20 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose

○ Emergent Reversal of LMWH dalteparin (FRAGMIN)

Dosing instructions to reverse LMWH dalteparin (FRAGMIN):

- If 8 hours or less since last dose: prescribe 1 mg of protamine for **each 100 units** of dalteparin administered
- If 8 to 12 hours since last dose: prescribe 0.5 mg of protamine for **each 100 units** of dalteparin administered

If life threatening LMWH bleeding persists **OR** significant renal impairment is present:

- A repeat dose of 0.5 mg protamine for each 1 mg of enoxaparin administered **can be considered** if anti-factor **Xa activity remains elevated after 2 to 4 hours**

* Protamine only **partially neutralizes (60%)** of the effects of low molecular weight heparins (LMWH)*

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once, then prescribe 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

No single protamine dose should exceed 50 mg administered over 10 minutes due to hypotension with rapid administration

☐ Protamine	intravenous, for 10 Minutes, Once, For 1 Doses -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine second dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses If total dose needed is greater than 50 mg, prescribe BALANCE of total dose -Start 10 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine third dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses If total dose needed is greater than 100 mg, prescribe BALANCE of total dose -Start 20 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose

○ Emergent Reversal of Factor Xa Inhibitors: apixaban (ELIQUIS), rivaroxaban (XARELTO), edoxaban (SAVAYSA), fondaparinux (ARIXTRA)

Medication Advisories

- **apixaban (ELIQUIS)**: Consider reversing only if patient has received a dose within past 2 days
  - (2 days with **renal dysfunction**)

- (3 days with **renal dysfunction**)

- **rivaroxaban (XARELTO)**: Consider reversing only if patient has received a dose within past 24 hours
  - (2 days if **CrCl is less than 30 mL/min**)

- **edoxaban (SAVAYSA)**: Consider reversing only if patient has received a dose within the **past 2 days**
  - (3 days if **CrCl 30-50 mL/min**, 4 days if **CrCl less than 30 mL/min**)

- **fondaparinux (ARIXTRA)**: Consider reversing only if patient has received a dose within 4 to 5 days
  - (Longer in **renal dysfunction** and in **elderly patients**)

Patient actively bleeding on Factor Xa Inhibitors:
- If patient is actively bleeding, administer supportive care: Fluids, transfusion, treatment of bleeding site
- For life-threatening bleeding **unresponsive to supportive care**, order 4F-PCC (KCENTRA)
- **Maximum** 4F-PCC (KCENTRA) dose is **5000 units**
- Elevated INR/PT screens for drug presence but is not quantitative

4-Factor Prothrombin Complex Concentrate (4F-PCC) [KCENTRA] product is **contraindicated in HIT**:
- Use a non-heparin containing 4F-PCC or Fresh Frozen Plasma (FFP)

☐ Prothrombin time with INR	STAT For 1 Occurrences, Blood
☐ four-factor PCC (KCENTRA) infusion	**"Followed by" Linked Panel**
☐ four-factor PCC (KCENTRA) infusion	50 Units/kg, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ Emergent Reversal of alteplase (ACTIVASE), tenecteplase (TNKase), or reteplase (RETAVase)

Consider reversing only if patient has received a dose within the last 24 hours

Recommended **first line** therapy is 10 units of cryoprecipitate

If blood products are required, use:
General - IP Blood and Blood Component Transfusion Therapy orderset to place orders

tranexamic acid (CYKLOKAPRON) is recommended **if cryoprecipitate is not available in a timely manner**

☐ tranexamic acid (CYKLOKAPRON): ONLY if cryoprecipitate is NOT available	1,000 mg, intravenous, for 20 Minutes, Once, For 1 Doses Tranexamic Acid Indication:

○ Emergent Reversal of dabigatran (PRADAXA) **"Followed by" Linked Panel**

Consider reversing only if patient has received a dose within:
- The last 3 days for CrCl greater than 50 mL/min
- The last 4 days for CrCl 30 to 50 mL/min
- The last 5 days for CrCl less than 30 mL/min

A second dose may be considered for rebound anticoagulation when:
- idaruCIZUmab (PRAXBIND) effect subsides (approximately 18 to 24hrs) ***and***
- There is clinical and laboratory **evidence of continued dabigatran-associated life-threatening hemorrhage**

*Elevated aPTT screens for drug **presence,** but it is **NOT quantitative***

☐ sodium chloride 0.9 % flush	25 mL, intravenous, Once, For 1 Doses Flush line with 25 mL of normal saline before AND after administration
☐ idaruCIZUmab (PRAXBIND) injection	2.5 g, intravenous, for 5 Minutes, Every 5 min, For 2 Doses -Flush line with 25 mL of normal saline before AND after administration -Give each IV bolus over 5 minutes.

☐ sodium chloride 0.9 % flush	-Administer via dedicated IV line 25 mL, intravenous, Once, For 1 Doses Flush line with 25 mL of normal saline before AND after administration	

○ Emergent Reversal of argatroban or bivalirudin (ANGIOMAX)

No antidote:

- Stop infusion
- Consider supportive transfusion
- Recombinant activated factor seven (NOVO-SEVEN) **not recommended** due to reports of thrombosis

☐ Prothrombin time with INR	Once For 1 Occurrences, Blood
☐ Activated partial thromboplastin time	Once For 1 Occurrences, Blood
☐ Activated clotting time (ACT)	Once For 1 Occurrences, Blood

Neurology - Ischemic Stroke Thrombolytic Admission [3040001243]

*If patient did **NOT** receive **alteplase (ACTIVASE)** in the ED, place the order through the **standalone order panel***

General

Order to Admit (Single Response) (Selection Required)

○ Admit to Inpatient	Diagnosis: Bed request comments:
○ Initiate observation status	Diagnosis: Bed request comments:

Code Status - No Active Code Status (Single Response) (Selection Required)

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Code Status (Single Response)

This patient already has a code status order for this admission. If you wish to change this status now, order a different status here and the previous code status order will be automatically discontinued and replaced with your new order.

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Isolation

☐ Initiate airborne isolation	Details
☐ Initiate contact isolation	Details
☐ Initiate droplet isolation	Details

Diet

☑ Diet - NPO	Diet effective now, Starting today Location: Until swallow screen passed.

Activity

☐ Activity: Strict Bedrest	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: Activity Instructions (Free Text): Type of Restriction: Strict Bedrest Bedrest Instructions:
☐ Activity: Bedrest with Bedside Commode	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: Bedside Commode Activity Instructions (Free Text): Type of Restriction: Strict Bedrest Bedrest Instructions:
☐ Activity: With Assistance	Until discontinued, Starting today Type of activity: Assistance Needed: with Assistance Assistive Device Needed: Activity Instructions (Free Text): Type of Restriction: Bedrest Instructions:

Precautions

☑ Bleeding precautions	- Monitor the patient closely for hemorrhage. Observe secretions for gross evidence of blood - Monitor coagulation studies, including prothrombin time, partial thromboplastin time, fibrinogen, fibrin degradation/split products, and platelet counts), as

	appropriate - Monitor orthostatic vital signs, including blood pressure lying, sitting, standing if appropriate - Maintain bedrest during active bleeding -Avoid injections (IV, IM, SQ), as appropriate -Use soft toothbrush or toothettes for oral care - Use electric razor, instead of straight-edge, for shaving - Avoid constipation (e.g., encourage fluids intake and stool softeners), as appropriate - Note hemoglobin/hematocrit levels before and after blood loss, as indicated
☑ Aspiration precautions	Details

Nursing

Vital Signs

☑ Vital Signs (specify frequency)	Daily Every 15 minutes X (occurrences): 8 Every 30 minutes X (occurrences): 12 Every 1 hour X (occurrences): 16 Every 2 hours X (occurrences): Every 4 hours X (occurrences): Every 8 hours X (occurrences): Then: Every 4 hours Includes: Temperature, Pulse, Respirations and Blood Pressure
☐ Pulse Oximetry	Once For 1 Occurrences
☐ Continuous Pulse Oximetry	Until discontinued, Starting today
☐ Monitor end tidal CO2	Routine, Once

Telemetry Monitoring

☑ Telemetry monitoring	Until discontinued, Starting today For Until specified Indication for telemetry: New Ischemic or Hemorrhagic Stroke Can the patient be off telemetry for activities (including therapy, ambulation, off-unit procedures, showers, bathroom)?

Notify provider

☑ Notify Physician (Acute Ischemic Stroke Parameters)	Until discontinued, Starting today Temperature greater than: 38 Temperature less than: Systolic blood pressure greater than: 185 Systolic blood pressure less than: 110 Diastolic blood pressure greater than: 105 Diastolic blood pressure less than: 60 Heart rate greater than: 110 Heart rate less than: 50 Respiratory rate greater than: 24 Respiratory rate less than: SpO2 less than: Fingerstick glucose greater than: 140 Fingerstick glucose less than: 60 Urine output less than: Other: Worsening of stroke symptoms or other decline in neurological status,Discomfort or inability to void,No BM in 48 hours

Nursing Assessments

☐ NIH Stroke Scale assessment	Until discontinued, Starting today Every 15 minutes X (occurrences): 8 Every 30 minutes X (occurrences): 12 Every 1 hour X (occurrences): 16 Every 2 hours X (occurrences): Every 4 hours X (occurrences): Until discharge Every 8 hours X (occurrences): Then: NIHSS as needed for new neurological changes
☐ Modified NIH Stroke Scale Assessment	Until discontinued, Starting today

☐ Modified NIH Stroke Scale Assessment	Until discontinued, Starting today Every 15 minutes X (occurrences): 8 Every 30 minutes X (occurrences): 12 Every 1 hour X (occurrences): 16 Every 2 hours X (occurrences): Every 4 hours X (occurrences): Until discharge Every 8 hours X (occurrences): Then: NIHSS as needed for new neurological changes
☐ Intake and output	Every shift
☐ Strict intake and output	Every shift For Until specified
☐ Weigh patient	Daily
☐ POCT Glucose, blood	Routine, 4 times daily before meals and at bedtime, Blood

Nursing Assessments - Swallow Screen

☑ Nursing swallow screen if not performed in ED	Once Repeat if suspected neurological changes or swallowing difficulties during stay

Nursing Interventions - Insert and Maintain IV

☐ Insert and Maintain IV	**"And" Linked Panel**
☐ Insert peripheral IV	STAT, Once For 1 Occurrences Saline lock:
☐ Maintain IV access	Until discontinued, Starting today
☐ Saline lock IV	Routine, Once For 1 Occurrences
☐ sodium chloride 0.9 % flush	10 mL, intravenous, Every 12 hours
☐ sodium chloride 0.9 % flush	10 mL, intravenous, As needed, line care

Nursing Interventions - Head of Bed (Single Response)

○ Head of bed 30 degrees	Until discontinued, Starting today Head of bed adjustment: 30 degrees
○ Head of bed 45 degrees	Until discontinued, Starting today Head of bed adjustment:
○ Head of bed 90 degrees or in chair for meals	Until discontinued, Starting today Head of bed adjustment:

Nursing Interventions - Bladder Scan/ISC

☐ Bladder scan	As needed for post void residuals, inability to void with discomfort, or inability to void within 6 hours
☐ Straight cath	As needed Intermittent Straight Cath if bladder scan residual is greater than: If straight catheterization needed more than 2 times, notify physician

Nursing Interventions - Stroke Patient Education

☑ Provide and document stroke education	Until discontinued, Starting today

Consults

Ancillary Consults

☑ SLP Clinical Swallow Evaluation	Routine, Until therapy completed Reason for swallow evaluation: Dysphasia
☐ SLP eval and treat: Language, Cognition, Speech and/or Voice	Routine, Until therapy completed Reasons for treatment: Language, cognition, speech or voice Can patient sit upright? Does patient have a tracheostomy?
☑ PT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason for PT? Other Specify other reason: Stroke
☑ OT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason(s) for OT? Other Specify other reason: Stroke

☐ Inpatient consult to Social Work	Specify other reason: Stroke Reason for Consult: Did you contact Social Work?
☐ Inpatient consult to Nutrition Services	Reason for Consultation:
☐ Inpatient consult to Palliative Care	Reason for consult? Did you contact the consultant?
☐ Inpatient consult to Physical Medicine Rehab	Reason for Consult? Level of Consultation: Did you contact the consultant? Routine
☐ Inpatient consult to Spiritual Care	Reason for Consult:
☐ Inpatient consult to Case Management	Reason for Consult: Did you contact Case Management?

Ancillary Consults - Stroke Coordinator

☐ Inpatient consult to Stroke Coordinator	Reason for Consult?

Physician Consult - Neurology

☑ Inpatient consult to Neurology	Reason for Consult? Stroke Level of Consultation: Consultation and Management Did you contact the consultant? Routine

Labs

Labs - Next AM

☐ Complete blood count	Morning draw For 1 Occurrences, Blood
☐ Basic metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Comprehensive metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Hemoglobin A1c	Once, Blood
☐ Lipid panel	Once, Blood
☐ Thyroid stimulating hormone	Morning draw For 1 Occurrences, Blood

Imaging

Imaging - Head and Neck

☐ CT Head wo Contrast	Routine, Once, Starting H+24 Hours For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Head wo and/or w Contrast	Routine, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Neck wo and/or w Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Brain wo Contrast	Routine, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Angio Head wo Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Angio Neck w Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ Vascular US duplex carotid bilateral	Routine, Once
☐ Vascular US transcranial Doppler (TCD) complete	Routine, Once
☐ Vascular US transcranial Doppler (TCD) limited	Routine, Once

Other Tests

Cardiac Studies - TTE

☐ Transthoracic echocardiogram (TTE) complete with contrast, bubble, and 3D PRN order panel

☐ Transthoracic echocardiogram (TTE) complete with contrast, bubble, and 3D PRN	Routine, Once Contrast Enhancement (Bubble Study, Definity, Optison) may be used if criteria listed in established evidence-based protocol has been identified. Contrast and bubble study per evidence based protocol Where should test be performed?

	Additional requests: Scheduling/ADT
☐ perflutren lipid microsphere (DEFINITY) 1.3 mL in sodium chloride 0.9 % 8.7 mL injection	10 mL, intravenous, for 10 Minutes, Once in imaging, For 1 Doses, CV Medication Orders

☐ Transthoracic echocardiogram (TTE) limited with contrast, bubble, and 3D PRN order panel

☐ Transthoracic echocardiogram (TTE) limited with contrast, bubble, and 3D PRN	Routine, Once Contrast Enhancement (Bubble Study, Definity, Optison) may be used if criteria listed in established evidence-based protocol has been identified. Contrast and bubble study per evidence based protocol Where should test be performed? Additional requests: Scheduling/ADT
☐ perflutren lipid microsphere (DEFINITY) 1.3 mL in sodium chloride 0.9 % 8.7 mL injection	10 mL, intravenous, for 10 Minutes, Once in imaging, For 1 Doses, CV Medication Orders

DVT/VTE Prophylaxis

DVT/VTE Prophylaxis - Mechanical

☑ Mechanical VTE Prophylaxsis (Single Response)

○ Place sequential compression device	Until discontinued, Starting today Upper or lower extremity: Lower Side:
○ Mechanical VTE Prophylaxis - SCDs + GCS	**"And" Linked Panel**
☐ Apply graduated compression stockings	Upper or lower extremity: Lower
☐ Place sequential compression device	Until discontinued, Starting today Upper or lower extremity: Lower Side:
○ Reason for no mechanical VTE prophylaxis	Reason for no VTE prophylaxis at admission?

Fluid and Electrolytes

IV Boluses (Single Response)

○ lactated ringers (LR) bolus	intravenous, Once, For 1 Doses
○ sodium chloride 0.9 % (NS) bolus	intravenous, Once, For 1 Doses

IV Fluids (Single Response)

○ lactated ringers infusion	intravenous, Continuous
○ sodium chloride 0.9% (NS) infusion	intravenous, Continuous

Medications

Antihypertensives Pre-Alteplase Administration (if BP is greater than 185/110 mmHg) (Single Response)

○ labetalol IV injection	20 mg, intravenous, for 2 Minutes, Every 10 min PRN, high blood pressure, BP greater than 185/110 mmHg in patient otherwise eligible for alteplase, For 2 Doses
○ niCARdipine IV infusion	2.5-15 mg/hr, intravenous, Continuous *ONLY if SBP GREATER than 185 or DBP GREATER than 110 PRIOR to alteplase* GOAL EFFECT: BP LESS than 185/110 *Adjust to maintain proper BP limits* INITIAL RATE: 5 mg/hr USUAL DOSE RANGE: 2.5-15 mg/hr TITRATION DOSE: 2.5 mg/hr TITRATION FREQUENCY: 5 min *Individual cases may require deviation from parameters (with prescriber approval)*

Antihypertensives Post-Alteplase Administration (Single Response)

For 24 hours following alteplase:

-Keep SBP **LESS** than **OR** equal to 180 mmHg

AND

-Keep DBP **LESS** than **OR** equal to 105 mmHg to avoid hemorrhagic conversion

After first several days post-stroke consider antihypertensive treatment for:

-SBP **GREATER** than **OR** equal to 140 mmHg

OR

-DBP **GREATER** than **OR** equal to 90 mmHg

- O IV Antihypertensives During and After Alteplase Administration (BP GREATER than 180/105 mmHg) (Single Response)
  - O labetalol (NORMODYNE) bolus and infusion
    - ☐ labetalol (NORMODYNE) - bolus — 10 mg, intravenous, Once as needed, high blood pressure, SBP above 180 or DBP above 105 during or after alteplase administration., For 1 Doses
      Bolus - to be given prior to initiating continuous labetalol infusion.
    - ☐ labetalol (NORMODYNE) - infusion — 0.5-8 mg/min, intravenous, Continuous
      GOAL EFFECT: SBP 180 mmHg or less, and DBP 105 mmHg or less during and after alteplase administration.
      START RATE: 2 mg/min
      TITRATION DOSE: 1 mg/min
      TITRATION FREQUENCY: 20 min
      CONTACT PRESCRIBER: Cannot maintain BP goals at maximum dose; HR less than 60 or greater than 120 BPM; maximum total daily dose of 300 mg

      Individual cases may require deviation from parameters (with prescriber approval)
  - O niCARdipine (CARDENE) - infusion — 5-15 mg/hr, intravenous, Continuous
    GOAL EFFECT: SBP 180 mmHg or less, and DBP 105 mmHg or less during and after alteplase administration.
    START RATE: 5 mg/hr
    TITRATION DOSE: 2.5 mg/hr
    TITRATION FREQUENCY: 5 min
    CONTACT PRESCRIBER: Cannot maintain BP goals at maximum dose.
    *Individual cases may require deviation from parameters (with prescriber approval)

Antithrombotics (Single Response) (Selection Required)

Begin antithrombotic agent 24 to 48 hours post-stroke, ensuring **at least 24 hours between alteplase and antithrombotic** administration

Generally aspirin plus clopidogrel (PLAVIX) **combination therapy** in post stroke patients is **only recommended** in those patients with recent AMI, ACS, or arterial stent placement

- O aspirin 325 mg daily - to start in 24 hours (Single Response)
  - O aspirin tablet — 162 mg, oral, Daily, Starting H+24 Hours
    Indication:
  - O aspirin chewable tablet — 162 mg, oral, Daily, Starting H+24 Hours
    Indication:
  - O aspirin suppository — 150 mg, rectal, Daily, Starting H+24 Hours
- O clopidogrel (PLAVIX) tablet 75 mg - to start in 24 hours — 75 mg, oral, Daily, Starting H+24 Hours
  Do not give with 24 hours of alteplase administration
- O dipyridamole-aspirin (AGGRENOX) capsule 25-200 mg - to start in 24 hours — 1 capsule, oral, 2 times daily, Starting H+24 Hours
  Do not give with 24 hours of alteplase administration.
- O Reason for not Administering Antithrombotic Therapy by EOD 2 — Reason for not administering antithrombotic therapy by end of day 2?

Statins (Single Response)

- O atorvastatin (LIPITOR) tablet 40 mg — 40 mg, oral, Daily
- O atorvastatin (LIPITOR) tablet 80 mg — 80 mg, oral, Daily
- O Reason For Not Prescribing Statin Medication At Discharge — Reason for not prescribing statin medication at discharge?

Nicotine Replacement

- ☐ Nicotine Replacement - Patch for GREATER than 10 Cigarettes Daily (Single Response)
  - O nicotine (NICODERM CQ) 21 mg/24 hr — 1 patch, transdermal, for 24 Hours, Daily

patch — Time to remove patch:

○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

☐ Nicotine Replacement - Patch for LESS than OR equal to 10 Cigarettes Daily (Single Response)

○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

○ nicotine (NICODERM CQ) 7 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

☐ nicotine (NICORETTE) gum - 4 mg dose if first cigarette smoked within 30 minutes of waking — 4 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke
Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

☐ nicotine (NICORETTE) gum - 2 mg dose if first cigarette smoked more than 30 minutes after waking — 2 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke
Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

PRN Medications

Analgesics - Mild Pain (Single Response)

○ acetaminophen (TYLENOL) — **"Or" Linked Panel**

☐ acetaminophen (TYLENOL) tablet — 1,000 mg, oral, Every 6 hours PRN, mild pain

☐ acetaminophen (TYLENOL) liquid — 975 mg, oral, Every 6 hours PRN, mild pain
Give oral liquid if patient prefers or per feeding tube if present.

☐ acetaminophen (TYLENOL) suppository — 975 mg, rectal, Every 6 hours PRN, mild pain
Give PR if unable to administer by mouth or feeding tube.

Antiemetics

☐ Nausea/Vomiting Treatment - 1st Line (Single Response)

○ ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV — **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet — 4 mg, oral, Every 8 hours PRN, nausea, vomiting
1st Line Option:
-Give IV if patient is unable to take orally.
-Patient should allow tablet to dissolve on tongue.
-Do not remove from blister pack until just before administering.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ ondansetron (ZOFRAN) IV — 4 mg, intravenous, Every 8 hours PRN, nausea, vomiting
1st Line Option:

-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ promethazine (PHENERGAN) PO or PR (Selection Required) — **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet — 25 mg, oral, Every 6 hours PRN, nausea, vomiting
1st Line Option:

-Give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ promethazine (PHENERGAN) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
1st Line Option:

-ONLY give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

O metoclopramide (REGLAN) PO or IV **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

O metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet — 5 mg, oral, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 5 mg, intravenous, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

O prochlorperazine (COMPAZINE) PO or IV/IM or PR **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
-ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ Nausea/Vomiting Treatment - 2nd Line (Single Response)

O ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet — 4 mg, oral, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-Patient should allow tablet to dissolve on tongue.
-Do not remove from blister pack until just before administering.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ ondansetron (ZOFRAN) IV — 4 mg, intravenous, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

O promethazine (PHENERGAN) PO or PR (Selection Required) **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet — 25 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ promethazine (PHENERGAN) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line

agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

○ metoclopramide (REGLAN) PO or IV **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet — 5 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 5 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ prochlorperazine (COMPAZINE) PO or IV/IM or PR **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
-ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

Neurology - Ischemic Stroke Nonthrombolytic Admission [3040001244]

Advisory: This order set is intended for use in the patient who has been determined NOT to be a thrombolytic candidate

General

Order to Admit (Single Response) (Selection Required)

○ Admit to Inpatient	Diagnosis: Bed request comments:
○ Initiate observation status	Diagnosis: Bed request comments:

Code Status - No Active Code Status (Single Response) (Selection Required)

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Code Status (Single Response)

This patient already has a code status order for this admission. If you wish to change this status now, order a different status here and the previous code status order will be automatically discontinued and replaced with your new order.

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Isolation

☐ Initiate airborne isolation	Details
☐ Initiate contact isolation	Details
☐ Initiate droplet isolation	Details

Diet - NPO

☐ Diet - NPO	Diet effective now, Starting today Location:

Activity

☐ As tolerated	Until discontinued, Starting today Type of activity: Up to chair as tolerated Assistance Needed: Assistive Device Needed: How Often to Sit up in Chair: How Often to Ambulate: Activity Instructions (Free Text): Type of Restriction: Bedrest Instructions:
☐ Up with assistance (ambulate)	Until discontinued, Starting today Type of activity: Ambulate patient as tolerated Assistance Needed: with Assistance Assistive Device Needed: How Often to Sit up in Chair: How Often to Ambulate: Activity Instructions (Free Text): Type of Restriction: Bedrest Instructions:
☐ Bedrest	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: How Often to Sit up in Chair: How Often to Ambulate: Activity Instructions (Free Text): Type of Restriction: Strict Bedrest Bedrest Instructions:
☐ Bedrest with bathroom privileges	Until discontinued, Starting today Type of activity: Assistance Needed:

	Assistance Needed: Assistive Device Needed: How Often to Sit up in Chair: How Often to Ambulate: Activity Instructions (Free Text): Type of Restriction: Bedrest with Bathroom Privileges Bedrest Instructions:
☐ Bedrest with bedside commode	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: Bedside Commode How Often to Sit up in Chair: How Often to Ambulate: Activity Instructions (Free Text): Type of Restriction: Bedrest with Bathroom Privileges Bedrest Instructions:

Precautions - Aspiration

☐ Aspiration precautions	Details

Precautions - Seizure

☐ Seizure precautions	Details

Nursing

Vital Signs

☑ Vital Signs (specify frequency)	Daily, Starting today Every 15 minutes X (occurrences): Every 30 minutes X (occurrences): Every 1 hour X (occurrences): Every 2 hours X (occurrences): 4 Every 4 hours X (occurrences): 10 Every 8 hours X (occurrences): Then: Every shift Includes: Temperature, Pulse, Respirations and Blood Pressure
☐ Pulse Oximetry	Once For 1 Occurrences
☐ Continuous Pulse Oximetry	Until discontinued, Starting today
☐ Monitor end tidal CO2	Routine, Once

Telemetry Monitoring

☑ Telemetry monitoring	Until discontinued, Starting today For Until specified Indication for telemetry: New Ischemic or Hemorrhagic Stroke Can the patient be off telemetry for activities (including therapy, ambulation, off-unit procedures, showers, bathroom)?

Notify provider

☑ Notify Physician (Acute Ischemic Stroke Parameters)	Until discontinued, Starting today Temperature greater than: 38 Temperature less than: Systolic blood pressure greater than: 220 Systolic blood pressure less than: 110 Diastolic blood pressure greater than: 120 Diastolic blood pressure less than: 60 Heart rate greater than: 110 Heart rate less than: 50 Respiratory rate greater than: 24 Respiratory rate less than: SpO2 less than: Fingerstick glucose greater than: 140 Fingerstick glucose less than: 60 Urine output less than: Other: Worsening of stroke symptoms or other decline in neurological status, any seizure activity, headache, change in level of consciousness,No BM in 48 hours

Nursing Assessments - Ischemic CVA Non-Thrombolytic Admission

☐ NIH Stroke Scale assessment	Until discontinued, Starting today

	Every 15 minutes X (occurrences): Every 30 minutes X (occurrences): Every 1 hour X (occurrences): Every 2 hours X (occurrences): 4 Every 4 hours X (occurrences): 10 Every 8 hours X (occurrences): Then: Every shift NIHSS as needed for new neurological changes
☑ Modified NIH Stroke Scale Assessment	Until discontinued, Starting today Every 15 minutes X (occurrences): Every 30 minutes X (occurrences): Every 1 hour X (occurrences): Every 2 hours X (occurrences): 4 Every 4 hours X (occurrences): 10 Every 8 hours X (occurrences): Then: Every shift
☐ Intake and output	Every shift
☐ Strict intake and output	Every shift For Until specified
☐ Weigh patient	Daily
☐ POCT Glucose, blood	Routine, 4 times daily before meals and at bedtime, Blood
Nursing Assessments - Swallow Screen	
☑ Nursing swallow screen if not performed in ED	Once Repeat if suspected neurological changes or swallowing difficulties during stay
Nursing Interventions - Stroke Patient Education	
☑ Provide and document stroke education	Until discontinued, Starting today
Nursing Interventions - Bladder Scan/ISC	
☐ Bladder scan	As needed For post void residuals , inability to void without discomfort, or inability to void within 6 hrs
☐ Intermittent straight cath	Until discontinued, Starting today Bladder scan shows urine volume > 300cc and bladder discomfort. Straight cath more than 2 times, notify physician
Nursing Interventions - Insert and Maintain IV	
☐ Insert and Maintain IV	**"And" Linked Panel**
☐ Insert peripheral IV	STAT, Once For 1 Occurrences Saline lock:
☐ Maintain IV access	Until discontinued, Starting today
☐ Saline lock IV	Routine, Once For 1 Occurrences
☐ sodium chloride 0.9 % flush	10 mL, intravenous, Every 12 hours
☐ sodium chloride 0.9 % flush	10 mL, intravenous, As needed, line care
Nursing Interventions - Head of Bed (Single Response)	
○ Head of bed 30 degrees	Until discontinued, Starting today Head of bed adjustment: 30 degrees
○ Head of bed 45 degrees	Until discontinued, Starting today Head of bed adjustment:
○ Head of bed 90 degrees or in chair for meals	Until discontinued, Starting today Head of bed adjustment:
Respiratory Interventions	
☐ Cough & deep breathe	Routine, Once
☐ Incentive spirometry	Routine, Every 1 hour For 72 Hours While awake x 10
☐ Nasal cannula oxygen therapy	Routine, Continuous Keep O2 Sat Above: 92% Device: Nasal Cannula Rate in liters per minute: FiO2:

Consults

Ancillary Consults

☑ SLP Clinical Swallow Evaluation	Routine, Until therapy completed

	Reason for swallow evaluation: Dysphasia
☐ SLP eval and treat: Language, Cognition, Speech and/or Voice	Routine, Until therapy completed Reasons for treatment: Language, cognition, speech or voice Can patient sit upright? Does patient have a tracheostomy?
☑ PT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason for PT? Other Specify other reason: Stroke
☑ OT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason(s) for OT? Other Specify other reason: Stroke
☐ Inpatient consult to Social Work	Reason for Consult: Did you contact Social Work?
☐ Inpatient consult to Nutrition Services	Reason for Consultation:
☐ Inpatient consult to Palliative Care	Reason for consult? Did you contact the consultant?
☐ Inpatient consult to Physical Medicine Rehab	Reason for Consult? Level of Consultation: Did you contact the consultant? Routine
☐ Inpatient consult to Spiritual Care	Reason for Consult:
☐ Inpatient consult to Case Management	Reason for Consult: Did you contact Case Management?
Ancillary Consults - Stroke Coordinator	
☐ Inpatient consult to Stroke Coordinator	Reason for Consult?
Physician Consult - Neurology	
☐ Inpatient consult to Neurology	Reason for Consult? Level of Consultation: Did you contact the consultant? Routine

Labs

Labs - Next AM

☐ Complete blood count	Morning draw For 1 Occurrences, Blood
☐ Basic metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Comprehensive metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Hemoglobin A1c	Once, Blood
☐ Lipid panel	Once, Blood
☐ Thyroid stimulating hormone	Morning draw For 1 Occurrences, Blood

Imaging

Imaging - Head and Neck

☐ CT Head wo Contrast	Routine, Once, Starting H+24 Hours For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Head wo and/or w Contrast	Routine, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Neck wo and/or w Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Brain wo Contrast	Routine, Once For 1 Occurrences Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Angio Head wo Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Angio Neck w Contrast	Routine, Once For 1

Is the patient pregnant?
What is the patient's sedation requirement?

- ☐ Vascular US duplex carotid bilateral — Routine, Once
- ☐ Vascular US transcranial Doppler (TCD) complete — Routine, Once
- ☐ Vascular US transcranial Doppler (TCD) limited — Routine, Once

Other Tests

Cardiac Studies

- ☐ Electrocardiogram, 12-lead Routine — Routine, Once For 1 Occurrences
  Reason for Exam:
- ☐ Electrocardiogram, 12 lead STAT — STAT, Once For 1 Occurrences
  Reason for Exam:

Cardiac Studies - TTE

- ☐ Transthoracic echocardiogram (TTE) complete with contrast, bubble, and 3D PRN order panel
  - ☐ Transthoracic echocardiogram (TTE) complete with contrast, bubble, and 3D PRN — Routine, Once
    Contrast Enhancement (Bubble Study, Definity, Optison) may be used if criteria listed in established evidence-based protocol has been identified. Contrast and bubble study per evidence based protocol
    Where should test be performed?
    Additional requests:
    Scheduling/ADT
  - ☐ perflutren lipid microsphere (DEFINITY) 1.3 mL in sodium chloride 0.9 % 8.7 mL injection — 10 mL, intravenous, for 10 Minutes, Once in imaging, For 1 Doses, CV Medication Orders
- ☐ Transthoracic echocardiogram (TTE) limited with contrast, bubble, and 3D PRN order panel
  - ☐ Transthoracic echocardiogram (TTE) limited with contrast, bubble, and 3D PRN — Routine, Once
    Contrast Enhancement (Bubble Study, Definity, Optison) may be used if criteria listed in established evidence-based protocol has been identified. Contrast and bubble study per evidence based protocol
    Where should test be performed?
    Additional requests:
    Scheduling/ADT
  - ☐ perflutren lipid microsphere (DEFINITY) 1.3 mL in sodium chloride 0.9 % 8.7 mL injection — 10 mL, intravenous, for 10 Minutes, Once in imaging, For 1 Doses, CV Medication Orders

PPD Test

- ☐ PPD Test (Selection Required) — **"And" Linked Panel**
  - ☐ tuberculin (5 units/0.1 mL) injection — 5 Units, intradermal, Once
  - ☐ Administer PPD Skin Test — Routine, Once
    Administer PPD Skin Test as ordered. A Read and Result task will be generated 48 hours from time given., Other

DVT/VTE Prophylaxis

VTE Prophylaxis (Selection Required)

- ☐ Medications for VTE Prophylaxis (Single Response) (Selection Required)
  - ○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis (Single Response)
    - ○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis
      - ☐ enoxaparin (LOVENOX) injection — 40 mg, subcutaneous, Every 24 hours scheduled
        Indication:
    - ○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis for Patient Weight LESS than 45 kg
      Dosing recommended for patients **weighing LESS than 45 kg**
      - ☐ enoxaparin (LOVENOX) injection — 30 mg, subcutaneous, Every 24 hours scheduled
        Indication:
    - ○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis for BMI GREATER than OR equal to 40
      Dosing recommended for patients with **BMI GREATER than OR equal to 40**
      - ☐ enoxaparin (LOVENOX) injection — 30 mg, subcutaneous, Every 12 hours scheduled

Indication:

○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis for CrCl LESS than 30 mL/min

Dosing recommended for **creatinine clearance LESS than 30 mL/min**

☐ enoxaparin (LOVENOX) injection — 30 mg, subcutaneous, Every 24 hours scheduled
Renal dosing
Indication:

○ enoxaparin (LOVENOX) - LMWH VTE Prophylaxis for BMI GREATER than OR equal to 40 and CrCl LESS than 30 mL/min

Dosing recommended for patients with **BMI GREATER than OR equal to 40 and CrCl LESS than 30 mL/min**

☐ enoxaparin (LOVENOX) injection — 40 mg, subcutaneous, Every 24 hours scheduled
Bariatric renal dosing
Indication:

○ Order if enoxaparin (LOVENOX) is NOT indicated or Contraindicated (Single Response) (Selection Required)

○ heparin (UFH) - VTE Prophylaxis (Single Response)

○ heparin (porcine) injection — 5,000 Units, subcutaneous, Every 8 hours scheduled
Enter Indication for use of heparin (UFH) instead of enoxaparin (LOVENOX): (free text):
Indication: VTE Prophylaxis

○ heparin (porcine) injection — 5,000 Units, subcutaneous, Every 12 hours scheduled
Enter Indication for use of heparin (UFH) instead of enoxaparin (LOVENOX): (free text):
Indication: VTE Prophylaxis

○ fondaparinux (ARIXTRA) - ONLY for heparin induced thrombocytopenia (HIT) (Single Response) (Selection Required)

○ fondaparinux (ARIXTRA) - VTE Prophylaxis (Single Response)

○ fondaparinux (ARIXTRA) injection — 2.5 mg, subcutaneous, Daily
Check daily for signs of bleeding and notify physician if bleeding noted
Indication:

○ Reason for no pharmacological VTE prophylaxis (Single Response)

○ Anticoagulant Not Indicated — Reason for No Prophylaxis?

○ Anticoagulant Contraindicated — Reason for No Prophylaxis?

○ Patient is Already Taking Anticoagulants — Reason for No Prophylaxis?

☐ Mechanical VTE Prophylaxsis (Single Response)

○ Place sequential compression device — Until discontinued, Starting today
Upper or lower extremity: Lower
Side:

○ Mechanical VTE Prophylaxis - SCDs + GCS — **"And" Linked Panel**

☐ Apply graduated compression stockings — Upper or lower extremity: Lower

☐ Place sequential compression device — Until discontinued, Starting today
Upper or lower extremity: Lower
Side:

○ Reason for no mechanical VTE prophylaxis — Reason for no VTE prophylaxis at admission?

Fluid and Electrolytes

IV Boluses (Single Response)

○ lactated ringers (LR) bolus — intravenous, Once, For 1 Doses

○ sodium chloride 0.9 % (NS) bolus — intravenous, Once, For 1 Doses

IV Fluids (Single Response)

○ lactated ringers infusion — intravenous, Continuous

○ sodium chloride 0.9% (NS) infusion — intravenous, Continuous

PRN Medications

Analgesics - Mild Pain (Single Response)

○ acetaminophen (TYLENOL) **"Or" Linked Panel**

☐ acetaminophen (TYLENOL) tablet	1,000 mg, oral, Every 6 hours PRN, mild pain
☐ acetaminophen (TYLENOL) liquid	975 mg, oral, Every 6 hours PRN, mild pain Give oral liquid if patient prefers or per feeding tube if present.
☐ acetaminophen (TYLENOL) suppository	975 mg, rectal, Every 6 hours PRN, mild pain Give PR if unable to administer by mouth or feeding tube.

Antiemetics

☐ Nausea/Vomiting Treatment - 1st Line (Single Response)

○ ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet	4 mg, oral, Every 8 hours PRN, nausea, vomiting 1st Line Option: -Give IV if patient is unable to take orally. -Patient should allow tablet to dissolve on tongue. -Do not remove from blister pack until just before administering. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.
☐ ondansetron (ZOFRAN) IV	4 mg, intravenous, Every 8 hours PRN, nausea, vomiting 1st Line Option: -ONLY give IV if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ promethazine (PHENERGAN) PO or PR (Selection Required) **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet	25 mg, oral, Every 6 hours PRN, nausea, vomiting 1st Line Option: -Give PR if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.
☐ promethazine (PHENERGAN) suppository	25 mg, rectal, Every 12 hours PRN, nausea, vomiting 1st Line Option: -ONLY give PR if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

○ metoclopramide (REGLAN) PO or IV **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet	10 mg, oral, Every 6 hours PRN, nausea, vomiting -Give IV if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.
☐ metoclopramide (REGLAN) injection	10 mg, intravenous, Every 6 hours PRN, nausea, vomiting 1st Line Option: -ONLY give IV if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet	5 mg, oral, Every 6 hours PRN, nausea, vomiting 1st Line Option: -Give IV if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.
☐ metoclopramide (REGLAN) injection	5 mg, intravenous, Every 6 hours PRN, nausea, vomiting 1st Line Option: -ONLY give IV if patient is unable to take orally. -If inadequate response within 30 minutes, proceed to next-line

-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ prochlorperazine (COMPAZINE) PO or IV/IM or PR **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
-ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ Nausea/Vomiting Treatment - 2nd Line (Single Response)

○ ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet — 4 mg, oral, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-Patient should allow tablet to dissolve on tongue.
-Do not remove from blister pack until just before administering.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ ondansetron (ZOFRAN) IV — 4 mg, intravenous, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ promethazine (PHENERGAN) PO or PR (Selection Required) **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet — 25 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ promethazine (PHENERGAN) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

○ metoclopramide (REGLAN) PO or IV **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet — 5 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line

agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 5 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ prochlorperazine (COMPAZINE) PO or IV/IM or PR **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
-ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

Bowel Management

☐ Constipation Prevention (Selection Required)

Select at least 1 preventative agent. Senna recommended if receiving scheduled opioids.

☐ senna-docusate (PERICOLACE) 8.6-50 mg per tablet — 1 tablet, oral, Nightly
Bowel Regimen - for prevention of constipation.

☐ polyethylene glycol (GLYCOLAX) packet — 17 g, oral, Daily
Bowel Regimen - for prevention of constipation.

☐ psyllium (METAMUCIL) packet — 1 packet, oral, Daily
Bowel Regimen - for prevention of constipation.

☐ senna (SENOKOT) tablet — 2 tablet, oral, Nightly
Bowel Regimen - for prevention of constipation.

☐ senna (SENOKOT) 8.8 mg/5 mL syrup — 10 mL, oral, Nightly
Bowel Regimen - for prevention of constipation.

☐ Constipation Treatment - 1st Line (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ bisacodyl (DULCOLAX) (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ bisacodyl (DULCOLAX) tablet — 10 mg, oral, Daily PRN, constipation
1st line for treatment of constipation - give scheduled if no bowel movement in past 24 hours.

○ magnesium hydroxide (MOM) - avoid if CrCl LESS than 30 mL/min (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ magnesium hydroxide (MOM) suspension — 30 mL, oral, Daily PRN, constipation
1st line for treatment of constipation - give scheduled if no bowel movement in past 24 hours

☐ Constipation Treatment - 2nd Line (Single Response)

Select agent to be added if no BM in previous 48 hours.

○ bisacodyl (DULCOLAX) suppository — 10 mg, rectal, Daily PRN, constipation
2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours

○ glycerin adult suppository — 1 suppository, rectal, Daily PRN, constipation
2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours

○ magnesium citrate solution — 296 mL, oral, Once as needed, constipation, constipation, For 1 Doses
2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours.
If no bowel movement within 3 hours of magnesium citrate administration, contact provider for further instructions.

☐ Constipation Treatment - 2nd Line (Renal) (Single Response)

Select agent to be added if no BM in previous 48 hours.

- O bisacodyl (DULCOLAX) suppository — 10 mg, rectal, Daily PRN, constipation
  2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours
- O glycerin adult suppository — 1 suppository, rectal, Daily PRN, constipation
  2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours

Medications

Antithrombotics (Single Response) (Selection Required)

Begin antithrombotic agent within 24 to 48 hours post-stroke, ensuring **at least 24 hours between alteplase and antithrombotic** administration

- O aspirin (Single Response)
  - O aspirin daily - start now (Single Response)
    - O aspirin tablet — 162 mg, oral, Daily, Starting today
      Indication:
    - O aspirin chewable tablet — 162 mg, nasogastric tube, Daily, Starting today
      Indication:
    - O aspirin suppository — 150 mg, rectal, Daily, Starting today
  - O aspirin daily - start in 24 hours (Single Response)
    - O aspirin tablet — 162 mg, oral, Daily, Starting H+24 Hours
      Indication:
    - O aspirin chewable tablet — 162 mg, nasogastric tube, Daily, Starting H+24 Hours
      Indication:
    - O aspirin suppository — 150 mg, rectal, Daily, Starting H+24 Hours
- O clopidogrel (PLAVIX) (Single Response)

  Begin antithrombotic agent within 24 to 48 hours post-stroke, ensuring **at least 24 hours between alteplase and antithrombotic** administration
  - O clopidogrel (PLAVIX) tablet 75 mg - start now — 75 mg, oral, Once, Starting today, For 1 Doses
  - O clopidogrel (PLAVIX) tablet 75 mg - start in 24 hours — 75 mg, oral, Daily, Starting H+24 Hours
- O aspirin + clopidogrel (PLAVIX) for Mild Stroke NIH score 5 or LESS
  - ☐ aspirin tablet 81 mg — 81 mg, oral, Daily
    Indication:
  - ☐ clopidogrel (PLAVIX) loading dose followed by 75 mg daily for 21 days (Selection Required) — **"And" Linked Panel**
    - ☐ clopidogrel (PLAVIX) tablet — 300 mg, oral, Once, For 1 Doses
    - ☐ clopidogrel (PLAVIX) tablet — 75 mg, oral, Daily, Starting tomorrow, For 21 Days
- O dipyridamole-aspirin (AGGRENOX) (Single Response)

  Begin antithrombotic agent within 24 to 48 hours post-stroke, ensuring **at least 24 hours between alteplase and antithrombotic** administration
  - O dipyridamole-aspirin (AGGRENOX) capsule 25-200 mg - start now — 1 capsule, oral, 2 times daily, Starting today
  - O dipyridamole-aspirin (AGGRENOX) capsule 25-200 mg - start in 24 hours — 1 capsule, oral, 2 times daily, Starting H+24 Hours
- O Reason for not Administering Antithrombotic Therapy by EOD 2 — Reason for not administering antithrombotic therapy by end of day 2?

Statins (Single Response)

- O atorvastatin (LIPITOR) tablet 40 mg — 40 mg, oral, Daily
- O atorvastatin (LIPITOR) tablet 80 mg — 80 mg, oral, Daily
- O Reason For Not Prescribing Statin Medication At Discharge — Reason for not prescribing statin medication at discharge?

Antihypertensives (Single Response)

During initial 24 hours post-stroke, **recommended to not lower blood pressure unless:**

-SBP **GREATER** than 220 mmHg

OR

-DBP **GREATER** than 120 mmHg

After first several days post-stroke consider antihypertensive treatment for:
-SBP **GREATER** than **OR** equal to 140 mmHg
OR
-DBP **GREATER** than **OR** equal to 90 mmHg

- O IV Antihypertensives for SBP GREATER than 220 mmHg OR DBP GREATER than 120 mmHg (Single Response)
  - O labetalol (NORMODYNE,TRANDATE) loading and maintenance doses
    - ☐ labetalol (NORMODYNE) - bolus — 10 mg, intravenous, for 1-2 Minutes, Once as needed, high blood pressure, blood pressure higher than 220/120, For 1 Doses
      Administer if SBP is above 220 mmHg or DBP is above 120 mmHg.
    - ☐ labetalol (NORMODYNE) - infusion — 0.5-8 mg/min, intravenous, Continuous
  - O niCARdipine (CARDENE) - infusion — 2.5-15 mg/hr, intravenous, Continuous
    Starting rate 5 mg/hr. May titrate by 2.5 mg/hr at 5 minute intervals to maintain goal SBP 220 or less, and DBP 120 or less. Maximum dose 15 mg/hr.

Anticoagulants for Atrial Fibrillation or Flutter (Single Response)
Risk of hemorrhagic conversion should be weighed against benefit of anticoagulation, **especially during the first 14 days post-stroke**. Carefully consider start date.

- O apixaban (ELIQUIS)
  - ☐ apixaban (ELIQUIS) (Single Response)
    - O apixaban (ELIQUIS) tablet — 5 mg, oral, 2 times daily
      Indication:
  - ☐ apixaban (ELIQUIS) - reduced dose if any 2 of the following: weight less than OR equal to 60 kg; age greater than OR equal to 80 yo; or SCr greater than OR equal to 1.5 mg/dL (Single Response)
    - O apixaban (ELIQUIS) tablet — 2.5 mg, oral, 2 times daily
      Indication:
- O rivaroxaban (XARELTO) — 20 mg, oral, Daily with dinner
  Indication:
- O dabigatran (PRADAXA) — 150 mg, oral, 2 times daily
  Indication:
- O warfarin (COUMADIN) (Single Response)
  - O warfarin (COUMADIN) with bridging options - Provider to Dose (Single Response)
    - O warfarin (COUMADIN) - Provider to Dose
      - ☐ warfarin (COUMADIN) - Provider to Dose (Single Response)
        - O warfarin (COUMADIN) - Provider to Dose — Indication for use of Warfarin:
      - ☐ Protime - INR (Single Response)
        - O Prothrombin time with INR — Daily, Blood
      - ☐ warfarin (COUMADIN) tablet (Single Response)
        - O warfarin (COUMADIN) tablet - one time dosing
          - ☐ warfarin (COUMADIN) tablet (Single Response)
            - O warfarin (COUMADIN) tablet — oral, Once, Starting today at 5:00 PM, For 1 Doses
              Indication for use of Warfarin:
          - ☐ warfarin (COUMADIN) placeholder for MAR (Single Response)
            - O Patient is on: warfarin (COUMADIN) one time dosing — Details
        - O warfarin (COUMADIN) - NO DOSE TODAY — Details
        - O warfarin (COUMADIN) tablet - other dosing (Single Response)
          - O warfarin (COUMADIN) tablet — oral
            Indication for use of Warfarin:

○ warfarin (COUMADIN) with enoxaparin (LOVENOX) bridging - Provider to Dose

☐ warfarin (COUMADIN) - Provider to Dose (Single Response)

○ warfarin (COUMADIN) - Provider to Dose — Indication for use of Warfarin:

☐ Protime - INR (Single Response)

○ Prothrombin time with INR — Daily, Blood

☐ enoxaparin (LOVENOX) injection — 1 mg/kg, subcutaneous, Every 12 hours scheduled
All bridging should be delayed until adequate hemostasis has been achieved
Indication:

☐ warfarin (COUMADIN) tablet (Single Response)

○ warfarin (COUMADIN) tablet - one time dosing

☐ warfarin (COUMADIN) tablet (Single Response)

○ warfarin (COUMADIN) tablet — oral, Once, Starting today at 5:00 PM, For 1 Doses
Indication for use of Warfarin:

☐ warfarin (COUMADIN) placeholder for MAR (Single Response)

○ Patient is on: warfarin (COUMADIN) one time dosing — Details

○ warfarin (COUMADIN) - NO DOSE TODAY — Details

○ warfarin (COUMADIN) tablet - other dosing (Single Response)

○ warfarin (COUMADIN) tablet — oral
Indication for use of Warfarin:

○ warfarin (COUMADIN) with enoxaparin (LOVENOX) bridging CrCl LESS than 30 mL/min - Provider to Dose

enoxaparin (LOVENOX) treatment is dosed daily for CrCl LESS than 30 mL/min.

☐ warfarin (COUMADIN) - Provider to Dose (Single Response)

○ warfarin (COUMADIN) - Provider to Dose — Indication for use of Warfarin:

☐ Protime - INR (Single Response)

○ Prothrombin time with INR — Daily, Blood

☐ enoxaparin (LOVENOX) injection — 1 mg/kg, subcutaneous, Every 24 hours scheduled
All bridging should be delayed until adequate hemostasis has been achieved
Indication:

☐ warfarin (COUMADIN) tablet (Single Response)

○ warfarin (COUMADIN) tablet - one time dosing

☐ warfarin (COUMADIN) tablet (Single Response)

○ warfarin (COUMADIN) tablet — oral, Once, Starting today at 5:00 PM, For 1 Doses
Indication for use of Warfarin:

☐ warfarin (COUMADIN) placeholder for MAR (Single Response)

○ Patient is on: warfarin (COUMADIN) one time dosing — Details

○ warfarin (COUMADIN) - NO DOSE TODAY — Details

○ warfarin (COUMADIN) tablet - other dosing (Single Response)

○ warfarin (COUMADIN) tablet — oral
Indication for use of Warfarin:

○ warfarin (COUMADIN) with heparin (UFH) bridging - [ONLY for CrCl LESS than 10 or on dialysis] - Provider to Dose

ONLY for CrCl LESS than 10 or on dialysis

- ☐ warfarin (COUMADIN) - Provider to Dose (Single Response)
  - ○ warfarin (COUMADIN) - Provider to Dose — Indication for use of Warfarin:
- ☐ Protime - INR (Single Response)
  - ○ Prothrombin time with INR — Daily, Blood
- ☐ heparin (UFH) subcutaneous injection (Single Response)
  - ○ heparin (UFH) injection — 5,000 Units, subcutaneous, Every 8 hours scheduled
    All bridging should be delayed until adequate hemostasis has been achieved
    Indication: VTE Prophylaxis
  - ○ heparin (UFH) injection — 5,000 Units, subcutaneous, Every 12 hours scheduled
    All bridging should be delayed until adequate hemostasis has been achieved
    Indication: VTE Prophylaxis
- ☐ warfarin (COUMADIN) tablet (Single Response)
  - ○ warfarin (COUMADIN) tablet - one time dosing
    - ☐ warfarin (COUMADIN) tablet (Single Response)
      - ○ warfarin (COUMADIN) tablet — oral, Once, Starting today at 5:00 PM, For 1 Doses
        Indication for use of Warfarin:
    - ☐ warfarin (COUMADIN) placeholder for MAR (Single Response)
      - ○ Patient is on: warfarin (COUMADIN) one time dosing — Details
  - ○ warfarin (COUMADIN) - NO DOSE TODAY — Details
  - ○ warfarin (COUMADIN) tablet - other dosing (Single Response)
    - ○ warfarin (COUMADIN) tablet — oral
      Indication for use of Warfarin:
- ○ warfarin (COUMADIN) with bridging options - Pharmacist to Dose Daily (Single Response)
  - ○ warfarin (COUMADIN) - Pharmacist to Dose Daily
    - ☐ warfarin (COUMADIN) - Pharmacy to Dose Daily — Routine, Once
      Indication for use of Warfarin:
    - ☐ Protime - INR (Single Response)
      - ○ Prothrombin time with INR — Daily, Blood
    - ☐ warfarin (COUMADIN) placeholder for MAR - Pharmacy to Dose (Single Response)
      - ○ Patient is on: warfarin (COUMADIN) one time dosing — Details
- ○ warfarin (COUMADIN) with enoxaparin (LOVENOX) bridging - Pharmacist to Dose Daily
  - ☐ warfarin (COUMADIN) - Pharmacy to Dose Daily — Routine, Once
    Indication for use of Warfarin:
  - ☐ Protime - INR (Single Response)
    - ○ Prothrombin time with INR — Daily, Blood
  - ☐ enoxaparin (LOVENOX) injection — 1 mg/kg, subcutaneous, Every 12 hours scheduled
    All bridging should be delayed until adequate hemostasis has been achieved
    Indication:
  - ☐ warfarin (COUMADIN) placeholder for MAR - Pharmacy to Dose (Single Response)
    - ○ Patient is on: warfarin (COUMADIN) one time dosing — Details
- ○ warfarin (COUMADIN) with enoxaparin (LOVENOX) bridging CrCl LESS than 30 mL/min - Pharmacist to Dose Daily

enoxaparin (LOVENOX) treatment is dosed daily for CrCl LESS than 30 mL/min.

☐ warfarin (COUMADIN) - Pharmacy to Dose Daily — Routine, Once; Indication for use of Warfarin:

☐ Protime - INR (Single Response)

○ Prothrombin time with INR — Daily, Blood

☐ enoxaparin (LOVENOX) injection — 1 mg/kg, subcutaneous, Every 24 hours scheduled; *All bridging should be delayed until adequate hemostasis has been achieved*; Indication:

☐ warfarin (COUMADIN) placeholder for MAR - Pharmacy to Dose (Single Response)

○ Patient is on: warfarin (COUMADIN) one time dosing — Details

○ warfarin (COUMADIN) with heparin (UFH) bridging - [ONLY for CrCl LESS than 10 or on dialysis] - Pharmacist to Dose Daily

ONLY for CrCl less than 10 or on dialysis

☐ warfarin (COUMADIN) - Pharmacy to Dose Daily — Routine, Once; Indication for use of Warfarin:

☐ Protime - INR (Single Response)

○ Prothrombin time with INR — Daily, Blood

☐ heparin (UFH) subcutaneous injection (Single Response)

○ heparin (UFH) injection — 5,000 Units, subcutaneous, Every 8 hours scheduled; *All bridging should be delayed until adequate hemostasis has been achieved*; Indication: VTE Prophylaxis

○ heparin (UFH) injection — 5,000 Units, subcutaneous, Every 12 hours scheduled; *All bridging should be delayed until adequate hemostasis has been achieved*; Indication: VTE Prophylaxis

☐ warfarin (COUMADIN) placeholder for MAR - Pharmacy to Dose (Single Response)

○ Patient is on: warfarin (COUMADIN) one time dosing — Details

Nicotine Replacement

☐ Nicotine Replacement - Patch for GREATER than 10 Cigarettes Daily (Single Response)

○ nicotine (NICODERM CQ) 21 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

☐ Nicotine Replacement - Patch for LESS than OR equal to 10 Cigarettes Daily (Single Response)

○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

○ nicotine (NICODERM CQ) 7 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily; Time to remove patch:

☐ nicotine (NICORETTE) gum - 4 mg dose if first cigarette smoked within 30 minutes of waking — 4 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke; Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

☐ nicotine (NICORETTE) gum - 2 mg dose if first cigarette smoked more than 30 minutes after waking — 2 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke; Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

Reason For Not Administering IV Thrombolytic (Selection Required)

☐ Reason for not initiating IV thrombolytic: Time last known well to arrival in the ED greater than 4.5 hrs — Reason for not initiatiing IV Thrombolytic?

known well to arrival in the ED greater than 4.5 hrs	
☐ Reason for not initiating IV thrombolytic: Patient received IV or IA t-PA at transferring hospital	Reason for not initiatiing IV Thrombolytic? Patient received IV or IA t-PA at a transferring hospital
☐ Reason for not initiating IV thrombolytic: Patient has a NIHSS score of zero	Reason for not initiatiing IV Thrombolytic? Patient has a NIHSS score of zero
☐ Reason for not initiating IV thrombolytic: Patient/family refused	Reason for not initiatiing IV Thrombolytic? Patient/family refused
☐ Reason for not initiating IV thrombolytic: Other (please provide additional details)	Reason for not initiatiing IV Thrombolytic?

Neurology - Hemorrhagic Stroke Admission [3040001242]

Initial monitoring and management of ICH patients should take place in an intensive care unit or dedicated stroke unit with physician and nursing neuroscience acute care expertise. (Class I; Level of Evidence B, AHA/ASA 2015)

General

Order to Admit (Single Response) (Selection Required)

○ Admit to Inpatient	Diagnosis: Bed request comments:
○ Initiate observation status	Diagnosis: Bed request comments:

Code Status - No Active Code Status (Single Response) (Selection Required)

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Code Status (Single Response)

This patient already has a code status order for this admission. If you wish to change this status now, order a different status here and the previous code status order will be automatically discontinued and replaced with your new order.

○ Full code - Default	Details
○ Full code - Confirmed	Details
○ No CPR/Do Not Intubate	Details
○ No CPR/Intubation OK	Details

Isolation

☐ Initiate airborne isolation	Details
☐ Initiate contact isolation	Details
☐ Initiate droplet isolation	Details

Diet - NPO

☐ Diet - NPO	Diet effective now, Starting today Location:

Activity

☐ Activity: Strict Bedrest	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: Activity Instructions (Free Text): Type of Restriction: Strict Bedrest Bedrest Instructions:
☐ Activity: Bedrest with Bedside Commode	Until discontinued, Starting today Type of activity: Assistance Needed: Assistive Device Needed: Bedside Commode Activity Instructions (Free Text): Type of Restriction: Strict Bedrest Bedrest Instructions:
☐ Activity: With Assistance	Until discontinued, Starting today Type of activity: Assistance Needed: with Assistance Assistive Device Needed: Activity Instructions (Free Text): Type of Restriction: Bedrest Instructions:

Precautions - Seizure

☐ Seizure precautions	Details

Nursing

Vital Signs

☑ Vital Signs (specify frequency)	Daily, Starting today Every 15 minutes X (occurrences):

	Every 30 minutes X (occurrences): Every 1 hour X (occurrences): Every 2 hours X (occurrences): 4 Every 4 hours X (occurrences): 10 Every 8 hours X (occurrences): Then: Every shift Includes: Temperature, Pulse, Respirations and Blood Pressure
☐ Pulse Oximetry	Once For 1 Occurrences
☐ Continuous Pulse Oximetry	Until discontinued, Starting today
☐ Monitor end tidal CO2	Routine, Once
Telemetry Monitoring	
☑ Telemetry monitoring	Until discontinued, Starting today For Until specified Indication for telemetry: New Ischemic or Hemorrhagic Stroke Can the patient be off telemetry for activities (including therapy, ambulation, off-unit procedures, showers, bathroom)?
Notify Provider	
☐ Notify Physician - Vital Signs (Standard Parameters)	Until discontinued, Starting today Temperature greater than: 38 Temperature less than: Systolic blood pressure greater than: 180 Systolic blood pressure less than: 90 Diastolic blood pressure greater than: 105 Diastolic blood pressure less than: 40 Heart rate greater than: 120 Heart rate less than: 50 Respiratory rate greater than: 30 Respiratory rate less than: 10 SpO2 less than: Other: Urine output below 0.5mL/kg/hr, symptomatic hypotension or bradycardia Provider to notify: Primary Service
☐ Notify provider - Target Blood Pressure	Until discontinued, Starting today Provider to notify: Primary Service Reason to notify provider: If target blood pressure 140/90 is not met within 1 hour of admission
☐ Notify Physician - Indicate Reason	Until discontinued, Starting today Provider to notify: Reason to notify provider:
☐ Notify provider - indicate reason	Until discontinued, Starting today Reason to notify provider: If target blood pressure of 140/90 is not met within 1 hour of admission.
Nursing Assessments - Glasgow Coma Scale	
☑ Glasgow Coma Scale Assessment	Every 4 hours For 48 Hours
Nursing Assessments - Swallow Screen	
☑ Nursing swallow screen if not performed in ED	Once Repeat if suspected neurological changes or swallowing difficulties during stay
Nursing Assessments - I&O / Daily Weight	
☐ Intake and output	Every shift
☐ Strict intake and output	Every shift
☐ Weigh patient	Daily
Nursing Interventions - Insert and Maintain IV	
☐ Insert and Maintain IV	**"And" Linked Panel**
☐ Insert peripheral IV	STAT, Once For 1 Occurrences Saline lock:
☐ Maintain IV access	Until discontinued, Starting today
☐ Saline lock IV	Routine, Once For 1 Occurrences
☐ sodium chloride 0.9 % flush	10 mL, intravenous, Every 12 hours

☐ sodium chloride 0.9 % flush	10 mL, intravenous, As needed, line care

Nursing Interventions - Head of Bed (Single Response)

○ Head of bed 30 degrees	Until discontinued, Starting today Head of bed adjustment: 30 degrees
○ Head of bed 45 degrees	Until discontinued, Starting today Head of bed adjustment:
○ Head of bed 90 degrees or in chair for meals	Until discontinued, Starting today Head of bed adjustment:

Nursing Interventions - Keep head midline

☐ Keep head midline	Until discontinued, Starting today

Nursing Assessment - ICP Monitoring

☐ ICP monitoring	Until discontinued, Starting today

Nursing Interventions - Ventriculostomy Care

☐ Ventriculostomy care	Until discontinued, Starting today Type of drain/tube: External Ventricular Drain/Ventriculostomy

Nursing Interventions - Stroke Patient Education

☑ Provide and document stroke education	Until discontinued, Starting today

Nursing Interventions - Bladder Scan/ISC

☐ Bladder scan	As needed for post void residuals, inability to void with discomfort, or inability to void within 6 hours
☐ Straight cath	As needed Intermittent Straight Cath if bladder scan residual is greater than: If straight catheterization needed more than 2 times, notify physician

Consults

Ancillary Consults

☑ SLP Clinical Swallow Evaluation	Routine, Until therapy completed Reason for swallow evaluation: Dysphasia
☐ SLP eval and treat: Language, Cognition, Speech and/or Voice	Routine, Until therapy completed Reasons for treatment: Language, cognition, speech or voice Can patient sit upright? Does patient have a tracheostomy?
☑ PT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason for PT? Other Specify other reason: Stroke
☑ OT eval and treat	Routine, Until therapy completed Weight bearing: Range of motion restrictions: Reason(s) for OT? Other Specify other reason: Stroke
☐ Inpatient consult to Social Work	Reason for Consult: Did you contact Social Work?
☐ Inpatient consult to Nutrition Services	Reason for Consultation:
☐ Inpatient consult to Palliative Care	Reason for consult? Did you contact the consultant?
☐ Inpatient consult to Physical Medicine Rehab	Reason for Consult? Level of Consultation: Did you contact the consultant? Routine
☐ Inpatient consult to Spiritual Care	Reason for Consult:
☐ Inpatient consult to Case Management	Reason for Consult: Did you contact Case Management?

Ancillary Consults - Stroke Coordinator

☐ Inpatient consult to Stroke Coordinator	Reason for Consult?

Physician Consult - Neurosurgery

☐ Consult to Neurosurgery — Reason for Consult? Routine

Physician Consult - Neurology

☐ Inpatient consult to Neurology — Reason for Consult? Level of Consultation: Did you contact the consultant? Routine

Labs

Labs - Next AM

☐ Complete blood count	Morning draw For 1 Occurrences, Blood
☐ Basic metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Comprehensive metabolic panel	Morning draw For 1 Occurrences, Blood
☐ Hemoglobin A1c	Once, Blood
☐ Lipid panel	Once, Blood
☐ Thyroid stimulating hormone	Morning draw For 1 Occurrences, Blood

Imaging

Imaging - Head and Neck

☐ CT Head wo Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Brain wo Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ CT Angio Head wo and/or w Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?
☐ MR Angio Head wo and w Contrast	Routine, Once For 1 Is the patient pregnant? What is the patient's sedation requirement?

DVT/VTE Prophylaxis

DVT/VTE Prophylaxis - Mechanical

☑ Mechanical VTE Prophylaxsis (Single Response)

○ Place sequential compression device	Until discontinued, Starting today Upper or lower extremity: Lower Side:
○ Mechanical VTE Prophylaxis - SCDs + GCS	**"And" Linked Panel**
☐ Apply graduated compression stockings	Upper or lower extremity: Lower
☐ Place sequential compression device	Until discontinued, Starting today Upper or lower extremity: Lower Side:
○ Reason for no mechanical VTE prophylaxis	Reason for no VTE prophylaxis at admission?

Fluid and Electrolytes

IV Fluids

☐ sodium chloride 0.9 % (NS) infusion — intravenous, Continuous

Medications

Anticoagulation Reversal (Single Response)

If blood products are required, use **General - IP Blood and Blood Component Transfusion Therapy** orderset to place orders

○ Emergent Reversal of warfarin (COUMADIN) for: Life-Threatening Bleed OR Need for Emergent Life-saving Procedure

For emergent full reversal of warfarin (COUMADIN) therapy in patients with:

- A life-threatening bleed
- The need for emergent life-saving surgery/procedure

*Consider reversing only if **INR greater than or equal to 1.4***

☐ Prothrombin time with INR — Once For 1 Occurrences, Blood

☐ phytonadione (VITAMIN K) IVPB for Administration with 4-Factor PCC (Single Response)

- ○ phytonadione (VITAMIN K) IVPB — 10 mg, intravenous, for 30 Minutes, Once, For 1 Doses; Indication for IVPB phytonadione (VITAMIN K)?
- ○ phytonadione (VITAMIN K) IVPB — 5 mg, intravenous, for 30 Minutes, Once, For 1 Doses; Indication for IVPB phytonadione (VITAMIN K)?

☐ Four-Factor Prothrombin Complex Concentrate (KCENTRA) (Single Response)

4-Factor Prothrombin Complex Concentrate (4F-PCC) [KCENTRA] product is **contraindicated in HIT**:

- Use a non-heparin containing 4F-PCC or Fresh Frozen Plasma (FFP)

○ Four-Factor Prothrombin Complex Concentrate (KCENTRA): Fixed Dosing (Single Response)

For severe life-threatening bleeding due to warfarin therapy:

- Provide **initial** fixed dose of **1500 units**
- Patients with a **weight greater than 100 kg** consider **increasing dose to 2000 units**
- Patients with a ***baseline*** **INR greater than 7.5** consider **increasing dose to 2000 units**

If necessary, repeat dosing to achieve goal INR:

- Provide dose of **500 units** if INR **5 or LESS**
- Provide dose of **1000 units** if INR **GREATER than 5**

○ four-factor prothrombin complex concentrate (KCENTRA): Initial Dosing (Single Response)

○ four-factor PCC (KCENTRA) infusion: initial fixed dose — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 1,500 Units, intravenous, Once, For 1 Doses; Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses; Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: weight greater than 100 kg — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 2,000 Units, intravenous, Once, For 1 Doses; Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses; Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: baseline INR greater than 7.5 — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 2,000 Units, intravenous, Once, For 1 Doses; Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses; Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor prothrombin complex concentrate (KCENTRA): Repeat Dosing (Single Response)

○ four-factor PCC (KCENTRA) infusion: repeat dose for an INR 1.5 to 5 — **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 500 Units, intravenous, Once, For 1 Doses; Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses; Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ four-factor PCC (KCENTRA) infusion: repeat dose for — **"Followed by" Linked Panel**

an INR greater than 5

- ☐ four-factor PCC (KCENTRA) infusion — 1,000 Units, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

O Four-Factor Prothrombin Complex Concentrate (KCENTRA): Weight Based Dosing (Single Response)

O INR 1.4 to 3.9: four-factor prothrombin complex concentrate (KCENTRA) **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 25 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

O INR 4.0 to 6.0: four-factor prothrombin complex concentrate (KCENTRA) **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 35 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

O INR 6.1 and Above: four-factor prothrombin complex concentrate (KCENTRA) **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 50 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

O Four-Factor Prothrombin Complex Concentrate (KCENTRA): INR Pending and Known Warfarin Use **"Followed by" Linked Panel**

- ☐ four-factor PCC (KCENTRA) infusion — 25 Units/kg, intravenous, Once, For 1 Doses
  Repeat INR fifteen to thirty minutes after administration
- ☐ sodium chloride 0.9 % flush — 50 mL, intravenous, Once, For 1 Doses
  Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA).
  Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

O Emergent Reversal of heparin (UFH)

Consider Reversing only if patient has received:

- IV heparin dose within 6 hours
- SQ **Therapeutic** heparin dose within 12 hours

Dosing instructions to reverse continuous infusion heparin:

- 0-30 minutes since heparin stopped: prescribe 1 mg of protamine for **each 100 units of heparin administered**
- 30-60 minutes since heparin stopped: prescribe 0.5 mg of protamine for **each 100 units of heparin administered**
- 60-120 minutes since heparin stopped: prescribe 0.375 mg of protamine for **each 100 units of heparin administered**
- 2-6 hours since heparin stopped: prescribe 0.25 mg of protamine for **each 100 units of heparin administered**

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

No single protamine dose should exceed 50 mg administered over 10 minutes due to hypotension with rapid administration

☐ Protamine	intravenous, for 10 Minutes, Once, For 1 Doses -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine second dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses If total dose needed is greater than 50 mg, prescribe BALANCE of total dose -Start 10 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine third dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses If total dose needed is greater than 100 mg, prescribe BALANCE of total dose -Start 20 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose

○ Emergent Reversal of Select Antiplatelet Agents: clopidogrel (PLAVIX), prasugrel (EFFIENT), ticagrelor (BRILLINTA)

Medication Advisories:

- **clopidogrel (PLAVIX) ADVISORY**: Consider reversing only if patient has **received a dose within 5 days**
- **prasugrel (EFFIENT) ADVISORY**: Consider reversing only if patient has **received a dose within 9 days**
- **ticagrelor (BRILINTA) ADVISORY**: Consider reversing only if patient has **received a dose within 3 days**

No antidote available, consider **desmopressin (DDAVP)** for:

- Intracranial hemorrhage
- Renal failure patients

Consider **platelet transfusion** for **surgical candidates:**

Transfuse STAT 2 x 5 pack of pooled random donor platelets if patient will undergo surgery

If blood products are required, use:

General - IP Blood and Blood Component Transfusion Therapy orderset to place orders

☐ desmopressin (DDAVP) for Reversal of Select Antiplatelet Agents	0.4 mcg/kg, intravenous, for 30 Minutes, Once, For 1 Doses

○ Emergent Reversal of LMWH enoxaparin (LOVENOX) and LMWH dalteparin (FRAGMIN) (Single Response)

○ Emergent Reversal of LMWH enoxaparin (LOVENOX)

Dosing instructions to reverse LMWH enoxaparin (LOVENOX):

- If 8 hours or less since last dose: prescribe 1 mg of protamine for **each 1 mg** of enoxaparin administered
- If 8 to 12 hours since last dose: prescribe 0.5 mg of protamine for **each 1 mg** of enoxaparin administered

If life threatening LMWH bleeding persists **OR** significant renal impairment is present:

- A repeat dose of 0.5 mg protamine for each 1 mg of enoxaparin administered **can be considered** if anti-factor **Xa activity remains elevated after 2 to 4 hours**

* Protamine only **partially neutralizes (60%)** of the effects of low molecular weight heparins (LMWH)*

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once, then prescribe 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

No single protamine dose should exceed 50 mg administered over 10 minutes due to hypotension with rapid administration

☐ Protamine	intravenous, for 10 Minutes, Once, For 1 Doses -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine second dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses If total dose needed is greater than 50 mg, prescribe BALANCE of total dose -Start 10 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine third dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses If total dose needed is greater than 100 mg, prescribe BALANCE of total dose -Start 20 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose

○ Emergent Reversal of LMWH dalteparin (FRAGMIN)

Dosing instructions to reverse LMWH dalteparin (FRAGMIN):

- If 8 hours or less since last dose: prescribe 1 mg of protamine for **each 100 units** of dalteparin administered
- If 8 to 12 hours since last dose: prescribe 0.5 mg of protamine for **each 100 units** of dalteparin administered

If life threatening LMWH bleeding persists **OR** significant renal impairment is present:

- A repeat dose of 0.5 mg protamine for each 1 mg of enoxaparin administered **can be considered** if anti-factor **Xa activity remains elevated after 2 to 4 hours**

* Protamine only **partially neutralizes (60%)** of the effects of low molecular weight heparins (LMWH)*

*If protamine **dose is greater than 50 mg**, prescribe protamine 50 mg IV once, then prescribe remainder of **total protamine dose** 10 minutes after completion of first dose*

*If protamine **dose is greater than 100 mg**, prescribe protamine 50 mg IV once, then prescribe 50 mg IV once after 10 minutes, then remainder of **total protamine dose** 20 minutes after completion of first dose*

No single protamine dose should exceed 50 mg administered over 10 minutes due to hypotension with rapid administration

☐ Protamine	intravenous, for 10 Minutes, Once, For 1 Doses -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine second dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+10 Minutes, For 1 Doses If total dose needed is greater than 50 mg, prescribe BALANCE of total dose -Start 10 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose
☐ Protamine third dose if needed-see dosing instructions	intravenous, for 10 Minutes, Once, Starting H+20 Minutes, For 1 Doses

dosing instructions	Doses
	If total dose needed is greater than 100 mg, prescribe BALANCE of total dose -Start 20 minutes after first dose is completely administered -Administer over at least 10 minutes, IV Push -Maximum 50 mg per dose

○ Emergent Reversal of Factor Xa Inhibitors: apixaban (ELIQUIS), rivaroxaban (XARELTO), edoxaban (SAVAYSA), fondaparinux (ARIXTRA)

Medication Advisories

- **apixaban (ELIQUIS)**: Consider reversing only if patient has received a dose within past 2 days
  - (3 days with **renal dysfunction**)
- **rivaroxaban (XARELTO)**: Consider reversing only if patient has received a dose within past 24 hours
  - (2 days if **CrCl is less than 30 mL/min**)
- **edoxaban (SAVAYSA)**: Consider reversing only if patient has received a dose within the **past 2 days**
  - (3 days if **CrCl 30-50 mL/min**, 4 days if **CrCl less than 30 mL/min**)
- **fondaparinux (ARIXTRA)**: Consider reversing only if patient has received a dose within 4 to 5 days
  - (Longer in **renal dysfunction** and in **elderly patients**)

Patient actively bleeding on Factor Xa Inhibitors:

- If patient is actively bleeding, administer supportive care: Fluids, transfusion, treatment of bleeding site
- For life-threatening bleeding **unresponsive to supportive care**, order 4F-PCC (KCENTRA)
- **Maximum** 4F-PCC (KCENTRA) dose is **5000 units**
- Elevated INR/PT screens for drug presence but is not quantitative

4-Factor Prothrombin Complex Concentrate (4F-PCC) [KCENTRA] product is **contraindicated in HIT**:

- Use a non-heparin containing 4F-PCC or Fresh Frozen Plasma (FFP)

☐ Prothrombin time with INR	STAT For 1 Occurrences, Blood
☐ four-factor PCC (KCENTRA) infusion	**"Followed by" Linked Panel**
☐ four-factor PCC (KCENTRA) infusion	50 Units/kg, intravenous, Once, For 1 Doses Repeat INR fifteen to thirty minutes after administration
☐ sodium chloride 0.9 % flush	50 mL, intravenous, Once, For 1 Doses Flush tubing used to administer Prothrombin Complex Concentrate (KCENTRA). Infuse at the same rate as KCENTRA after KCENTRA infused to ensure complete dose is delivered.

○ Emergent Reversal of alteplase (ACTIVASE), tenecteplase (TNKase), or reteplase (RETAVase)

Consider reversing only if patient has received a dose within the last 24 hours

Recommended **first line** therapy is 10 units of cryoprecipitate

If blood products are required, use:

General - IP Blood and Blood Component Transfusion Therapy orderset to place orders

tranexamic acid (CYKLOKAPRON) is recommended **if cryoprecipitate is not available in a timely manner**

☐ tranexamic acid (CYKLOKAPRON): ONLY if cryoprecipitate is NOT available	1,000 mg, intravenous, for 20 Minutes, Once, For 1 Doses Tranexamic Acid Indication:

○ Emergent Reversal of dabigatran (PRADAXA) **"Followed by" Linked Panel**

Consider reversing only if patient has received a dose within:

- The last 3 days for CrCl greater than 50 mL/min
- The last 4 days for CrCl 30 to 50 mL/min
- The last 5 days for CrCl less than 30 mL/min

A second dose may be considered for rebound anticoagulation when:

- idaruCIZUmab (PRAXBIND) effect subsides (approximately 18 to 24hrs) ***and***

- There is clinical and laboratory **evidence of continued dabigatran-associated life-threatening hemorrhage**

*Elevated aPTT screens for drug **presence,** but it is **NOT quantitative***

☐ sodium chloride 0.9 % flush	25 mL, intravenous, Once, For 1 Doses Flush line with 25 mL of normal saline before AND after administration
☐ idaruCIZUmab (PRAXBIND) injection	2.5 g, intravenous, for 5 Minutes, Every 5 min, For 2 Doses -Flush line with 25 mL of normal saline before AND after administration -Give each IV bolus over 5 minutes. -Administer via dedicated IV line
☐ sodium chloride 0.9 % flush	25 mL, intravenous, Once, For 1 Doses Flush line with 25 mL of normal saline before AND after administration

○ Emergent Reversal of argatroban or bivalirudin (ANGIOMAX)

No antidote:

- Stop infusion
- Consider supportive transfusion
- Recombinant activated factor seven (NOVO-SEVEN) **not recommended** due to reports of thrombosis

☐ Prothrombin time with INR	Once For 1 Occurrences, Blood
☐ Activated partial thromboplastin time	Once For 1 Occurrences, Blood
☐ Activated clotting time (ACT)	Once For 1 Occurrences, Blood

Acute Blood Pressure Management (Single Response)

Standard blood pressure goals are SBP **LESS** than 140 **OR** MAP **LESS** than 110:
If alternate blood pressure goals are desired, select agent and **update** desired blood pressure goals **in goal effect section of administration instructions**

For SBP **GREATER** than 220 mmHg **OR** MAP **GREATER** than 150 mmHg:
-Consider aggressive reduction of BP using a continuous intravenous infusion
-BP monitoring every 5 minutes

For SBP **GREATER** than 150 mmHg **OR** MAP **GREATER** than 130 mmHg:
-Consider reduction of BP to systolic target of **LESS** than 140 mmHg using intermittent or continuous intravenous medications
-Clinically reexamine the patient every 15 minutes

○ Antihypertensives (Single Response)

○ labetalol (NORMODYNE) - intermittent injection	intravenous, for 2 Minutes, Every 15 min PRN, high blood pressure, PRN SBP greater than or equal to 140 mmHg or DBP greater than or equal to 90 mmHg. Clinically reexamine the patient every 15 minutes. If goal blood pressure not attained after 3 doses, contact prescriber for further guidance.
○ niCARdipine (CARDENE) - infusion	2.5-15 mg/hr, intravenous, Continuous GOAL EFFECT: SBP less than 140 mmHg or MAP less than 110 mmHg START RATE: 2.5 mg/hr DOSE RANGE: 2.5 - 15 mg/hr TITRATION DOSE: 2.5 mg/hr TITRATION FREQUENCY: 5 min CONTACT PRESCRIBER: SBP less than 90 or greater than 180 mmHg * Individual cases may require deviation from parameters (with provider approval) Goal Blood Pressure (mmHg): SBP less than 140 mmHg

○ labetalol infusion with bolus doses

☐ labetalol (NORMODYNE) - bolus	20 mg, intravenous, for 2 Minutes, Once, For 1 Doses *Loading Dose*
☐ labetalol (NORMODYNE) - infusion	0.5-8 mg/min, intravenous, Continuous GOAL EFFECT: SBP less than 140 mmHg or MAP less than 110 mmHg START RATE: 2 mg/min DOSE RANGE: 0.5-8 mg/min

DOSE RANGE: 0.5-8 mg/min
TITRATION DOSE: 1 mg/min
TITRATION FREQUENCY: 20 min
CONTACT PRESCRIBER: HR less than 60 or greater than 120 BPM; SBP less than 90 or greater than 180 mmHg; maximum total daily dose of 300 mg
*Individual cases may require deviation from parameters (with prescriber approval)

Cerebral Edema Management (Single Response)

○ sodium chloride (HYPERTONIC) - for Cerebral Edema / Elevated ICP

<u>*DO NOT USE THIS FOR TREATMENT OF HYPONATREMIA*</u>

-Use sodium chloride (HYPERTONIC) 3% - for Hyponatremia panel

NOT RECOMMENDED IF SODIUM LESS THAN 130 mEq/L

-Usual Serum sodium goal for cerebral edema is 145 - 155 mEq/L

-A **central line is REQUIRED for 23.4%** sodium chloride administration

-For sodium chloride **3%** infusions, administer through a **central line if available** (preferred if infusion time **GREATER** than 24hrs)

-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein

-Consider 3% sodium infusion mixed **50:50 with sodium acetate and sodium chloride salts** to prevent hyperchloremic metabolic acidosis

-Infusion rates for 3% sodium infusion mixed **50:50 with sodium acetate and sodium chloride salts** average 0.5 mL/kg/hr to 1.5 mL/kg/hr

☐ Notify provider
Until discontinued, Starting today
Provider to notify:
Reason to notify provider: Notify for serum sodium GREATER than 155 mEq/L, increase of GREATER than 10 mEq/L over first 12h, or GREATER than 12 mEq/L over any 24h period; serum osmolality GREATER than 340 mOsm/L; or ICP GREATER than 20 mmHg for 5 minutes or GREATER

☐ Labs (Selection Required)

☐ Initial Electrolyte and Osmolality Labs

May start therapy once labs are drawn

☐ Electrolyte panel - STAT — Once For 1 Occurrences, *May start therapy once labs are drawn*, Blood

☐ Osmolality - STAT — Once For 1 Occurrences, *May start therapy once labs are drawn*, Blood

☐ Maintenance Electrolyte Labs (Single Response) (Selection Required)

○ Electrolyte panel - Every 4 hours — Every 4 hours, Starting H+4 Hours, Blood

○ Electrolyte panel - Every 6 hours — Every 6 hours, Starting H+6 Hours, Blood

☐ Hypertonic Saline bolus and infusion (Single Response)

<u>*Choose based on your institution's policies*:</u> Contact pharmacy for questions

○ Hypertonic Saline - Intermittent Bolus for Elevated Intracranial Pressure (Single Response)

○ sodium chloride 3% (HYPERTONIC) IVPB — 250 mL, intravenous, for 30 Minutes, Every 6 hours PRN, other, As needed for intracranial pressure (ICP) GREATER than 20 mmHg for 5 minutes AND serum sodium LESS than 160 mEq/L
-Infuse over 30 minutes via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein

○ Hypertonic Saline - sodium chloride 3% bolus and sodium chloride 3% infusion

☐ sodium chloride (HYPERTONIC) 3% bolus

☐ sodium chloride (HYPERTONIC) 3% bolus (Single Response)

○ sodium chloride (HYPERTONIC) 3% — 250 mL, intravenous, for 30 Minutes, Once, For 1 Doses

bolus

-Infuse over 30 minutes via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein

☐ sodium chloride (HYPERTONIC) 3% bolus from infusion (Single Response)

○ sodium chloride (HYPERTONIC) 3% bolus from infusion — 250 mL, intravenous, for 30 Minutes, Once, For 1 Doses
-Infuse over 30 minutes via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein

☐ sodium chloride (HYPERTONIC) 3 % infusion - cerebral edema — 50 mL/hr, intravenous, Continuous
-Infuse via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein
-Avoid abrupt discontinuation

○ Hypertonic Saline - sodium chloride 3% bolus and sodium 3% (CHLORIDE-ACETATE) infusion

☐ sodium chloride (HYPERTONIC) 3% bolus — 250 mL, intravenous, for 30 Minutes, Once, For 1 Doses
-Infuse over 30 minutes via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein

☐ sodium 3% (CHLORIDE-ACETATE) infusion - cerebral edema — 50 mL/hr, intravenous, Continuous
-Infuse via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein
-Avoid abrupt discontinuation

○ Hypertonic Saline - sodium chloride 23.4% bolus and 3% infusion options

☐ sodium chloride 23.4% (HYPERTONIC) bolus (Single Response)

○ sodium chloride 23.4% (HYPERTONIC) bolus IVPB (Single Response)

○ sodium chloride 23.4% (HYPERTONIC) bolus — 30 mL, intravenous, for 10 Minutes, Once, For 1 Doses
Administer via CENTRAL LINE ONLY

○ sodium chloride 23.4% (HYPERTONIC) bolus IV PUSH (Single Response)

○ sodium chloride 23.4% (HYPERTONIC) bolus — 30 mL, intravenous, for 5 Minutes, Once, For 1 Doses
Administer via CENTRAL LINE ONLY

☐ Hypertonic Saline Infusion (Single Response) (Selection Required)

○ sodium chloride (HYPERTONIC) 3% infusion - cerebral edema — 50 mL/hr, intravenous, Continuous
-Infuse via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein
-Avoid abrupt discontinuation

○ sodium 3% (CHLORIDE-ACETATE) infusion - cerebral edema — 50 mL/hr, intravenous, Continuous
-Infuse via central line if available
-For peripheral infusion, ensure IV is well placed in a moderate to high volume vein
-Avoid abrupt discontinuation

○ mannitol 20% - for Cerebral Edema

☐ Notify Provider

☐ Notify provider — Until discontinued, Starting today
Provider to notify:
Reason to notify provider: Notify for ICP GREATER than 20 mmHg after completion of mannitol infusion; serum osmol GREATER than 320 mOsm/kg

☐ Labs

☐ BUN — Daily, Blood

☐ Creatinine serum — Daily, Blood

☐ Osmolality — Daily, Blood

☐ Mannitol for Cerebral Edema — **"Followed by" Linked Panel**

☐ mannitol 20% - loading dose	1 g/kg, Intravenous, for 30 Minutes, Once, For 1 Doses Before infusing, ensure no crystallization. Administer using a 0.22 micron filter.
☐ mannitol 20% - IVPB	intravenous, for 30 Minutes, Every 4 hours PRN, Intracranial pressure GREATER than 20 mmHg for GREATER than 5 minutes -Administer STAT for intracranial pressure GREATER than 20 mmHg for GREATER than 5 minutes -Hold if serum osmolality is GREATER than 320 and contact provider

Bowel Management

☐ Constipation Prevention (Selection Required)

Select at least 1 preventative agent. Senna recommended if receiving scheduled opioids.

☐ senna-docusate (PERICOLACE) 8.6-50 mg per tablet	1 tablet, oral, Nightly Bowel Regimen - for prevention of constipation.
☐ polyethylene glycol (GLYCOLAX) packet	17 g, oral, Daily Bowel Regimen - for prevention of constipation.
☐ psyllium (METAMUCIL) packet	1 packet, oral, Daily Bowel Regimen - for prevention of constipation.
☐ senna (SENOKOT) tablet	2 tablet, oral, Nightly Bowel Regimen - for prevention of constipation.
☐ senna (SENOKOT) 8.8 mg/5 mL syrup	10 mL, oral, Nightly Bowel Regimen - for prevention of constipation.

☐ Constipation Treatment - 1st Line (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ bisacodyl (DULCOLAX) (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ bisacodyl (DULCOLAX) tablet	10 mg, oral, Daily PRN, constipation 1st line for treatment of constipation - give scheduled if no bowel movement in past 24 hours.

○ magnesium hydroxide (MOM) - avoid if CrCl LESS than 30 mL/min (Single Response)

Select agent to be given if no BM in previous 24 hours.

○ magnesium hydroxide (MOM) suspension	30 mL, oral, Daily PRN, constipation 1st line for treatment of constipation - give scheduled if no bowel movement in past 24 hours

☐ Constipation Treatment - 2nd Line (Single Response)

Select agent to be added if no BM in previous 48 hours.

○ bisacodyl (DULCOLAX) suppository	10 mg, rectal, Daily PRN, constipation 2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours
○ glycerin adult suppository	1 suppository, rectal, Daily PRN, constipation 2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours
○ magnesium citrate solution	296 mL, oral, Once as needed, constipation, constipation, For 1 Doses 2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours. If no bowel movement within 3 hours of magnesium citrate administration, contact provider for further instructions.

☐ Constipation Treatment - 2nd Line (Renal) (Single Response)

Select agent to be added if no BM in previous 48 hours.

○ bisacodyl (DULCOLAX) suppository	10 mg, rectal, Daily PRN, constipation 2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours
○ glycerin adult suppository	1 suppository, rectal, Daily PRN, constipation 2nd line for treatment of constipation - give scheduled (in addition to 1st line agent) if no bowel movement in past 48 hours

Antiemetics

☐ Nausea/Vomiting Treatment - 1st Line (Single Response)

○ ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet	4 mg, oral, Every 8 hours PRN, nausea, vomiting 1st Line Option:

-Give IV if patient is unable to take orally.
-Patient should allow tablet to dissolve on tongue.
-Do not remove from blister pack until just before administering.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ ondansetron (ZOFRAN) IV — 4 mg, intravenous, Every 8 hours PRN, nausea, vomiting
1st Line Option:

-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ promethazine (PHENERGAN) PO or PR (Selection Required) — **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet — 25 mg, oral, Every 6 hours PRN, nausea, vomiting
1st Line Option:

-Give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ promethazine (PHENERGAN) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
1st Line Option:

-ONLY give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

○ metoclopramide (REGLAN) PO or IV — **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) — **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet — 5 mg, oral, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 5 mg, intravenous, Every 6 hours PRN, nausea, vomiting
1st Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ prochlorperazine (COMPAZINE) PO or IV/IM or PR — **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
-ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
-If inadequate response within 30 minutes, proceed to next-line

agent or contact provider if no further options ordered.

☐ Nausea/Vomiting Treatment - 2nd Line (Single Response)

○ ondansetron (ZOFRAN ODT, ZOFRAN) PO or IV **"Or" Linked Panel**

☐ ondansetron (ZOFRAN-ODT) dispersible tablet — 4 mg, oral, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-Patient should allow tablet to dissolve on tongue.
-Do not remove from blister pack until just before administering.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ ondansetron (ZOFRAN) IV — 4 mg, intravenous, Every 8 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ promethazine (PHENERGAN) PO or PR (Selection Required) **"Or" Linked Panel**

☐ promethazine (PHENERGAN) tablet — 25 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ promethazine (PHENERGAN) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give PR if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (Single Response)

○ metoclopramide (REGLAN) PO or IV **"Or" Linked Panel**

☐ metoclopramide (REGLAN) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ metoclopramide (REGLAN) PO or IV (for CrCl LESS than 40 mL/min) **"Or" Linked Panel**

Suggested dosing based on patient's CrCl

☐ metoclopramide (REGLAN) tablet — 5 mg, oral, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-Give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ metoclopramide (REGLAN) injection — 5 mg, intravenous, Every 6 hours PRN, nausea, vomiting
2nd Line Option:
-ONLY give IV if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

○ prochlorperazine (COMPAZINE) PO or IV/IM or PR **"Or" Linked Panel**

☐ prochlorperazine (COMPAZINE) tablet — 10 mg, oral, Every 6 hours PRN, nausea, vomiting
-Give IV or IM if patient is unable to take orally.
-If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

☐ prochlorperazine (COMPAZINE) injection — 10 mg, intravenous, Every 6 hours PRN, nausea, vomiting
-ONLY give IV if patient is unable to take orally.
-Give IM if patient does not have IV Access
-If inadequate response within 30 minutes, proceed to next-line

agent or contact provider if no further options ordered.

- ☐ prochlorperazine (COMPAZINE) suppository — 25 mg, rectal, Every 12 hours PRN, nausea, vomiting
  -ONLY give PR if patient is unable to take orally and cannot receive IV/IM.
  -If inadequate response within 30 minutes, proceed to next-line agent or contact provider if no further options ordered.

Nicotine Replacement

☐ Nicotine Replacement - Patch for GREATER than 10 Cigarettes Daily (Single Response)

- ○ nicotine (NICODERM CQ) 21 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily
  Time to remove patch:
- ○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily
  Time to remove patch:

☐ Nicotine Replacement - Patch for LESS than OR equal to 10 Cigarettes Daily (Single Response)

- ○ nicotine (NICODERM CQ) 14 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily
  Time to remove patch:
- ○ nicotine (NICODERM CQ) 7 mg/24 hr patch — 1 patch, transdermal, for 24 Hours, Daily
  Time to remove patch:

☐ nicotine (NICORETTE) gum - 4 mg dose if first cigarette smoked within 30 minutes of waking — 4 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke
Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

☐ nicotine (NICORETTE) gum - 2 mg dose if first cigarette smoked more than 30 minutes after waking — 2 mg, buccal, Every 1 hour PRN, smoking cessation, nicotine craving, urge to smoke
Instruct patient to chew into gum, then place between the cheek and gum to enhance absorption. To increase chances of quitting, recommended to chew and park at least 9 pieces per day in the first 6 weeks of cessation.

PRN Medications

Pain Management (Single Response)

○ acetaminophen (TYLENOL) — **"Or" Linked Panel**

- ☐ acetaminophen (TYLENOL) tablet — 1,000 mg, oral, Every 6 hours PRN, mild pain, PRN mild pain or fever greater than 38 °C
- ☐ acetaminophen (TYLENOL) suppository — 975 mg, rectal, Every 6 hours PRN, PRN mild pain or fever greater than 38 °C

2021 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01 — Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01 — Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01 — Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 — Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01 — Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01 — Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01 — Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01 — Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01 — Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01 — Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01 — Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

7

SAINT JOSEPH
Regional Medical Center

Infection Control Information for Medical Staff 2019

Greetings and welcome to SJRMC!

The next few pages will give you some highlights of our facility's Infection Prevention program, the status of the various key elements of the program and the importance of your role in the plan.

Each year, an Infection Prevention Risk Assessment is performed with input from front line associates, managers, directors, infection prevention nurses, Infectious Disease physicians and Occupational Health. Information from the risk assessment is combined with the previous year's plan to formulate a yearly Infection Prevention Plan. Following are some of the key elements from the plan and some quick ready reference information to help you as you care for patients.

Hand Hygiene:

Our goal for hand hygiene is that every health care worker performs hand hygiene prior to and following contact with the patient or the patient environment. Alcohol hand rub is recommended for most of these situations. Dispensers are located in the hallways on units, inside inpatient rooms, and inside procedural rooms. Sinks available inside inpatient and most outpatient rooms for use of soap and water when hands are visibly soiled or when a patient has diarrhea or c difficile. Infection Prevention uses secret shoppers regularly to oversee hand hygiene compliance, and to educate as needed.

We follow the World Health Organization's Your 5 moments for Hand Hygiene. Please see the attachment, which will help guide you on when to clean your hands during patient care activities.

Standard Precautions:

Standard precautions represent the minimum infection prevention measures that apply to all patient care in any setting where health care is delivered. These evidence based practices are designed to both protect health care personnel and prevent the spread of infections between patients. Standard Precautions include: 1) hand hygiene; 2) use of personal protective equipment (e.g., gloves, gowns, facemasks), depending on the anticipated exposure; 3) respiratory hygiene and cough etiquette; 4) safe injection practices; and 5) safe handling of potentially contaminated equipment or surfaces.

Mishawaka
5215 Holy Cross Parkway
Mishawaka, IN 46545
574.335.5000

Plymouth
1915 Lake Avenue
Plymouth, IN 46563
574.948.4000

South Bend
707 East Cedar Street
South Bend, IN 46617
574.335.5000

Rehabilitation Institute
60205 Bodnar Boulevard
Mishawaka, IN 46544
574.335.8800

Physician Network
707 East Cedar Street, Suite 200
South Bend, IN 46617
574.335.0750

The Foundation
707 East Cedar Street, Suite 175
South Bend, IN 46617
574.335.4540

Outreach Services
215 West 4th Street, Suite LL201
Mishawaka, IN 46544
574.335.3898

Graduate Medical Education
611 East Douglas Road, Suite 412
Mishawaka, IN 46545
574.335.6550

Medical Staff Office - Mishawaka
5215 Holy Cross Parkway
Mishawaka, IN 46545
p: 574.335.1050 • f: 574.335.1053

Medical Staff Office - Plymouth
1915 Lake Avenue
Plymouth, IN 46563
p: 574.948.5005 • f: 574.948.5478

Isolation

We are your partners in completely eliminating nosocomial infections. We empower front line Health Care Workers (HCW) to place patients in isolation based on signs and symptoms. This helps stop the spread of organisms, since we know patients can be infectious prior to knowledge of the organism. Patients who are in isolation will have a colored stop sign placed outside their door. The signs provide instructions on required PPE and recommendations for key patient care activities. Following are the isolations we use, the color of the stop signs and examples of situations they would be used:

Contact – marigold- MDRO's : MRSA, VRE, ESBLs, VISA/VRSA, resistant S. Pneumonia, lice, RSV,

Contact/enteric –brown- clostridium difficile, diarrhea of unknown etiology(see algorithm attached regarding ordering of clostridium difficile cultures)

Droplet – green- influenza, mumps, meningitis, pertussis

Airborne- blue- TB, including R/O TB , measles, disseminated varicella, chicken pox

Strict Contact-red- CRE

Some patients will have a history of multiple drug resistant organisms (MDRO). These patients will have a system generated isolation order in the EMR.

Inpatients that have an order for AFB cultures will have a system generated order for airborne isolation. This is an engineering control to alert the associates to the possible need for airborne isolation. These orders can only be discontinued by a Licensed Independent Practitioner (LIP). If a patient is not suspicious for TB, these orders can be discontinued. We advocate the use of Positive Air Purifying Respirators (PAPRs) for airborne isolation. The PAPRs provide better protection than the N-95 masks, which require annual fit testing and require refitting when there is a change in mask vendors. Some of our associates will use the N-95s. This is a departmental decision made in conjunction with Employee Health. Examples of these departments are Respiratory Therapy, Emergency department personnel, and lab personnel.

MDROs:

Patients found to be infected or colonized with MDROs through routine microbiology cultures or active surveillance cultures will be effectively isolated. MDROs of interest include:

MRSA- Methicillin resistant staphylococcus aureus

VRE – Vancomycin resistant enterococcus

ESBL – Extended spectrum beta lactamase producing strains of E coli and K pneumonia

CRE – Carbapenase resistant enterobacteriacea

Standard and contact precautions are implemented. The specific PPE is listed and pictured on the colored stop signs. Most rooms will have PPE in the nurse servers just outside the patient rooms. Dedicated non critical equipment is used and should remain at the bedside. If you use your own stethoscope, please cleanse with the wipes that are available outside the patient room. If you are aware of a patient's history of MDRO, please alert the nursing staff immediately. If you know of a patient that has a history of CRE, please alert the nursing staff and Infection Prevention. We implement additional engineering controls for patients with CRE.

Antibiotic Stewardship:

As part of our annual plan, an antibiogram is provided by the South Bend Medical Foundation. The antibiogram lists the most common organisms and sensitivities for our hospital and the other health care entities that use SBMF for their micro. Our Antibiotic Stewardship Committee is a sub-committee of the Infection Prevention Committee. One activity of the Antibiotic Stewardship Committee is antibiotic therapy review. A Pharmacist on the team reviews ordered antibiotic therapy in an effort to de-escalate antibiotics to the most specific coverage for the organism being treated and to determine if the antibiotic is still needed. In addition, penicillin skin testing has recently been implemented to determine if patients who state that they have a long standing PCN allergy still exhibit signs and symptoms of an allergic reaction. Through this practice, some patients have been found to not have a PCN allergy which has allowed for de-escalation from a broad spectrum antibiotic. You may be contacted by a Pharmacist regarding antibiotic therapy.

Exposures:

Please contact Employee Health if you have a Blood Borne Pathogen exposure. Employee Health will follow up on employee exposures related to meningitis, pertussis, TB, and other organisms based on our community and state experience.

Surveillance for and prevention of Hospital Acquired Infections (HAIs):

The requirement from hospitals to actively survey for specific infections increases year by year. Infection Prevention reviews all positive cultures and all National Health and Safety Network defined surgeries. The reportable infections to NHSN

and Trinity Health are: 1) Central Line Associated Blood stream infections (CLABSIs); 2) Catheter Associated Urinary Tract Infections (CAUTIs); 3) Ventilator Associated Events (VAEs); 4) Hospital Acquired Blood MRSA infections; 5) Hospital acquired C-Diff infections; and 6) Surgical site infections.

Medical Device Related Infections, specifically central lines and urinary catheters. We appreciate your assistance in 1) reviewing the need daily for these devices; 2) avoiding their use when able; and 3) discontinuing them as soon as possible. Our IV team places most PICC lines. We have a Nurse Driven Foley Removal Protocol that has been passed by the Medical Executive Committee. This policy empowers nurses to remove Foley catheters from patients who do not meet specific criteria for the continuation of the Foley catheter. The Central Line Policy gives specific patient criteria when a central line may be needed. Central lines are placed using maximum barriers, including masks, full drape, gowns, gloves and use of chlorhexidine gluconate (CHG).

Hospital acquired c-diff is defined by the National Healthcare Safety Network (NHSN) as a specimen that comes back positive greater than 2 days after a patient is admitted. It is imperative that the attached algorithm be utilized to accurately capture hospital acquired c-diff infections. A PCR and an EIA test should be ordered when testing for c-diff.

Infection Prevention Oversite

The Infection Prevention Committee is a highly engaged multidisciplinary team that meets every month. The Chairperson for the committee is Dr. Meredith Wierman Schmidt Infectious Disease email wiermanm@sjrmc.com. If you would like to participate on the committee, feel free to e-mail Dr. Wierman. The committee actively reviews HAIs, cleaning processes, all new construction, and employee exposures among many other topics.

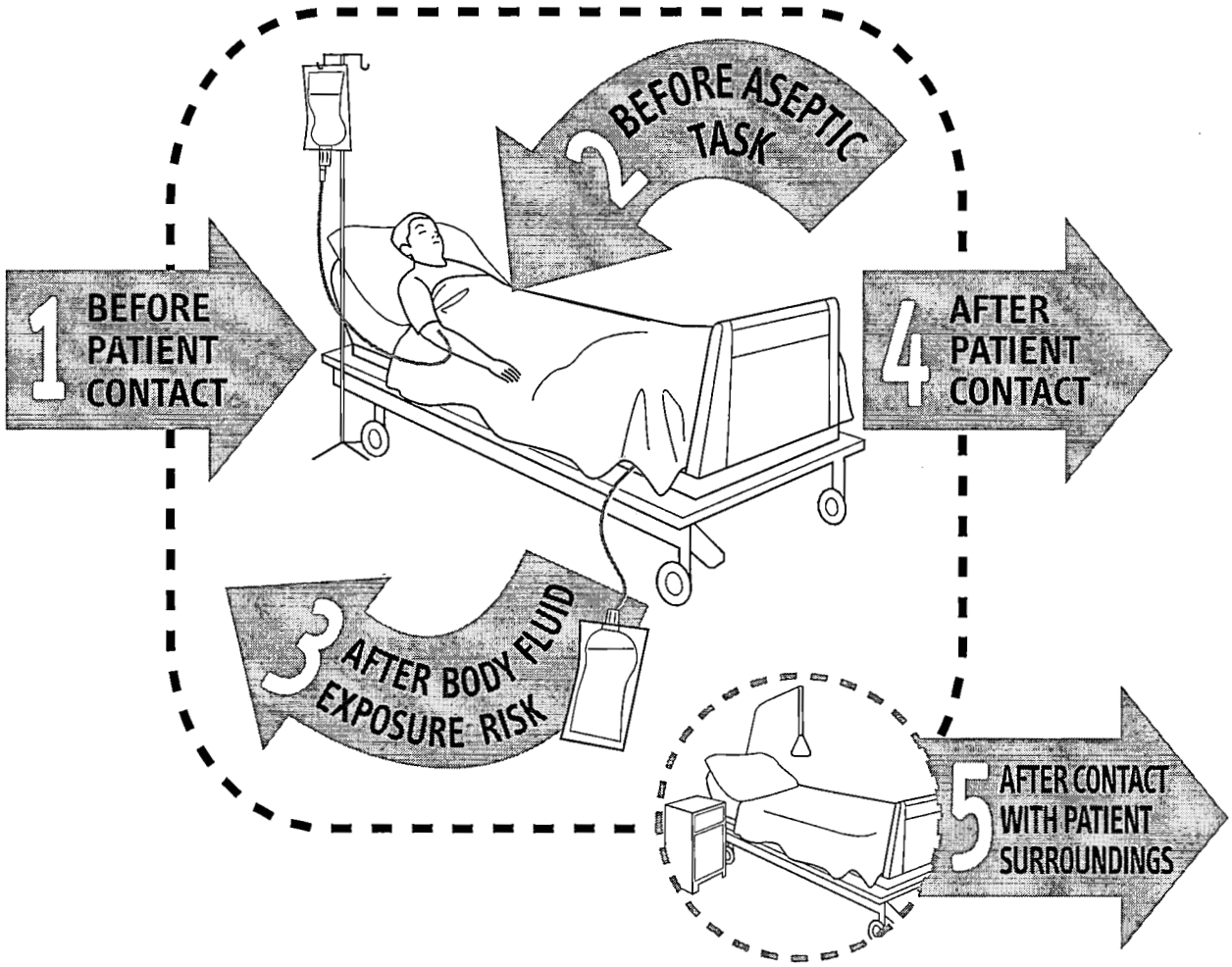
Welcome to SJRMC! We are very glad that you are here. If you have an interest in any components of our IP plan or would like inclusion on our committee, please contact Amy or me at the following:

Amy Bennitt RN BSN office 335.2460 email amy.bennitt@sjrmc.com

Rena Snell RN BSN office 335.1450 email snello@sjrmc.com

Your 5 moments for HAND HYGIENE

Design: mouldfragile network



1 BEFORE PATIENT CONTACT	**WHEN?** Clean your hands before touching a patient when approaching him or her **WHY?** To protect the patient against harmful germs carried on your hands
2 BEFORE AN ASEPTIC TASK	**WHEN?** Clean your hands immediately before any aseptic task **WHY?** To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 AFTER BODY FLUID EXPOSURE RISK	**WHEN?** Clean your hands immediately after an exposure risk to body fluids (and after glove removal) **WHY?** To protect yourself and the health-care environment from harmful patient germs
4 AFTER PATIENT CONTACT	**WHEN?** Clean your hands after touching a patient and his or her immediate surroundings when leaving **WHY?** To protect yourself and the health-care environment from harmful patient germs
5 AFTER CONTACT WITH PATIENT SURROUNDINGS	**WHEN?** Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient **WHY?** To protect yourself and the health-care environment from harmful patient germs

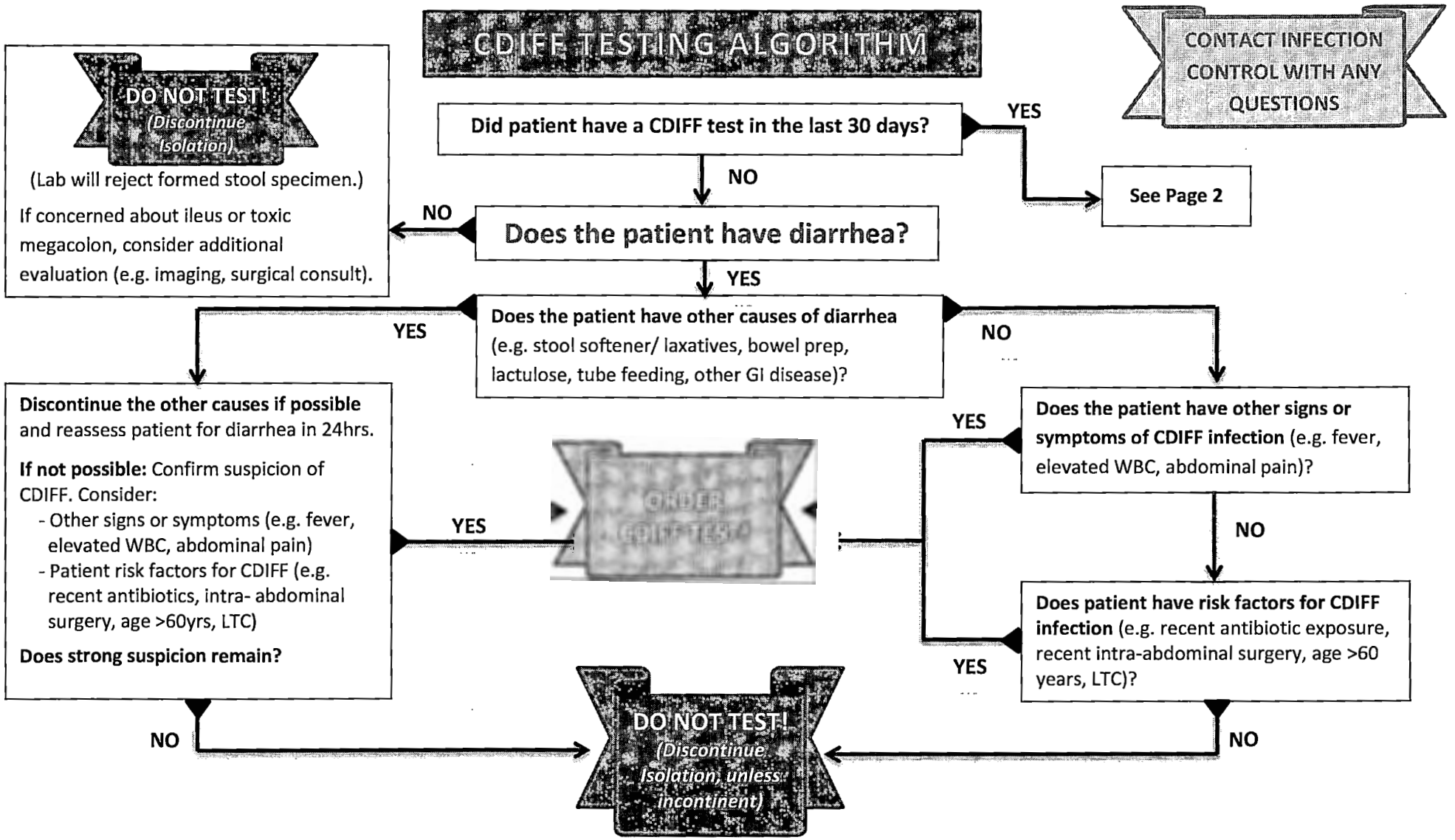
WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

World Health Organization

October 2006, version 1.

CDIFF ISOLATION ALGORITHM

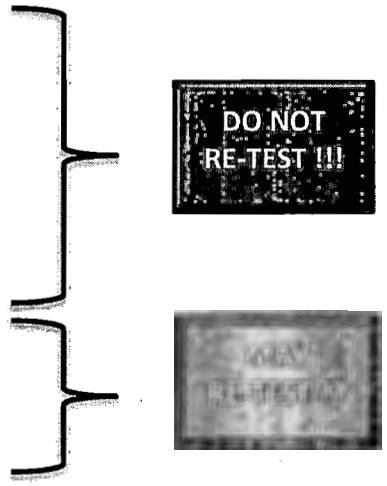
- Isolate patient **UPON 1ST SUSPICION** (Don't wait for test order or result)! **ENTER ISOLATION ORDER** in PowerChart!
- Test is positive: isolate patient for **THE ENTIRE LENGTH OF STAY** and treat according to most recent guidelines.
- Test is negative: discontinue isolation.
- Unable to collect specimen (no more liquid stool for 48hrs) : discontinue isolation & **VOID CDIFF TEST ORDER**
- **RETESTING** a previously positive patient is **NOT RECOMMENDED**! (Especially not for test of cure, to discontinue isolation or SNF request)



Thinking about retesting for CDIFF?

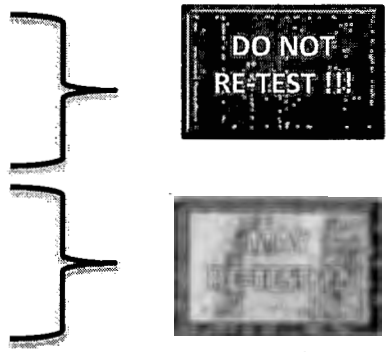
PRIOR POSITIVE TEST:

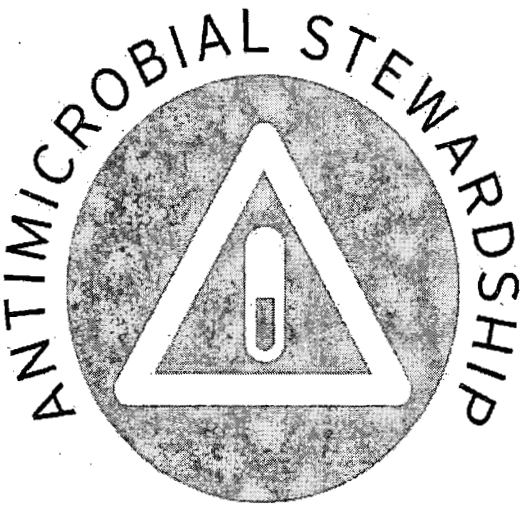
- Retesting to document **CLEARANCE** of the toxin/organism is **NOT** recommended because patients may shed the organism or toxin for several weeks after treatment.
- Retesting to **DISCONTINUE ISOLATION** should **NOT** be done. CDIFF positive Patients will remain on isolation for the entire length of their stay!
- Retesting upon **REQUEST OF RECEIVING FACILITY** to show proof of a negative test should **NOT** be done. If this happens please contact Infection Control.
- Retesting due to **RE-EMERGENCE OF SYMPTOMS** (patient was treated for CDIFF, clinically improved; but is showing symptoms again consistent with CDIFF) **MAY BE APPROPRIATE**; consider evaluation by an Infectious Disease physician or empiric treatment.



PRIOR NEGATIVE TEST: (in the last 7 days)

- Retesting to **CONFIRM A PRIOR NEGATIVE** is typically **NOT** necessary. Sensitivity of the CDIFF PCR is higher (>99%) than previously employed assays, obviating the need for multiple tests.
- If strong suspicion for CDIFF remains (risk factors, symptoms other than diarrhea), and alternative causes have been ruled out, consider evaluation by an Infectious Disease physician or empiric treatment.





Antimicrobial Stewardship at St Joseph Health System (SJHS), Mishawaka/Plymouth

WHAT IS ANTIMICROBIAL STEWARDSHIP?

- Antimicrobial stewardship is a coordinated program that promotes the appropriate use of **antimicrobials** (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

WHAT IS ASP?

- An antimicrobial stewardship Program (ASP) limits inappropriate and excessive use of antimicrobials while optimizing therapy to improve clinical outcomes for patients.

DOES SJHS HAVE AN ASP PROGRAM?

- Yes! SJHS has had an effective ASP program since 2016 and is comprised of an Infectious Disease specialist, doctors, pharmacists, and nurses. They work to optimize antimicrobial care for each individual infected patient at SJHS.

DID YOU KNOW....

As of Jan 1, 2017, the Joint Commission and CMS require all hospitals to have an ASP

→20-50% all antibiotics prescribed in U.S. are unnecessary or inappropriate

→Antimicrobials increase the risk of side effects such as adverse reactions, selection of pathogenic organisms (CDiff), emergence of resistance

→Estimated 2 million people infected with antibiotic-resistant organisms which equals ~23,000 deaths annually (CDiff adds additional 15,000 more deaths), $20 billion in excess healthcare costs

→Antimicrobials are the only class of drugs with potential for adverse impact on patients not even exposed to them

THE WHITE HOUSE
WASHINGTON

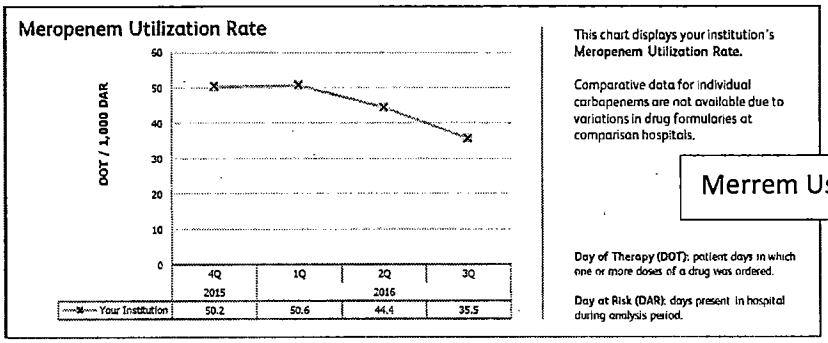
NATIONAL ACTION PLAN FOR COMBATING ANTIBIOTIC-RESISTANT BACTERIA

On Sept 18, 2014, President Obama issued a National Action Plan to implement the National Strategy for Combating Antibiotic-Resistant Bacteria. Its goal is to guide all healthcare in a common effort to address serious drug-resistant threats that affect people in the U.S. and around the world, with a specific target date by the year 2020.

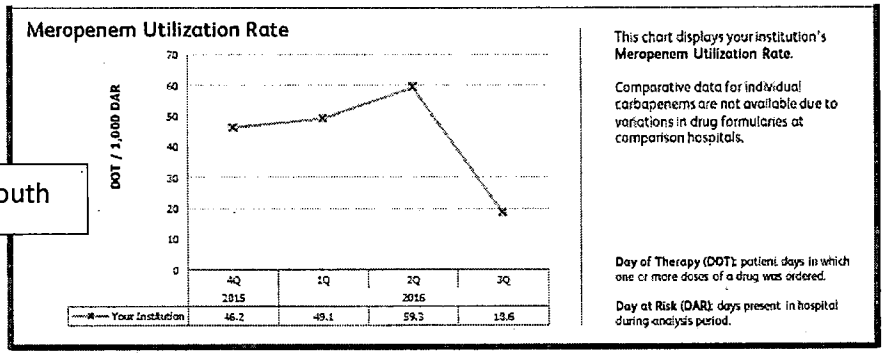
What does the Antimicrobial Stewardship Program (ASP) at St Joseph Health System (SJHS), Mishawaka/Plymouth, currently look like?

ONGOING INITIATIVES

- ⇨ Pharmacist review of antimicrobials with **recommendations for new agents** if needed, and **de-escalation** of others (narrowing antibiotic therapy to cover only a small number of specific organisms as opposed to broad coverage of multiple organisms)
- ⇨ Pharmacist automatic **IV to PO switch** for those patients meeting criteria (helps patients transition out of the hospital on oral meds and saves money on drug and administration costs)
- ⇨ Automatic pharmacist utilization of **dose optimization** for certain antibiotics (e.g extended infusion Merrem / Zosyn, altered dosing schedules of cefazolin and cefepime) to enhance killing power of the antibiotic, reduce side effects, decrease costs
- ⇨ **NAAT testing** with the SBMF (rapid blood culture reporting of resistance mechanisms and identified organisms) to help identify organisms quicker, allowing for more appropriate targeted antimicrobial therapy up to 24-48hr quicker
- ⇨ Automatic pharmacist **renal dose adjustment** of antimicrobials to reduce toxicities of over-dosing medications in patients with renal insufficiency
- ⇨ Pharmacist education and **oversight** on the utilization of the broad-spectrum class **carbapenems** (Merrem, Invanz) to decrease side effects of overusing this antibiotic, and keeping its use as a viable option when resistant organisms are present. See graph below on the success both Mishawaka and Plymouth Hospitals have had in the reduction of Merrem usage.



Merrem Usage at SJHS, Mishawaka



Merrem Usage at SJHS, Plymouth

Objectives

- Discuss the importance of Antimicrobial Stewardship in protecting our patients and the public from emergence of resistance and development of pathogenic organisms
- Describe the goals and core elements of an Antimicrobial Stewardship Program (ASP)
- Discuss who on the health-care team is responsible for Antimicrobial Stewardship and describe the roles of each member

Patient Safety

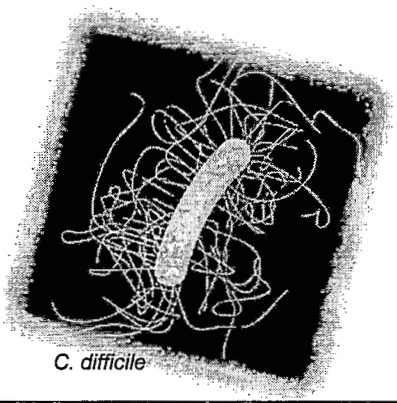
CDC and Joint Commission proposed standard: "Improving use of antibiotics is a patient safety and public health issue as well as a national priority…"

- **30-50% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate**
- Overuse and misuse of antibiotics have resulted in increasing emergence and spread of resistant bacteria
  - Cdiff (*Clostridioides difficile)*
  - MRSA (methicillin-resistant *Staphylococcus aureus*)
  - VRE (vancomycin-resistant enterococcus)
  - CRE (cephalosporin-resistant Enterobacteriaceae)
  - Other MDROs (multi-drug resistant organisms)

Patient Safety

- Drug-resistant bacteria:
  - Estimated 2 million people infected with antibiotic-resistant organisms
  - Cause ~23,000 deaths annually (counting *Clostridioides difficile* → adds additional 15,000 deaths)
- Avoidable healthcare costs from antibiotic misuse ranges from $27 billion to $42 billion per year
- Antibiotics are the only class of drugs with potential for adverse impact on patients not even exposed to them!

20% of hospitalized patients who receive an antibiotic have an adverse drug event (from that antibiotic) within 30 - 90 days



C. difficile

Tamma, JAMA Internal Medicine, 2017

Antimicrobial Stewardship Programs (ASP)

Antimicrobial Stewardship is encouraged by:

- IDSA (Infection Diseases Society of America)
- SHEA (Society of Healthcare Epidemiology of America)
- CDC (Center for Disease Control)

Effective Antimicrobial Stewardship Program is **REQUIRED** by:

- The Joint Commission

Antimicrobal Stewardship - What is it?

Definition: Appropriate use of antimicrobial therapy to optimize clinical outcomes while minimizing unintended consequences of use. An effective ASP also reduces healthcare costs without adversely impacting quality of care

- Appropriate antibiotic selection
  - Correct empiric antibiotic selection
  - De-escalate antibiotic therapy when new clinical information available (narrow therapy)
- Appropriate dose
- Appropriate duration
- Appropriate route

ASP Goals

- Reduce unnecessary use of antimicrobials
- Improve cure rates
- Reduce adverse drug events
- Slow emergence of antimicrobial resistance
- Reduce *C. difficile* infection

Who has a role in Antimicrobial Stewardship?

- Physicians
- Pharmacists
- Advanced practice professionals
- Nurses
- Infection preventionists
- Clinical microbiologist
- Information system specialist
- Hospital administration
- Quality improvement

ASP Core Elements

Leadership commitment: Identify ASP as an institutional priority by dedicating necessary human, financial, and information technology resources

Accountability: Establish responsible leaders (Antimicrobial Stewardship Committee; Physician and Pharmacist Leaders)

Drug expertise: Pharmacists working with physicians to guide antibiotic use; ID Physician and Pharmacist collaboration to disseminate treatment guidelines

Action: Implementing evaluation of treatment need; antibiotic "time-out" after 48-72 hours to assess continued need for antibiotics or changes in therapy

ASP Core Elements

Tracking: Monitor antibiotic prescribing, resistance patterns, and antibiotic use process measures

Reporting: Disseminate information on antimicrobial use and resistance to physicians, pharmacists, nurses, and other relevant staff

Education: Educate practitioners, staff, and patients on the importance of antimicrobial stewardship

ASP: Physician's Role

- Ensure cultures are ordered before starting antibiotics
- Avoid ordering urine culture in the absence of clinical symptoms
  - Avoid treatment of asymptomatic bacteriuria
- Thoughtful selection of empiric antibiotics with consideration of evidence-based clinical guidelines (*see Antibiotic Guidelines; St Joseph Health System booklet—online and in print)
- Perform antibiotic "time-out" after 48-72 hours to re-assess treatment or continued need for antibiotics
- Prompt review of new culture results with de-escalation, discontinuation, or escalation of antibiotics as appropriate
- Document dose, expected duration, and indication for antibiotic

ASP: Pharmacist's Role

- Take active role in evaluation of empiric antibiotic selection and initiate discussion with prescriber, as appropriate
- Optimize antibiotic dosing based on clinical infection and organ dysfunction
- Provide input on antibiotic selection based on allergy profile

  Example: Referencing Beta-Lactam Cross-Reaction literature for stated penicillin and/or cephalosporin allergies; also utilizing the hospital's Penicillin/Cefazolin Skin Testing Policy as needed for best antibiotic selection
- Ensure compliance with SJHS criteria for antimicrobial use
- Review new culture results promptly and recommend therapy adjustments or discontinuation, as needed
- Expedite IV to Oral conversion of antibiotics

ASP: Nurse's Role

- Ensure cultures are obtained before starting antibiotics
- Document thorough and specific history of allergic reactions (e.g. rash, itching vs anaphylaxis, or shortness of breath—NOT side effects such as nausea/diarrhea) to facilitate optimal antibiotic selection
- Be aware of new culture results used to guide therapy
- Identify signs/symptoms of sepsis to alert physician
- Identify readiness for IV to oral conversion of antibiotics
- Collaborate with Pharmacists in rounds/on the unit
- Patient/Family education

WHITE PAPER

ANA AMERICAN NURSES ASSOCIATION | CDC

Redefining the Antibiotic Stewardship Team: Recommendations from the American Nurses Association/Centers for Disease Control and Prevention Workgroup on the Role of Registered Nurses in Hospital Antibiotic Stewardship Practices

http://www.nursingworld.org/ANA-CDC-AntibioticStewardship-WhitePaper

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ASP: Infection Preventionist's Role

- Coordinate facility-wide monitoring and prevention of healthcare-associated infections
- Assist in the monitoring and reporting of resistance and *Clostridioides difficile* infection (CDI) trends
- Work collaboratively with the Antimicrobial Stewardship team

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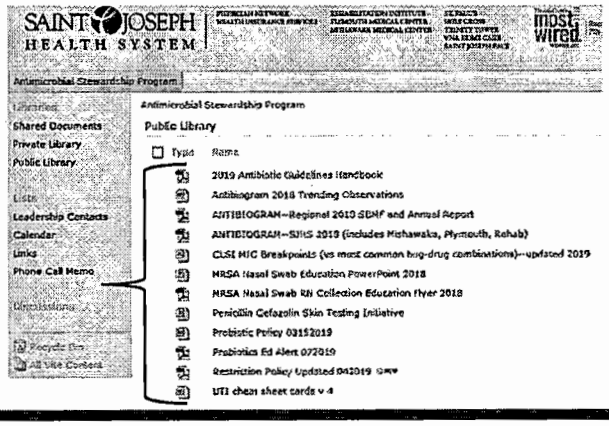
Antimicrobial Stewardship Resources—on the Daily Dose

- Updated practice guidelines developed by ASP team
- Up-to-date antibiogram information
- Information on hospital ASP initiatives

Antimicrobial Stewardship Resources—on the Daily Dose

- See example information below after clicking on the Antimicrobial Stewardship icon
- Click on each link to download for further information



External Resources / References

Core Elements of Hospital Antibiotic Stewardship Programs from Center for Disease Control (CDC)
https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements.html

- New Antimicrobial Stewardship Medication Management Standard 09.01.01 from The Joint Commission
https://www.jointcommission.org/assets/1/6/New_Antimicrobial_Stewardship_Standard.pdf
- Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship from Infectious Diseases Society of America (IDSA) http://www.idsociety.org/uploadedFiles/IDSA/Guidelines-Patient_Care/PDF_Library/Antimicrobial%20Stewardship.pdf
- National Quality Partners Playbook: Antibiotic Stewardship in Acute Care by National Quality Forum

SAINT JOSEPH HEALTH SYSTEM

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For questions/feedback, please contact:

Laura Gillespie, PharmD, Antimicrobial Stewardship Pharmacist
Email: gillesla@sjrmc.com
Available on Doc Halo
Office phone: 574 335 2449

SAINT JOSEPH HEALTH SYSTEM

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SAINT JOSEPH
Regional Medical Center

Version #: 9

Title: FLU VACCINATION

Document Owner: Teresa Onken	PI Team: N/A	Date Created: 10/10/2012
Approver(s): Denise Duschek, Karyn Delgado, Teresa Onken	Date Approved with no Changes: 12/18/2018	Date Approved: 12/18/2018 12/12/2012
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Medical Staff Services

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. In accordance with CDC guidelines and following the CDC's criteria for Flu vaccination, all credentialed practitioners are required to have an annual flu vaccination.

PROCEDURE:

A. This policy will be effective September 2013. Documentation of flu vaccination, or medical or religious exemption, will be required for all credentialed physicians and allied health practitioners at SJRMC by December 1 each year or membership and privileges will be temporarily suspended until vaccination is received or exemption is approved.

B. All initial appointments between October and March (or until the CDC states the flu season is over) of each year are required to submit documentation of flu vaccination, or medical or religious exemption request before appointment and/or privileges will be granted.

C. Practitioners requesting a religious or medical exemption must submit an exemption letter by November 1 for consideration of approval. The medical exemption letter must be signed by his/her primary care physician stating the medical reason for exemption. A committee with representation from physicians, Employee Health, HR, Infection Prevention, Spiritual Care and legal departments will review exemption requests and notify practitioner of approval status.

D. If the exemption is granted based on a temporary condition, the employee must resubmit a request for a medical exemption each year. If the request is based on a permanent condition, (ie. An allergy or a history of Guillain - Barre after a previous influenza vaccination) the exemption does not need to be requested each year unless vaccine technology changes to eliminate issues regarding such allergies.

E. The Flu vaccination results will be recorded and placed in the respective credentials file.

F. Flu vaccinations are available through the Employee Health Office.

G. If a practitioner receives the flu vaccination outside the hospital proper documentation, on the site letterhead with the practitioner name and date given should be submitted to the Medical Staff office at fax number 574-335-1013 Mishawaka or 574-948-5478 Plymouth.

H. Telemedicine physicians are not required to submit documentation of an annual Flu vaccination.

WAY TO RECEIVE YOUR FLU VACCINATION:

Saint Joseph Regional Medical Center – Mishawaka
Employee Health Office – No Charge
You can stop by or call to make an appointment.

Location:	Garden Level, Suite A0039, Medical Center
Hours:	8:00 am – 12:00 pm and 1:00 pm – 4:00 pm

Title: FLU VACCINATION

Phone Number: 574-335-1030

Saint Joseph Regional Medical Center – Plymouth
Call Employee Health at 574-948-4100. If Employee Health is unavailable leave a message for the nurse to contact you or call the Administrative Supervisor at 574-948-4351.

References/Standards:

- Policy Origin Date: October 2012 (M)
- Review Date: December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date: June 2014 (M), September 2014 (M)
- Effective Date: December 2012 (M), September 2012 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 194

SAINT JOSEPH
Regional Medical Center

Version #: 4

Title: Blood Borne Pathogen Exposure

Document Owner: Cheryl Bousquet	PI Team: Infection Prevention Team	Date Created: 09/1992
Approver(s): Loretta Schmidt	Date Approved with no Changes: 02/13/2019	Date Approved: 02/13/2019 05/12/2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Employee Health Services

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Healthcare workers may be exposed to persons with known disease. Hepatitis B, Hepatitis C and HIV may be transmitted via needle punctures, cutaneous exposure, or body fluid splashes from infected individuals to health care workers. An exposure incident is defined as a specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material. Post exposure prophylaxis (PEP) recommendations are based on the most recent CDC recommendations.

GUIDELINES:

A. When a blood exposure has occurred do the following:
   1) Provide immediate care to the exposed site;
      a) Wash wound and skin with soap and water;
      b) Flush mucous membranes with water immediately or as soon as feasible following contact;
   2) Inform Employee Health Services or Administrative Supervisor immediately after the exposure. **DO NOT GO TO THE EMERGENCY DEPARTMENT**
   3) **Complete online Complete a THEIR, Trinity Health Employee Incident Report form. The THEIR icon found on Novell-delivered applications. Obtain and initiate a "Red Packet" for instructions, lab slips and consent forms.** Red packets are available in Employee Health Services or from Administrative Supervisor/Clinical Director when Employee Health is not available.

B. Identification of the source patient and the status of the source patient, if possible.
   1) If there is no previous testing for Blood borne Pathogens on the source patient, consent from the source should be obtained and placed in the patient's chart. Lab should be paged for STAT lab draw. A lab requisition for the following is in the red packet.
      a) Stat HIV 1&2 with Western Blot if indicated
      b) HBsAg
      c) HCV
      d) The source patient's physician shall be responsible to notify and counsel patient if baseline labs indicate the presence of blood borne pathogens.
   2) If baseline testing indicates that the source patient is not infected with a blood borne pathogen, further follow-up testing of the exposed employee is NOT necessary. SJRMC will provide associate baseline testing for Blood borne Pathogens upon request.

3) If source patient is known to be positive for HIV, Hepatitis B or Hepatitis C as documented on his/her chart, proceed with immediate treatment of the employee as appropriate. Source patient lab testing can be deferred for any test which is documented as positive on his/her chart.
4) If source is unknown, the employee will have baseline testing at the time of exposure by utilizing the anonymous lab requisition found in the red packet. See post exposure evaluation and follow up testing, #1 for laboratory tests.

C. Post exposure evaluation and follow-up testing of exposed employee:
   1) Follow-up testing of employees exposed to blood borne pathogen, or if source is unknown:
      a) HIV exposure – HIV 1&2 with Western Blot if indicated at baseline, 6, 12 and 26 weeks
      b) HBV exposure-
         (1) Establish HBsAB status of associate, if immune-no treatment indicated
         (2) If HBsAB non immune, then HBIG x1 and initiate revaccination.
      c) HCV exposure –
         (1) HCV and ALT;
         (2) HCV-RNA and ALT at 6 weeks
         (3) HCV and ALT at 26 weeks
      d) Unknown source, employee has immune HBsAb –
         (1) HIV 1&2 with Western Blot if indicated, HBV, HCV, and ALT
         (2) HIV 1&2 with Western Blot if indicated, HCV-RNA, and ALT at 6 weeks
         (3) HIV 1&2 with Western Blot if indicated at 12 weeks
         (4) HIV 1&2 with Western Blot if indicated, HCV, and ALT at 26 weeks
      e) Unknown source, employee has non-reactive HBsAb –
         (1) HIV 1&2 with Western Blot if indicated, HBV,HCV, and ALT
         (2) Offer Hepatitis B series (or booster) within 7 days of exposure. Complete series and send for HbsAb.
         (3) HIV 1&2 with Western Blot if indicated, HBV, HCV-RNA, and ALT at 6 weeks.
         (4) HIV 1&2 with Western Blot if indicated at 12 weeks, HBV
         (5) HIV 1&2 with Western Blot if indicated, HBV, HCV, and ALT at 26 weeks.

D. The employee will be given appropriate counseling concerning current CDC precautions to take during the period after the incident, potential illnesses to be alert for, and to report any related experiences to Employee Health Services.

E. **Any person exposed to a source patient who is known to be HIV positive-.** Stat HIV 1&2 results should be available in 1-2 hours. If indicated, the Medical Director of Employee Health, designee, or Emergency Department physician will order the appropriate anti-viral medication recommended by the CDC. A prescription will be given to the employee, with all treatment being covered under Worker's Compensation. For post-exposure prophylaxis information, contact the CDC/PEP hotline at 1-888-448-4911. The following information is beneficial to obtain prior to calling the hotline:
   1) Source patient's viral load;

2) Source patient's HIV medications;
3) Source patient's daily medications.

F. For employees exposed to an **HCV positive source**:
1) Documentation of exposure shall include:
2) Any employee who has a positive baseline HCV will be referred to his/her personal physician by Employee Health Services.
3) An ALT will be added to the employee's baseline labs. Elevated baseline ALT would result in referral to the employee's personal physician.
4) Employee Health Services will continue to test the employee at 6 and 26 weeks for HCV and ALT.
5) All positive HCV results will be confirmed by RIBA (recombinant immunoblot assay) testing.
6) If the employee becomes positive for HCV, Employee Health Services will refer the employee to Physicians Urgent Care.

G. Documentation of exposure shall include:
1) Time and date of exposure;
2) Route of exposure;
3) Immunization status of the employee;
4) Circumstances of the exposure.

H. Results of employee and source patient lab results will be kept in the employee's confidential Health File in the Employee Health Office and separate from the personnel files.
1) Results will be sent to the employee.
2) Source results will be sent as positive or negative.
3) The employee will be counseled regarding the confidentiality of source patient information.
4) The employee will be informed that positive results will be reported to the Indiana Department of Health.

I. Saint Joseph Regional Medical Center will pay for baseline testing of the source patient involved in an exposure to medical staff, contracted staff, contract service providers, patients, visitors or other customers who experience a blood exposure incident at SJRMC.

Title: Blood Borne Pathogen Exposure

Related Documents:

RECOMMENDATIONS FOR PROPHYLAXIS FOLLOWING PERCUTANEOUS OR PERMUCOSAL EXPOSURE to HEPATITIS B VIRUS

EXPOSED PERSON	SOURCE HbsAg POSITIVE*	SOURCE HbsAg NEGATIVE	SOURCE NOT TESTED
Unvaccinated	HBIG** times one and initiate HB vaccine	Initiate HB vaccine	Initiate HB vaccine
Previous Vaccinated			
Known responder	No treatment	No treatment	No treatment
Known non-responder	HBIG times two or HBIG times one and initiate revaccination	No treatment	If known high-risk source, treat as if source were HbsAg positive
Response unknown	Test exposed person for anti-HBs If adequate #, no treatment; if inadequate, HBIG times one and vaccine booster	No treatment	Test exposed person for anti-HBs If adequate #, no treatment; if inadequate, HBIG times one and vaccine booster

*HbsAg = Hepatitis B surface antigen

**HBIG = Hepatitis B immune globulin; dose 0.06ml.kg IM

adequate anti-HBs is $\leq$ 10mIU/ml

RECOMMENDED HIV Post-Exposure Prophylaxis (PEP)

Exposure type	HIV Class 1[1]	HIV Class 2[2]	Source unknown HIV status[3]	Unknown[4] Source	HIV-negative
Less severe[5] Percutaneous Injuries	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] for source with HIV risk factors	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] in settings where exposure to HIV-infected persons is likely	No PEP warranted
More severe[7] Percutaneous Injuries	Recommend expanded 3-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] for source with HIV risk factors	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] in settings where exposure to HIV-infected persons is likely	No PEP warranted
Small volume[8] for mucous membrane & non-intact skin[9] exposures	Consider 2-drug PEP	Recommend basic 2-drug PEP	Generally, no PEP warranted	Generally, no PEP warranted	No PEP warranted
Large volume[10] for mucous membrane & non-intact skin exposures	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] for source with HIV risk factors	Generally, no PEP warranted; however, consider basic 2-drug PEP[6] in settings where exposure to HIV-infected	No PEP warranted

				persons is likely	

[1]Asymptomatic HIV infection or known low viral load (<1500 RNA copies/ml). If drug resistance is a concern, obtain expert consultation, initiation of PEP should not be delayed pending expert consultation, and because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

[2]Symptomatic HIV infection, AIDS, acute seroconversion or known high viral load. If drug resistance is a concern, obtain expert consultation, initiation of PEP should not be delayed pending expert consultation, and because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

[3]E.g. deceased source person with no samples available for HIV testing.

[4]E.g. a needle for a sharps disposal container.

[5]E.g. solid needle and superficial injury

[6]The designation "consider PEP" indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

[7]E.g. large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein

[8]i.e. a few drops

[9]For skin exposures, follow-up is indicated only if there is evidence of compromised skin integrity (dermatitis, abrasion or open wound)

[10]Major blood splash

References/Standards:

- CR MMWR September 30, 2005 / Vol. 54 / No. RR-9
- www.osha.gov/pls/oshaweb/owadisp.show_document_table=STANDARDS&p_id
- http://www.cdc.gov/hepatitis/HBV/PEP.htm
- The Joint Commission: Infection Prevention and Control Chapter

8

SAINT JOSEPH VNA HOME CARE...YOUR TRUSTED HOME CARE PARTNER FOR LIFE

Saint Joseph VNA Home Care combines clinical excellence with compassionate, personalized care in the comfort of your home. The result: We are your trusted home health care partner for life. Home health care is often the ideal solution for people recovering from injury or illness. Working closely with our patient's primary physician, we provide care to help prevent re-hospitalization and provide a bridge between a patient's recent hospitalization or rehab stay and their return to everyday activities.

With offices in Mishawka and Plymouth, our skilled professionals bring quality health care into the lives of families in St. Joseph, Elkhart, Marshall, LaPorte, Starke and Kosciusko Counties in Indiana and Berrien and Cass Counties in Michigan.

ADVANCED SERVICES

With our multidisciplinary staff of registered nurses, certified home health aides, therapists and social workers, Saint Joseph VNA Home Care provides a wide range of high-quality home care services including:

- Skilled Nursing
- Physical, Occupational and Speech Therapies
- Assistance with personal care
- Social work services
- Comprehensive assessment and care plan development
- Wound care and other treatments
- IV Infusion nursing
- Patient education related to current conditions, medications, treatments and chronic illnesses

Every client receives a personal evaluation in the comfort of his home. This one-on-one approach ensures that each patient's plan of care is individualized to optimize his treatment plan and to make sure that their needs are met.

SPECIALTY SERVICES

In additional of traditional home health care services, we also offer more specialized services to keep pace with today's high tech medical needs. Our staff can provide in-home infusion services and wound care for patients with complex wound needs.

We also offer Cardiac PARTNERS, a focused cardiac care program for patient's suffering from congestive heart failure. This program uses a multi-discipline approach to care and we can offer patients the use of our Telehealth monitoring system which patient's use daily to monitor weights, blood pressure and oxygen levels. The results are sent directly through the equipment to our office in Mishawaka where we have staff who monitor the results daily and identify possible problem readings or results resulting in a scheduled visit from one of our nurses or a call to the patient's primary care physician to discuss readings or trends.

Beyond Balance is another specialty program which focuses on fall prevention and instruction by our therapy team to help ensure patients can move safely and confidently around their home or community.

LIFELINE MONITORING SYSTEMS

LifeLine monitoring services gives the freedom of independent living, plus the security of an immediate link to help should it be needed. A LifeLine communicator is installed in the client's home telephone and a personal help button is worn around the neck or wrist. Activating the button in the event of a fall or injury will alert outside help, including ambulance service and/or the local police department if necessary. This service does require a monthly fee.

Saint Joseph VNA Home Care provides exceptional home health care seven days a week and offers 24-hour on-call access for admissions and clinical intervention. We accept Medicare, Medicaid and most other third party payers. For more information, please contact our office at (574) 335-8600 or (800) 962-2554. We are located at 3838 N. Main Street, Suite 100 in Mishawaka.

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CRITERIA FOR MEDICAL NECESSITY OF IUD UTILIZATION

Mirena IUD is the only IUD recommended for the following diagnosis:

Endometriosis	617.9	N80.9
Menorrhagia:		
Abnormal uterine bleeding		
Excessive of Frequent Menstruation		
Heavy Periods	626.2	N92.0
Dysmenorrhea: Painful Menstruation:	625.3 (2nd DX)	N94.5

An IUD will be provided for current Saint Joseph Physician Network patients under the following circumstances:

Pregnancy test will be given on day of appointment before insertion to confirm that the patient is not pregnant.

Patient has had an examination within the last year, was found to have one of the above listed diagnoses that can be successfully treated with the insertion of the Mirena IUD, and has been unsuccessfully treated with medications. **SJPN does not insert IUDs for Contraception but only does so for medical necessity as determined by treating physician(s).**

Bayer Women's HealthCare Specialty Pharmacy Application for Mirena IUD has been completed. Application will be held for 2 weeks and the patient will be called to confirm she wants the IUD before the application is sent in.

Bayer has approved the application and the IUD has been sent to us for insertion.

Patient will be called when the IUD arrives and instructed that she will need to abstain from intercourse for 2 weeks and an appointment will be scheduled.

Consent for IUD and Financial Responsibility Agreement will be signed before insertion by patient, parent, or guardian.

Professional Practice Ethics Guidelines
with Respect to Prescribing Contraceptives

The health care professionals affiliated with Saint Joseph Regional Medical Center (SJRMC) are critical to its mission. The mission of SJRMC is to provide, within the Catholic vision of health care, health and healing for individuals and the community. SJRMC fully appreciates the fact that the health care professionals affiliated with SJRMC are competent experts in their respective specialties. These health care professionals seek to provide dedicated, quality health care to those whom they serve.

SJRMC and its affiliated health care professionals all recognize that the provision of health care is as much about serving the human good and dignity of the patient as it is about exercising professional competency and expertise. In fact, everything that is done in the name of good medicine is done because it is regarded by the health care provider as ultimately comporting with the human dignity of the patient. No one would provide health care if it were known to be contrary to the human good of the patient.

The Catholic identity of SJRMC is founded upon a vision of the human good and dignity of the person. This vision permeates all that SJRMC does and is the ultimate measure by which it provides health care. Consistent with a health care provider's vision of human dignity, certain procedures and activities will be either allowed or disallowed. Therefore, the particular configuration of health care provided by SJRMC does not represent an interference by the Catholic Church in the practice of medicine. Rather, it represents the provision of health care consistent with a vision of human dignity that can be different from other views in some respects.

The *Ethical and Religious Directives for Catholic Health Care Services* ("ERDs") represent the ethical standard of Catholic health care to which SJRMC adheres. All services provided by SJRMC and its subsidiaries comply with the ERDs. The ERDs are implemented by the Roman Catholic Bishop in fulfillment of his responsibility for the Catholic identity of Catholic health care services serving within the Diocese of Fort Wayne/South Bend, Indiana.

Given the obligations of SJRMC to preserve its own Catholic identity, and to ensure that it acts according to its vision of the human dignity of the patients it serves, the following guidelines are established for physicians, nurse practitioners, and physician assistants.

The source of the NCBC model is Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, OP, *Catholic Health Care Ethics: A Manual for Practitioners*, Second Edition (also in First Edition). Philadelphia: The National Catholic Bioethics Center, 2009, pp. 99-101.

GUIDELINES

Physicians, Nurse Practitioners, and Physician Assistants

1.1 Any physician, nurse practitioner or physician assistant who prescribes or refers for medications or devices for contraceptive purposes on the premises of Saint Joseph Regional Medical Center does so in a limited private practice capacity contrary to any intention on the part of SJRMC or its sponsors.

1.2 No prescription pad printed with the names of SJRMC, any of its subsidiaries, or any associated logos may be used for the prescription of a medication or device for contraceptive purposes.

1.3 SJRMC will not process bills or collect revenue for work exclusively identified with medications or devices prescribed for contraceptive purposes.

1.4 Any physician, nurse practitioner, or physician assistant offering obstetrical or gynecological services on the premises must also provide Natural Family Planning ("NFP") literature and be able to make referrals for NFP instruction.

1.5 Simple signage, similar to other signs or posters typically placed in examination rooms, must be placed in the patient examination rooms that states that prescriptions for contraceptives are provided by the health care professional in his or her limited private practice capacity. An acceptable alternative approach to signage would be for a similar statement to be placed on the patient informed consent form, where it is clearly visible.

1.6 Physicians, nurse practitioners, and physician assistants may not provide or prescribe any medication or device whose *directly intended sole immediate effect* is to cause an abortion.

1.7 Physicians, nurse practitioners, and physician assistants cannot provide a recommendation or formal referral for abortion.

1.8 Physicians, nurse practitioners, and physician assistants, based on their personal beliefs and consciences, are not required to prescribe medications or devices for contraceptive purposes. They are also not required to refer patients to providers that do offer this service but may do so in a limited practice capacity as referenced in 1.1.

The source of the NCBC model is Edward J. Furton, Peter J. Cataldo and Albert S. Moraczewski, OP, *Catholic Health Care Ethics: A Manual for Practitioners*, Second Edition (also in First Edition). Philadelphia: The National Catholic Bioethics Center, 2009, pp. 99-101.

Ethical and Religious Directives for Catholic Health Care Services

Sixth Edition

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

This sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB at its June 2018 Plenary Assembly. This edition of the *Directives* replaces all previous editions, is recommended for implementation by the diocesan bishop, and is authorized for publication by the undersigned.

Msgr. J. Brian Bransfield, STD
General Secretary, USCCB

Digital Edition, June 2018

Contents

Preamble

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Services.*

These Directives presuppose our statement *Health and Health Care* published in 1981.[1] There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.[2] The purpose of these *Ethical and Religious Directives* then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and

medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

General Introduction

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:29-34; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev 21:3-4).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.[3] In the United States, the many religious communities as well as dioceses that sponsor and staff this country's Catholic health care institutions and services have established an effective Catholic presence in health care. Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.[4] By virtue of their Baptism, lay

faithful are called to participate actively in the Church's life and mission.[5] Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church's health care mission by many men and women who are not Catholic.

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.[6] While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care.

PART ONE
The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.[7]

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.[8] Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.[9]

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.

2. Catholic health care should be marked by a spirit of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO
The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: "I was ill and you cared for me" (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[11] Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay alike—should have appropriate professional preparation, including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious. It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.[12]

17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.[13] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[14] In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.

18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.[15]

19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its baptism/confirmation registers.

20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have

full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.

PART THREE
The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.

Directives

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance

directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the

person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.[18]

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19]

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.

PART FOUR
Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

> This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.[21]
>
> Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.[22]

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[23] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[24]

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for

good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

> The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.[25]

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.[26]

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.[28]

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).[29]

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[30]

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling, adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be

concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.[31]

49. For a proportionate reason, labor may be induced after the fetus is viable.

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[32]

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.[33]

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[34]

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

PART FIVE
Issues in Care for the Seriously Ill and Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.[35] The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.[36]

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.[37]

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness,

accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[39]

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.[40] Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."[41] For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.[42]

61. Patients should be kept as free of pain as possible so that they may die comfortably and

with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.[43]

PART SIX
Collaborative Arrangements with Other Health Care Organizations and Providers[44]

Introduction

In and through her compassionate care for the sick and suffering members of the human family, the Church extends Jesus' healing mission and serves the fundamental human dignity of every person made in God's image and likeness. Catholic health care, in serving the common good, has historically worked in collaboration with a variety of non-Catholic partners. Various factors in the current health care environment in the United States, however, have led to a multiplication of collaborative arrangements among health care institutions, between Catholic institutions as well as between Catholic and non-Catholic institutions.

Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ. For example, collaborative arrangements can provide opportunities for Catholic health care institutions to influence the healing profession through their witness to the Gospel of Jesus Christ. Moreover, they can be opportunities to realign the local delivery system to provide a continuum of health care to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care. Collaboration can even, in some instances, ensure the continued presence of a Catholic institution, or the presence of any health care facility at all, in a given area.

When considering a collaboration, Catholic health care administrators should seek first to establish arrangements with Catholic institutions or other institutions that operate in conformity with the Church's moral teaching. It is not uncommon, however, that arrangements with Catholic institutions are not practicable and that, in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the Church's moral teaching.

Such collaborative arrangements can pose particular challenges if they would involve institutional connections with activities that conflict with the natural moral law, church teaching, or canon law. Immoral actions are always contrary to "the singular dignity of the human person, 'the only creature that God has wanted for its own sake.'"[45] It is precisely because Catholic health care services are called to respect the inherent dignity of every human being and to contribute to the common good that they should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.

The Catholic moral tradition provides principles for assessing cooperation with the wrongdoing of others to determine the conditions under which cooperation may or may not be

morally justified, distinguishing between "formal" and "material" cooperation. *Formal* cooperation "occurs when an action, either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [immoral] act . . . or a sharing in the immoral intention of the person committing it."[46] Therefore, cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong.

The cooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. While some instances of material cooperation are morally wrong, others are morally justified. There are many factors to consider when assessing whether or not material cooperation is justified, including: whether the cooperator's act is morally good or neutral in itself, how significant is its causal contribution to the wrongdoer's act, how serious is the immoral act of the wrongdoer, and how important are the goods to be preserved or the harms to be avoided by cooperating. Assessing material cooperation can be complex, and legitimate disagreements may arise over which factors are most relevant in a given case. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation.

Any moral analysis of a collaborative arrangement must also take into account the danger of scandal, which is "an attitude or behavior which leads another to do evil."[47] The cooperation of a Catholic institution with other health care entities engaged in immoral activities, even when such cooperation is morally justified in all other respects, might, in certain cases, lead people to conclude that those activities are morally acceptable. This could lead people to sin. The danger of scandal, therefore, needs to be carefully evaluated in each case. In some cases, the danger of scandal can be mitigated by certain measures, such as providing an explanation as to why the Catholic institution is cooperating in this way at this time. In any event, prudential judgments that take into account the particular circumstances need to be made about the risk and degree of scandal and about whether they can be effectively addressed.

Even when there are good reasons for establishing collaborative arrangements that involve material cooperation with wrongdoing, leaders of Catholic healthcare institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution's ability to fulfill its mission of providing health care as a witness to the Catholic faith and an embodiment of Jesus' concern for the sick. They must do everything they can to ensure that the integrity of the Church's witness to Christ and his Gospel is not adversely affected by a collaborative arrangement.

In sum, collaborative arrangements with entities that do not share our Catholic moral tradition present both opportunities and challenges. The opportunities to further the mission of Catholic health care can be significant. The challenges do not necessarily preclude all such arrangements on moral grounds, but they do make it imperative for Catholic leaders to undertake careful analyses to ensure that new collaborative arrangements—as well as those that already exist—abide by the principles governing cooperation, effectively address the risk of scandal, abide by canon law, and sustain the Church's witness to Christ and his saving message.

While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the ultimate responsibility for interpreting and applying of the Directives rests with the diocesan bishop.

Directives

67. Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal, or undermine the Church's witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.
68. When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a risk of scandal, the diocesan bishop is to be consulted in a timely manner. In addition, the diocesan bishop's approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop's *nihil obstat* is to be obtained.
69. In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system's affiliated institutions are located to approve locally the prospective collaborative arrangement or to grant the requisite *nihil obstat*, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system's headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.
70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.[48]
71. When considering opportunities for collaborative arrangements that entail material cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal[49] might be given and whether the Church's witness might be undermined. In some cases, the risk of scandal can be appropriately mitigated or removed by an explanation of what is in fact being done by the health care organization under Catholic auspices. Nevertheless, a

collaborative arrangement that in all other respects is morally licit may need to be refused because of the scandal that might be caused or because the Church's witness might be undermined.

72. The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law.
73. Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.
74. In any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives.
75. It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.
76. Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their consent to any decisions proximately connected with such procedures. Great care must be exercised to avoid giving scandal or adversely affecting the witness of the Church.
77. If it is discovered that a Catholic health care institution might be wrongly cooperating with immoral procedures, the local diocesan bishop should be informed immediately and the leaders of the institution should resolve the situation as soon as reasonably possible.

Conclusion

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: "When you hold a banquet, invite the poor, the crippled, the lame, the blind" (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ's healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus' ministry and God's love for us.

Notes

1. United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (Washington, DC: United States Conference of Catholic Bishops, 1981).
2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms "institution" and/or "services" in order to encompass the variety of settings in which Catholic health care is provided.
3. *Health and Health Care,* p. 5.
4. Second Vatican Ecumenical Council, *Decree on the Apostolate of the Laity* (*Apostolicam Actuositatem*) (1965), no. 1.
5. Pope John Paul II, Post-Synodal Apostolic Exhortation *On the Vocation and the Mission of the Lay Faithful in the Church and in the World* (*Christifideles Laici*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 29.
6. As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* (*Donum Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1987).
7. Pope John XXIII, Encyclical Letter *Peace on Earth* (*Pacem in Terris*) (Washington, DC: United States Conference of Catholic Bishops, 1963), no. 11; *Health and Health Care,* pp. 5, 17-18; *Catechism of the Catholic Church,* 2nd ed. (Washington, DC: Libreria Editrice Vaticana–United States Conference of Catholic Bishops, 2000), no. 2211.
8. Pope John Paul II, *On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of "Populorum Progressio"* (*Sollicitudo Rei Socialis*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
9. United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, DC: United States Conference of Catholic Bishops, 1986), no. 80.
10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.
11. *Health and Health Care,* p. 12.
12. Cf. *Code of Canon Law,* cc. 921-923.
13. Cf. ibid., c. 867, § 2, and c. 871.
14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the

Holy Spirit."

15. Cf. c. 883, 3°.

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. *Declaration on Euthanasia,* Part IV; cf. also directives 56-57.

19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.

20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.

21. Second Vatican Ecumenical Council, *Pastoral Constitution on the Church in the Modern World (Gaudium et Spes)* (1965), no. 49.

22. Ibid., no. 50.

23. Pope Paul VI, Encyclical Letter *On the Regulation of Birth (Humanae Vitae)* (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.

24. Ibid., no. 12.

25. Pope John XXIII, Encyclical Letter *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae,* no. 4.

26. Pope John Paul II, Encyclical Letter *The Splendor of Truth (Veritatis Splendor)* (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.

27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (*Donum Vitae,* Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. Ibid., Part II, A, no. 2.

29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"'" (*Donum Vitae,* Part II, B, no. 6).

30. Ibid., Part II, A, no. 3.

31. Cf. directive 45.

32. *Donum Vitae,* Part I, no. 2.

33. Cf. ibid., no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.

34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, *Origins* 24 (1994): 211-212.

35. Pope John Paul II, Apostolic Letter *On the Christian Meaning of Human Suffering (Salvifici Doloris)* (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.

36. United States Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

37. See *Declaration on Euthanasia.*

38. Ibid., Part II.

39. Ibid., Part IV; Pope John Paul II, Encyclical Letter *On the Value and Inviolability of Human Life* (*Evangelium Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1995), no. 65.

40. See Pope John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), no. 4, where he emphasized that "the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*." See also Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (August 1, 2007).

41. Congregation for the Doctrine of the Faith, Commentary on "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration."

42. See *Declaration on Euthanasia*, Part IV.

43. *Donum Vitae,* Part I, no. 4.

44. See: Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with non-Catholic Entities in the Provision of Healthcare Services," published in *The National Catholic Bioethics Quarterly* (Summer 2014), 337-40.

45. Pope John Paul II, *Veritatis Splendor*, no. 13.

46. Pope John Paul II, *Evangelium Vitae*, no. 74.

47. *Catechism of the Catholic Church*, no. 2284.

48. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II's Ad Limina Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in *Origins* 28 (1998): 283. See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*), March 13, 1975, Origins 6 (1976): 33-35: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, a fortiori, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil." This directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops on September 15, 1977, in *Origins* 7 (1977): 399-400.

49. See *Catechism of the Catholic Church*: "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).