SoHum Health
Southern Humboldt Community Healthcare District
733 Cedar Street
Garberville, CA 95542
(707) 923-3921

DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 4
SUBJECT: 72-Hour Involuntary Hold (5150)	EFFECTIVE DATE: 7/28/2021	SUPERCEDES: 07/25/2013

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") to identify, assess, evaluate, treat, and/or detain any person, because of mental disorder, that is a danger to ~~the~~others~~, patient, a danger to others~~themselves, or gravely disabled. Any person who has been authorized may, upon probable cause, take the person into custody, and place him in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour evaluation and treatment.

The facility must receive a written application and checklist with medical clearance stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of a mental disorder, a danger to others or to himself, or gravely disabled. If the probable cause is based upon the statement of a person other than the officer, member of the attending staff, or professional person, such a person can be held liable in a civil action for intentionally giving such a statement if he knows it is false.

PURPOSE:
The purpose of this policy and procedure is to provide a standardized and summarized procedure for placing a patient on a 72-hour involuntary hold (5150) and the completion of the application for 72-hour detention for evaluation and treatment of those patients requiring involuntary detention of "5150."

PROCEDURE:
When it is necessary to detain and transfer a person who is gravely disabled, a danger to himself or others because of a mental illness and the patient has been medically cleared:

- NOTE: Once a 72-hour hold has been initiated, the person cannot voluntarily leave until the 72-hour hold has been resolved.

1. An authorized person must complete the application for involuntary detention.
   - The authorized persons who may complete the application are:
     a. All law enforcement officials
     b. Medical Director
     c. And All "ON DUTY" Emergency Physicians

2. The person will be transferred to an authorized "5150" receiving facility. The only authorized "5150" facility in Humboldt County is Semper Virens located at 720 Wood Street, Eureka, CA.

3. ~~Due to the fact that~~Since, Semper Virens is a psychiatric facility and not a hospital, all referrals must be medically cleared with all necessary labs and exams before they can be accepted. The Medical Clearance Check List provided by Semper Virens is included in the packet.

   - Lab work includes but is not limited to: CBC, CMP, UDS, TSH and ETOH.

4. Complete the **CHECKLIST FOR A SAFE ENVIRONMENT FOR ALL PATIENTS ON A 5150 HOLD.**

5. If the patient has suicidal ideations, refer to the Suicide Risk Screening and Suicide Precautions Policy and Procedure.

6. **DOCUMENTATION:**

    a. **ALL** PATIENTS WILL HAVE A CIWA (Clinical Institute for Alcohol Withdrawal), a COWS (Clinical Opiate Withdrawal Scale) and the psychiatric suicidal assessment at least every 2 hours unless a need to have them completed sooner is necessary. If the patient's drug and alcohol screenings are negative only 1 CIWA and 1 COWS will be needed in the chart.

    b. The time and date of the 5150 hold will be documented in the chart as well as time and date of discontinuation or transfer.

    c. Any and all belongings will be listed in the chart.

    d. A behavioral assessment note will be completed hourly including but not limited to level of agitation, activity, and any medications given.

    e. Assess the patient's physical/emotional condition and suicide potential every 2 hours.

7. If Admission is necessary to an Acute Care Service for medical necessity for treatment, evaluation and stabilization before transfer to Semper Virens, the following will apply:

    a. The physician must write an order for, and arrangements must be made, for suicide prevention and precautions as per policy.

    b. If transferred to another acute care facility for higher level of care, the receiving hospital must be advised of 5150 status by telephone and writing.

8. The application for 72-hour detention is completed by an authorized person as listed above. The ORIGINAL copy is sent with the medical records to Semper Virens. A copy of the form is placed with the patient's hospital medical record.

    a. Humboldt County Mental Health - Semper Virens Physical exam form should be filled out by the ED physician and should accompany the patient to Semper Virens as part of the transfer paperwork along with the Medical Clearance Check list. A copy of this form should be retained for our records.

    b. A 5150 hold is not a clinical document. The information on it should be comprehensible to non-specialists such as psychiatrists, social workers, therapists, nurses, mental health workers, court and hearing officers, advocates for patients' rights and even private attorneys. Use of behavioral descriptions by QUOTING the **patient** are highly desirable. Do not say "Patient has suicidal ideation." Do quote "I am going to take all my pills," "I can't live with this pain anymore," "I'm angry that I'm still alive," etc. The client's own words are best.

    c. Our standard transfer form must be filled out for ~~any and all~~all transfers in compliance with EMTALA.

    d. Semper Virens Crisis nurse is ~~called~~called, and all patient records are to be faxed for their physician to review. The phone number is 707-445-7715 and the fax number is 707-476-4066. SV crisis nurse usually gives a verbal acceptance for the attending psychiatrist and can also inform about bed availability.

9. The following guidelines should be used when transporting "5150" patients to the authorized facility:

    a. Once the physician has signed the application for 72-hour detention, that physician has responsibility for that patient until admitted to Semper Virens and reasonable steps must be taken to ensure that patient's safety during transfer.

b. All 5150 patients **must** be transferred by ambulance. If the patient becomes aggressive or threatens hospital staff, the HCSO can be called to transport the patient.
c. If the physician has not signed the application form but the patient requests voluntary admission to Semper Virens, the patient may be transported by private car.

d. Patients who are transported by private car may change their minds and often will not arrive at Semper Virens for further evaluation and treatment.

10. Hospital staff must attempt to obtain the name and contact information of the patient's health plan and notify them of transfer by the following means:

a. requesting the patient's healthcare service plan member ~~card;~~card.
b. asking the patient; or
c. asking the patient's family or other person accompanying the patient.

11. Hospital staff that are requesting the transfer are not required to make more than one call to the health plan. The hospital staff are required to document the call or attempt to notify the patient's healthcare plan.

12. Discontinuing a 5150

The following professionals are eligible to discontinue a W&I Code section 5150 hold, if the person can be properly served without being detained:

a. Certain on-duty licensed employees of the Department of Health & Human Services (DHHS) – Mental Health.~~;~~

b. On-duty emergency room physicians at any of the hospitals offering emergency room services in Humboldt County.

c. On-duty psychiatrists including those providing services through tele psychiatry at any of the acute care hospitals in Humboldt County.

d. On-duty physicians offering emergency services at the K'ima:w Medical Center.

13. Under Which Conditions Will a 5150 Hold be discontinued?

Upon assessment, if in the judgment of the designated professional the person can be properly served without being detained, then the 5150 hold can be discontinued and the person provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. Referrals can be made for follow up appointment with ongoing provider of the client's choice, primary care provider, or mental health professionals.

14. Discharge/Referrals

a. All patients being discharged from 5150 or those seeking mental health referrals MUST be provided the DHHS (Dept. of Health and Human Services) resource list for Humboldt County for follow up care.

b. Patients who are being discharged should have a final mental health assessment submitted into ~~Healthland~~ Epic prior to discharge.

c. Upon discharge: document any family or friends that will assume responsibility for the patient.

d. Discharge the patient with proper documentation including the advice to consult psychiatrist, mental health clinic and/or primary care physician as well as patient received mental health resource list.

REFERENCES:

California SB 364 – Changes to the Lanterman-Petris-Short (LPS) Act February 2018, Pub. #5546.01
Retrieved from: http://www.disabilityrightsca.org/pubs/554601.pdf
Emergency Nurses Association (ENA). (2016). Position Statement: Use of Protocols in the Emergency Setting. ENA Board of Directors.
Humboldt County Board of Supervisors. DHHS – Mental Health 5150 Manual. October 2018.
Retrieved from: https://humboldtgov.org/DocumentCenter/View/52548/DHHS-Mental-Health-5150-Manual-PDF.
W&I Code division 5-part 1 chapter 1 section 5000 and part 1.5 section 5585 2 Disability Rights

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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 1
SUBJECT: Administration of Potassium Chloride Intravenously	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: NEW

POLICY: It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to treat all patients with hypokalemia effectively and safely.

PURPOSE:
The purpose of this policy and procedure is to ensure that intravenous Potassium Chloride will be safely prepared and administered.

INTRAVENOUS POTASSIUM CHLORIDE CAN BE FATAL IF GIVEN INAPPROPRIATELY.

PROCEDURE:

IV ACCESS:
Peripheral vein, large
20-gauge intravenous catheter or larger

DILUENTS:
- NS, D5W or LR
- MEDICATION / DILUTIONS / INFUSION RATES
  a) 10 mEq / 100 ml / 1 hr
  b) 20 mEq / 250 ml / 2 hr
  c) 40 mEq / 500 ml / 4 hr
- Maximum Concentration of Potassium Chloride is 1 mEq / 10 ml
- Maximum Infusion Rate is 10 mEq / hr

ADMINISTRATION PROCEDURES:
Intravenous Potassium Chloride is delivered via a dedicated ~~line;~~line, no other solutions or connections to the line. Potassium Chloride is **never** delivered as a bolus.
ALL IV INFUSIONS OF POTASSIUM MUST BE DELIVERED BY AN INFUSION PUMP.
Intravenous Potassium Chloride solutions should be prepared immediately prior to administration and the bag should be adequately mixed by inverting the bag at least 10 times. The infusion must be properly labeled with the ~~M~~medication, dose, and patient sticker. Potassium Chloride must be documented in ~~full,~~full; abbreviations are not acceptable. Disconnect the infusion line as soon as infusion is completed.

MONITORING
Cardiac Monitor, continuously, as may cause arrhythmias and EKG changes.
Assess infusion site frequently for pain and extravasation.
Immediately stop infusion if there are any signs and symptoms of infiltration and report to the ordering provider.

REFERENCES:
Woodland,G. (2019, April 30). *How should intravenous (IV) potassium chloride be administered in adults?* Specialist Pharmacy Service. https://www.sps.nhs.uk/articles/how-should-intravenous-iv-potassium-chloride-be-administered-in-adults/

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: Alcoholism, Drug Abuse and Psychiatric Patients	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 02/28/2013

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to meet the individual needs of patients admitted with problems brought about by alcoholism, drug abuse, and psychiatric disorders; to enable the Medical Staff to have readily available the information concerning community resources available to provide the necessary treatment for these patients and to provide the steps necessary to carry out this plan.

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PURPOSE:

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To meet the individual needs of patients admitted with problems brought about by alcoholism, drug abuse, and psychiatric disorders; to enable the Medical Staff to have readily available the information concerning community resources available to provide the necessary treatment for these patients and to provide the steps necessary to carry out this plan.

MEDICAL STAFF RESPONSIBILITIES:

1. Patients who have a secondary diagnosis of psychiatric disorder, alcoholism or drug abuse may be admitted for acute medical or surgical treatment.
2. When their medical or surgical condition permits, these patients are to be transferred to an appropriate facility.
3. The physician shall be required to request transfer of their patients who are or become emotionally ill or suffer alcoholic or drug abuse while hospitalized.
4. The physician shall contact the psychiatrist on the Medical Staff of the appropriate facility and request transfer of his patient to that facility for care under his psychiatric supervision.
5. The physician must follow the "Patient Transfer" policy and procedure to ensure EMTALA compliance.

ALCOHOLIC DETOXIFICATION

Although we are not a Detoxification Center, many patients have Acute Alcohol Withdrawal as a secondary diagnosis. The Emergency Room physician will treat the Emergency Medical Condition and Acute Alcohol Withdrawal according to our abilities or will be transferred to the appropriate level of care in accordance with EMTALA.

Referral to Official Agencies:

1. Patients shall be referred to official agencies for outpatient treatment when requested by, or approved by, their attending physician.
2. Referral shall include, but not be limited to: Sempervirens, AA, or Public Health.
3. Patients shall be instructed in the procedure for which they will be responsible to obtain an appointment, or an appointment will be made for them by the nursing staff.

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Assessment and Vital Signs Guidelines**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/22/2019

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide emergent assessment and vital signs guidelines to the Emergency Department (ED) nursing staff.

PROCEDURE:

A. Triage
All patients will have vital signs assessed at Triage, including an initial pain assessment. Pediatrics are defined as less than 14 years old and/or up to 21 years old at physician's discretion. Not obtaining a Pediatrics blood pressure (BP) is acceptable unless the chief complaint warrants initial vital signs such as:

- Altered level of consciousness (ALOC)
- Trauma
- Hemorrhage
- Severe Headache
- Sepsis
- Cardiogenic Shock

Pediatric Vital Sign Guidelines:

	Resp. Rate	Heart Rate	Systolic BP
Preterm (<37wks):	50-70	120-180	40-60
Newborn (37-42wks):	40-60	100-170	50-70
Neonate (1-28 days):	30-50	90-160	60-80
Infant (1-12 months):	25-40	80-160	70-100
Toddler (1-3 ~~yrs~~yrs.):	20-30	80-130	70-110
Preschooler (3-5 ~~yrs~~yrs.):	20-30	80-110	80-110
School Age (6-12 ~~yrs~~yrs.):	20-24	75-100	80-120
Adolescent (>13 ~~yrs~~yrs.):	12-20	60-90	94-130

Vital signs in the ED should be taken at least once an hour or more depending on condition

B. Discharge
Discharge vital signs will be obtained within 30 minutes of discharge on the following patients:

1. Any patient with an initial triage level of 1, 2, 3.
2. Any patient who has received an intravenous (IV), intramuscular (IM), subcutaneous (SQ) or nebulized medication.
3. Any patient who has had abnormal vital signs during their course in the ED.
4. Any patient who complains of light-headedness, has had a syncopal episode or who is "abnormally" unstable when ambulating.
5. Anytime the nurse is concerned about the patient's readiness for discharge.

C. Triage Priority Level 1-Emergency/Unstable
Patients with life or limb threatening illnesses or injuries requiring immediate emergency medical care. Sudden onset of a medical/traumatic condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, symptoms of substance abuse or any woman presenting with a chief complaint of pregnancy and/or labor at a time when delivery is imminent) such that the absence of immediate medical attention could reasonably be expected to result in:

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1. Placing the individual's health in severe jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. Placing others at risk.

These patients (adult/pediatrics) are unstable, may not be referred elsewhere for care and are to be taken immediately to the treatment area of the Emergency Department for further evaluation. **Nurses will reassess all patients in this category every 30 minutes or more frequently as the patient's condition dictates.** If afebrile (temp. <100.5/38 °C), repeat the temperature every 2 hours.

D. Triage Priority Level 2-Emergent
An Emergency Medical Condition is present or cannot be ruled out, requiring treatment/evaluation ranging from prompt to within several hours to prevent loss of life or limb. **Nurses will reassess patients in this category every hour or more frequently if the condition requires.** If afebrile (temp. <100.5° F or 38° C), repeat temperature every four hours.

E. Triage Priority Level 3-Urgent
This patient does not exhibit signs or symptoms consistent with an Emergency Medical Condition. Patients in this category have illnesses or injuries that require follow-up, but where time is not a critical factor. If these patients remain within the Emergency Department (waiting room or treatment areas), **nurses will reassess this patient every two hours or more frequently if the conditions require.**

F. Triage Priority 4-Urgent/Stable
The patient does not exhibit signs and symptoms consistent with an Emergency Medical Condition. Conditions that place a patient in Level 4 have usually developed slowly and have been tolerated by the patient for some time. **If these patients are kept within the Emergency Department, they will be reassessed typically at triage and then discharge or more often if needed.**

G. Triage Priority Level 5-Non-Urgent

REFERENCES:
B. Brown. "Sutter Coast Community Hospital Policy." *Sutter Coast Hospital*. Rita Nicklas, n.d. Web. 09 Jan. 2013.

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Assisting With Abdominal Paracentesis**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with abdominal paracentesis.

Purpose:
The purpose of this policy and procedure is to provide guidelines for the nursing staff to assist with abdominal paracentesis.

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Equipment:
- Sterile paracentesis tray and gloves
- Local anesthetic
- Drape or cotton blankets
- Collection bottle (vacuum bottle)
- Skin preparation (antiseptic)
- Specimen bottles and laboratory forms

Procedure:

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Preparatory Phase
1. Explain procedure to the patient.
2. Ensure procedural consent form was signed by the patient and the provider.
3. Document pre-procedural vital signs.
4. The patient should be placed on the bedside ~~monitor;~~monitor, monitor heart rate, saturations and blood pressure.
5. Have the patient void before the procedure.
6. Position patient in Fowler's position with the back, arms, and feet supported.
7. Drape the patient with a sheet keeping the abdomen exposed.

Performance Phase
1. Assist in preparing skin with antiseptic solution.
2. Open and set up the sterile tray and sterile gloves, have the antiseptic for the skin ready to apply.
3. Have the collection bottles and tubing available.
4. Access pulse and respiratory status frequently during the procedure; watch for pallor, cyanosis, or syncope. These signs indicate shock. Keep emergency medications available.
5. The provider will administer local anesthesia and introduce the needle trocar.
6. The needle trocar is connected to tubing and a vacuum bottle or syringe; fluid is slowly drained from the peritoneal cavity. Drainage is usually limited to 1-2 liters to relieve acute symptoms and minimize risk of hypovolemia and shock.
7. Apply dressing when the needle is withdrawn. Usually a dressing is sufficient: however, if the trocar wound is large, the provider may close the incision with sutures.

Follow–up ~~Phase~~Phase.

1. When the procedure is finished, assist the patient to a comfortable position.
2. Record the amount and characteristics of the fluid removed, number the specimens sent to the laboratory and the patient's condition during the treatment.
3. Check blood pressure and vital signs every ½ hour for 2 hours, every hour for 4 hours and every 4 hours for 24 hours. Close observation will detect poor circulatory adjustment and possible development of shock.
4. Watch for leakage or scrotal edema after paracentesis. If seen, report at once.

REFERENCES:

Nettina, S. M. (2019). Lippincott manual of nursing practice (11th ed.). Lippincott Williams and Wilkins.

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: **Brain Death**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") not to diagnose Brain Death. Pursuant to AB 2565, effective January 1, 2009, the District enacts the following provisions.

Purpose:
The purpose of this policy and procedure is to delineate the procedures to follow when a patient exhibits signs and symptoms of Brain Death, as defined in California Health and Safety Code (HSC) Section 7180.

Procedure:

1. Patients who present to the Emergency Room in full cardiac arrest, or who arrest during their ED stay, will have resuscitation procedures initiated /continued following appropriate guidelines.
2. In the event the patient is not resuscitated; that is, does not regain a spontaneous heartbeat and respirations, the patient is pronounced dead by the physician.
3. In the event the patient's resuscitative efforts result in the patient exhibiting signs of brain death, without cardiopulmonary death, the facility will transfer the patient to a higher level of care. The facility does not have the technology or the trained medical personnel to determine brain death. Ventilator support will continue if appropriate.
4. Attempts will be made to have appropriate family or next of kin at the patient's bedside after resuscitation efforts have ceased.
5. If reasonable for this patient, special religious or cultural practices or concerns will be met at this time. In determining what is reasonable, the facility will consider the needs of other patients and prospective patients in need of urgent care.
6. All requirements for distribution of policies pursuant to HSC 1254.4 (c.) will be done by the receiving ~~facility, since~~facility since Brain Death would be determined there.

References:
Mason,T. (2014, May). California Health & Safety Code - Section 1254.4. AB 2565 Assembly Bill. https://www.thaddeuspope.com/images/1254.4_death_accommodate.pdf

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: **Care of the Patient Under the Influence**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and treatment to those patients presenting to the Emergency Department under the influence of alcohol or drugs.

Purpose:

To provide guidelines for the management of the patient under the influence of alcohol or drugs.
The initial management of the patient under the influence of alcohol or drugs is the same as for other patients presenting for care in the Emergency Department. All alcohol or drug impaired patients will receive a medical screening exam (MSE) to assess underlying medical conditions and to provide stabilization before discharge. Discharge of impaired patients may result in injury to the patient or to others.

The emergency physician will examine and determine if the patient ~~is in need of~~needs acute hospital care or transfer to a higher level of care.

While in the Emergency Department, the patient will be monitored according to their medical condition.

The patient under the influence of alcohol or drugs will be treated with the respect that all patients are to receive, using a non-judgmental and supportive attitude in the care of the patient who has a specific medical disease.

Procedures:

1. Complete an assessment and determine if any injuries have occurred.
2. **All** patients will have a CIWA (Clinical Institute for Withdrawal Assessment), a COWS (Clinical Opiate Withdrawal Scale) assessment at least every 2 hours unless a need to have them completed sooner is necessary. If the patient's drug and alcohol screenings are negative only 1 CIWA and 1 COWS will be needed in the chart.
3. Obtain a blood alcohol level with indications of alcohol ingestion. Repeat blood alcohol level prior to discharge at the Provider's discretion.
4. Vital signs will be taken based on the patient's condition/Provider's order.
5. Do not allow consents from adult patients where obvious impairment is noted.
6. Patients who leave AMA whose blood alcohol level is above the legal limit for the operation of a motor vehicle will be reported to the police. If the physician deems it necessary, the Garberville Sheriff's Substation or CHP may be contacted for assistance in controlling a patient who becomes a public nuisance for disturbing the peace.

References:

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction 84:1353-1357, 1989.
Sellers, E. S. (2021). *CIWA-Ar for Alcohol Withdrawal*. MDCalc. https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 4
SUBJECT: **Care of the Patient With Burns**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with burns.

PURPOSE:
The purpose of this policy and procedure is to minimize extent of injury, to provide pain relief and to preserve organ function for a patient with burns.

DEFINITIONS:
First Degree (Superficial) – epidermis - damage to the skin is limited to the outer layer (epidermis.) The skin is intact and typically appears to be pink/red in color, very warm or hot to the touch and painful. Swelling and small blisters may be present. Common cause: sunburn.

Second Degree (Partial Thickness) - epidermis and dermis - damage to the skin includes the outer layer and penetrates to the middle layer of tissue (dermis). The wound is typically moist/wet and red. Swelling is usually present, there may be blisters or sloughing (loss) of skin; it is very painful.

Third Degree (Full Thickness) - all three layers of the skin (epidermis, dermis and hypodermis/subcutaneous tissue) are damaged; the injury can include deep penetration into muscles, organs and bones. The affected area is dry, leathery and may present in many colors (i.e., whitish, charred or tan-colored). Due to nerve destruction, full thickness areas are non-sensate (loss of feeling/sensation)

PROCEDURE:

Initial Steps:
- Assemble your team.
- Prepare your room and assign roles: early IVF access and airway assessment are critical in this patient population.
- Evaluate goals of care. Consider early conversations with patient and ~~family~~family, if possible, in the clinical context. Patients with a Baux Score (Age + TBSA) >160 have nearly a 100% mortality rate.
- Calculate the total body surface area (TBSA) that has been burned. Diagram listed in policy if needed.
- Administer 100% oxygen by simple mask or non-rebreather

Assessment:
1. Airway, Breathing, Circulation:
   Maintain open airway, provide humidification, evaluate for inhalation injury (i.e., singed nasal hairs, face or neck burns, carbonaceous sputum, soot in the upper airways, voice changes or wheezing).
   Anticipate possible need for intubation, cricothyrotomy or tracheostomy. (Stridor, respiratory distress, hypoventilation, or decreased mental status).
2. Examine and treat for external and internal bleeding, fractures, head trauma, abdominal injuries, etc.

Stop Burning Process:
1. Cut away all clothing - do not pull adhered clothing from wound.
2. Cool the burn by applying cool, sterile water as ordered.
3. Wrap patient in a sterile sheet after removing clothing.

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Estimate Severity:

1. Size and depth of burn - use "Rule of Nines."
2. Age of patient.
3. Past medical history including allergies, current medicines, and last tetanus prophylaxis.
4. Concurrent injuries.

Consider Major Burn If:

1. The injury is 3rd degree over 10% of body surface, or 2nd degree over 20% of body surface.
2. The patient is under 4 years of age, or over 60 years of age.
3. There are concurrent injuries.
4. There is chronic or severe medical illness.
5. The burn involves the hands, face, feet, or perineum.
6. It is an electrical injury.
7. There is an inhalation injury.

Respiratory and Fluid Guidelines:

1. Start oxygen via nasal cannula @ 4L per minute. If pulmonary injury or carbon monoxide poisoning is suspected, rate can be increased to 8L per minute or use non-rebreather mask (15L).
2. If carbon monoxide poisoning or inhalation injury suspected by respiratory distress or by history (trapped in a closed space), draw carboxyhemoglobin level and arterial blood gases. Do not wait for results; go forward with transfer arrangements if indicated.
3. Endotracheal intubation via nose or mouth if indicated for airway obstruction or Pa O2 less than 60 mm Hg.
4. Anticipate need for 2 large bore peripheral IVs. Ideally, a central line should be inserted in an unburned area.
5. Amount of Ringer's Lactate for initial 24-hour load:
   - 4 x % BSA burned (average) x Wt (Kg)= ~~24 hour~~24-hour fluid requirement
   - rate of administration:
     1/2 during 1st 8 hours
     1/4 in each following 8-hour period
6. Time is calculated from onset of burn.
7. It is important that each Ringer's Lactate bottle is labeled in order of administration (1, 2, 3, etc.)
8. Goal of urine output via Foley catheter is 0.5ml/kg/hr

Medication:

1. Tetanus prophylaxis, if indicated.
2. Narcotic analgesic: IV only when indicated. Avoid IM or subcutaneous routes due to poor circulation and fluid shift process.
3. Silvadene cream should be applied as directed by physician.

Wound Care:

1. Everyone involved in care is in sterile gown, gloves, mask, and shoe covers. Aseptic technique is maintained during initial burn dressings.
2. Cleanse gently with mild soap and water.
3. Remove debris.
4. Leave blisters intact.
5. Cover patient for warmth.
6. If wound dressings are required, apply a non-adherent bandage such as telfa with cling wrap. Do not use tape on skin.

Additional Care:

1. Keep patient NPO.
2. Urethral catheterization to measure hourly output. (Should be 0.5 cc/kg/hour.)
3. Anticipate possible need for nasogastric tube in patients who are unconscious or with burns 30% or greater to relieve gastric dilatation which occurs in burns of this magnitude.
4. Transfer - see area wide transfer protocol. Use transfer patient checklist along with usual transfer forms.

Electrical Burns:

An electrical burn causes injury as a result of heat generated by an electrical current passing through tissue. One of the major concerns with electrical injuries is the development of cardiac dysrhythmia. In cases of electrical burns check urine for myoglobin and ph.

Emotional Support:

Reassure patient and allow them to express feelings about disfigurement.

Documentation:

1. Chart all pertinent findings.
2. Monitor vital signs, including urinary output every 15 minutes, or as ordered by attending physician.
3. Vital signs, including cardiac monitoring, may need to be noted more frequently as indicated/ordered.

Discharge Planning:

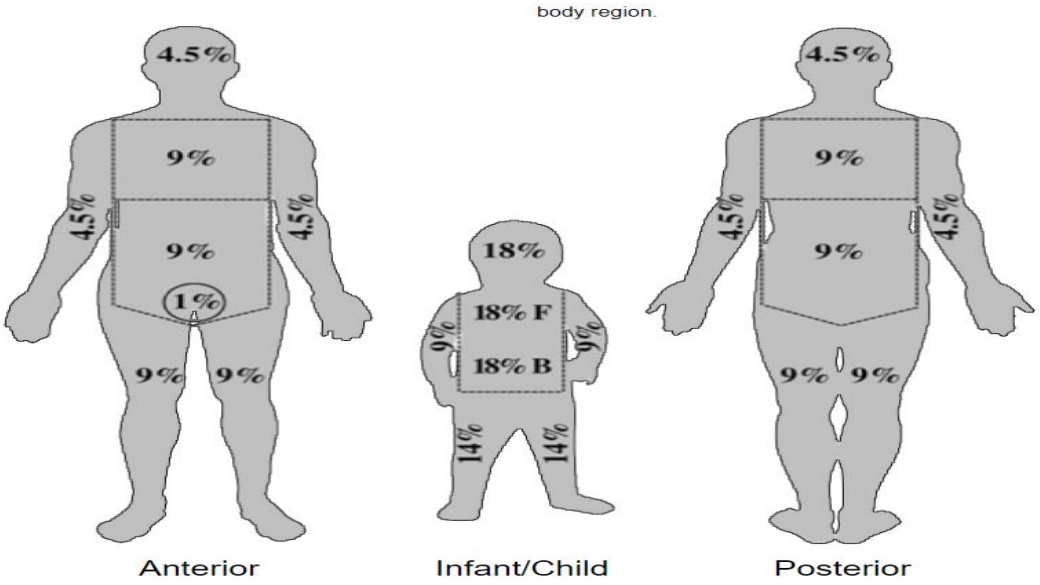
1. Consult transfer agreements for anticipated out-of-area transfers. Transfer per area-wide transfer protocol.
2. Telephone physician in charge of the burn unit for further instructions or aid in transfer.

Who Typically Requires Admission to a Burn Center

- Partial Thickness burns >10% of TBSA (age <10 or >50) or >20% of TBSA (age 10-50)
- Third Degree Burns
- Electrical Burns (including lightning injury)
- Chemical Burns
- Inhalation Injury
- Circumferential burns
- Burns to hands, face, genitalia, perineum, major joints
- Burns in patients with other medical comorbidities that may prolong recovery

Remember

- Follow your ABCs. Remember, these patients can present with rapidly evolving, critical airways.
- Obtain a directed history from patient or EMS regarding burning agent (don't forget about chemical burns!), whether injury was sustained in an open or enclosed space, risk of blast injury.
- Treat CO and cyanide if history, exam, or labs are suggestive.
- Begin resuscitation with IV fluids (LR) based on specific burn formula (ISR, Brooke, Parkland).
- Don't forget that burn patients can be MORE than just a burn: think about trauma, toxicologic etiologies, and blast injuries.
- Pain management is paramount in this critically ill population. Reassess early and often.



Remember Palmer Hands: Each hand is 1%

REFERENCES:

Understanding Burn Care. (2018). *Determining Burn Severity*.

Steinvall I, Elmasry M, Fredrikson M, Sjoberg F. (2016) Standardized mortality ratio based on the sum of age and percentage total body surface area burned is an adequate quality indicator in burn care: An exploratory review. Burns. 2016; 42(1):28-40.

Cline D, Meckler G, Ma OJ et al. (2017) Tintinalli's Emergency Medicine Manual, Eighth Edition. McGraw-Hill Education / Medical.
Latenser BA. Critical Care of the Burn Patient. In: Hall JB, Schmidt GA, Kress JP. eds. Principles of Critical Care, 4e New York, NY: McGraw-Hill; 2014.

http://accessmedicine.mhmedical.com.foyer.swmed.edu/content.aspx?bookid=1340&sectionid=80027724. Accessed November 22, 2017.

Al-Benna S. (2011). Fluid resuscitation protocols for burn patients at intensive care units of the United Kingdom and Ireland. *German medical science : GMS e-journal*, *9*, Doc14. https://doi.org/10.3205/000137

The above initial burn care is recommended by Bothin Burn Center, St. Francis Hospital, San Francisco, CA, (415) 355-6255.

An alternate burn center: U.C. Davis Burn Center (916) 734-3636. Updated 7/12/2021

REVIEWED BY:

Chief Nursing Officer
ED/Acute Nurse Manager
Medical Director

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DEPARTMENT: Emergency Services	APPROVED:	Page 1 of 3
SUBJECT: **Caregiver-Child Separation During the Event of a Disaster**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to protect our vulnerable pediatric patients during the event of a disaster.

Purpose:

To minimize parent-child separation and provide methods for reuniting separated children with their families.

Definitions:

Child
Any persons under the age of 18.

Unaccompanied children
(Also called unaccompanied minors)- are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.

Tracing
In the case of children, the process of searching for family members or primary legal or customary caregivers. The term also refers to the search for children whose parents are looking for them. The objective of tracing is reunification with parents or close caregivers.

Identification
The process of establishing which children have been separated from their families or other caregivers.

Verification
The process of establishing the validity of relationships and confirming the willingness of the child and the family member to be reunited.

Reunification
The process of bringing together the child and family or previous care-provider for the purpose of establishing or re-establishing long-term care.

Pediatric patients separated from parents have rights:

- The right to physical and legal protection
- The right to not be separated from their ~~parents~~parents.
- The right to provisions for their basic ~~sustenance~~sustenance.
- The right to care and assistance appropriate to their age and developmental ~~needs~~needs.
- The right to participate in decisions about their ~~future~~future.

Procedure:

- During the event of a natural disaster all patients will be triaged using the S.T.A.R.T method as discussed in safety manual policies and procedures located in the red binder at the nurse's station.

- If there are pediatric patients who are found to be separated from family, then it will become the Emergency Department Doctor/Nurse's responsibility to provide services that reunite families as quickly as possible.

- If a child's identity is not known, the relevant authorities should take appropriate measures to ascertain it. A new identity should be established only as a last resort. Proper documentation by medical staff that describes

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the child's approximate age, the child's appearance and characteristics may help family identify the unidentifiable pediatric patient at a later time. Taking a photograph of the child during registration and prior to imminent transfer will help families to identify their children accordingly. Any clothing that may be removed from the child for medical treatment should be saved for family members to help identify the pediatric patient.

- Precautions must be taken when sharing and publishing information on unaccompanied and separated children, including photographs of children for tracing. It is important to know who will have access to the information collected.
- If large numbers of children are separated from their parents or other relatives in an emergency, priority should be given to the most vulnerable, whether accompanied or unaccompanied.
- A child's opinion should be listened to and given due weight in relation to the child's age and maturity. Children must be kept informed about plans being made for them including placement of care, tracing, and reunification.
- Cooperation among all organizations concerned are critical for the care and protection of separated children. It is important that action be coordinated with local agencies such as Humboldt County, Red Cross, Redwoods Rural, local schools, and other relevant authorities. Dialogue and coordination mechanisms need to start in the early phases of the emergency and be maintained throughout the process. A communication strategy through the local media would be warranted in the case of child/caregiver separation.
- Roles such as "sitter" for the stable children will be implemented appropriately to those who are qualified based on credentials and availability.
- The pediatric patient who was separated from family members and is in need of being transported to a facility with needed higher level of care will be traced accordingly so when the patient's family is able to make ~~contact~~contact, they are well informed of where their child is. It will be this facility's responsibility to try to locate the closest most appropriate higher level of care for the pediatric patient.

REFERENCES:

Emergency Planning With Children (2021). FEMA. https://www.fema.gov/emergency-managers/individuals-communities/children

Disaster Relief and Recovery Services. (2021). American Red Cross. https://www.redcross.org/get-help/disaster-relief-and-recovery-services/contact-and-locate-loved-ones.html

Disaster Safety for Children. (2021). American Red Cross. https://www.redcross.org/get-help/how-to-prepare-for-emergencies/disaster-safety-for-children.html

How Families Can Prepare for Emergencies. (2021). American Red Cross. https://www.redcross.org/get-help/how-to-prepare-for-emergencies/teaching-kids-about-emergency-preparedness/how-families-can-prepare-for-emergencies.html

REVIEWED BY:

Chief Nursing Officer

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 10
SUBJECT: **Central Venous Catheter Care**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/22/2019

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to require~~s~~ clinicians and healthcare providers including registered nurses, LVN's and techs to adhere to practices that reduce the risk of harm, including infection, during insertion, care, and removal of central venous catheters.

Purpose:

The purpose of this policy and procedure is to ensure standard of practice is utilized in IV therapy with central venous catheters performed safely, appropriately, and effectively, utilizing devices and practices to reduce risk of blood borne pathogen exposure due to needle-stick.

Central Venous Catheters (CVC) will be inserted utilizing evidence-based practices known to reduce the risk of central line-associated bloodstream infections, including the following:

- Hand Hygiene by the inserter and all assistants
- Maximal Sterile Barriers Precautions, including sterile gloves, sterile gown, cap, mask, and, full body sterile ~~drape~~drape.
- Appropriate skin prep:
  - Chlorhexidine gluconate if 2 months of age or over, unless ~~contraindicated~~contraindicated.
  - Povidone iodine or alcohol if less than 2 months of age.
- The skin prep is allowed to completely dry before insertion.
- The femoral vein should be avoided when possible.
- If a catheter is placed during a medical emergency when adherence to aseptic technique cannot be ensured, the catheter should be replaced within 48 hours.

Procedure:

ASSISTING WITH CVC INSERTION:

This section applies to CVC insertion at the bedside. When assisting with CVC insertion, the primary goals are to ensure patient safety and prevent complications:

1. Obtain the Central Line Checklist prior to the procedure.
2. Verify the correct patient and procedure by conducting or participating in the Procedural Pause and verifying that the Informed Consent process has been completed and documented.
3. Complete any needed patient teaching, such as what the patient can expect during the procedure, how long it may last, and what the patient should report during the procedure.
4. A nurse should stay at bedside to assist with procedure preparation, to assist with monitoring compliance with sterile technique, monitor patients' condition and to assist the physician as they deem necessary.
5. Protect patient safety by ensuring compliance with required safety measures during the procedure including: Hand Hygiene for all assistants before and after procedure
6. Maximal Sterile Barrier precautions during the procedure (mask, cap, sterile gloves, sterile gown, full body, sterile drape). When lines are placed emergently, the proceduralist adheres to insertion practices to the extent possible, recognizing the stability of the patient takes precedence over compliance with practice guidelines.

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7. Appropriate skin prep: (check for allergies)
    - Chlorhexidine gluconate if > 2 months of age (unless contraindicated)
    - Povidone iodine or alcohol if < 2 months of age may be used for umbilical lines in neonates and those with allergy to CHG.
    - Allow skin prep to dry completely before insertion.
    - Maintenance of Sterile Technique throughout the procedure.
    - If a break in Sterile Technique is seen or suspected, immediately inform the proceduralist. The procedure should be paused, then the break in Sterile Technique is remediated by whatever means is appropriate (replace supplies, redrape the field, change operator gloves, etc.).
    - The decision regarding the appropriate steps to take to remediate the apparent or possible break in Sterile Technique is made by the proceduralist (MD).
    - Whenever a procedure is interrupted because of a possible or apparent break in Sterile Technique, a Quality Review Report (RL solution) is completed, detailing the events and remediation steps.

8. Assist physician with the procedure by:
    - Assembling the required supplies and equipment. Note that these vary with the exact procedure being performed. Generally, they will include a CVC kit (proceduralist is to specify the kit), Maximal Sterile Barrier supplies, which should be assembled with the kit, IV supplies (fluids, tubing, caps), and forms for documentation.
    - The proceduralist should review the assembled supplies and equipment before beginning the procedure.
    - Position the patient appropriately for the procedure.
        - For Subclavian and Internal Jugular vein approaches, this may entail a Trendelenburg position for the patient if tolerated, and with the patient's head turned away from the side the procedure is performed on.
        - Other procedures will require different patient positioning, check with proceduralist.
    - Place the supplies and equipment on a suitable surface, such as a Mayo Stand or over bed table. Do not begin opening sterile supplies until directed by the proceduralist.
    - While the procedure is underway, assist the proceduralist by obtaining needed supplies or equipment, patient positioning, and other assistance as requested.

9. Monitor the patient during the procedure as appropriate to the clinical situation. This may entail recording the vital signs before and after the procedure, observing the electrocardiogram monitor, and monitoring the patient's mentation, anxiety, and tolerance of the procedure.

10. CVAD placement is confirmed, and insertion related complications are identified radiographically as appropriate.
    a. Confirmation of appropriate placement is made before the use of the CVAD, except in emergent situations.
    b. Femoral line placement does not require radiographic confirmation.

Maintenance

1. Assessment

a. The site, surrounding skin and dressing are assessed at least every shift and with each change in caregiver or more often as needed.
b. The physician evaluates the continued need for the device daily. The nurse will also document the Daily review of the line and the necessity.

2. CVAD Dressing Change

Equipment:

- Central Line Dressing Kit
- Stat Lock (unless catheter is sutured)
- Nurse and patient shall wear a standard surgical mask.
- Sterile gloves
    a. Dressing changes are performed as a sterile procedure.
    b. Remove post-procedure dressing approximately 24 hours after insertion (or sooner if saturated with blood) and apply transparent dressing unless drainage mandates reapplication of gauze dressing.

  Patient conditions are considered in selection of the appropriate dressing.
    i. A biopatch in which is CHG-impregnated is used unless contraindicated OR unless the patient has an implanted port.
    ii. Gauze is used when the patient is allergic to adhesives or where significant oozing is present.

iii. For infants less than 2 months of age, a transparent dressing is used.

c. **Transparent** dressings are changed every **Friday** or when damp, soiled, bloody, or non-occlusive.
d. **Gauze** dressings and gauze under transparent dressings are changed every 2 days or if saturated to allow site assessment. This includes gauze dressings covered with a transparent dressing.
e. If using a securement device, it is changed with the dressing change.
f. Place a label on the dressing with date of the dressing change and initials. Do not write directly on the dressing.

Procedure

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Steps: Note: the first portion of the procedure is clean; the second portion is sterile.

1. Identify patient using 2 patient identifiers.
2. Perform hand hygiene before and after procedure.
3. Position patient with face turned away from insertion site.
4. Put on non-sterile gloves and mask. Wear sterile gloves for neutropenic patient.
5. Before removing the dressing, assess for pain/tenderness along the vein tract by light palpation.
6. Remove dressing from insertion site, being careful not to dislodge the catheter. Remove Stat Lock if present. It may be necessary to temporarily tape the hub or tubing to prevent it from being dislodged while the Stat Lock is not present.
7. Inspect site and catheter for redness, drainage, swelling, tenderness, catheter migration or alteration in sutures, if present. If any of these problems are noted, complete the dressing change, and notify the physician.
8. Remove gloves and put on sterile gloves.
9. Prep site:
    a. Use alcohol swab to remove visible exudates or other foreign material.
    b. Disinfect site with 2% Chlorhexidine: apply liberally to exit site; then apply to a small area of surrounding skin **using gentle back and forth scrubbing motion for 30 seconds.**
    c. If patient is allergic or demonstrates sensitivity to Chlorhexidine, may substitute with Povidone Iodine or alcohol.
    d. Allow to air dry completely.
10. Apply new Stat Lock.
11. Apply transparent dressing.
12. Secure catheter hub to skin with tape.
13. Label dressing with date, time, and initials.

Documentation

A. The proceduralist shall document insertion procedure, including but not limited to:
    1. Adherence to hand hygiene
    2. Use of components of barrier precautions
    3. Type of skin preparation
    4. Type and location of catheter and
    5. Any complications of insertion known at the time of documentation
B. The Nurse documents
    1. Patient/family education
    2. Pre-procedure verification and time-out
    3. Daily assessment of site
    4. Dressing changes every Friday or if saturated
    5. Discontinuation of catheter

PREEXISTING CVC (UPON ADMISSION)

A preexisting CVC (a CVC that is in place when the patient comes to the hospital) may generally be used, ~~provided that~~if it functions correctly, there is no evidence of complications, and the patient continues to require central venous access.

1. Identify the type and size of catheter so that appropriate maintenance can be done.
2. If possible, obtain the insertion record.
3. Perform a thorough assessment of the catheter and insertion site and change the dressing if it is undated or if more than a week will pass by the next routine dressing change day, or if it is loose, soiled, bloody, or wet.
4. Change the injection cap and flush.

5. If the catheter is occluded, see **Addendum A: Management of Common Problems/Complications** below.
6. A Daily Necessity evaluation is to be performed and documented each day. Obtain a physician order to discontinue lines that are deemed no longer necessary at the earliest opportunity.

Accessing the CVAD

1. Perform hand hygiene before and after manipulation of the line.
2. Catheter access is minimized.
3. Aseptic technique is utilized in accessing the catheter hub or injection caps for any reason.
4. Scrub the hub/connector or port vigorously to disinfect access port for at least 5 seconds with a 70% alcohol wipe or 2 % CHG w/alcohol prep swab.
5. Allow time to dry before accessing.
6. The lumens when not in use remain capped and protected at all times.
7. Replace administration sets not used for blood products at intervals not longer than 96 hours. (IV tubing)

FLUSHING - All Central Venous Catheters

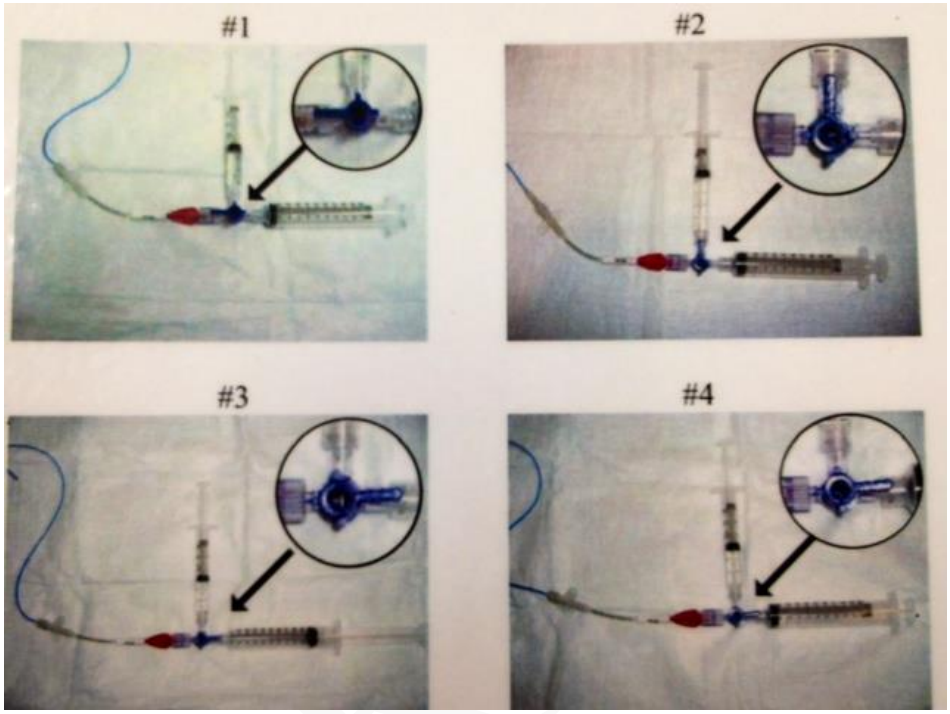
1. Flush each lumen according to the following guidelines:
   a. "Regular" catheters (i.e., IJ, subclavian, femoral) at least every 12 hours with 5-10 ml NS followed by 2.5 ml Heparin Flush Solution (100u/ml). Also flush before, between, and after medications as above.
   b. Groshong catheters only need to be flushed with NS once a week, or before, between, and after meds as above. Heparin is not needed (except in rare circumstances where the valve is "incompetent", then it is flushed like a regular catheter.)
2. For pediatric patients: decrease flush volume in proportion to catheter size; use preservative free normal saline for pediatric patients < 1 year old.
3. Avoid the use of Heparin in patients with Heparin Induced Thrombocytopenia (HIT) or reported Heparin allergy/hypersensitivity.

OCCULDED CATHETER OR PORT

1. Reposition patient (upper body and arm movement) and have patient cough to rule out posture related block or kink in catheter. Check that sutures at hub of non-tunneled catheters are not too tight.
2. Access the line/port per standard. Verify occlusion by attaching a 10-20 ml syringe of normal saline. Attempt to withdraw blood. The lumen is flushed with normal saline using a PULSATILE Stop- Start Technique.
3. If **successful,** aspirate line of all clots, then irrigate with 20ml of sterile normal saline. Follow with a heparin flush for ports and NON-Groshong catheters (lines with clamps are NON-Groshong).
4. If **not successful**, attempt to clear catheter by using an alternating irrigation/aspiration technique with a 10-20 ml syringe only filled with 5 ml of normal saline (a smaller syringe will exert too much pressure). As mentioned above, DO NOT force solution into catheter. ~~It may result in damage to catheter.~~ It may result in damage to catheter integrity or force a slot into the blood stream.
5. If still **not successful**, check with MD regarding use of a fibrinolytic agent (Cath-Flo 2mg). Include order to repeat x 1 if necessary. Never leave an occluded catheter untreated as this presents a high risk for infection.
6. Use of **Cath-Flo:**
   - Gather supplies: Cath-Flo (a de-clotting agent), vial of sterile water for injection, empty 10cc and 3cc syringes, three way stop-cock, 2 or 3 pre-filled syringes of normal saline, gloves, alcohol wipes and a catheter cap.
   - Using the 3-cc syringe, dilute 2 mg vial of Cath-Flo in 2.2 ml of sterile water per manufacturer's instructions.
   - Remove the catheter cap connection to the patient and discard. Cleanse hub of catheter with alcohol wipes and **attach stopcock to patient with stopcock in "off" position to patient.** Attach the 3cc syringe with diluted Cath-Flo to the middle port and the empty 10cc syringe to the remaining port. (See **Diagram #1** below)
   - Begin with the Cath-Flo port in the "off" position (see **Diagram #2** below) and using the 10-cc syringe, aspirate a full 10cc (of air) from the catheter/port (see **Diagram #3** below) and while maintaining the negative pressure, switch the stopcock so that the 10cc syringe is now "off" and the Cath-Flow is open to the patient (see Diagram #4 below). The 10-cc syringe will empty of air; this is not a problem.
   - Repeat this step until all the Cath-Flo has been instilled into the catheter. (If some of the medication is in 10-cc syringe, transfer it back to the 3-cc syringe.) Periodically, **gently** try instilling the Cath-Flo, using the 3-cc syringe. **Do not force** as this might damage the catheter. (It is possible that the catheter will open after less than the 2 ml has been instilled; this is a success!)
   - Allow the Cath-Flo to dwell in the catheter for 20-30 minutes and then try gently flushing the catheter with normal saline.
   - If **successfu**l, flush line/port with 20 ml of normal saline. Attach new catheter cap. Follow with heparin flush for ports and NON-Groshong catheters.

- If **not successful**, repeat process (if order obtained). If procedure remains unsuccessful, inform MD as line may need to be replaced.

(See photo examples below)



INJECTION CAP CHANGE - All Central Venous Catheters

Change the injection cap:

- After blood withdrawal/infusion
- If cap is soiled, damaged or leaking
- Weekly with dressing change

Equipment:

- Non-sterile gloves, mask
- Luer-slip syringe (optional)
- 2 alcohol prep pads
- 1 sterile 4x4 gauze pad
- New injection cap

Steps:

1. Identify patient using 2 patient identifiers.
2. Perform hand hygiene before and after procedure.
3. Place patient in supine position (not needed for valved catheters).
4. Put on non-sterile gloves, mask.
5. On clean surface, place open alcohol prep packets, cap (in package) and syringe.
6. **Clamp catheter** using (atraumatic) catheter clamp. (Do not need to clamp Groshong catheters.)

7. Put on non-sterile gloves, mask. If visibly dirty/crusted, clean the catheter/cap junction vigorously with alcohol prep pad.
8. Remove and discard old cap.
9. If the hub is visibly contaminated with foreign material, clean carefully to avoid getting material into the hub/lumen. One method to do this is to put a luer-slip syringe in the hub prior to cleaning.
10. Attach new injection cap onto catheter hub.
11. Unclamp the catheter and resume IV infusion **or** flush lumen(s) with Heparin flush solution. Prevent reflux by clamping the catheter **before** removing the syringe (except with positive displacement injection caps).

BLOOD SAMPLING - All Central Venous Catheters

1. Blood specimen tubes must be labeled with patient name and hospital number, date/time of draw and initials of person collecting the specimen. Place in Biohazard bag for transport to lab.
2. After blood withdrawal, **all** lumens must be flushed, and **unused** lumens must also be heparinized (except Groshong catheters).
3. Cap change is required after blood withdrawal.

Equipment:

- Nonsterile gloves
- Labeled blood specimen tubes
- Alcohol Prep Pad
- 10ml syringe (empty) (have as many at hand as will be needed for the amount of blood to be drawn)
- Blood Transfer Device, or other sharps safety method of transferring blood from syringe to tube
- (2) 10ml syringe filled w/NS
- 5ml syringe w/Heparin Flush solution

Steps:

1. Identify correct patient using 2 patient identifiers.
2. Perform hand hygiene before and after procedure.
3. **Stop and clamp all infusions for at least one minute (unless clinically contraindicated).**
4. Disinfect injection cap with alcohol.
5. Connect syringe with saline and slowly aspirate until positive blood return is obtained. Flush with 10/20* ml NS using a pulsatile motion. **Wait 1 minute.**
6. Withdraw 5 - 10* ml blood for discard.
7. Withdraw blood needed.
8. Fill specimen tubes by connecting syringe to Blood Transfer Device (or equivalent), then put tube into other end and push tube in, to push onto spike.
9. Flush lumen(s) with 10ml NS using a pulsatile motion.
10. Perform cap change.
11. Resume IV infusion **or** flush lumen(s) with Heparin flush solution. Maintain positive pressure by clamping the catheter **before** removing the syringe.

If the catheter will flush, but not withdraw, reposition the patient. Have them lie down on their side. Then try to withdraw the blood sample. Try the other side if not successful.

CATHETER REMOVAL - All CVCs

**Peripherally Inserted Central Catheters (PICCS) are central lines and must be managed as central lines

A physician order is required to remove a CVC.

Safety Precautions and Monitoring:

- Place patient in Trendelenburg position during removal of a CVC whose entrance site is in the thorax.
- Have patient hold breath or slowly exhale during removal.
- Place an occlusive dressing over insertion site for 24 hours post removal.
- Monitor patient post removal.
- Assess patient post removal.

Equipment:

- (2) 2x2 gauze and tape, or
- Transparent Sterile Dressing
- Suture removal kit (if CVC sutured in place)

- Nonsterile gloves
- Betadine Ointment

Steps:

1. Perform hand hygiene before and after procedure.
2. Discontinue administration of all infusions.
3. Place patient in Trendelenburg position (for removal of a CVC whose entrance site is in the thorax).
4. Wearing non-sterile gloves remove dressing from insertion site. Evaluate insertion and suture sites.
5. Open suture removal kit. Remove suture.
6. Instruct patient to hold breath or slowly exhale while catheter is removed.
7. Place 2 fingers of non-dominant hand lightly above catheter-skin junction with sterile 2 x 2 gauze between fingers. Hold sterile gauze at insertion site while removing the catheter with dominant hand.
8. If resistance is met, stop a moment before trying again. Do not force it. If continued resistance is met, redress site and notify the physician.
9. Apply pressure with sterile gauze pad to insertion site after catheter removal. Maintain pressure for 5 minutes minimum and until all bleeding has ceased.
10. Apply new gauze pad with occlusive betadine ointment. Cover with tape. Alternatively, the site may be covered with a TSD.
11. Re-check site in 15 minutes.
12. Check integrity of removed catheter. Notify the physician immediately if catheter not removed intact.
13. Change dressing every 24 hours until exit site healed.

ACCESSING or CHANGING NEEDLE of an IMPLANTED PORT

1. Use non-coring needle (Huber) only to access implanted port.
2. Change the non-coring needle with extension tubing weekly and PRN.
3. Select needle length that approximates the depth needed to ensure needle stabilization and gauge appropriate for intended therapy.

ACCESSING PORT

Equipment:

- Central Line Dressing Kit
- Injection cap
- Nonsterile gloves
- Sterile 90 degree, bent non-coring needle/extension tubing
- 10ml syringe* with 10ml Normal Saline
- 5ml syringe with Heparin flush solution
- Power port Needle or Non-power port needle

*Pre-filled syringes are not sterile on the exterior (although special sterile ones may also be ordered).

Steps:

1. Consider the use of topical analgesic cream to anesthetize puncture site. Apply per manufacturer's directions.
2. Put on mask. Perform hand hygiene before and after procedure.
3. Attach injection cap onto non-coring needle/extension tubing. Attach syringe filled with the 10ml NS to the injection cap, prime tubing.
4. Palpate port. Note: some ports have 2 lumens. These are typically oval. Power Ports have 3 bumps in the shape of a triangle.
5. Put on sterile gloves.
6. Prep site:
    a. Pre-clean with alcohol swab as needed to remove visible dirt, drainage.
    b. Disinfect site with 2% Chlorhexidine **using gentle back and forth scrubbing motion for 30 seconds.** Allow to fully dry.
    c. **If patient is allergic or demonstrates sensitivity to Chlorhexidine, may substitute with Povidone Iodine.**
7. While stabilizing port with non-dominant hand, insert the non-coring needle perpendicular to the skin and into the center of the port.
8. Aspirate for blood return.
9. Flush with 10ml NS.
10. Apply transparent dressing.

11. Unclamp extension tubing and begin IV infusion **or** flush port with Heparin flush solution. Prevent reflux by clamping the needle extension-tubing **before** removing the syringe.

DE-ACCESSING PORT

Equipment:
- 10ml syringe with 5ml NS
- 2 Alcohol swabs
- 5ml syringe with 5ml Heparin flush solution
- Gloves
- Sterile 2x2 gauze pad

Steps:
1. Perform hand hygiene before and after procedure.
2. Disconnect IV tubing from extension injection cap.
3. Disinfect extension tubing cap with alcohol.
4. Open clamp, aspirate for blood return and flush port with normal saline followed by Heparin flush solution.
5. Prevent reflux by clamping the needle extension-tubing before removing the syringe.
6. Gently remove the transparent dressing covering the port site while holding the non-coring needle in place.
7. Remove needle from port by gently pulling it directly out. Do not twist or angle.
8. Discard needle in sharps container.
9. If bleeding occurs, apply pressure with a sterile gauze pad.
10. Leave the port site open to air, unless otherwise directed by the physician.

ADDENDUM A - Management of Common Problems/Complications

Unable to Aspirate Blood Return from Catheter
Catheter flushes freely and normally but will not provide blood return with aspiration. This condition is known as Persistent Withdrawal Occlusion (PWO). The most common cause is the formation of a fibrin flap or sheath that blocks the catheter tip during aspiration, but which does not impede normal outflow from catheter. **If the catheter will flush, but not withdraw, reposition the patient. Have them lie down on their side. Then try to withdraw the blood sample. Try the other side if not successful.**

1. If patient is receiving vesicant therapy notify the MD for diagnostic evaluation of catheter prior to start of therapy.
2. If patient receiving irritants or large volume administrations and catheter function cannot be verified with blood return: carefully monitor patient for therapy-related problems, educate patient regarding reportable symptoms. Periodic dye studies may be indicated, such as at the beginning of a new course of therapy.
3. Other therapies, such as routine flushing, and administration of small volume medications which are non-vesicant and non-irritant may be done without repeated dye studies if an initial evaluation verifies correct catheter functioning and the patient is stable with no evidence of therapy-related problems.

Blocked Catheter-Unable to flush the catheter or port using normal pressure

Nursing Action:
1. Reposition patient (upper body and arm movement) and have patient cough to rule out posture related block or kink in catheter. Check that sutures at hub of non-tunneled catheters are not too tight.
2. Access the line/port per standard. Verify occlusion by attaching a 10-20 ml syringe of normal saline. Attempt to withdraw blood.
3. If successful, aspirate line of all clots then irrigate with 20 ml of sterile normal saline. Follow with Heparin flush if not a Groshong valve catheter.
4. If not successful, attempt to clear catheter by using an alternating irrigation/aspiration technique with a 10-20 ml syringe only filled with 5 ml NS. DO NOT force solution into catheter. It may result in damage to catheter integrity or force a clot into the blood stream.
5. If still not successful, call the M.D.

Malposition of Tip of Catheter
NOTE: Silicone catheters "float" in the venous system and may naturally change positions with activity or exertion (coughing, vomiting) without any signs or symptoms.
- Against vein wall or valve: unable to draw blood
- Location in Axilla/Jugular vein: edema and signs of venous distention

- Pain or discomfort with infusion: loop in catheter during insertion, loop evident on X-ray

Nursing Action:
1. Notify physician. Placement should be verified via radiological exam.
2. Immediately discontinue all infusions and attempt to instill heparin flush.
3. Have patient turn head and cough. Reposition patient – lift arms, lie down and sit up.
4. Flush rapidly through catheter as ordered by physician.
5. Catheter may be partially withdrawn using aseptic technique, as ordered by the physician.
6. If catheter is in jugular vein, place patient in semi-Fowlers or Fowlers position to infuse fluids.
7. A tunneled catheter or implanted port may need to be replaced.

Air Embolism
Chest pain; complaint of shoulder or low back pain; shortness of breath; wheezing; cyanosis; tachycardia; tachypnea; syncope or LOC; cardiac arrest

NURSING ACTION: THIS IS AN EMERGENCY!
1. Clamp the catheter immediately proximal to any breaks or leaks.
2. Position the patient on left side with head lower than heart (Trendelenburg).
3. Call physician. If cardiac arrest occurs, begin CPR.

Phlebitis
Discomfort at insertion site, along the catheter pathway or underneath the axilla; increased warmth; inability to move affected arm due to discomfort; fever, edema to ipsilateral face, neck, and arm; erythema; swelling; induration.

Nursing Action:
1. Apply intermittent warm, moist heat for 20-minute periods, 3-4 times per day with MD order.
2. Notify the physician.
3. Elevate affected extremity.
4. Monitor temperature, condition of arm, general condition of patient.
5. Observe for signs of local or systemic infection. Generally, the phlebitis improves or completely resolves within 24 hours.
6. Encourage patient to use pain medication if needed.

Thrombosis
Formation of fibrin along the internal wall or lumen of the vein. Pain or burning in the neck or chest area; ipsilateral swelling of arm, neck, or face; edema at catheter exit site; possible difficulty with catheter irrigation or catheter occlusion; tachycardia or SOB

Nursing Action:
1. Call the physician immediately. Radiologic studies may be necessary to confirm catheter placement and presence of thrombosis.
2. Initiate anticoagulant or thrombolytic therapy as ordered.

Sepsis
Fever; chills; backache; malaise; muscle aches; vomiting; headache; weakness; tachycardia; hypotension; mental status changes.

NURSING ACTION: THIS IS AN EMERGENCY!
1. Immediately call the physician. Obtain order for blood culture and insertion site culture. Intravenous antibiotics should be administered immediately following cultures.
2. Remove catheter if ordered.
3. Monitor patient closely for signs of shock

Catheter Displacement
Extended length of catheter from insertion site; inability to infuse solution; leaking at catheter site; pain with infusion; unexplained wet dressing.

Nursing Action:
1. Tape catheter securely. Apply occlusive sterile dressing.
2. Notify physician. Placement should be verified by radiological exam.

Suture Tension – Percutaneous Central Catheters

Red, slightly swollen area around the suture; tenderness; catheter length has increased on outside of insertion site since catheter last inspected; catheter moves easily when dressing removed.

Nursing Action:

1. Sutures are to remain in place for purpose of anchoring the catheter. If they become dislodged, consider use of Stat-Lock or Steri-Strips or replacement by a qualified person (A PICC certified RN may replace the suture if requested to by the attending MD). Loose sutures may remain intact if they are not painful and catheter stability is certain.
2. If sutures are too tight and skin are irritated, carefully cut sutures using sterile scissors if directed by physician. Allow the skin to heal before re-suturing the catheter. Temporarily, apply Steri-Strips to anchor the catheter prior to placement of dressing.

Local Skin Irritations/Rashes

Itching, redness, rash, or blisters; edema; pain or tenderness; demarcation from dressing.

Nursing Action:

1. Notify the physician, especially if the skin irritation is near the insertion site. Evaluate for signs of localized infection.
2. Assess patient for possible allergies.
3. Use a skin barrier wipe.
4. If the skin irritation/rash closely follows the border of the dressing itself, try a hypoallergenic branch of transparent dressings or an occlusive gauze and tape dressing.

REFERENCES:

Guidelines for Prevention of Intravascular Catheter-Related Infections, 2011. Centers for Disease Control.

Intravenous Nurses Society. Policies and procedures for infusion nursing, 3rd Edition, 2016.

Intravenous Nurses Society. Infusion nursing standards of practice. Journal of Intravenous Nursing, 2017, 29 (1S).
The Joint Commission Comprehensive Accreditation Manual for Hospitals 2012. National Patient Safety Goal 07.04.01 Healthcare Associated Infections: Central Line Associated Infection Prevention.

American Society of Anesthesiologists. (March 2016). Practice Guidelines for Central Venous Access. Anesthesiology, 116(3).

Mosby Skills: Central Venous Catheter Insertion, Removal, Blood Sampling, Peripherally Inserted Central Catheter; Central Venous Access Devices: Declotting with Alteplase; Implantable Port Access, Deaccess and Care. 2018.

Marschall, J., Mermel, LA, Fakih, M. et al. Strategies to prevent central line associated bloodstream infections in acute care hospitals: 2014 Update ICHE, 35:7 and 35(S2), pp 753-771.

Appendix

Central Line Insertion Checklist (CLIP)

REVIEWED BY:

Chief Nursing Officer
ED/Acute Nurse Manager
Medical Director
Skilled Nursing Manager

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: Chaperones	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to preserve the dignity of all patients by providing chaperones during any, and all sensitive medical examinations and/or procedures involving opposite gender patient/provider interactions. A patient and/or a provider may at any time request a chaperone and that request will be honored. The job of the chaperone is to enhance the patient's and provider's comfort, safety, privacy, security and dignity during sensitive exams or procedures. It is understood by all parties involved that professional standard of privacy and confidentiality will be maintained.

PURPOSE:
The purpose of this policy is to ensure the dignity of all patients during sensitive medical examinations.

Procedure:
1. It is strongly recommended that all practitioners have an appropriate chaperone with them during physical examinations of breasts, vagina, penile, scrotal or rectum.

2. The need for the presence of a chaperone may be waived by any patient; this must be documented in the medical record.

3. A chaperone will be offered/provided whenever requested by a patient.

4. Chaperones must be SHCHD employees and must be at least 18 years old. All chaperones be healthcare professionals.

5. Family members may be present during exams and procedures if this is desired by the patient and is acceptable to the practitioner. However, the family member is not considered a chaperone. An SHCHD healthcare professional must also be in attendance.

References:
Use of Chaperones (2021). American Medical Association. https://www.ama-assn.org/delivering-care/ethics/use-chaperones

Code of Medical Ethics Patient-physician relationships. (2020). American Medical Association. https://www.ama-assn.org/delivering-care/ethics/use-chaperones

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Chest Pain Protocols**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of Southern Humboldt Healthcare District ("SHCHD" or "District") to follow American Heart Association Advanced Cardiac Life Support (ACLS) OR PALS (Pediatric Advanced Life Support) guidelines for the management of patients presenting to the facility with chest pain, as appropriate based on the availability of resources.

Purpose:
To provide interventions and stabilization of patients with potential or recognized cardiac problems.

Recognition

American Heart Association.

ACS Signs & Symptoms
Chest pain- any non-traumatic pain between the jaw & umbilicus
Chest pressure, discomfort or tightness
Complaints of "heart racing" or palpitations
Bradycardia
Syncope
Weakness in patients > 45 years old
New onset stroke symptoms
Difficulty breathing (without obvious cause i.e. asthma or CHF)

STEMI Criteria
ST segment elevation of ≥ 1 mm in 2 contiguous leads with or without signs & symptoms of ACS

12 Lead EMS ECG Criteria
Patients > 20 years old experiencing any ACS signs & symptoms
OR
Any age patient with ACS signs & symptoms AND a history of:

HTN	Cardiac disease
Smoking	Diabetes mellitus
Severe Obesity	High Cholesterol

Recent recreational drug use

When in Doubt, Obtain an ECG

PEARLS:
- Females, diabetics and geriatric patients often have atypical signs/symptoms, or only generalized complaints
- Remember Erectile Dysfunction drugs are now being used to treat pulmonary hypertension
- Do not administer Nitroglycerin in any patient who has used Viagra (sildenafil) or Levitra (vardenafil) in the past 24 hours or Cialis (tadalafil) in the past 36 hours due to potential severe hypotension
- If possible, establish a second IV on STEMI patients

Procedure:
1. Patients presenting to the facility with chest pains are triaged into the Emergency Department immediately. The ED physician will be contacted as soon as possible.

2. A Registered Nurse will do the following:

First Steps
a. Place patient on gurney in gown preferably in Bed 1 with at least one handrail up at all times.
b. Apply cardiac monitor leads and enter patient into the cardiac monitor system.

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c. Minimize patient exertion
d. Assess Airway, Breathing, and Circulation
e. Obtain a Full set of Vital Signs, Continuous Pulse Oximeter and ECG within 10 minutes of patient contact.
f. If STEMI, alert physician for immediate transport to appropriate PCI capable hospital (St. Joseph's Hospital in Eureka).
g. Place Oxygen on patient via nasal cannula starting at 2 LPM as needed, if a mask is appropriate use a simple mask at 6 LPM
h. Place IV Lab draw preferably an 18G – CBC, basic metabolic panel, cardiac enzymes, PT, PTT
i. Aspirin total 325 mg once on arrival (chew and swallow 4 non-enteric baby aspirin 81 mg each) Contraindicated (aspirin allergy)
j. Screen for Viagra, Levitra and Cialis in the past 48 hours

If SBP>110mmHg

0.4 mg nitroglycerin SL tablet or SL spray q 5 minutes until pain is gone or max 3 doses. Maintain SBP > 110 mmHg
Pain unrelieved by Nitro: Morphine 2-4mg slow IVP max 20mg **OR** Fentanyl 1mcg/kg q 15 minutes max 200 mcg

If SBP falls < 110 mmHg in response to treatment: Discontinue Nitro and Analgesic Treatments and place patient supine

k. Document effectiveness of all medication. Obtain vitals prior to giving all doses.
l. MD may prefer Nitroglycerin paste- apply ½ to 1 inch topically to chest wall once at arrival per MD.
m. Obtain portable chest X-Ray.

3. Obtain a detailed history and document patient's chest pain, including:
   - Onset of pain (e.g., abrupt or gradual)
   - Provocation/Palliation (which activities provoke pain, which alleviate pain)
   - Quality of pain (e.g., sharp, squeezing, pleuritic)
   - Radiation (e.g., shoulder, jaw, back)
   - Site of pain (e.g., substernal, chest wall, diffuse, localized)
   - Timing (e.g., constant, or episodic, duration of episodes, when pain began and at what time)

4. Prepare patient for possible stat transfer. If patient is positive for a STEMI, follow the St. Joseph's STEMI fast track protocol.

PLEASE NOTE: It is optimal if items listed be performed in the order presented. However, many tasks are done simultaneously and/or the order may be varied to accommodate the patient's condition and other factors.

REFERENCES:

American Heart Association. (2016). Advance Cardiac Life Support. AHA.

Emergency Nurses Association (ENA). (2016). Position Statement: Use of Protocols in the Emergency Setting. ENA Board of Directors.

Savino, B. Et al. Chest Pain of Suspected Cardiac Origin: Current Evidence-based Recommendations for Prehospital Care. *Western Journal of Emergency Medicine: Integrated Emergency Care with Population Health.* 16(7).

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Chief Nursing Officer
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Medical Director

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Chest Tube Insertion in the Emergency Department**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when caring for the patient with chest tubes.

Purpose:
The purpose of this policy and procedure is to provide guidelines for caring for a patient with chest tubes.

Procedure:
Supplies:
- Thoracotomy tray
- Local anesthetic (typically 1% or 2% lidocaine with epinephrine) with syringe and needles
- MobiVac-II suction with canister
- Chest tube drainage system (Pleur-evac)
- Sterile suction tubing for suction machine
- 500 ml sterile water
- PPE including Sterile gloves, sterile gown, shoe covers, and mask with face shield
- If conscious sedation, obtain sedatives per physician preference.
- 2 bedside tables (mayo stands)
- Vaseline gauze
- Sterile 4x4's

During the preparatory phase:
1. Assess the patient for pneumothorax, hemothorax, presence of respiratory distress
2. Document a full lung assessment
3. Obtain a chest X-ray and/or CT
4. Obtain Informed Consent
5. Pre-medicate if indicated
6. Assemble the drainage system
7. Position the patient on the opposite side or per physician preference

Positioning
- Whether the patient is awake, sedated, or intubated, positioning is vital to the proper placement of a chest tube both in terms of the appropriate anatomical location as well as the directionality and position of the tube within the pleural cavity. The patient should be lying supine with the ipsilateral arm flexed and abducted above or behind the patient's head.
- The anatomical site should then be chosen and marked with a marking pen.
- The physician and nurse should check and recheck with the diagnostic imaging modality that has provided the diagnosis to assure the procedure is being performed on the correct side.

Set up drainage system (Pleur-evac)
1. Remove the Pleur-evac from its sterile packaging and check to ensure that all the parts and the unit are intact. (Refer to package insert).
2. Using the funnel provided, add sterile water through the short suction tube in the "water seal chamber" to the "fill to here" line. This is the 2 cm line seen on the front of the water seal chamber.
3. Add sterile water to the "Suction Control Chamber" by first removing the "Atmospheric Vent" cover and using the funnel. Pour sterile water through the "Atmospheric Vent" filling to the 20 cm level line or to the level ordered by the physician. Remove the funnel and replace the cover. In the event either

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chamber is over filled, remove excess water by using a 20-cc syringe with ~~18 gauge~~18-gauge needle and aspirating through the ports provided on the front of the Pleur-evac.

4. Connect the long tube from the "Collection Chamber" to the patient's thoracic catheter. (Some catheters have a blue cap on the distal end, which must be cut off to attach the chest tube to the Pleur-evac tubing). Connect the "Suction Chamber" tubing (short tube in the water seal chamber) to the suction source using sterile suction extension tubing. Suction is provided by using the MobIVac-II. Select continuous suction and adjust to the lowest setting then increase until gentle bubbling is seen in the water seal chamber.

Assisting with Insertion (Thoracotomy)

1. Set up the Mayo stand with sterile gloves, Betadine with 4x4's for prep, sterile field, chest tube insertion tray, and chest tube of the size ordered by the MD.
2. Set up sterile field: items from kit, syringe/needles, trocar (if requested), sterile gloves, and minor suture tray (if requested).
3. Position the patient on the opposite side.
4. Assist with insertion and securing tube. Connect to suction as outlined above. Tape all connections.
5. After insertion, dress site with Vaseline gauze, 4x4s and 2" tape with a pressure dressing. Apply a dry, occlusive dressing with or without petroleum gauze.
    a. Take 3 layers of 4×4 gauze, cut a line through them to the midpoint, and insert them over the chest tube so that the tube lies within the middle of the gauze. You may choose to apply petroleum gauze directly to where the tube rests on the skin prior to 4×4 occlusive dressing.
    b. Using 3–4-inch adhesive tape or tegaderm adhesive dressings, seal each corner of the gauze.
    c. Once the occlusive dressing is applied, you may further utilize either adhesive tape or tegaderm to secure the more distal tubing to the anterolateral chest wall and flank. The adhesive tape or tegaderm should be applied horizontally across the tubing as it runs down the chest wall.

Post procedure:

- Re- assess the patent for presence of respiratory distress
- Document a full lung assessment
- Observe drainage system for blood/air
- Observe that there is free fluctuation of water in the tube on respiration
- Obtain a follow-up chest x-ray
- Assess for bleeding, infection, leakage of air and fluid around the tube
- Keep the drainage system below the patient's chest level
- Check the connections periodically. The tube should be as straight as possible
- Mark the original fluid level with tape outside of the drainage system (mark hourly)
- Report immediately to the physician signs of rapid, shallow breathing, cyanosis, chest pressure, subcutaneous emphysema, or signs of hemorrhage
- Make sure there is fluctuation tidaling of the fluid level in the drainage system. This is an indication of patency and intrapleural pressure.
- With patient sitting upright, encourage deep breathing and coughing every 2 hours
- Do not clamp the tube; this is only done briefly with drainage system replacement, and chest tube removal to assure lungs are re-expanded

REFERENCES:

1. Tintinalli, Judith E., et al. *Tintinalli's Emergency Medicine: a Comprehensive Study Guide*. McGraw-Hill Education, 2016.
2. Marino, Paul L. *Marino's the ICU Book*. Wolters Kluwer Health, 2014.
3. Parrillo, Joseph E. *Critical Care Medicine: Principles of Diagnosis and Management in the Adult*. Elsevier, 2019.
4. Gilbert, Timothy B., et al. "Chest Tubes: Indications, Placement, Management, and Complications." *Journal of Intensive Care Medicine*, vol. 8, no. 2, 1993, pp. 73–86., doi:10.1177/088506669300800203.

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Chief Nursing Officer
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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 1
SUBJECT: **Child Passenger Restraints**	EFFECTIVE DATE: **07/28/2021**	SUPERCEDES: **08/22/2019**

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide and discuss information regarding child passenger restraint systems as required by law.

PURPOSE:
The purpose of this policy and procedure is to describe the method by which this information will be disseminated and discussed.

PROCEDURE:

1. This procedure applies to all children who are released from the district who are under the age of 6 years old or weighing less than 60 pounds. The person to whom the child is released (authorized person) must be given the following information:

    a. A summary of the current state law requiring child passenger restraint systems to be used when transporting a child or children in motor vehicles.
    b. A listing of where individuals can obtain low-cost car seats or loan programs for car seats within the county.
    c. Information describing the risks of death or serious injury associated with the failure to use a child passenger restraint system.

2. Clinic patients - parents of clinic patients will be given this information one time. It is not necessary to follow this procedure with each visit.

3. The above information will be given to the authorized person, and he/she will be asked to sign a form acknowledging the receipt of this information. One copy of this form is given to the authorized person and the original is placed in the patient's medical record.

4. The staff is required to provide and discuss information regarding child passenger restraint system laws only. The hospital is NOT required to, or should not attempt to, prevent a parent or other authorized person from transporting a child in a vehicle that does not have a child passenger restraint system.

5. Staff should not instruct authorized persons regarding how to install a car seat or help them install a car seat. Parents with questions about appropriate car seat installation should be referred to the local police or fire station or local California Highway Patrol office.

6. All nursing staff will be trained at orientation, and thereafter as deemed appropriate, in the use of this policy and the major points of the law regarding child passenger restraint systems.

REFERENCES:
California Health and Safety Codes: §1204.3, 1212 and 1268.
California Vehicle Codes: §27315(c), 27360(a), 27360(b), 27360(c), 27360(d), 27361, 27363(a), 27363(b) 27363(c) and 15620.
California Healthcare Association Consent Manual (2005).

REVIEWED BY:
Chief Nursing Officer
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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Code Blue**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to elicit an organized response to an emergency.

Purpose:
1. The purpose of this policy and procedure is to elicit an organized response to an emergency from assigned personnel and alert all areas of the hospital to the emergency.
2. To prepare for a known incoming code in a calm, orderly manner
3. To define the extent of autonomous nursing intervention during an emergency response

A **Code Blue** is called for cardiac arrest, respiratory arrest, or any acute life-threatening situation at any time when patient condition is deteriorating rapidly such that an emergency response is needed. All Code Blue particulars are documented on the Resuscitation Record. Code Blue – refers to any new, sudden onset clinical deterioration of an emergent life-threatening nature (e.g., cardiac, respiratory arrest) for an adult patient 14 years or older in the hospital.

Procedure:
1. To initiate a Code Blue team response:
   a. To call a Code Blue, use any hospital extension and dial ~~page 4~~*8000.
   b. If in the ED, you can activate a Code Blue using the Code buttons near Bed 4 or right across from Bed 1.
   c. For adult patients, state "Code Blue" and give the specific room location.

Code team members are assigned every morning by the shift supervisor or the primary emergency room nurse. The assignments are given according to experience and skill. The roles are listed here with some of them having extra explanations below.

Team Leader:
- Directs the resuscitation
- Monitors performance of tasks
- Models excellent team behavior

IV/IO:
- Gains IV/O Access
- Prepares medications and fluids
- Administers medications and fluids

Monitor/Defibrillator:
- Establishes ECG monitoring
- Checks pulse
- Operates monitor/defibrillator
- Runs ECG strips
- Checks for vital signs (Full Set)

Observer/Recorder:
- Very Important role
- Records all; times, medications, procedures
- Stays alert, and asks questions

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Airway:
- Set up intubation tray
- Check oxygen set up and sets up the ventilator
- Inserts airways as needed
- Performs bag-mask ventilation
- Inserts nasogastric tube

Compressor:
- Performs chest compressions
- If chest compressions not needed during a case this team member may obtain equipment, fluids, and medications (Float)or assist the observer/recorder

Leadership:

Until the arrival of a physician, Emergency room nurse or shift supervisor acts as Code Leader as follows:

1. Initiates the resuscitation according to ACLS Protocol.
2. Reports all treatment as ordered to the recorder.
3. Assigns specific personnel for the following tasks:
   - Attachment of EKG monitoring leads and obtain rhythm strips (bilateral arm and leg lead placement for 3-lead rhythm).
   - Continuous monitoring of heart rhythm, with all changes reported all to Code Team and recorder.
   - Defibrillation/Cardioversion as necessary; report to recorder.
   - Peripheral IV placement; fluid administration per physician order/protocol.
   - Medication administration; report to recorder.
   - Opening of emergency cart: distribution of contents as needed.

REFERENCES:

Algorithms for Advanced Cardiac Life Support 2021. (2021). ACLS Training Center. https://www.acls.net/aclsalg

Panchal, A., Berg,K., Hirsch, K., Kudenchuk, P., Rios, M., Cbanas, J., Link, M., Kurz, M., .Advanced Cardiac Life Support Algorithms 2019.(2019). American Heart Association. https://www.ahajournals.org/doi/10.1161/CIR.0000000000000732

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: Consent for Treatment of Emergency Room Patients	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 07/25/2013

POLICY:
Southern Humboldt Community Healthcare District (SHCHD) recognizes that every competent adult has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise this right, such as minors and incompetent adults, have the right to be represented by another party who will protect their interests and preserve their basic rights.

PURPOSE:
The purpose of this policy is to delineate when "implied consent" overrides the fundamental right of self-determination over a one's body and property.

PROCEDURE:
When a patient presents to the Emergency Room seeking medical attention, consent for treatment will be obtained on the conditions of admission form and witnessed by a hospital employee.

EMERGENCY TREATMENT EXCEPTION:
Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or of a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able, or if a qualified legal representative were present, the consent would be given. This exception applies to minors as well as to adult patients.

If the patient is unable to give the informed consent due to unconsciousness or mental impairment all attempts will be made to obtain consent from next of kin. Unconscious patients brought to the ER shall be treated immediately. If relatives cannot be reached, the Physician on duty presumes permission and will proceed, as necessary.

If available, the next of kin or responsible party will sign the conditions of admission form and relationship to the patient established.

When a minor is brought into the Emergency Room by a responsible adult, e.g., teacher, coach, babysitter, grandparent, police officer, etc., every effort should be made to reach the parent. A telephone consent witnessed by two persons before treatment is instituted (except for life-threatening situations). Preauthorized written consent signed by the parent may be sent with the responsible adult.

A married person or emancipated minor under the age of 18 years of age may sign for his/her own treatment in the Emergency Services.

REFERENCES:
California Hospital Association Consent Manual, 2018

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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 2
SUBJECT: **Consent for Treatment of Minors in the Emergency Department**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 11/21/2013

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to clarify the circumstances under which minors may receive treatment in the Emergency Department without the written or phone permission of the parent or legal guardian.

PURPOSE:
Minors presenting to the ED require a parent's or legal guardian's permission to receive treatment. Written consent is preferred. However, there are times when this may not legitimately occur. The California Healthcare Association Consent Manual, Chapter 2, provides the basis for the guidelines contained in this policy and should be referenced for any situation regarding consent that is not clearly addressed in this policy or in the attachment: **Legal Consent Requirements for Medical Treatment of Minors.**

PROCEDURE:

A. Presentation to the Emergency Department
All minors who arrive at the ED unaccompanied by a parent or guardian shall be entered into the Emergency Department Log and provided a medical screening examination in accordance with hospital policy.

B. Parent or Legal guardian's consent for minors
1. It is preferable that consent for treatment of a minor be provided in writing by a parent or legal guardian at the time of the visit.
2. If a minor does not meet "special circumstances" (III. C), and the parent or legal guardian is not physically present to give consent, telephone consent should be obtained by a Registration or ED staff member, and a second staff member should serve as a listening witness.
3. Should a minor arrive at the ED and the parent or guardian cannot be contacted via telephone despite repeated attempts, treatment will be provided to the minor if the minor's condition would benefit from the treatment. The decision to treat is at the discretion of the ED physician. Attempts to reach the parent or guardian must be documented in the medical record.
4. A minor who has been placed in Juvenile Hall by the Juvenile Court System is considered to be a "dependent" youth. As such, the parents generally retain the right and authority to consent to medical treatment, unless there is a specific court order that removes this right. A court order identifying that status of the minor should accompany him/her when brought to the ED from Juvenile Hall. The court order will clarify who may provide consent.

C. Special Circumstances in Which a Minor does not require Consent from a Parent or Legal Guardian:
1. **Emergency Medical Condition** (requires immediate care for the alleviation of severe pain or immediate diagnosis and treatment of unforeseeable medical conditions which, if not immediately diagnosed and treated would lead to serious disability or death.
    a. Minor may consent without the parent or legal guardian. **Note: Only the emergency condition may be treated.**
    b. The physician will inform the parent or legal guardian of the minor's condition as soon as possible.
2. **Pregnancy** (care related to the prevention or treatment of pregnancy)
    a. Minor may consent to treatment without the parent or legal guardian.
    b. The physician is NOT permitted to notify the parent or legal guardian without consent of the minor.
3. **Sexual Assault** (includes acts of oral copulation, sodomy, and other violent crimes of sexual nature)
    a. Minor may consent without the parent or legal guardian, if they are not available, **OR if it is suspected that the parent or legal guardian committed the assault.**
    b. The physician must attempt to contact the parent or legal guardian UNLESS he/she is suspected of committing the assault.

4. **Rape** (non-consensual sexual intercourse)
    a. **ALL** minors may consent to treatment without a parent or guardian.
    b. **Minors under the age of 12:** The physician MUST attempt to notify the parent or legal guardian unless he/she is suspected of committing the crime.
    c. **Minors over the age of 12:** The physician MAY inform the parent or guardian.

5. **Sexually Transmitted Diseases**
    a. **Minors, 12 years and older,** may consent without parent or guardian.
    b. The physician is NOT permitted to inform the parent or guardian without the minor's consent.
    c. The health department must be notified per ***SHCHD ED Administrative Policy***: **Confidential Morbidity Reporting.**

6. **Self-Sufficient Minor** (age 15 years or older and living separate and apart from the parent or guardian)
    a. The minor must:
        - Be managing his/her own financial affairs, regardless of the source of income.
        - Be capable of giving a valid consent for medical care.
    b. The minor should affirm the above conditions are met by completing the "Self-Sufficient Minor Information Form (Consent Manual Form 2-1). However, if the minor refuses to complete the above form, the ED staff may proceed with treatment based on the statement of the minor. The statement of the minor regarding self-sufficiency should be clearly documented in the medical record.
    c. The duration of the separation from the parent or guardian is not relevant.
    d. The physician MAY advise the parent or guardian without the minor's consent.

7. **Emancipated Minor (14 years of age or older)**
    a. Granted by court order to a minor 14 years of age or older who has petitioned for emancipation. If the court grants the petition, the Department of Motor Vehicles will issue an identification card that states that the minor is emancipated.
    b. Minor may consent to medical treatment without consent of parent or guardian.
    c. The physician may NOT advise the parent or guardian without the minor's consent.
    d. If the minor does not have a card from the DMV, the facility should determine if the minor is self-sufficient as described in III. C. 6. a.

NOTE: For all situations with unusual or unclear circumstances related to consent from a minor; refer to California Healthcare Association CONSENT MANUAL, Chapter 2, and the attachment "Legal Consent Requirements for Medical Treatment of Minors" at the end of the chapter.

REFERENCES:
The California Healthcare Association Consent Manual, Chapter 2 and attachment: **Legal Consent Requirements for Medical Treatment of Minors.**

SHCHD ED Administrative Policy: **Confidential Morbidity Reporting.**
"Self-Sufficient Minor Information Form" (Consent Manual Form 2-1)

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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 1
SUBJECT: **Controlled Substances and Ambulance Procedures**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to supply the local ambulance company with certain controlled substances as allowed by state and local EMS policies. Ultimate responsibility for controlled substances on board the ambulance lies with the district pharmacist.

PURPOSE:
Ambulance services are not permitted by law to purchase controlled substances but may administer both Morphine and Valium per EMS protocols. This policy and procedure delineate how the district will supply, account for, and bill for controlled substances.

PROCEDURE:

1. City Ambulance is the ambulance company mainly responsible for prehospital care in this area. However, other services are utilized as backup when necessary.
2. City Ambulance carries both Morphine Sulfate and Valium injectables for use per EMS protocols.
3. In the ambulance, these medications are stored and counted per ambulance policy and applicable law.
4. Controlled substances are administered to prehospital patients by qualified ambulance personnel via radio order and/or protocols from their medical provider.
5. Controlled substances used by the ambulance service on transported patients will be restocked from the Emergency Department.
    a. The ED RN will verify with the ambulance personnel, which medications were used by reviewing the prehospital radio run report. All medications requested by the ambulance personnel **must** have been authorized or reported to the nurse or physician before they will be replaced.
    b. The ED RN will replace the medication from the ED locked narcotic drawer. Both the ED RN and the ambulance personnel will sign the Narcotics Log including date, time, patient name and "EMS" in the "room" column.
6. The ED Nurse Manager, CNO and Pharmacist routinely review all completed narcotic logs. During this review, any medications given to the ambulance company will be listed on the "Ambulance Medication Stock Requisition." This form will be forwarded to Materials Management quarterly for the purposes of billing the ambulance service.

REFERENCES:
North Coast Emergency Medical Services

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 5
SUBJECT: **Crash Carts and Emergency Patient Care Equipment**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to maintain the equipment necessary to provide basic and advanced cardiac life support, as appropriate for each patient.

Purpose:
The purpose of this policy and procedure is to describe the emergency equipment, its location, and its use during a medical emergency.

Procedure:

A. Crash Carts – Two (2) Advanced Life Support crash carts and one (1) Pediatric Life Support crash cart

1. There are three (3) crash carts located in the facility — Two (2) Adult Advanced Life Support crash carts; one is in the Emergency Room between beds 1 and 2 and the other in Room 109 on the Acute unit. The Pediatric Life Support crash cart is in the Emergency Room next to bed 4.
2. The carts include:
   a. Defibrillator/pacer/oxygen saturation monitor/blood pressure monitor
   b. Oral suction machine, catheters, Yankauer suction
   c. Oral airways, bag-valve-mask, face masks
   d. Cart with drawers for emergency airway management and pharmacological management
   e. Backboard
   f. Clipboard with checklists and code records
3. The Emergency Department cart MUST always remain in the Emergency Room area when there is a patient present.
4. The Crash Carts are kept sealed when not in use. The equipment not sealed in the cart is checked each shift by the ER nurse. Documentation of checks is made on the "Crash Cart Checklist." See example ED-Crash Cart Checklist attached. Documentation also includes noting that the drawers are locked with a red band. The number on the band is documented.
5. In the event that a cart is opened and used, the nurse who used the cart is responsible to review the "Crash Cart Contents" list, the nurse may give the list to either the Pharmacy Technician or the Pharmacist. If the cart needs to be restocked prior to the start of the business day the nurse may gather and restock needed supplies and medication, so the cart is always at the ready. The EARLIEST outdated drug or supply is noted on a piece of tape and placed on the front of the cart. The cart is then sealed with a yellow tag, and a note is left with the pharmacist to replace this with a red tag. The pharmacist will take this opportunity to review the medications in the cart. Additionally, at the end of each month the Pharmacy Tech and/or the Pharmacist will check the contents for refreshing supplies, removing outdated and/or expired supplies and place a new red tag on the cart.

   Note: The cart contents checklist is available on the clipboard attached to the cart. This list is to state exactly how many of each item is in the cart. Additional items should not be added to the cart. This list MUST be an accurate reflection of the contents and expiration date of the items in the cart. Nurses checking the cart should use this list to assure the cart is stocked adequately.

6. If an arrest occurs on the Acute or Skilled Nursing unit, the cart in Room 109 is taken to the arresting patient's room and resuscitation is started according to American Heart Association guidelines.

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B. Emergency Equipment for Clinic – Basic Life Support

1. The Clinic is a Basic Life Support provider. In the event of a cardiac or respiratory emergency, the Clinic staff will begin basic life support and call "911" to dispatch the ambulance to take the patient to the Emergency Department.
2. The Clinic is equipped with airways, bag-valve-mask ventilator, oxygen, and masks.

C. Emergency Equipment for the remainder of the facility – Basic Life Support

1. For cardiac arrests that occur in any other part of the Acute facility, Basic Life Support (CPR) should be started by the first responder, usually the staff person in that department. A staff person should page "Code Blue and the location" three times. ED staff will respond, if available. The cart from the acute unit will be taken to the department. When the patient is stable, he/she will be transported to the ED.

REFERENCES:

Advanced Cardiac Life Support.(2015).American Heart Association.
California Administrative Code, Title 22. https://post.ca.gov/Portals/0/post_docs/training/EMSAMaterials/PSFinalReg-nostrikeouts.pdf

Crash Carts.(2021).ACLS Medical Training. https://www.aclsmedicaltraining.com/

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ER - CRASH CART CHECKLIST

TOP OF CART		
LEFT SIDE	**CENTER**	**RIGHT SIDE**
1. Adult Ambu Bag with End Tidal CO_2 Detector & Capnometer - (1) 2. Oral Airways	Defib Battery Check Leads Suction - tubing, yankauer, cath kit Behind Cart : Backboard	1. O_2 Tank

Drawer #1 - Code Drugs	**Expiration**	**Drawer #2 - Secondary Drugs**	**Expiration**
Adenocard (Adenosine) - (3)		Benadryl 50 mg - (4)	
Atropine Jet - (4)		Calcium Gluconate 10% - (4)	
Calcium Chloride Jet - 1 gm - (1)		Decadron 4 mg - (3)	
Dextrose 50% Jet (1)		Digoxin 0.5 mg - (3)	
Lidocaine Jet - (6)		Epinephrine 1 1000 - (4)	
Narcan 0.4 mg/ml - (10)		Glucagon - (1)	
Sodium Bicarbonate 50 mEq - (2)		Metoprolol 5mg/5ml - (3)	
Verapamil 10 mg/4 ml - (3)		Lasix 10 ml/cc - (4)	
Amiodarone 150mg- (4)		NTG SL tabs - (1) bottle	
Epinephrine Jet - (6)		Physostigmine 2 mg/2 ml - (2)	
		Solu-Cortef 500 mg - (2)	
		Vasotec 1.25 mg/ml - (1)	
		Tranexamic Acid- (4)	
		EXTRA:	
		Epinephrine Jet - (2)	
		Atropine Jet- (2)	
Drawer #3 - Medication Adjuncts	**Expiration**	**Drawer #4 - Pacer & Defib**	**Expiration**
Assorted syringes, needles		Defib Pads:	
Alcohol preps and tape		Adult - (1)	
Blood collection tubes- (6)		Pediatric - (2)	
Sterile H_2O 20 ml - (2)		Infant/pediatric electrodes – (1 pkg)	
Bacteriostatic NS 30 ml - (2)		Foam Electrodes - (1 pkg)	
Bacteriostatic H_2O 30 ml - (2)			
Sterile NS 10 ml pre-filled syringes - (4)			
20 ml syringes - (2)			

ER- CRASH CART CHECKLIST

Drawer #5 - Salem Sumps	Expiration	Drawer #6 - Intubation	Expiration
#16 Salem sump - (2)		St. Blade - #3 - (1)	
#14 Salem sump- (1)		St. Blade - #4 - (1)	
Cath Plugs - (2)		Curved Blade - #3 - (2)	
5 in Connectors - (3)		Curved Blade - #4 - (1)	
60 cc Irrigation Syringes - (3)		Laryngoscope Handle - (1)	
Surgical lube - (6) pkts.		ET Tubes - #5 - (3)	
Tube Clamp - (1)		ET Tubes - #6 - (3)	
Yankauer- (2)		ET Tubes - #7 - (3)	
		ET Tubes - #7.5 - (3)	
		ET Tubes - #8 - (3)	
		ET Tubes - #9 - (2)	
		Stylets - #5 (4), #7.5 (2)	
		10 cc Syringes - (3)	
		2 % Xylocaine Jelly - (1)	
		“C” cell batteries - (2)	
		Welch Allyn Bulbs - (2)	
		Surgical Lube - (6)	
		Tape - (2)	
Drawer #7 - Airway Adjuncts	**Expiration**	**Drawer #8 - I.V. Supplies**	**Expiration**
Quick-Trach Tray - (1)		Mini I.V. Tray 20 1 & 18 G IV - (2 ea.)	
Magill Forceps - (1)		Sterile NS 10 ml pre-filled syringes - (2)	
Scissors - (1)		Blood collection tubes (rainbow)	
Asstd. Oral & Nasopharyngeal		NTG tubing- (1)	
Airways (Variety)		Secondary Set - (2)	
Yankauers - (2)		Primary Set - (2)	
Suction Kits - #8 - (1)		100 cc. DSW - (1)	
Suction Kits - #10 - (1)		100 cc. NS - (4)	
Suction Kits - #14 - (3)		250 cc. NS - (1)	
Salem Sump - #14 & #18 - (1 each)		1,000 ml Ringers Injection - (1)	
Benzoin (4), Tape (2), Tongue Blades(6)		1,000 ml NS- (1)	
Bougie- 15FR (2)		Med Labels- (6)	

ER - CRASH CART CHECKLIST

Drawer #9 - I.V. Drips	Expiration	Drawer #10 - CVC	Expiration
Lidocaine: 2 GM Pre-Mix / 250 D5W (1)		CVC Kits - (2)	
Dobutamine: 250mg/20ml (1)		Lidocaine solution (1/ kit)	
Dopamine: 400mg vials, 250 ml NS (1)		Transparent Dsgs- (2)	
NTG – Pre-fill 50mg/250ml D5W (2)		Sterile gloves:	
Magnesium: 2 GM (1)		(1) Of each of size: 6, 6 ½ , 7,	
Procainamide: 1 GM/2ml (2)		7 ½, 8 ½, and 9	
100ml NS (2)		Betadine swabs sticks (8)	
500ml NS (1)		3x3 sterile gauze (8)	
250ml NS (1)			
500ml D5W (1)			
100ml D5W (1)			
Medication Labels (4)			
Drip Charts (1)			
Saline Flush 10ml (2)			

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 3
SUBJECT: **Death of a Child in the Emergency Department**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure all healthcare professionals who come in contact with the family and ill/injured child at the time of initial crisis adequately assess and respond to the emotional, cultural, and procedural issues required of caring for ill and injured children who die. This is most often a sudden, unexpected event and for many families the process of bereavement after the loss of a child begins in the ED.

Purpose:
The purpose of this policy and procedure is to best prepare healthcare professionals to provide effective communication, convey empathy and compassion and minimize misunderstanding during this uncommon event. Procedure must include support for the grieving family, notification of the child's primary care physician, and appropriate authorities. No single policy or plan can address all situations, but the following protocol can better prepare staff.

Procedure:

Initial Care:
When an infant or young child presents in the emergency department of the hospital in a lifeless or near lifeless condition, the child is evaluated, and emergency resuscitative measures are instituted if necessary and appropriate. It is very reassuring for parents to know that everything possible is being done for their child.

Medical Evaluation and Diagnosis:
Before speaking with the family, the emergency personnel team should review information provided by parents, caretakers, police, and ambulance personnel. This review will assist the healthcare team in determining an appropriate and sensitive approach to discuss the child's death with family members.

In cases of sudden and unexpected infant or child death, causes, which should be considered, are:

1. Infections: sepsis, meningitis, encephalitis, pneumonia, and botulism
2. Cardiac disease: myocarditis, congenital heart disease, and sudden arrhythmia
3. Aspiration or airway obstruction
4. Injury
5. Congenital anomalies
6. Genetic disorders
7. Seizure disorders
8. Sudden Infant Death Syndrome (SIDS) or sudden unexpected death in childhood

Any diagnosis made in the emergency department is tentative pending an autopsy and death investigation unless there is a documented disease or obvious severe injury. The medical examiner, who must be notified regarding the infant's death, makes the final decision concerning the performance of the autopsy and determination of final cause of death.

SIDS is diagnosed based on the absence of diagnostic conditions plus autopsy findings consistent with the typical findings of SIDS (intrathoracic petechiae, mild pulmonary edema, and minor inflammatory changes in the airway.) SIDS is the final diagnosis in about 85% of sudden and unexplained infant deaths.

Additional pertinent information, which may be helpful in assisting the pathologist as well as those providing counseling, may be documented on the emergency room form. (See Appendix B)

Informing the Parents

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It is desirable that the doctor in charge of the resuscitative effort or the primary care physician (if present in the emergency department), and the emergency team member who has been assigned to the family be present when the family is informed of the child's death. The physician may tell the family: "We know your child died suddenly and unexpectedly; an autopsy must be performed to establish the cause of death."

If the family is resistant to the idea of autopsy, the physician or nurse may be able to alleviate anxiety associated with this procedure.

1. It is helpful to explain to parents that an autopsy is a medical procedure like surgery or an "operation." A specialized physician or pathologist performs this operation in a respectful manner.
2. Besides ruling out injury, an autopsy will eliminate or confirm any unsuspected illness or congenital anomaly as the cause of death.
3. In almost all cases in which autopsies are NOT performed, the family may have lingering doubts as to the cause of death. It may be difficult or impossible for parents to assimilate information during the state of shock usually experienced at this time of crisis. It is important to provide adequate information to families, but only as much as they can handle at this time. Information about the cause of death will be repeated and discussed more thoroughly through counseling.

Parent Support

Each person reacts differently to the sudden, unexpected death of a child. It is important for emergency personnel to respond to the needs of family members, keeping in mind individual differences and cultural patterns. A member of the emergency team should stay with the parents as much as possible to provide support and answer questions. In the event of complicated grief reactions, a social worker, psychiatric nurse, or chaplain may be contacted for immediate crisis intervention.

Be prepared for difficult situations, including extremes in behavior such as screaming, collapsing, or even expressing no emotion. Encourage the parents to talk about the child; use the child's name. Give permission for next of kin to grieve. Appropriate support during this time may set the tone for the entire process of grieving.

- Parents should be encouraged to see and hold their child. Spending time with the child assists parents in focusing on the reality of the death while providing an opportunity to say goodbye.
- Efforts should be made to contact absent family members or any individual whose presence is important to the family. The presence of a member of the clergy and/or performance of family rituals such as baptism should be discussed.
- Since many parents are unfamiliar with funeral arrangements, it may be helpful to inform the family of the necessity of contacting a funeral director and/or a member of the clergy for assistance. The funeral director will assume the responsibility for the infant's body after its release from the medical examiner or hospital.

Emergency room staff should:

- Listen.
- Ask open-ended questions.
- Develop a rapport with the family that will allow free expression and facilitate a healthy grieving process.
- Direct family to services that offer support for the bereaved:
  - ❖ Bereavement counseling and information
  - ❖ Parent support group meetings
  - ❖ Peer support contacts

Follow-Up

Before the family leaves the emergency room, inform them when and by whom they will be told of the autopsy results. Find out where they can be reached - frequently families do not return to their own homes.

1. Give the family further information about the cause of death.
2. Review the autopsy findings.
3. Provide anticipatory guidance through the grief process.
4. Assess the family for any pre-existing problems or potential problems initiated by the death. Respond to questions.
5. Make available information about counseling, home visits, parent support groups, and parent-to-parent contacts and referral for mental health counseling.

Emergency Team Conference

It may be helpful for the emergency room staff to meet for support to discuss feelings and concerns regarding unsuccessful resuscitation and the family's anguish. The emotional drain on the emergency room staff needs to be

considered and addressed. It is also helpful to evaluate intervention strategies with families to gain a sense of competency. Was the family supported at the time of crisis and was provision made for follow-up care? Appropriate intervention in the emergency room sets the tone for how parents begin to cope with the impact of their child's death. Supportive care in the immediate crisis period in conjunction with long-term follow-up promotes mental health and reduces the incidence of psychiatric morbidity.

REFERENCES:

American Academy of Pediatrics; Death of a Child in the Emergency Department; Patricia O'Malley, Isabel Barata, Sally Snow, AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee and EMERGENCY NURSES ASSOCIATION Pediatric Committee
Pediatrics July 2014, 134 (1) e313-e330; DOI: https://doi.org/10.1542/peds.2014-1246

American Academy of Pediatrics; Identifying Abuse Fatalities During Infancy; Vincent J. Palusci, Council on Child Abuse and Neglect, Amanda J. Kay, Erich Batra, Section on Child Death Review and Prevention, Rachel Y. Moon, Task Force on Sudden Infant Death Syndrome, NATIONAL ASSOCIATION OF MEDICAL EXAMINERS, Tracey S. Corey, Thomas Andrew and Michael Graham
Pediatrics September 2019, 144 (3) e20192076; DOI: https://doi.org/10.1542/peds.2019-2076

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DEPARTMENT: Emergency ~~Services~~Department	APPROVED:	Page 1 of 7
SUBJECT: **Disaster Plan: Decontamination**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/22/2019

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure all health care professionals are prepared on how and where to properly decontaminate patients who have been exposed to hazardous materials such as: chemical, biological, radiological, or nuclear agents.

PURPOSE:
The purpose of this policy and procedure is to best prepare health care professionals to provide effective decontamination of patients exposed to hazardous materials. As hospitals become confronted with patients who have been compromised by residual biological spores, chemical and or radioactive effects from natural or man-made disasters, this policy will set forth a process for establishing and facilitating safe and efficient decontamination of suspected patients. Decontamination will take place as indicated or required.

DEFINITIONS:

- **Appropriate Disaster Response Protocol Level 1** (Minor impact on the facility) Emergency Department (ED) able to cope with casualty. DECON showers will not be used during a Level 1.
- **Appropriate Disaster Response Protocol Level 2** (Moderate impact on the facility) Incorporates hazardous material incident with potential casualties or affecting hospital operations. The assumption should always be to ready the DECON showers and team unless specifically told otherwise by Incident command.
- **Appropriate Disaster Response Protocol Level 3** (Major impact on the facility) Incorporates mass casualty incident requiring high level support. The assumption should always be to ready the DECON showers and team unless specifically told otherwise by Incident command.
- **Casualty –** a person who has been exposed to hazardous materials, residual biological spores, chemical and/or radioactive contaminants that pose a risk of short- or long-term injury or death.
- **Chemical weapon –** any chemical agent intended to cause injury or death.
- **Cold Zone –** area protected from contaminants and contaminated patients.
- **DCO (Decontamination Control Officer) -** Trained leader of the decontamination unit. Any properly trained "operations level" DECON tech can assume the role of the DCO, preferably a clinical MD or NP. The DCO observes the decontamination process and progress of the decontamination unit (DU). The DCO intervenes if a casualty requires immediate medical attention. The DCO is situated to ensure observation of casualties advancing to DECON showers.
- **DECON showers –** Especially designed portable showers used for the express purpose of cleansing the human body to remove contamination by hazardous materials including chemicals, radioactive substances, and infectious material.
- **DSO (Decontamination Safety Officer) –** Trained in decontamination operations. Any properly trained "operations level" DECON tech can assume the role of the DSO, preferably a clinical MD, NP or RN. The DSO is assigned to ensure safety of the DU team and to prevent contaminated casualties from entering cold zone. The DSO is located at the bridge of warm and cold zone.
- **DU (Decontamination Unit) -** A decontamination unit operates within the hot zone and consist of six or more personnel. DU is also used for "decontamination unit team member".
- **ED** – Emergency Department
- **Hazardous material –** a substance that poses a risk of short or long term injury or death.
- **Hot Zone –** contaminated or potentially contaminated area where decontamination (decon) is performed.
- **HSO –** Office of Emergency Services-County of Humboldt-Sheriff's Office
- **IC - Incident Commander –** In a disaster, organizes and directs the Hospital Command Center (HCC). Gives overall strategic direction for hospital incident management and support activities, including emergency response and recovery. Authorizes total facility evacuation if warranted.
- **ID –** Identification
- **JumpSTART -** The **JumpSTART Pediatric MCI Triage Tool** is the world's first objective tool developed specifically for the triage of children in the multi-casualty/disaster setting. JumpSTART was developed in 1995

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to parallel the structure of the **START** system, the adult MCI triage tool most commonly used in the United States and adopted in many countries around the world.

- **Low toxicity contaminant –** any chemical agent that is unlikely to cause injury or death due to short-term exposure ~~i.e.~~i.e., motor oil, detergent, vegetable oils, and paints.
- **Mass Casualty -** is defined as a number ten or greater.
- **OEM/DOH –** Office of Emergency Management/Department of Health
- **PHD –** Public Health Department
- **PPE (Personal Protective Equipment) –** masks/respirators, gloves, hoods, suits, masks, respirators, gloves etc. designed to protect health care workers from hazardous materials or agents.
- **Radioactive particle –** any substance that emits radiation.
- **REAC/TS -** Radiation Emergency Assistance Center/Training Site.
- **RSO (Radiation Safety Officer) –** Staff member assigned to monitor radiation levels if detection devices are available.
- **START - Simple triage and rapid treatment** (**START**) is a triage method used by first responders to quickly classify victims during a mass casualty incident (MCI) based on the severity of their injury. The method was developed in 1983 by the staff members of Hoag Hospital and Newport Beach Fire Department located in California, and is currently widely used in the United States.
- **Warm Zone –** transition area from Hot to Cold Zone. This area will likely be the upper ambulance bay to the ambulance bay doors.

PROCEDURE:

Types of Contamination:

- **Solids** – Biological spores, or dusty agents that could appear as particles.
- **Liquids** – Liquid droplets that fall like rain. Droplets can range from thick and sticky to a misty consistency of water.
- **Vapors and gases** – Created by bursting munitions or generators. These clouds are affected by the weather and can be local or diffuse.
- **Aerosols** – Fine liquids or solid particles suspended in the air. They behave much like vapors.

THE DECONTAMINATION DECISION:

The decision to commence decontamination procedures may occur in one of three ways. The ED may elect to manage a smaller decontamination incident without activating an appropriate Disaster Response Protocol:

- **STANDARD ACTIVATION** - by a communication from the County of Humboldt-Office of Emergency Services (HSO) or emergency services.
- **MEDIA ACTIVATION** - In response to the media (Television/Radio) broadcast describing a citywide emergency the hospital may implement a state of decontamination readiness in preparation for an influx of real and "concerned" patients.
- **DEPARTMENTAL ACTIVATION** - The ED recognition of one or, a number of patients requiring decontamination:

If one or more of the above criteria is met the ED will close and restrict access preventing contaminated casualties from entering the ED until the ED manager, nurse, or physician has verbalized readiness to commence decontamination.

The hospital's main priorities in a decontamination event are responder safety, limiting the spread of contamination, patient triage, decontamination, and medical care, as well as medical monitoring of patients and staff.

DEPARTMENTAL ACTIVATION
ACTIONS ON SUSPECTED CHEMICAL CASUALTIES PRESENTING TO THE EMERGENCY DEPARTMENT RECEPTION/TRIAGE:

a. NO physical contact with the casualty shall take place. If contact has taken place by a staff member the involved staff member will be considered contaminated and will be required to immediately enter the decontamination shower "DECON" shower.
b. The Nurse in charge will make a rapid verbal assessment of the casualty. NO physical contact with the casualty shall take place. The nurse will direct the casualty to the shower area to prepare decontamination. The casualty shall be directed to disrobe, change into a white gown, and proceed to the decontamination shower.
c. If any hospital staff (triage nurse, reception etc.) suspects that a patient has been chemically contaminated they should IMMEDIATELY ask the patient to stand outside the department entrance, following the same path they used to enter. The triage nurse or the nurse in charge will make a rapid verbal assessment of the casualty. NO physical contact with the casualty shall take place. The nurse will direct the contaminated

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individual(s) to the shower area to prepare decontamination. The casualty shall be asked to undress, change into a white gown, and proceed to the DECON shower.

d. All casualties involved will be asked to wait until proper decontamination has been completed before entry to the ED is allowed. All areas contaminated by casualties will be cordoned off. All secondary exists and entrances within the department will also be cordoned off to prevent contamination breach.
e. If a casualty presents with any ED personnel, who are unaware of possible contamination, and it is determined that the casualty is contaminated then the ED personnel are also to be considered contaminated and directed to decontamination (see step "c" above).
f. All individuals who have had physical contact with the casualty will be considered contaminated and be directed to proceed with step "c".
g. Casualties will be decontaminated using the patient decontamination procedure.
h. At any time during the decontamination process should ten casualties or more present with similar history, signs, and symptoms the emergency department will assume the event as a mass casualty incident.

If the hospital is in "lockdown mode'" due to contamination, staff members who arrive from outside the hospital will require evaluation before being allowed entrance to the ED.

EMPLOYEES OUTSIDE THE HOSPITAL

1. Staff members who arrive from outside the hospital will require evaluation before entrance to the ED and or hospital is permitted. All staff members will be evaluated for possible contamination.
2. Hospital staff members who produce hospital identification will be treated as a priority. This priority will allow immediate decontamination and access to the facility.
3. If no detection devices are being used the assumption is that the staff member requires decontamination before being permitted to report to duty. If detection devices are to be used and no contaminates are detected the staff will be allowed access to the hospital without decontamination.

PATIENT DECONTAMINATION PROCEDURE:

"The RINSE, CLEAN, and RINSE technique"

Each casualty will be decontaminated a standard time of six minutes. Once the time has elapsed the casualty will be directed to the ED. Detection devices, if appropriate and available, will also be used at the end of the shower.

At the ~~decon~~ DECON station, curtains when available, are to be erected either around the patient or before the casualties are permitted entrance to the DECON shower, for their privacy and protection of others. The showers will be segregated into three sections (when possible):

I. Section 1 Female additionally ambulatory Children aged 2 years or over.
II. Section 2 Male.
III. Section 3 Non-ambulatory (Individuals who require special assistance will be directed via this route).

The aforementioned sections are now considered the "Hot Zone" and no one may enter if not appropriately garbed.

a. Unless specifically informed otherwise by Department of Health or Office of Emergency Management (DOH/OEM) and/or the Incident Commander (IC) ALL casualties will be scanned for radiation. Detection for radiation may stop after one hour if no casualties are tested positive. Radiation injury rarely causes unconsciousness or immediate visible signs of injury and is not immediately life threatening; ~~therefore~~therefore, other causes of injury or illness must be considered.
b. The patient is given a pre-decon kit (based on the hospital decontamination kit sold by Aramsco Corporation that includes a pre and post-decon kit. Included in these kits ~~are:~~are towels, a white gown, a blue gown, booties, soap, fingernail brush, red bag containers, bar-coded ID bands and a personal item bag) and must completely disrobe, or be disrobed and changed into a white gown as provided. ***"White is DECON site."*** **Verbal instruction, if necessary, will be given to assist the casualty.**
c. The casualty, when capable, should place all clothing into the red contaminated clothing bag and personal effects/valuables in the silver personal effects bag. A marker is provided with the pre-decon kit and the casualty, if capable, will be encouraged to use the pen to write their name and contents on the bag. Please note: The highest percentage of contaminants is found on the outer garments. For this reason, it is imperative that the casualties attempt to do this unassisted. If the casualty is unable to do this the Decontamination Unit (DU) will assist. The casualty must wear the bar-coded bracelet contained in the decon kit. The bar-coded bracelet matches the bar code on the red contaminated and personal effects bag. The property will be stored/secured.
d. During a radiation incident the clothing and personal belongings of the casualty are also considered contaminated until sufficient time lapses for verification of the level of radiation. ALL clothing is considered contaminated and must be placed in the red contaminated clothing bag. The casualty, if capable, will decontaminate the outer surface of the sealed personal belonging bag. The red and silver bag is bar-coded. Once the outer bag has become decontaminated the bag will be surrendered to the staff and secured in a pre-

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determined locked box (if/when available).

e. No staff member is to have close contact with any contaminated or potentially contaminated patient before that staff member has donned appropriate protective gear (for which they have received appropriate training), regardless of the patient's condition.
f. A DU member will remain situated at the entrance to section 1 and 2 and visually demonstrate the rinse, clean and rinse technique. All gross contaminants should be gently scraped off. Scrubbing is to be avoided unless specifically advised to do so by the Public Health Department (PHD), DOH/OEM or the IC. The casualties will clean under nails, breasts, in groin/buttock region. Two DU team members (gender appropriate when possible) will be situated at the exit of the section 1 and 2 shower policing the rinse, clean and rinse technique. Two DU team members will focus on the non-ambulatory and special populations.
g. After the shower non-ambulatory patients are wheeled to the "warm zone". The stretchers/chairs must NOT cross the hot/warm zone line. If detection devices are utilized, casualties are checked and if clear, patients are transferred off the "hot zone" stretcher onto a warm zone stretcher. If not clear of contaminates a plain unmarked ID band is placed on the casualty (the plain ID band signifies that the patient is entering the showers a second time.) and the shower is repeated. If no contaminant is detected after the second wash the patient will then be considered decontaminated and the plain ID band removed. If a contaminant is still present a DU team member will physically wash the casualty. If after a third wash contaminates are present the casualty will be treated as internally contaminated.
h. Proper application of the rinse, clean and rinse technique using warm water and hypoallergenic soap will likely be sufficient to remove contaminants the first time.
i. Casualties unable to stand will be placed on a long board on top of a stretcher (all mattresses will be removed from stretcher prior to use) and be decontaminated by the non-ambulatory DU team. All non-ambulatory casualties will be a higher priority than ambulatory casualties.
j. During a DU scenario Poison Control should be considered a resource for help, advice, and reporting.
k. Resuscitative efforts may proceed during decontamination only when appropriately protected trained staff are available. The medical screener determines the priority of patients entering the shower. If a casualty requires life-saving intervention, this will be implemented by the DCO. JumpSTART and START triage is not in effect until the cold zone.
l. Once decontaminated the casualty will change into a blue gown ***"Blue is through"*** (post decon kit). This color will provide a visual confirmation for the DSO that the patient has showered. If a detection device is required, this will be used before permitting the casualty to enter the ED and undergoing main triage within the cold zone. If an individual is not wearing the blue gown the patient will be directed to return to the showers.
m. If a contaminated patient walks into or is brought into the ED, wherever they are, and wherever they passed, is now immediately considered a "Hot Zone" and is to be cordoned off accordingly. The patient should be escorted as rapidly as possible via the same route of arrival to the decontamination area as soon as appropriately protected staff becomes available to move the patient.

RADIOACTIVE INCIDENT

Detection devices are to be used if available. In the area where survey meters are utilized post-decontamination and contaminants are still detected, the casualty will be showered a second time. Do not touch the casualty with the detection device. A plain ID band will be applied to the patient to signify second shower. If a casualty returns with a band and is still contaminated a member of the DU will wash the patient. In an event of a radiation incident where the patient tests positive to contaminants after a second time, consider that the contaminant is internal. If signs, symptoms, history speak to external contamination only, vector the tertiary decontamination attempt accordingly. For example, consider that the casualties' nails should be brushed clean and hair can be clipped (not shaved). Complete decontamination, which returns the area to a background survey reading, is not always possible because some radioactive material can remain fixed on the skin surface (or as previously stated internal to the patient/casualty). Decontamination should be only as thorough as practical.

1. Unless specifically informed otherwise by DOH/OEM and or the IC ALL casualties will be scanned for radiation. Detection for radiation may stop after one hour if no casualties have tested positive to radiation. Radiation injury rarely causes unconsciousness or immediate visible signs of injury and is not immediately life threatening; therefore, other causes of injury or illness must be considered.
2. Brief radiological survey will be performed to determine if the victim is contaminated. Any radiation survey meter reading above the level dictated by the Radiation Safety Officer (RSO) or responding governmental agency should be considered to indicate the possibility of contamination (positive). If the radiation survey meter reading is higher than the background (as established by the RSO), the casualty will be required to disrobe and enter the DECON shower.
3. If the radiation survey meter reading is higher than the background on a patient during a mass casualty event, this will be considered positive and the radiation response team/nuclear medicine will be notified, regardless of medical excuse or information that the casualty may present (recent nuclear medicine test).

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4. Commence DECONTAMINATION procedures IF NO LIFE OR LIMB THREATENING
5. CONDITION EXISTS. Serious medical problems always have priority over radiological concerns, and immediate attention is directed to life-threatening problems. These patients may require direct medical/surgical intervention and radiation safety personnel should be available to advise clinical staff on the best method for managing these patients in the emergency department or operating rooms. These patients may require decontamination in the ED simultaneous to resuscitation.
6. The clothing and personal belongings of the casualty is considered contaminated until sufficient time has lapsed to verify the level of radiation. Clothing must be placed in the red contaminated clothing bag. The casualty if capable will decontaminate the outer surface of the sealed personal belonging bag. The red and silver bag is barcoded. Once the outer bag has become decontaminated the bag will be surrendered to the staff and secured in a pre-determined locked box.
7. The casualty should be assessed for wounds upon initial evaluation/intake. All wounds should be covered with waterproof draping to limit the spread of radioactive contamination to the rest of the body. In an ideal setting, the decontamination team should attempt to decontaminate the wound first, then decontaminate the remaining body surface area. However, it is acknowledged that in a disaster situation the wound may be covered immediately with a waterproof material before decontamination of the body, then decontaminate the remaining body surface area, and then dispatch the casualty to a designated area for further wound decontamination.
8. The decontamination team must remain vigilant to reduce the opportunity and prevalence for contamination running off the body into an open wound.
9. The decontamination procedure stops when the radioactivity level cannot be reduced to a lower level. Patients with persistent contamination will need further evaluation by radiation safety personnel or other radiation trained clinician to determine the location and type of contamination and any necessary steps needed.

MANAGEMENT OF INTERNAL CONTAMINATION

1. If appropriate and indicated (See #6 above) after decontamination is complete, all open wounds are to be immediately covered, preferably with a waterproof material, to limit the spread of radioactivity.
2. The decontamination procedure stops for a repeated positive casualty when the patient has entered the shower three times and the radioactivity level cannot be reduced to a lower level. Contamination may be internal, subcutaneous, or persistent and may not be treatable with external decontamination.
3. Casualties who remain contaminated after three washes will be managed as internally contaminated (even though they may just have persistent contamination of hair/skin).
4. All radiological casualties who have tested persistently positive should be segregated near an outside entrance.
5. People who are internally contaminated can expose people near them to radiation from the radioactive material inside their bodies. The body fluids (blood, sweat, urine, vomitus, and feces) of an internally contaminated person can contain radioactive materials. Coming in contact with these body fluids can result in contamination and/or exposure. Hospital and medical personnel encounter patients with internal contamination such as this frequently after nuclear medicine diagnostic tests or certain radiation treatments. Management of these patients will be similar.
6. Patients who are internally contaminated DO NOT require isolation in a negative pressure room unless an underlying medical problem requires isolation. This might need to be in a separate section on preparing the ED, and not in a section on internal contamination. Strict adherence to standard precautions to protect from contaminated body fluids to be enforced.
7. Before permitting any radiological casualties into the ED, the designated area must be cleared of visitors and patients. Remove or cover any equipment that will not be needed during emergency care of the radiation accident victim.
8. This route should then be roped off and marked to prevent unauthorized entry.
9. Brown paper or "butcher paper" three to four feet wide can be unrolled to make a path from the ambulance entrance to the holding treatment area. Ordinary cloth sheets or square absorbent pads can be used if paper is unavailable. Whatever the floor covering, it should be taped securely to the floor. The floor of the decontamination room or treatment area should be covered in a similar way if time allows. This will make cleanup of the area easier.
10. A radiation dosimeter, if available, should be assigned to each team member and attached to the outside of the surgical gown at the neck.
11. The emergency response teams (as recommended by Radiation Emergency Assistance Center/Training Site [REAC/TS]) should dress in surgical clothing (scrub suit, gown, mask, cap, eye protection, and gloves). Waterproof shoe covers should be used. All open seams and cuffs should be taped using masking or adhesive tape. Fold-over tape tabs, at the end of each taped area, will assist with their removal. Two pairs of surgical gloves should be worn. The first pair of gloves should be under the arm cuff and secured by tape. The second pair of gloves should be easily removable and replaced if they become contaminated.

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12. There is very little likelihood that contaminants will become suspended in air and enter the ventilation system. Hence, no special precautions are advised. (Ref.: AMA. A Guide to the Hospital Management of Injuries Arises from Exposure to or Involving Ionizing Radiation. 1984 and REAC/TS 2002).
13. The RSO and the IC will assign an individual to monitor and compare radiation levels using a detection device for background radiation from both the "Hot Zone" and the ED. The "Hot Zone" reading will be taken by a DU with a detection device. The assigned monitor will take the ED reading. The monitor will take a local background reading every thirty minutes for a minimum of three times. These readings will be discussed with the RSO and plan of action will be implemented.

SPECIAL POPULATION CONSIDERATION

The following addresses how special patient groups will be managed during a mass decontamination:

1. **Children:** Will remain with parent or guardian. Attempts will be made to keep children and parent/ guardian together. (Consideration will be given to "up-triaging" parent/guardian to pediatric triage acuity, when the child is deemed a higher acuity.)
2. The parent or guardian will be instructed to undress first. All children presenting to SHCHD from a contaminated site must be decontaminated before being allowed entry into the hospital.

CHILDREN 8 – 18 YEARS OF AGE:

1. Ambulatory children should disrobe when instructed to do so by DU personal. Children will enter the shower with their parent/guardian. The parent/guardian will be instructed to decontaminate or assist in decontaminating the child first, and then decontaminating themselves.
2. Non-ambulatory children will be placed on a stretcher by DU personal and decontaminated.

CHILDREN 2 TO 8 YEARS OF AGE:

1. Ambulatory children should disrobe when instructed to do so by DU personal. Children will enter the shower with either the parent/guardian.
2. Non-ambulatory children will be placed on a stretcher by DU personal and decontaminated.
3. Children between ages 2 and 8 should not be separated from their parent/guardian. The triage acuity for children between ages 2 and 8 will reflect the highest category between themselves and their parent/guardian.

CHILDREN LESS THAN 2 YEARS OF AGE:

1. Either the child's parent/guardian or DU personal should disrobe infants/ toddlers. The infant/toddler will be placed on a stretcher and decontaminated with a ~~hand held~~handheld lower pressure decontamination shower. The infant/toddler will not be carried due to the possibility of accidental trauma resulting in a fall. Attention must be paid to the toddler or infants airway while in the shower.

- **Visually Impaired**: All casualties that are visually impaired will be assisted by a DU through the shower. The DU will observe and assist if necessary to wash the casualty. If the casualty has an AID/working dog, the dog will also require decontamination before entry is permitted to the ED.
- **Pets**: Only Aid/working animals will be permitted to enter the DECON shower and the ED.
- **Physically or mentally impaired casualties**: Directed via the non-ambulatory corridor and decontaminated.
- **Prosthetics**: With assistance all prosthetics will be removed and decontaminated.
- The affected site will also be washed. The prosthetic will then be replaced.
- **Elderly**: Directed to ambulatory or non-ambulatory corridor depending upon present mobile status.
- If a casualty from the above population group is experiencing difficulty, a DU will intervene and assist.

CLEANSING OF THE DECONTAMINATION UNIT

The DSO will inform the DCO via the radio when sixty minutes has elapsed. The DCO will initiate stand down of the present team. Stand down will be implemented in increments. The DCO will recall two team members at a time. This will be in exchange for two "new" team members. The "new" team member's primary role before commencing casualty decon is to decontaminate the team members standing down. This method is repeated until the old team is replaced. At the end of the decontamination process all persons wearing PPE should be decontaminated, changed into temporary clothing, enter the ED and showered again. Once decontaminated a medical assessment is implemented before returning to their normal clothing.

ENVIRONMENTAL CONCERNS

Every effort will made to control run-water. Garberville Sanitary (707-923-9566) will be informed that contaminated water may have entered the sewage system.

EVACUATION

The evacuation will be performed as follows:

a. If the IC determines that the ED has become contaminated, or is otherwise unable to function as a "Cold Zone", the ED will be evacuated.
b. The Clinic is the first alternative care site for the ED.
c. DU activities will continue as long as decontaminated patients can safely be taken into the hospital.

THE CONTAMINATED DEAD

Depending on the nature of the attack (chemical or biological) the contaminated dead present a continuing risk to health care staff, the ED and the public, and in particular to mortuary staff. Mortuary staff have systems in place in managing patients with high-risk biological contamination, however they may not be familiar with chemically contaminated casualties, particularly chemical warfare agents. A particular danger to mortuary staff is "off gassing" of chemical agents. If the body, or a number of bodies are stored in a confined space, concentrations of the agent may rise to toxic levels causing harm to anyone who enters that storage space without protection. In the event of a chemical or biological attack the contaminated dead are the exclusive jurisdiction of the Coroner, who will be assisted by the police conducting a criminal investigation. The Coroner's Office has its own Major Incident Plan with regard to dealing with mass casualty dead however the following initial management is recommended:

a. Contaminated bodies should be stored in a "gas tight" body bag if available.
b. Bodies should be stored in an open space, outside and away from public view, until a decision has been made regarding their further management.
c. Consideration should be given to the establishment of a temporary mortuary (possible disposable tents) in a secluded open space for the conduction of an autopsy.
d. Mortuary staff should seek advice with regards to conducting an autopsy wearing PPE.

CONTAMINATED PERSONAL BELONGINGS

a. Personal belongings will be contaminated.
b. Personal belongings and particularly any item that may identify a casualty (alive or dead) should be placed in the silver "valuables" personal effects bag and secured in a pre-determined lock box until it can be given to the custody of law enforcement.

REFERENCES:

CENTER FOR BIOTERRORISM PREPAREDNESS AND PLANNING. (n.d.). *Continuum Heath partners*. Retrieved December 22, 2013, from www.nyc.gov/html/doh/downloads/pdf/bhpp/bhpp-focus-hosp-chpprot-decon.pdf

AMA. A Guide to the Hospital Management of Injuries Arises from Exposure to or Involving Ionizing Radiation, 1984 and REAC/TS 2002.

The JumpSTART Pediatric MCI Triage Tool and other pediatric disaster and emergency medicine resources. Lou E. Romig, MD, FAAP, FACEP, Team Life Support, Inc., ©2011. The Combined START/JumpSTART Triage Algorithm: http://www.jumpstarttriage.com

REAC/TS Radiation Emergency Assistance Center/Training Site. www.orise.orau.gov/react

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Disaster Plan-Surge Capacity for Injured and Non-Injured**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/22/2019

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure all health care professionals are prepared and capable to give a quality level of care during a surge of capacity event.

PURPOSE:
The purpose of this policy and procedure is to organize a plan to best prepare health care professionals to provide effective and organized communication and care during a disaster.

PROCEDURE:
Surge capacity is when several patients arrive to the Emergency Department (ED) at the same time requiring additional staff and resources. However, no single definition or measurement standard for surge capacity exists but there is a general agreement on its key components, which are referred to as the "4 S's":

- **Staff:** refers to all available personnel and departments
- **Stuff:** consists of supplies and equipment
- **Structure:** refers to facilities- hospitals, public health dept., gymnasiums, etc.
- **Systems:** include integrated management policies and processes- EMS, home health, Physician offices.

These key components may be described as "defining attributes," which are the cluster of attributes most frequently connected with the concept.

- Step 1:
  ED physician and ED Registered Nurse (RN) determine a surge capacity event is occurring and activate the Phone Tree to ensure additional staff arrive. (See Appendix A- "Phone Tree")

- Step 2:
  Retrieve Disaster Plan Manual, located in the Dimmick room. Utilize "Activating Disaster Plan" policy and procedure (P&P) to assist with determination of Level I Disaster or Level II Disaster.

- Step 3:
  Designate an experienced triage officer (~~e.g.~~e.g., emergency physician, emergency RN, charge nurse/shift supervisor) to begin triaging patients using triage tags. (See "Key Disaster Locations Map" for placement of patient based on patient's stability). As staff arrive distribute appropriate roles: chain-of-command, incident commander, liaison officer, etc. (See "Disaster Plan Summary" P&P).

- Step 4:
  As staff arrive delegate staff to set up surge tent. If possible, have administration staff, EVS, and dietary staff set up tent; to allow all available medical staff (MD, DO, FNP, PA-C, RN, LVN, CNA) to focus on patient care. Potential locations within the hospital that may be converted into patient rooms include but are not limited to administrative areas of hospital, clinic rooms, etc.

- Step 5:
  All inpatient and outpatient cases are to be assessed for the ability to cancel, discharge early, transfer to another caregiver, or transfer to a different section of the hospital. All Clinic patient appointments are to be cancelled and rescheduled by admitting.
  All Emergency Departments are to divert patients to alternative triage sites, urgent care clinics or primary care clinics, reserving the ED for life-threatening emergencies.

- Step 6:
  See "Communication During A Disaster" policy and procedure to ensure communication lines are open and being properly utilized.

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REFERENCES:

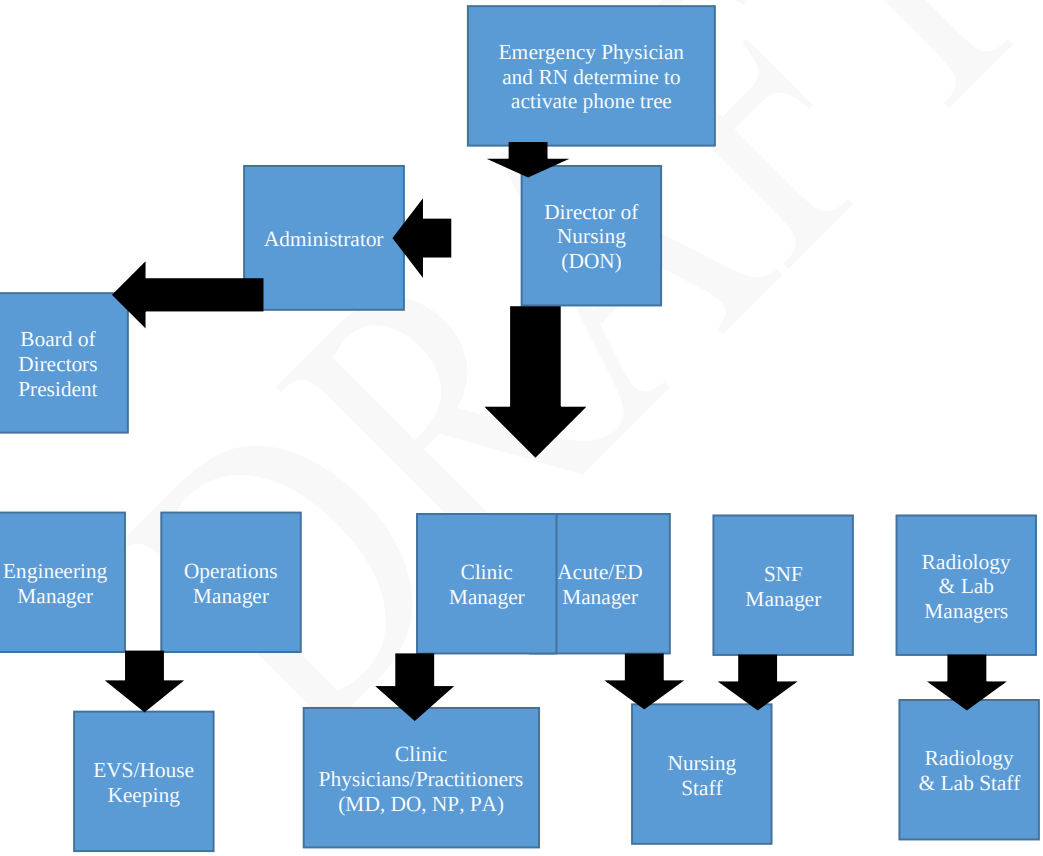
Adams, L. P. (n.d.). Exploring the Concept of Surge Capacity. *Exploring the Concept of Surge Capacity*. Retrieved December 11, 2013, from: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No2May09/Articles-Previous-Topics/Surge-Capacity.aspx

REVIEWED BY:

Chief Nursing Officer
ED/Acute Nurse Manager
Medical Director
Skilled Nursing Manager

PHONE TREE

Appendix A



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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 2
SUBJECT: **Discharge Instructions**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to give clear and appropriate Discharge Instructions from our Emergency Department that include verbal and written instructions.

PURPOSE:
The purpose of this policy is to ensure every patient receives written and verbal discharge instructions, specific to their condition, upon being discharged from the emergency Department.

PROCEDURE:

1. The Emergency Department provider will write and give clear Discharge Instructions specific to the patient's condition. The District supplies **wound care, head injury, bruise, fracture or sprain**, and **general discharge instruction sheets** along with exit care, which will have a variety of options.

2. The nurse will explain the Discharge Instructions and have the patient sign stating they read and understand the instructions. If the nurse deems necessary to add additional information, they may use exit care or Up-To-Date to provide additional instructions.

3. Patients and family members will be encouraged to engage and participate in the process of discharge as equal partners. The needs, wishes and rights of the patient will be paramount throughout the process.

4. Discharge must be timely. Discharge shall occur within 30 minutes of the discharge order unless the patient is not medically fit or safe to be discharged and then the discharge will be cancelled.

5. Assessment and vitals related to the discharge will commence at the earliest opportunity. The last set of vitals should be collected within 30 minutes of discharge. If abnormal, vitals should be repeated, and doctor informed prior to discharge.

DISCHARGE INSTRUCTIONS

1. The physician will provide written discharge instructions providing a clear management of care for the patient's condition. The doctor will ensure the patient is medically fit and any outstanding assessments or interventions are communicated to the nurse.

2. All patients rendered emergency care will be referred to their private physician or referred to a specialist, or having no private physician, will be referred to the health department or the Clinic for any procedure or follow-up care deemed necessary by the emergency department physician.

3. The emergency department physician may also want the patient to follow up in the ED and an out-patient follow-up order will be created for the patient to come back to receive services.

4. Nursing Responsibility:
    a. The nurse will ensure that all orders have been completed prior to discharge and any abnormal vitals or assessments are communicated to the physician.
    b. All patients must be told to seek further medical assistance if they get worse or fail to get better.
    c. Nurses are to inform patients of what to expect (common symptoms that may persist, any activity or dietary restrictions, and when to come back to the ED.

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d. Document patient's understanding of discharge instructions. Give a copy of the instructions to the patient or those responsible for the patient, verbally and in writing.

Common Example of Symptoms that require a return to the emergency department or private physician:

1. Wounds: If the wound becomes red or swollen, develops pus, red streaks or feels sorer rather than less sore as days go by.

2. Head injury: Patients with head injuries and persons caring for them must understand the necessity to return if the patient has:
   a. Persistent vomiting, stiff neck, fever, or headache.
   b. Unequal sized pupils (one large pupil, one small).
   c. Confusion, unusual drowsiness, or dizziness.
   d. Inappropriate or slurred speech.
   e. Convulsions or unconsciousness.
   f. Stumbling or other problems with the normal use of arms or legs; areas of numbness of the skin.
   g. Persistent nosebleed or fluid draining from nose or ear.

3. Eye injuries: Patient must return if they have increasing pain one (1) hour after anesthetic wears off.

4. Splinted patients should return and have checked immediately if the injury:
   a. Gets cold
   b. Feels numb
   c. Becomes very painful
   d. Swells markedly
   e. Turns blue or dark
   f. Cap refill greater than 3 seconds.

5. As directed by the emergency department provider.

REFERENCES:

Kornburger, C., Gibson, C., Sadowski, S., Maletta, K., & Klingbeil, C. (2016). Using "teachback" to promote a safe transition from hospital to home: An evidence-based approach to improving the discharge process. Journal of Pediatric Nursing, 28(3), 282–291.

Samuels-Kalow, M. E., Stack, A. M., & Porter, S. C. (2014). Effective discharge communication in the emergency department. Annals of Emergency Medicine, 60(2), 152– 159.

The Joint Commission. (2017, February 27). 'What did the doctor say?: Improving health literacy to protect patient safety. Retrieved from http://www.jointcommission.org/What_Did_the_Doctor_Say/

REVIEWED BY:

Chief Nursing Officer
ED/Acute Nurse Manager
Medical Director

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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 2
SUBJECT: **Discharge Plan for the Homeless Patient**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/01/2020

Policy:
It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") to provide the appropriate discharge support for those patients who identify as homeless in accordance with Senate Bill (SB) 1152.

Purpose:
The purpose of this policy and procedure is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services. Housing status will not be used to discriminate against a patient or prevent medically necessary care or hospital admission. This policy applies to patients discharged from the Emergency Department, In-patient Acute Care and Swing Bed Program.

Definition of Homelessness:

- The patient lacks a fixed and regular nighttime residence, or
- Has a primary nighttime residence that is supervised publicly- or privately-operated shelter designed to provide temporary living accommodations, or
- Is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

Procedure:

1. Patients who identify as homeless when presenting to the Emergency Department will be identified at Triage; the Homeless Assessment will be completed.
2. The patient who identifies as homeless will be noted in the Homeless Patient Log which is maintained in the ED.
3. The patient will receive a Medical Screening Exam and appropriate interventions as identified by the ED physician or provider.
4. When the patient is deemed ready for discharge from the In-patient unit, Swing Bed program or the ED by the ED physician or provider, the following items will be provided to the patient by the nursing staff:

    - All information provided to patients at the time of discharge will be provided to the homeless patient in a culturally competent manner.
    - The case manager, nurse or social worker will prepare an individual discharge plan for each homeless patient guided by the best interest of the homeless patient, his or her physical and mental condition, and his or her preferences for placement.

5. A post discharge destination will be identified for each patient
    - A social Service agency: that has agreed to accept the patient, or
    - Non-profit social services provider: that has agreed to accept the patient, or
    - Governmental services provider: that has agreed to accept the ~~patient~~patient.
    - The name of the person at the receiving agency or shelter who agreed to accept the patient.
    - The Hospital must send the receiving agency written or electronic information about the patient's post-discharge health and behavioral health needs.
    - The homeless patient's "residence" defined as "the location identified to the hospital by the patient as his or her principal dwelling place" will be noted in the post discharge information.
    - An alternative destination will be provided to the receiving agency as indicated by the homeless patient.

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6. The patient will be provided a comprehensive list of the Community Resources which includes but is not limited to:
    - Low-cost and subsidized housing
    - Clean and Sober housing
    - Homeless shelters and other services for the homeless
    - Food and clothing resources
    - Mental Health Services
    - Substance abuse treatment
    - Financial assistance

7. Each homeless patient will be offered the following services/supplies prior to discharge:
    - Consultation with the hospital Financial Services office, when available, including the business card given to the patient.
    - The patient will be screened for and helped to enroll in any affordable health insurance coverage for which he or she is eligible.
    - The patient will be given referrals for any needed follow-up care, both medical and behavioral as determined by the treating physician; this may include contacting the patient's PCP or any other coordination of care that may be needed.
    - The patient will be provided discharge medications as determined by the treating physician.
    - The hospital will offer infectious disease screening as determined necessary by the treating physician; but could include any of the following: HIV testing, Chlamydia, Gonorrhea and Hepatitis C.
    - Patients will be offered vaccinations appropriate to his or her presenting medical condition, as determined by the treating physician, but could include seasonal Influenza, and pneumococcal vaccination.
    - A hospital provided meal or high calorie meal bar will be offered/provided to the patient prior to discharge, this will be determined by the time of day and access to dietary personnel and the kitchen.
    - In the event that the patient requires clothing, the department will offer "sweatpants" and a "sweatshirt" that are new.
    - A rain poncho will be offered, if necessary, D/T inclement weather.
    - An inclement emergency blanket will be provided, as necessary.
    - The patient will be offered transportation; by means of a bus ticket if that destination is within 30 miles or 30 minutes of the hospital.

Addendum:

1. Mental Health Program Contact Information; Department of Health and Human Services; Humboldt County
2. Substance Use Disorder Treatment Programs in Humboldt County

REFERENCES:

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Discharge Planning for Homeless Patients. (2019). California Hospital Association. https://calhospital.org/publications/discharge-planning-homeless-patients/

SB-1152 Hospital patient discharge process: homeless patients. (2018). California Legislative Information. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152

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Chief Nursing Officer/Director of Patient Care Service
Compliance Officer
Emergency Department/Acute Care Nurse Manager
Laboratory Manager
Medical Director Emergency Services

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Risk Manager

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: **Duties of the Emergency Department Physician**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 05/30/2019

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure the immediate response by the Emergency Department Physician to in-patients ~~with~~ in regard to all emergencies (e.g., codes)

Purpose:
To ensure that patients and/or residents are cared for appropriately during any urgent or emergent life-threatening situation.

Procedure:
The ED physician will respond to a new ED patient within 30 minutes of arrival.

Any member of the hospital staff, upon discovery of a suspected cardiac arrest or grave emergency condition, shall immediately begin CPR and call for help, notifying the physician as soon as possible. The *ED* physician and *ED* nurse will go immediately to the scene and assume the responsibility for resuscitation. The nurse will make temporary reassignment of staff to cover all nursing areas during the emergency. The physician will direct resuscitation until the emergency is resolved.

Procedure for Admission of the Patient to the Hospital

1. The attending ED physician writes all orders in ~~the Computerized Physician Order Entry (CPOE) Icon.~~Epic.
2. The ED physician in an emergency assumes the responsibility of the work-up until the clinic physician is contacted or arrives. If the clinic physician is not available after hours or while using paid time off, the ED physician assumes responsibilities for the in-patient and Swing patients.
3. When the patient is ready to go to a room, the ED nurse notifies nursing staff. The ED nurse will ensure admitting orders have been placed in the system and inform the physician about any additional orders not entered (i.e., diet, activity).
4. The ED nurse will take the patient to the room when possible or call the nurses station for available nursing staff.
5. Money and valuables are given to the family or secured in a patient belongings envelope and locked at the nurses' station. All items that will leave the patients' bedside will be documented in the Notes section of ~~Healthland.~~Epic.
6. All clothes are placed in a plastic Belongings bag and given to the family or sent to the patient's room with a patient sticker attached. The belongings will be documented into the system or it will be documented that items sent home with family member with date and time.
7. The registration clerk is notified of the patient's admission, admitting diagnosis, and room number. The admission slip will be given to registration or left in the registration office if after hours.

Reviewed By:
ED/Acute Nurse Manager
Chief Nursing Officer

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Medical Director

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DEPARTMENT: Emergency Department~~Nursing~~	APPROVED:	Page 1 of 1
SUBJECT: **Emergency Department Follow Up**	EFFECTIVE DATE: **07/28/2021**	SUPERSEDES: **08/01/2020**

~~Policy~~POLICY: It is the policy of ~~SHCHD~~ the Southern Humboldt Community Healthcare Districe, ("district" or SHCHD), to assure appropriate follow-up care is provided for patients in the Emergency Room.

~~Purpose:~~ PURPOSE:

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The purpose of this policy and procedure is to assure that patients' x-rays and laboratory results are evaluated when the final results come back after the patient has been discharged from our care.

~~Procedure~~PROCEDURE:

1. Lab or x-ray results requiring follow-up will be placed in a folder in the MD office for review by MD on call.
2. After review by the MD, the follow ups are placed in the appropriate nursing supervisor's mailbox or office.
3. The follow-up will be analyzed by the MD for Emergency Department RN involvement, as necessary.
4. If new orders or follow-up information is added, this will be noted in the patient medical record.
5. There is a clipboard in the ED that will show the patients needing a call back the following day by RN on duty.

It is the expectation that this process will be implemented within 24 hours of receipt of the x-ray or laboratory results, or other need for follow up.

~~References~~REFERENCES:

Best Practices: Emergency Department Follow-Up Office. (2010). Urgent matters. https://smhs.gwu.edu/urgentmatters/news/best-practices-emergency-department-follow-office

~~Reviewed By~~REVIEWED BY:

Chief Nursing Officer
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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 4
SUBJECT: **Envenomation: Rattlesnake Bites**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/01/2020

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District to assure appropriate care is provided for patients who present to the Emergency Room due to rattlesnake bite.

PURPOSE:

The purpose of this policy and procedure is to provide guidance in the case of rattlesnake bites and prevent complications from envenomation such as local tissue necrosis and to ensure early antivenin administration.

PROCEDURE:

Assessment

1. Immediately bring patient into the ED and notify the physician if snake bite occurred.
2. Obtain Vital Signs every 15 minutes.
3. Obtain history of incident including description of reptile and approximate time of envenomation.
4. Attach cardiac monitor to patient.
5. Immobilize affected area at heart level and in physiologic position.
6. Cleanse the puncture wounds with ~~h~~Hibiclens and Sterile water.
7. Use a skin marker to outline the area that has been affected. Mark the leading edge of swelling and measure the circumference at 10 cm and 20 cm proximal to the bite every 15 minutes.
8. Remove jewelry.
9. Ask about any allergies to medications, latex, or food.
10. **AVOID** nasogastric tubes, arterial punctures, aspirin containing products, ice or heat application, tourniquets.

Emotional Support

Keep patient at rest and provide reassurance to patient and family.

Anticipate:

1. Mild sedation is often indicated.
2. Lab studies
3. Diagnostic Studies: EKG
4. Strict Bed rest
5. Treatment: Antivenin, antibiotics, tetanus prophylaxis, pain control, steroids, and antihistamines may be given per MD order.
6. NPO for 24 hours
7. Foley Catheter with I & O's
8. Notify **1-87-SERP-DRUG (1-877-377-3784)** or Poison Control
9. Start the **transfer** as soon as possible to a receiving facility.

OBSERVE and DOCUMENT EVERY 15 MINUTES FOR:

1. Signs of shock
2. Pain (0-10 scale; may be 0 in envenomated diabetics)
3. Swelling (mark the leading edge and measure the circumference at 10 cm and 20 cm proximal to the bite; may be none in a severely envenomated patient)
4. Weakness or faintness
5. Numbness or tingling (face, scalp, tongue, lips, fingers, toes, site of the bite)
6. Change in taste (metallic, rubbery, or minty taste in the mouth = rattlesnake envenomation)

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7. Fasciculations (most noticeable on the face and over the muscle of the back and neck, as well as the bitten extremity)
8. Nausea/vomiting/diarrhea
9. Diaphoresis
10. Difficulty swallowing
11. Erythema
12. Ecchymosis (appears where skin rubs against skin or where slight injury occurs)
13. Bleeding

Report to the physician any changing signs or symptoms of envenomation or any abnormal lab values.

Antivenin Administration

The importance of early antivenin administration preferably intravenously (IV) cannot be overemphasized. The amount to be used depends upon the species and size of the snake, the site envenomation, the size of the patient and other factors. Increased efficacy if given within 4 hours of a bite. It is recommended to administer the antivenin up to 24 hours.

The medication is stored in the ED Pyxis refrigerator and in the main Pyxis refrigerator. It is a white box with green letters and states Crotalidae Polyvalent Immune Fab (Ovine) CroFab®

Dosages

- The starting dose of CroFab® may vary from a minimum of 4 vials to a maximum of 12 vials based on clinical judgement and severity of envenomation.
- Infuse over 60 minutes, proceeding slowly over the first 10 minutes at 25 to 50 mL/hour with careful observation for any allergic reaction.
- If no allergic reaction occurs, increase infusion to the full 250 mL/hour until completion • If necessary, administer an additional 4-6 vials of CroFab® ~1 hour after end of first infusion.

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Reconstitution

CROFab
crotalidae polyvalent immune fab (ovine)

1 Select and fill syringe with 18 mL of 0.9% sodium chloride

2 Inject diluent slowly into CroFab® vial

3 Rotate vial 180 degrees and manually invert up to twice per second until no solid material remains in the vial. Do not shake. The entire dose should then be further diluted in normal saline to a final total volume of 250 mL for infusion

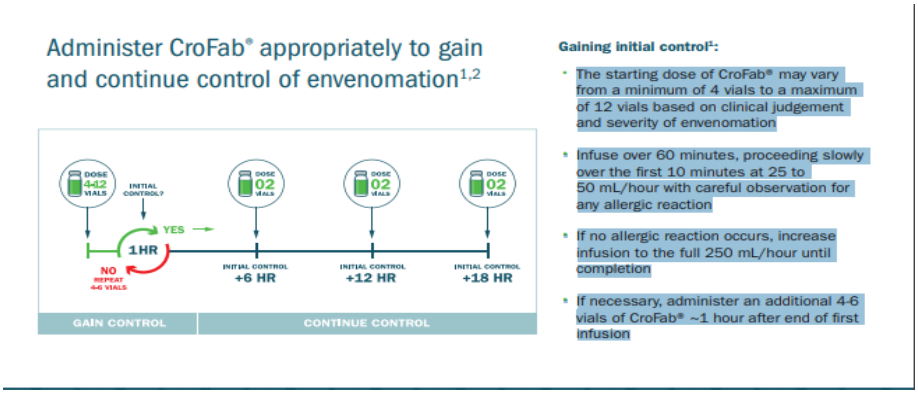
Step-by-Step Instructions:

1. Select appropriate sized syringe
2. Fill syringe with 18 mL 0.9% sodium chloride
3. Insert syringe into CroFab® vial
4. Inject sterile saline slowly into the vial
5. If necessary, vent the vial
6. Remove needle and hold the vial between thumb and forefinger
7. Rotate the vial 180 degrees and reverse the motion for one manual inversion. Do not shake.
8. Continue to manually invert up to twice per second until no solid materials remain in the vial
9. Some bubbles may form at the top of the vial during reconstitution
10. Reconstituted product should be used within 4 hours

The above picture is a correctly reconstituted CroFab® vial
The reconstituted product will appear colorless to pale yellow, and opalescent (not clear)

Indication

CroFab® Crotalidae Polyvalent Immune Fab (Ovine) is a sheep-derived antivenin indicated for the management of adult and pediatric patients with North American crotalid envenomation. The term crotalid is used to describe the Crotalinae subfamily (formerly known as Crotalidae) of venomous snakes which includes rattlesnakes, copperheads and cottonmouths/water moccasins.



Discharge/ Transfer/ Obtaining Additional Doses of Antivenin

A safe discharge would include a fibrin degradation Product (FDP) of 10-40 or greater than 40 can be predictive of a worsening condition. **This is a test in which our facility must send out and therefore the patient will need to be transferred before discharge**.

If we are unable to transfer before the 1st dose is completed, we need to obtain additional CroFab from Redwood Memorial or St. Joseph's in Eureka.

Resources

Rocky Mountain Poison and Drug Center CroFab Line
1-87-SERP-DRUG (1-877-377-3784)
OR
Contact your local or state Poison Information Center 1-800-222-1222

References:

CroFab® Crotalidae polyvalent Immune Fab.(2021). SERB completes acquisition of BTG Specialty Pharmaceuticals. https://crofab.com/?utm_source=google&utm_medium=cpc&utm_campaign=Crofab%20|%20Brand&utm_content=CroFab&utm_term=%20%2Bcrofab&gclid=CjwKCAjw87SHBhBiEiwAukSeUQT28we7wao2ULZX5MyA7b2RCb60HaNISe-fiHYnTuwbwB3KiaQaPhoCwP4QAvD_BwE

Lavonas EJ, Ruha AM, Banner W, et al. (2018). Unified treatment algorithm for the management of crotaline snakebite in the United States: results of an evidence-informed consensus workshop. BMC Emerg Med. 11:2-15

Soskis, J. (2014) Complete Guide to Snakebite Care. Tallahassee Memorial Hospital.

Reviewed By:

Chief Nursing Officer
ED/Acute Care Manager
ED Medical Director
Lab Manager

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 3
SUBJECT: **General Guidelines: Emergency Department Nurses and Technicians**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") that Nursing and Emergency Department Technician ("Tech") staff will follow the General Guidelines of the Emergency Department ("ED").

PURPOSE:
The purpose of this policy is to establish a guideline for nurses and techs to treat patients in the ED and the requirements of discharge or admission.

GENERAL GUIDELINES OF THE EMERGENCY DEPARTMENT:

1. Health Information Management/Patient Financial Services:

a. An electronic health record ("EHR") must be created for all patients treated in the ED.
b. All individuals presenting to the ED for treatment must be registered, even if patient leaves prior to Medical Screening Exam ("MSE").
c. A patient seeking treatment in the ED will sign the Consent for Treatment form prior to being treated. If the patient is unable to sign, this will be documented in the patient's medical record.
d. When a minor, or an adult lacking capacity to consent, is brought to the ED for treatment, every effort should be made to reach the parent or guardian of the patient to obtain the Consent for Treatment.
e. If there is no threat to life or limb, a verbal Consent for Treatment may be obtained via telephone. This must be witnessed by two persons and documented in the patient's medical record. An adult family member, friend, or other responsible party may be named as parent/guardian's proxy to sign Consent for Treatment and accept and acknowledge discharge instructions.
f. There are many instances where a minor patient may sign their own Consent for Treatment. Please refer to the California Hospital Association's Consent Requirements for Medical Treatment of Minors, and relevant Health Information Management Policies for a detailed list of exceptions.
g. Treatment of a minor patient under emergency conditions, such as a threat to life or limb, without written or verbal consent from a parent or guardian, is authorized by the Doctrine of Implied Consent.
h. Unconscious, unresponsive, or patients in extreme duress that are unable to consent to treatment, that are brought into the ED shall be treated immediately. If relatives, or other named medical decision makers, cannot be reached, the physician on duty presumes permission and proceeds as necessary until such time appropriate parties are notified and patient is in stable condition.

2. Radiology:

a. After regular hours, the radiology department is closed with a tech on call Monday through Sunday.
b. Prior to calling a tech in for an x-ray or CT, all documents/lab work must be completed, and patient must be appropriately dressed for exam. Notify tech of type, location, and urgency of exam.
c. Patients may receive a copy of their exam on compact disc (CD).

3. ED Bed Protocol

a. Place patient on gurney or procedure chair in a gown with at least one handrail up at all times.
b. Obtain vital signs including blood pressure/pulse/temp/pulse ox/ EKG as needed.
c. Start oxygen on 2 L via nasal cannula if dyspneic.
d. Start IV on all Triage Level (1 or 2) – if pediatric patient, ask MD prior to starting.
e. If child is under the age of 5, obtain a rectal temperature.
f. Cardiac patients will be screened immediately by appropriate medical staff and given priority care.

4. What a nurse may do before a physician arrives:

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a. Start oxygen, if necessary, start at 2L.
b. Stop bleeding using ordinary first-aid measures (e.g., pressure bandage)
c. Begin CPR and ACLS when indicated and call a code Blue as indicated.
d. Defibrillate if patient's heart rhythm in ventricular fibrillation.
e. Prepare the patient:
   - Shave, if necessary, except the eyebrows.
   - If lacerated, clean area with Betadine/Hibiclens and apply sterile gauze sponge.
   - Take history.

9. Procedure for taking care of valuables.
a. Valuables may be given to family if present.
b. If family is not present:
   - Valuables will be placed in specially provided envelope with items listed on the front of the envelope and put in the safe.
   - All valuables stored will be recorded in patient's chart.

10. Reporting: The ED nurse is responsible for the ED at all times and must report any incident of a serious nature as well as of the following:
a. Personnel threatened by patient or people accompanying them.
b. Attempted suicide.
c. Overflow patients requiring extra help.
d. Critical Values.
e. Any other unusual occurrence.

Disposition of the Emergency Department Record
1. Each patient treated in the Emergency Department will be appropriately dispositioned in the electronic health system, with all necessary assessments and other documentation completed.
2. A copy of the discharge instructions and a summary of the visit will be given to the patient at the time of discharge. The patient must also sign the discharge acknowledgment.

Procedure for admission of the patient to the hospital
1. The attending ED physician places an order for admission ~~io~~n ~~to~~ the patient's EHR.
2. The ED physician on duty, or clinic physician if they accept patient, assumes the responsibility for the admitted patient and will complete all needed documentation for admission and care of patient until ED shift changes or patient discharged.
3. Nursing staff in the ED will coordinate with Nurse Manager and nursing staff in the hospital to find suitable placement for new admission and transport patient appropriately to their new bed.
4. Money, valuables, and belongings are given to family of the patient, or secured in a patient Belongings envelope/bag and locked in a secure place. This storage must be documented in the EHR.
5. Nursing will fill out the Patient Admission half-sheet form, with the patient's admission information, admitting diagnosis, and room number, and deliver to the ED registrar on duty during business hours. If after-hours admission, form should be left in the registration inbox located in the ED.

Treatment of individuals on the premises
In the event a non-employee (e.g., visitor) is injured on District premises they shall be seen in the ED by the ED physician on duty (if the patient consents to treatment). The ED physician is to make a thorough examination and report of his findings. An incident report shall be filled out and a copy of the ED findings attached. This report should be submitted confidentially to the Chief Nursing Officer (CNO), or ED Nurse Manager.

Employee Injury/Illness
Employees who become ill/injured while on duty shall report to their manager immediately. Department Manager will reference the Human Resources Employee Injury Policy and take appropriate action as deemed necessary.

REFERENCES:
Consent Requirements for Medical Treatment of Minors. (2020). California Hospital association. https://calhospital.org/wp-content/uploads/2009/08/minorsquickreferenceguide.pdf

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HIM/PFS Team Lead
HIM/PFS Representative

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DEPARTMENT: Emergency Department	APPROVED:	Page 1 of 3
SUBJECT: **Initial Management of Amputations (Severed Extremities)**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/01/2020

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when initial management of amputations (severed extremities) are presented in the Emergency Department.

PURPOSE:
The purpose of this policy and procedure is to stabilizeation and limb preservation. Stump and amputated part vessels remain viable preoperatively.

Definitions (1,2)

- **Partial Amputation:** bone, muscle, or tissue keeps the amputated segment connected to the body.
  - Ideal treatment = revascularization
- **Complete Amputation:** no connecting tissue
  - Ideal treatment = re-implantation
- **Sharp/Guillotine Amputation:** Well-defined edges, minimal damage to associated anatomy.
  - Best prognosis for re-implantation
- **Crush Amputation:** extensive soft tissue & arterial damage
  - Re-implantation less likely to be successful.
- **Avulsion Amputation**: forceful overstretching & tearing of nerves & vascular tissue at many different levels from the site of separation.
  - Re-implantation unlikely

ED management is the same for ALL types of traumatic amputation => ALL patients are candidates for re-implantation until a surgeon says otherwise!

PROCEDURE:
The viability of the amputated limb depends on multiple factors, including the care delivered by all providers who come in contact with the patient. Knowing what not to do is as important as knowing what care to give. At any point, re-implantation may be made impossible with the wrong intervention.

STEPS:

1. Airway and ventilation problems recognized and controlled.
2. Major bleeding controlled by pressure and elevation of the affected extremity. Splint injured extremity.
3. Cardiac function evaluation.
4. Anticipate need for large bore IV for volume replacement. Obtain physician's order for same.
5. Anticipate antibiotic order. Check for allergies and sensitivities to same.
6. Inquire about current status of tetanus prophylaxis.
7. Keep patient NPO.
8. See standard for shock management.

SPIRITUAL/EMOTIONAL SUPPORT:
Give emotional support to patient and family and opportunity to express feelings of loss and disfigurement.

Care of the amputated segment (1,2,3)

- Irrigate with saline or sterile water & remove gross contamination.
- Remove all jewelry.
- Control any bleeding with a pressure dressing.
- Wrap in moistened sterile gauze & seal in water-tight container.
- Place container on ice, in ice water bath, or in refrigerator.
- Do NOT allow limb to freeze!

Care of the stump (2,4)

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- Elevate the limb.
- Irrigate with saline & cover with damp gauze.
- Splint obvious/unstable fractures, keep as near anatomic position as possible.
- Control hemorrhage!

Tourniquet Use

- Indications for tourniquet use (5,6)
  - Uncontrollable bleeding from a site amenable to proximal placement of a tourniquet.
  - Limb amputation or mangled extremity.
  - Exsanguinating wound associated with shock.
  - Life-threatening hemorrhage inadequately controlled with direct pressure, elevation and other hemostatic methods.
- Tourniquet application (5)
  - Place the tourniquet as distal as possible, at least 5 cm proximal to the injury.
  - Spare joints as much as possible.
  - Apply directly onto exposed skin.
  - Time of application should be recorded.
  - Any amputated limb should be transported with the patient to the hospital.

Remember Life over limb!

Other Considerations

- Tetanus prophylaxis
- Prophylactic antibiotics (2,7)
  - Strep & staph coverage
  - Should be given within 6 hours of trauma.
    - Cefuroxime 1.5g IV q8h or Cefazolin 0.5-1.5g IV or IM q6-8h
      - Peds: 25-100mg/kg/d divided q8hr (max 6g/d)
    - MRSA coverage: Vancomycin 15-20mg/kg IV q12h
    - Clostridia coverage: Piperacillin/Tazobactam 80mg/kg IV q8h
  - Immediate surgical consultation – orthopedics, plastics, vascular, trauma! Time is limb!

Traumatic amputation is a surgical emergency! Get the patient to a surgeon ASAP!

PHYSICIAN CONTACT:

California Pacific Medical Center- Davies Campus; Emergency Department, San Francisco, CA. Phone number; 415-600-0600

DOCUMENTATION:

1. Documentation of assessments, treatments, procedure(s).
2. Copy all pertinent medical data for transport protocol.
3. Transfer per Hospital Wide Transfer Protocol.

REFERENCES:

Meenach, Dean. (Apr 2014) "How to manage traumatic amputations and uncontrolled bleeding." *EMS In Focus.*

Schaider, J. (2015). Amputation Traumatic/Replantation. ROSEN & BARKIN'S 5-MINUTE EMERGENCY MEDICINE CONSULT.

Van Beek AL, Kutz JE, Zook EG. (1978). Importance of the ribbon sign, indicating unsuitability of the vessel, in replanting a finger. Plastic and Reconstructive Surgery, 61(1):32-5.

Stone, C. (2015). Traumatic Amputation. CURRENT ESSENTIALS OF EMERGENCY MEDICINE.

Lee C, Porter KM, Hodgetts TJ. (2017). Tourniquet use in the civilian prehospital setting. Emergency Medicine Journal, 24, 584-7.

Rush RM, Arrington ED, & Hsu JR. (2012). Management of complex extremity injuries: Tourniquets, compartment syndrome detection, fasciotomy, and amputation care. Surgical Clinics of North America, 92(4), 987-1007.

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Schmitt, SK. (2018). Treatment and prevention of osteomyelitis following trauma in adults. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA.

Microsurgery Unit at California Pacific Medical-Davies Campus, San Francisco, CA
Emergency Nurse Core Curriculum, 6th Edition, 2017

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: Medical Screening Exam and Treatment	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

~~Policy~~**POLICY:** It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure that all individuals presenting to the hospital or outpatient clinic for emergency services or care will receive a prompt Medical Screening Examination ("MSE") sufficient to determine whether an individual has an Emergency Medical Condition ("EMC"). The MSE will be conducted by either a physician or by individuals determined qualified by Medical Staff Rules and Regulations who are approved by the Governing Board.
Should any individual be found to have an EMC, that person will receive stabilizing treatment without being delayed for inquiry about insurance or payment methods. **No patient with an EMC will be refused care due to an inability to pay. No one shall be discriminated against because of race, religion, color, national origin, ancestry, physical handicap, marital status, age, or sex.**

Definitions:

A. "Emergency Medical Condition" ("EMC"): An acute medical condition manifesting itself by symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the individual (or, with respect to a pregnant woman or her unborn child) in serious ~~jeopardy;~~jeopardy.

2. With respect to a pregnant woman who is having contractions:

   - That there is inadequate time to ~~effect~~affect a safe transfer to another hospital before delivery, or
   - That the transfer may pose a threat to the health or safety of the woman or her unborn child.

3. Serious impairment to any bodily ~~functions;~~functions.

4. Serious dysfunction of any bodily organ or part.

B. "Medical Screening Exam" ("MSE"): An MSE is an ongoing and tiered process of increasingly complex medical evaluations to identify or rule out the existence of an EMC. A MSE will be provided to the extent of the capacity of the hospital's Emergency Room and will include ancillary services routinely available to the Emergency Room.

1. Any individual who presents to the ED and requests medical treatment must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and treatment.

2. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions, (see Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) Policy).

C. "Stabilizing Treatment": Patients with EMCs will receive medical treatment as necessary to assure, within reasonable medical probability, that no material deterioration to the condition is likely to result from, or occur during, the transfer; or with respect to a pregnant woman who is having contractions, that the woman has delivered the baby and the placenta.

1. Even if an individual arrives at Jerold Phelps Emergency Department, which is not designated as an on-call hospital within the community call plan, this hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability. There are no subspecialties available at this facility and thus we participate in the community call plan by stabilizing to the best of our ability and transferring patients to the closest appropriate facility.

PROCEDURE:

A. Upon entering ~~into~~ the Emergency Department, a patient requesting medical attention, will receive an initial MSE to rule out the existence or potential existence of an EMC.

B. The MSE will be conducted by a physician.

The initial Medical Screening Examination will consist of:

1. Assessment of chief complaint (complaint, at risk, or a true emergency)
2. Vital signs
3. Mental Status (evidence of change in mental status)
4. Skin (evidence of dehydration, poor perfusion)
5. Ability to walk
6. Focused physical exam (relative to the patient's chief complaint)

D. Documentation will consist of:

1. History and Physical Examination
2. Medically indicated screens, tests, mental status evaluations
3. Impressions and diagnoses (supported by a history and physical examination, laboratory, or other test results)
4. For obstetrical patients, evidence that the screening examination included the ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of the membranes
5. For psychiatric patients, documentation of suicide attempt or risk, and disorientation or assaultive behavior indicative of the need for emergency services.

E. Following the initial MSE, the physician will determine the disposition of the patient based on the following categorization:

1. EMC exists: This patient will be provided with immediate stabilizing treatment.

2. EMC potentially exists: This patient will receive further evaluation to rule out an EMC.

3. EMC does not exist. This patient will be seen in the Emergency Room or will be triaged to the clinic during clinic hours.

F. Should a patient refuse to consent to examination or stabilizing treatment the following steps shall be taken.

1. The provider will offer the patient further medical examination or stabilizing treatment

2. The provider informs the patient of the risks and benefits to the patient of the examination and treatment; and

3. The provider shall take all reasonable steps to secure the written informed refusal of the individual.

G. Should the patient request transfer to another hospital or care provider, refer to transfer policy/procedures.

REFERNCES:

-Bitterman,R.,FACEP, J.(1997).What is an "Appropriate" Medical Screening Examination Under COBRA?. Emergency/ED Legal Letter. https://www.reliasmedia.com/articles/37379-what-is-an-appropriate-medical-screening-examination-under-cobra

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EMTALA Fact Sheet.(2021). American College of Emergency Physicians. https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: **Observation Patients**	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

POLICY: It is the policy of the Southern Humboldt Community Healthcare District, ("district" or "SHCHD") to provide a period of time for the patient in the Emergency Room (ER) that can be used for definitive observation and care. Observation patients are either not sick enough for full admission or are still in process of being diagnosed.

PURPOSE:
The purpose of this policy is to ensure patients receive adequate care and treatment for the illness/injury they presented to the Emergency Department for which requires them to stay longer than 24 hours.

PROCEDURE:

1. The ER provider fills out pre-printed order sheet.
2. The ER provider and nursing staff determine if the patient will remain in the ER or go the Acute floor. If the patient moves to the Acute floor, the Acute care nurse will assume care for the patient.
3. Observation status requires a goal and reassessment throughout the patient's stay. There must be hourly charting done for patient in observation status.
4. The ER provider and nursing staff will ensure that patient has received the Medicare Outpatient Observation Notice (MOON form) for Medicare patients. Or the Outpatient Observation Notice (OON form) for non-Medicare patients, and that it has been signed and dated appropriately.
5. Observation Patients need to be admitted as Inpatients, transfer to a higher level of care, or discharge home after 48 hours of admission.

REFERENCES:

Departmen1" Of Health Miti h ur-..1an Services.(2013). Hospitals' Use of Observation Stays and Short Inpatient Stays. https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf

Dada, R. S., & Sule, A. A. (2019). Factors Affecting Length of Stay for Observation Patients. *Cureus*, *11*(4), e4547. https://doi.org/10.7759/cureus.4547

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DEPARTMENT: Emergency Department~~Services~~/EDAP	APPROVED:	Page 1 of 1
SUBJECT: **Pediatric Medication Safety**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide safe administration of medications to the pediatric patient. For the purposes of this section pediatric patients are defined as less than fourteen (14) years old and below fifty (50) kg in weight.

Purpose:

To safely administer medication to the pediatric patient.

Procedure:

1. Weight-based pediatric medication orders:
    a. All neonatal orders will be written as weight-based in kilograms. The order will contain the weight-based dosing parameter.
    b. All pediatric medication orders with the exception of the following will be written as weight-based. The order will contain the weight-based dosing parameter and the MD will calculate the specific dosage.
        - Vitamins and iron preparations
        - Topical preparations
        - Vaccines
        - Nebulized medication(s)

2. All pediatric medications, require an independent double check* by a second nurse, after the initial review process by the nurse administrating the medication has been completed. The second nurse practicing in their scope will review the order for accuracy, dosage calculation and medication appropriateness. If another nurse is not available, the provider or pharmacist will be contacted to complete the second check.

3. The nurse will review the current order and the eMAR at the patient's bedside:
    - Identify patient using the ~~two patient~~two-patient identifier process; name and date of birth
    - Check for allergies.
    - Compare medication to eMAR for right patient, right medication, right dose, right route and right time/frequency.
    - Document the actual administration time at "point of care."

4. The nurse will remain with the patient until the medication is taken. Medications are not left at the bedside. For pediatric patients, parents may give oral medications in the RN or LVN's presence.

5. If the patient or patient's guardian refuses the medication, the nurse will return the unopened/unused medication to the appropriate medication drawer and document on the eMAR as "not given."

References:

Benjamin, L., Frush, K. et al. (2018 March). *Pediatric Medication Safety in the Emergency Department.* American Academy of Pediatrics: Committee on Pediatric Emergency Medicine and American College of Emergency Physicians. 141 (3) e20174066

Smith,S., Duell, D. and Martin, B. (2018). Clinical Nursing Skills, Basic to Advanced Skills, 7th edition Pearson Education, Inc. Upper Saddle River, New Jersey, 07258. Chapter 28, pp 1070- 1127

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DEPARTMENT: Emergency Department~~Services~~/EDAP	APPROVED:	Page 1 of 1
SUBJECT: **Pediatric Standards of Care**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 03/24/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) to make sure that nursing staff will follow approved protocol in caring for pediatric cases.

PURPOSE:

The purpose of this policy is to ensure quality care is given for the pediatric patient.

Procedure:

A. Blood pressure is required on all pediatric patients over 10 years old or on any pediatric patient whose chief complaint warrants initial vital signs.

B. Weights are to be taken and recorded in kg on all children.

C. Temperatures are to be obtained on all pediatric patients, either, rectally, tympanic, orally. Axillary temps are not to be taken. Rectal temps will be assessed on all patients less than 5 years of age.

D. Special supplies needed to treat the pediatric patient are to be kept in the Emergency Department at all times. This includes but is not limited to the following:
   1. Pediatric paddles for the defibrillator
   2. Pediatric laryngoscope blades
   3. Pediatric airways, suction tubing and equipment
   4. Pediatric 0_2 masks and ambu bag
   5. Pediatric splints
   6. Pediatric lumbar puncture tray
   7. Pediatric chest tubes
   8. Broslow tape is kept on the pediatric crash cart listing dosages for emergency drugs for the pediatric patient based on length and weight.
   9. Pediatric patients requiring specialized intensive care services will be transferred to an appropriate pediatric hospital

References:

Moore, B., Shah,M., Owusu-Ansah,S., Gross,T., Brown, K., Gausche-Hill, M., Remick, K., Adelgais,K., Lyng, J.,Rappaport, L., Snow,S., Wright-Johnson, C., Leonard, J.(2020). Pediatric Readiness in Emergency Medical Services Systems. Official Journal of the American Academy of Pediatrics.https://doi.org/10.1542/peds.2019-3307.
https://apastyle.apa.org/style-grammar-guidelines/references/examples/journal-article-references#1 (Pediatrics January 2020, 145 (1) e20193307; DOI: https://doi.org/10.1542/peds.2019-3307)

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: **Pelvic Exams in the Emergency Department**	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

POLICY: It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when assisting with pelvic exams.

PURPOSE:
The purpose of this policy and procedure is to outline guidelines to assist the emergency room provider with a pelvic exam. All providers need a chaperone.

PROCEDURE:

Set up equipment for a Standard Vaginal Exam Tray:

- Lubrication (use warm water for evidentiary collections)
- Speculum
- Light
- Culture
- Large cotton swab
- Wet mount prep (Tube with sterile NS)
- G/C & Chlamydia Swab
- Provider Gloves

Provide the patient with a drape or blanket for comfort.

Explain procedure to patient, provide screening, drape sheet and remind patient to empty bladder prior to exam if possible and collect urine sample for any possible testing.

Assist patient to dorsal recumbent or lithotomy position as required by physician, assist patient with foot stirrups if lithotomy position is used.

Encourage patient to use deep breathing for relaxation of pelvic muscles during exam. Offer comfort to patient during any painful or uncomfortable procedures.

Assist physician when needed, with culture, swabbing, or lab tests.

After exam, assist patient to sitting position, provide warm water and cloth for cleansing perineum.

REFERENCES:
Banas DA, Cromer BA, Santana M, Worley SE, Bena JF, McIntyre SL, Rome ES. Comparison of clinical evaluation of genitourinary symptoms in female adolescents among primary care versus emergency department physicians. J Pediatr Adolesc Gynecol. 2010 Apr;23(2):71-6. doi: 10.1016/j.jpag.2009.05.010. Epub 2009 Jul 29. PMID: 19643640.

Brown, J., Fleming, R., Aristzabel, J., & Gishta, R. (2011). Does pelvic exam in the emergency department add useful information?. *The western journal of emergency medicine*, *12*(2), 208–212.

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: **Penetrating Injuries**	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

Policy: It is the policy of the Southern Humboldt Community Healthcare District that all gunshot and stab wounds are reportable incidents to law enforcement, following California Penal Code #11160. Forensic considerations include careful documentation of patient's condition with accurate description of injury, careful removal of clothing, evidence handling and disposition of bullets, weapons.

Purpose: To ensure the following in a patient with trauma resulting from stab wounds and gunshot wounds: local bleeding controlled (hypovolemic shock avoided by adequate fluid volume), wound cleansed and prepared, reduction or elimination of pain, appropriate reporting to law enforcement agencies and appropriate handling of evidence.

Procedure:

ASSESSMENTS/OBSERVATIONS:

Stab Wounds

1. With penetrating chest and abdominal injuries, watch for respiratory insufficiency.
2. Obtain data on length/size of weapon.
3. Check neurovascular status of affected limbs.
4. Check for arterial injury with continued bleeding and hypovolemic shock.
5. Document time elapsed since injury.

Gunshot Wounds

1. Look for entrance and exit wounds.
2. Find out type of gun and bullet caliber, if possible, distance from victim and time elapsed.
3. Assess for bleeding/hypovolemic shock.
4. Check for pulses and neurovascular status.

INTERVENTIONS:

1. Notify physician immediately of patient condition upon arrival.
2. Control active bleeding by direct pressure, maintain circulation, airway, and breathing status.
3. Establish (2) large bore IV's.
4. Monitor neurovascular status upon arrival and every two hours.
5. Don't attempt to remove if there is an impaled object, instead stabilize and secure the object.
6. Administer analgesia as order by physician.
7. Assist with debriding, irrigating, removal of missile and closing procedures as needed, or prepare patient for surgery.
8. Notify appropriate law enforcement agency and complete a Suspicious Injury Form.
9. Do not give patient's name or circumstances to anyone except immediate family; consider registering as a confidential patient.
10. Anticipate administration of IV antibiotics and tetanus immunization.
11. Bag clothing removed in paper bags and preserve for evidence collection.
12. Bag patient hands in cases of gunshot wound when circumstances are unknown.

DOCUMENTATION:
Initial assessment, as described, and all interventions performed with outcomes. Document notification of law enforcement and disposition of all evidence in the nurse's notes and indicate there is supplemental documentation in the Secondary Assessment. Document the officer's name and the case or CAD number on the Suspicious Injury Report.

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EMOTIONAL/FAMILY SUPPORT:
Attempt to decrease patient/family's anxiety by explaining procedures and interventions. With physician approval, allow calm significant others to accompany patient in treatment area. Notify clergy/social services as appropriate.

PATIENT EDUCATION:
If patient is discharged, instruct on proper wound care and provide instructions using discharge sheet.

REFERENCES:

Lotfollahzadeh S, Burns B. Penetrating Abdominal Trauma. [Updated 2020 Dec 1]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459123/

Cuthbert, D., Bucher,J., (2017). Penetrating Wounds in the Emergency Department: Considerations for Management. emDocs. http://www.emdocs.net/penetrating-wounds-emergency-department-considerations-management/

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 1
SUBJECT: ~~Post Mortem~~Postmortem Care – Coroner Cases	EFFECTIVE DATE: 03/24/2020	SUPERCEDES: 07/28/2021

Policy:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow when there is a death in the facility.

Purpose:

The purpose of this policy is to provide procedures to Emergency Department staff to follow in postmortem cases.

Procedure:

1. Contact the attending physician or the physician on-call to make the pronouncement of death.
2. Contact the patient's family or designated person(s).
3. Contact the County Coroner for all Coroner cases:
   - All DOAs.
   - Death without medical attendance.
   - Death during continued absence of physician (7 days).
   - Where attending physician is unable to state cause of death.
   - In suspected cases of Sudden Infant Death.
   - Where patient has been in hospital less than 24 hours.
   - Where the deceased patient was killed or committed suicide.
   - Where the deceased patient dies as a result of an accident.
   - Under circumstances affording reasonable grounds to suspect death was caused by the criminal act of another.
   - When in doubt, report the case.
4. Leave identification band on the body.
5. Collect patient's possessions and valuables and give to the family member or designated person(s), including all medications except controlled substances. Controlled substances should be placed in the drug room in pharmacist's locked box with controlled drug record.
6. If not a Coroner's case, contact the mortuary of the family's preference.
7. Make body presentable. Remove all IVs and tubes, except in Coroner cases – leave everything as is.
8. Notify mortuary of any contagious or infectious disease they would need to take precautions for when caring for the body. A body bag may be placed on the body as a precaution as needed.
9. Complete the **Consent to Release of Body** form. The person entitled to control the disposition of the remains must sign this form. If unable to have form signed by the next of kin who are present in the hospital, consent by telephone with a witness is adequate.
10. The mortuary director, or his designated representative, receiving the body must complete the **Consent to Release of Body** form.
11. Have physician who pronounced the death sign the death certificate prior to release of the body, if possible. If it is a Coroner case, the physician does not sign the death ~~certificate~~certificate, nor does he solicit autopsy permit or order an autopsy without permission of the Coroner.
12. Contact the organ/tissue donation center to report all deaths, regardless of age or morbidity: 1-800-55-DONOR.
13. Send **Dismissal Slip** to admitting, **Dietary Communication** slip to dietary, and document death and time on the census sheet.

References:

California Legislative Information. (2016). California Code; Government Code- GOV 27491; GOV 27491.4. Corner to inquire of all violent, sudden, or unusual deaths. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=27491

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Chief Nursing Officer
ED/Acute Nurse Manager
Skilled Nursing Manager
Medical Director

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
~~SUBJECT:~~ **Emergency Department Precipitous Delivery Procedure**	~~EFFECTIVE DATE:~~ **07/28/2021**	~~SUPERSEDES:~~ **08/01/2020**

POLICY: It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to transfer patients to the nearest most appropriate Childbirth Center when indicated, or to provide successful delivery of infant in the Emergency Department when delivery is imminent. If the patient is crowning, and there is insufficient time to transport the patient to the Childbirth Center, the delivery is controlled by the ED physician following the standard delivery process. Both mother and infant are cared for in a safe manner while taking measures to prevent any complications.

PURPOSE:
The purpose of this policy is to provide a procedure for a safe delivery in the case of imminent childbirth in the Emergency Department setting.

EQUIPMENT AND LOCATION:
The OB packs are secured in the Emergency Department on the bottom shelf of the metal rack in room two. The infant warming unit is obtained from the changing room ~~the room on the acute floor located by the old birthing room and environmental services~~across the hall from the Emergency Department.

PROCEDURE:

1. Notify the receiving Childbirth Center of imminent delivery.

2. Obtain history on patient including prenatal care, EDC, gravidity and parity, drug/alcohol use and HIV status/GBS.

3. Prepare for imminent delivery if the fetal head is visible at the introitus, or if the woman is multigravida, is completely dilated with sudden rupture of the membranes, and complains of rectal pressure.

4. Care of the mother:
   - Maintain CAB, start large bore IV.
   - Assist physician with delivery process as necessary.
   - Provide breathing instructions, avoiding expulsive pushing. Panting may be encouraged.
   - Note time of delivery.
   - Collect 10cc of cord blood (two tall, 6cc, red top tubes located in the lab) to be sent with mother and infant to the Childbirth Center.
   - Monitor for postpartum hemorrhage (blood loss >500cc).
   - Anticipate administration of IM Oxytocin (10 units IM).
   - Perform fundal massage as ordered by physician.
   - Include family/significant others in process, providing emotional support.

5. Care of the infant (as directed by the attending):
   - Check for cord around neck and gently remove, if present.
   - Suction infant's nose and airway immediately upon presentation with a bulb syringe.
   - Assist with clamping and cutting the cord after it has stopped pulsating.
   - Dry infant and place on top of mother, allowing for breastfeeding and bonding
   - Perform **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, and **R**espiration or **APGAR Score** at 1 minute and 5 minute intervals. See table on next page.

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Sign	SCORE		
	0	1	2
Colour	Blue or pale grey	Pink body, blue extremities	Pink all over
Heartbeat	Absent	Less than 100 beats/minute	More than 100 beats/minute
Respiration	Absent	Slow, irregular, gasping	Normal
Grimace (response to stimuli)	None	Grimace (slight)	Cry
Activity (muscle tone)	Limp	Some flexion of extremities	Active motion

- Keep infant warm with blankets and infant warmer.
- Baby is banded immediately after delivery to match bracelet of mother.
- Treat newborn eyes with Erythromycin ointment within 2 hours after birth, after eye contact between mother and baby has been established.
- Weigh and measure infant.
- Check cord for bleeding every 15 minutes x 3, then every 2 hours.
- Notify the physician of any of the following:

a. Grunting, flaring, retractions or abnormal cyanosis.
b. APGAR less than 7 at one minute or less than 8 at ten minutes.
c. Birth weight of less than 5 pounds or greater than 9 pounds.

- Initiate breast feeding at mother's request as soon as possible after birth.
- Support parents in touching and holding infant.
- Assist as necessary with infant feeding technique.

6. After the delivery, and when the mother and newborn are stable, notify the Childbirth Center of transfer of mother and infant to their location.

REFERENCES:

Beaird Dt, Ladd M, Kahwaji Ci. Ems Prehospital Deliveries. [Updated 2020 Dec 27]. In: Statpearls [Internet]. Treasure Island (Fl): Statpearls Publishing; 2021 Jan-. Available From: Https://Www.Ncbi.Nlm.Nih.Gov/Books/Nbk525996/

Justin Morgenstern, "Precipitous Delivery In The Ed", First10em Blog, March 7, 2015. Available At: Https://First10em.Com/Precipitous-Delivery-In-The-Ed/.

Threatening & Imminent Delivery. (2013). Saint Joseph's Hospital, Eureka. Print.

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DEPARTMENT: Emergency Department~~Services~~	APPROVED:	Page 1 of 3
SUBJECT: **Procedural Sedation**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 08/01/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide guidelines for procedural sedation. This policy is to provide all patients receiving in any setting, for any purpose, by any route, procedural sedation as defined in this policy. The organization currently defines two (2) levels of procedural sedation:

A. **Minimal sedation (anxiolysis)** – a drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

B. **Moderate sedation/analgesia ("conscious sedation")** – a drug induced depression of consciousness during which patients respond purposefully to verbal commands (Note: Reflex withdrawal from a painful stimulus is not considered a purposeful response), either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Pediatrics:

A pediatric patient is defined as anyone under the age of 14 and/or up to the age of 21 at the Physician's discretion.

This policy does not apply to medications used for the management of pain control, seizures, pre-operative mediations, or medication given to an intubated patient on a ventilator.

Purpose:

The purpose of this policy and procedure is to provide guidelines for appropriate monitoring of patients receiving procedural sedation before and after the procedure.

Procedure:

Before Sedation:

A. Obtain Informed Consent.

B. Bring up conscious sedation flow sheet in the EMR (electronic medical record).

C. Document allergies and weight.

D. **NPO Status:** (Nothing by mouth) Evaluate recent food/fluid intake. (The use of sedation must be preceded by an evaluation of food and fluid intake. Since protective airway reflexes can be lost, gastric contents may be regurgitated into the airway. Therefore, patients with a history of recent oral intake or with known risk factors, such as trauma, decreased level of consciousness, extreme obesity, pregnancy, or bowel motility dysfunction, require careful evaluation before administration of sedatives. If possible, such patients may benefit from delaying the procedure and administering appropriate pharmacologic treatment to reduce gastric volume and increase gastric P~~p~~H. When proper fasting has not been assured, the increased risks of sedation must be carefully weighed against its benefits, and the lightest effective sedation should be used. An emergency patient may require protection of the airway before sedation (intubation).

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1. The following NPO guidelines apply for otherwise healthy patients:
   a. Patients less than 2 years old - may take solids and formula up to 6 hours prior to ~~surgery~~the procedure, may take human milk up to 4 hours prior to surgery, and may take clear liquids up to 2 hours before procedure.
   b. Patients greater than 2 years old - may take clear liquids up to 4 hours before procedure and may have a light meal up to 6 hours before procedure.

2. Documentation of the time of the last oral intake. Variations in these guidelines may be indicated because of the patient's clinical presentation.

E. **Equipment needed before sedation:**

1. Have appropriate sized Ambu bag and mask ready to go.
2. Oxygen (2L NC on patient) and suction at bedside/
3. Have all emergency equipment, including reversal drugs and defibrillator available.
4. Obtain baseline vital signs (continuous pulse oximeter and blood pressure monitor) and pre-procedure cardiac monitoring strip.
5. IV or saline lock in place when indicated.

During Sedation/Treatment:

A. Use **Procedural Sedation Flow Sheet**
B. Continuous monitoring of O2 saturation by oximetry, heart rate, blood pressure and respiration rate every 15 minutes.
C. Document all treatments and medications as they are done.

Significant changes to be reported immediately by the registered nurse to the attending practitioner:

1. Heart rate changes:
   a. Adult: +/- 20% change from baseline; < 60 or > 100 beats per minute
   b. Pediatric: +/- 20% change from baseline
2. Oxygen saturation changes:
   a. Adult: - 10% drop and/or saturation < 92%
   b. Pediatric: -5% drop and/or saturation < 92%
3. Level of consciousness changes or if the patient cannot be aroused
4. Tissue perfusion changes with cyanosis, mottled skin or clamminess.
5. Infants with a history of apnea, those born prematurely (less than 37 weeks gestation) who are less than 60 weeks post conceptual age, or full-term newborns less than 44 weeks post-conceptual age are monitored for 12 hours following moderate sedation. The degree of monitoring post-procedure is determined by measures of appropriate discharge criteria from the department in which the procedure occurred.

Personnel Requirements:

A. All procedural sedation must be administered under the direct supervision of a licensed physician practitioner who holds clinical privileges for the level of procedural sedation that is being administered.
B. A qualified registered nurse or qualified physician must have the primary responsibility for medication administration and monitoring the patient's vital signs and level of consciousness during the administration of procedural sedation.
C. The registered nurse administering medication, monitoring, or recovering the patient receiving procedural sedation must demonstrate current competence, as evidenced by completion current ACLS & PALS certification and demonstrated competency in the following areas:
   1. Airway Management
   2. Cardiac Monitoring and arrhythmia recognition
   3. Use of sedation and reversal agents
   4. Oxygen therapy
   5. The ability to intervene in the event of complications
   6. Procedural Sedation hospital-wide policy

If administering sedation to a pediatric patient, PALS or NRP certification is required.

Vital signs pre-procedure; then q15 minutes during procedure; then q30 minutes post-procedure until discharge criteria is met

After Treatment:

A. Continuous monitoring and vital signs every 30 minutes until patient meets discharge criteria as stated on **Procedural Sedation Flow Sheet**.

Discharge Criteria (all must be present before discharge)

- Cardiovascular function within normal limits (vital signs stable, SaO2 WNL).
- Patient's protective reflexes are present and patient is alert and oriented x 3.
- Patient can ambulate unaided without difficulty.
- A Discharge & Procedural Sedation Instructions given and patient verbalizes understanding of them.

B. Obtain physician order for discharge.

C. Discharge with appropriate instruction form.

REFERENCES:

American College of Emergency Physicians; Policy Statement; Procedural Sedation in the Emergency Department; *A joint policy statement of the American College of Emergency Physicians and the Emergency Nurses Association;* Copyright © 2017 American College of Emergency Physicians. Retrieved 3/2/2020 from https://www.acep.org/globalassets/new-pdfs/policy-statements/procedural.sedation.in.the.ed.pdf

Nettina, S. M. (2018). *Lippincott manual of nursing practice* (11th ed.). Lippincott Williams and Wilkins.

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: **Referrals from the Emergency Department**	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

Policy: It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide appropriate referrals to patients who have been seen in the Emergency Department (ED).

Purpose:
The purpose of this policy and procedure is to delineate the procedures for obtaining referrals through the ED.

Procedure:
1. *Non-urgent referrals* can be done through the ED. If the ED physician feels that a referral is needed, he/she will instruct the patient, via the Discharge Instructions, on how the referral process works.

2. *Urgent referrals,* those that should be done within 72 hours should be done as needed in the ED.

3. The following steps should be taken for all referrals out of the ED:

   a. The ED physician will document that there is no Emergency Medical Condition (EMC) present indicating that the patient is "stable" (per EMTALA) and a *referral*, rather than a *transfer*, is appropriate.

   b. The ~~nurse will have the~~ physician will enter~~fill out~~ the referral ~~form and give a copy of the referral form to the patient~~within Epic.

   c. ~~The form will be put with the patient's paper chart to be scanned to the patient's electronic chart by Health Information Management.~~The Referrals Coordinator will retrieve the referral from within Epic to process.

   d. ~~A copy of all referrals will go in the "referrals" folder that is located in the ED to the right of the nurse's station. The Referrals Coordinator will check the folder daily for referrals~~.

   e. The nurse will document that a referral was made in the Emergency Department in the nurses' notes section of the patient's Electronic Medical Record.

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DEPARTMENT: ED/Acute Care	APPROVED:	Page 1 of 1
SUBJECT: EFFECTIVE DATE: **Stroke Policy and Procedure**	SUPERSEDES: **07/28/2021**	**01/31/2019**

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide optimal patient care and the following procedures for the staff to follow using an evidence-based approach to treat and care for patients who present with signs and symptoms consistent with acute stoke. Although these guidelines assist in guiding the care of the patient, responsibility to determine appropriate care for each individual remains with the provider themselves.

PURPOSE:
The purpose of this policy and procedure is to provide guidelines for the care of patients with signs and symptoms of acute stroke.

P~~ROCEDURE~~ROCEDURE:

OUTCOMES/GOALS	1. Rapid Identification of Stoke 2. Manage patient appropriately and efficiently 3. Evaluate in a cost-effective manner
TRIAGE/REGISTRATION	• Document Chief Complaint such as sudden onset of weakness, numbness, difficulty speaking, vision changes, severe headache, and dizziness. • Screen for suspected stoke using the NIHSS stroke screen and swallow study. If one positive finding and onset was less than 12 hours prior, then level for ESI Level 1 or 2 per patient condition. • If onset is greater than 12 hours or symptoms have resolved, and patient's ~~is~~ ABCs are stable then the triage level ESI Level 3 is applied. May upgrade as needed. • Registration should be done at bedside.
RN	Notify doctor, CT, and lab to anticipate STOKE orders. Anticipate Orders for: CT without contrast Labs for CBC, CMP, PT/INR, aPTT, serum HCG female less than 50 Obtain capillary blood glucose 12 lead EKG CXR (chest X-ray) if indicated
ED PHYSICIAN	If symptom onset was less than 12 hours prior to visit, evaluate for suspected stroke within **10** minutes of patient arrival. • ORDER STAT HEAD-CT without contrast. • LABS: CBC with diff, INR, PTT, POC troponin, POC Chem 8. • Order STAT tele-neuro consult if NIHSS > 6. If NIHSS is greater than 6 then order a STAT CTA. CTA for patients who could be candidates to bridge from IV tPA to intra-arterial intervention- DO NOT DELAY tPA TO COMPLETE THE CTA] **If the patient has a significant neurological deficit (i.e. NIHSS > 6) and/or CTA demonstrates proximal vessel occlusion, the patient needs neurointerventional and needs to be transferred STAT.** • Obtain and read 12 lead EKG within 45 minutes of patient arrival. Obtain CXR as needed.

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	• Obtain patient History including age, time of onset (when last seen normal), duration, type of symptoms, medications (antiplatelets and anti-coagulants), past medical HX, previous strokes/TIA, illicit drug use • Exam: NIH Stroke Scale to document visual fields, extraocular muscles, speech impairment, weakness or sensory deficits, incoordination, ataxia
ED NURSE	a. Establish 2 IV sites, including stat 20 or 18 gauge antecubital IV for CTA (ideally on right), start 0.9% NS 250- 500 cc bolus followed by NS @ 80 cc/hour b. Cardiac monitor, pulse oximeter, continuous vital signs c. 12 lead EKG and CXR after CT – unless experiencing chest pain d. Clinical evaluation for active illicit drug use (toxicology screen) or ETOH intoxication e. Obtain **patient weight** early f. Notify manager early regarding potential tPA preparation.
ACUTE/SWING INPATIENT	**For those patients with a suspected stroke while hospitalized:** 1. Alert the ED physician and nurse. 2. Stat bedside glucose 3. Stat Head CT, CTA if NIHSS > 6 4. Place order for IV tPA- notify Manager 5. Order stat stroke labs 6. tPA approved by ED physician. tPA can be given by the ED nurse or a nurse with critical care licensing. 7. Transfer patient to ED for tele-neuro and better observation 8. Establish 2 IV sites, including stat 18 or 20 gauge antecubital for CTA, start 0.9% NS 250 cc bolus followed by NS @ at 80 ml/hour 9. Cardiac monitor, pulse oximeter, monitor vital signs 10. Initiate transfer **Once tPA has been started –** **Do not perform for 24 hours post tPA unless procedure is life-saving:** • Arterial or central venous punctures/lines, IM injections, nasogastric tubes, Foley catheters • Place the patient on anticoagulation precautions until 24 hours after the infusion • Do not give any antithrombotic drugs (including heparin, warfarin, aspirin, clopidogrel, dipyridamole, ticlopidine, or NSAIDS) x 24hrs

ADMINISTRATION OF ACTIVASE (TPA), ED NURSE AND MD RESPONSIBILITIES	**Administration**
	• After speaking with tele-neuro or neurologist at accepting hospital, administer IV tPA with ED physician order and manager being aware.
	• Administer tPA in monitored setting (emergency room) Bolus may be given on floor for in-house strokes as long as critical care or ED nurse is present
	• Mix a 100 mg tPA vial with 100 cc NS- 1ml=1mg
	• Weight should be on file for all patients being admitted. Use weight to calculate dose. Should be done once by physician and then by nurse.
	• Calculate TOTAL tPA DOSE: 0.9 mg per kg (not to exceed 90 mg total dose)
	  ○ Give 10% as IV bolus over 1 minute
	  ○ Give other 90% as IV infusion over 60 minutes – infuse 50 ml NS after dose to flush medication
	• Vital signs and neuro-checks at least every 15 min for first 2 hours, including NIHSS scores, which must be documented and a swallow screening.
	• Treat systolic BP if it rises to >180 mm Hg or diastolic BP >105 mm Hg for more than 15 minutes Pause infusion while BP is being controlled.
	• Avoid BP decrease <160/ 85 mm Hg
	• Notify physician immediately if SBP/DBP greater than 175/100
	• Do not insert Foley catheter or nasogastric tube unless ordered

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- Document hourly neurologic reassessment (more frequently if changes occur)
- ED physician: Calculate IV tPA dose based on weight estimate and tPA dosing table: Document estimated weight; Review with nursing staff to ensure accuracy Confirm BP within safe limits Write order for tPA total dose as a bolus plus infusion Administer the 10% bolus over 1 minute and document time on ED medication order sheet.
- Repeat NIHSS evaluation if patient exam has changed significantly Strict control of blood pressure for 24 hours.
- The patient remains under the care of the ED until officially transferred to accepting facility.

tPA Dosing (estimated weight)

Estimated Weight (lbs)	Conversion to Kilograms (Kg)	Total iv t-PA Dose (mg) at 0.9 mg/kg	t-PA Bolus (mg) *10% of total*	t-PA Bolus (ml)	Discard Dose t-PA (Not for infusion)	Infusion Dose (mg)	Infusion Rate (ml/hr)
220+	100.0	90.0	9.0	9.0	10.0	81.0	81.0
210	95.5	85.9	8.6	8.6	14.1	77.3	77.3
200	90.9	81.8	8.2	8.2	18.2	73.6	73.6
190	86.4	77.7	7.8	7.8	22.3	70.0	70.0
180	81.8	73.6	7.4	7.4	26.4	66.3	66.3
170	77.3	69.5	7.0	7.0	30.5	62.6	62.6
160	72.7	65.5	6.5	6.5	34.5	58.9	58.9
150	68.2	61.4	6.1	6.1	38.6	55.2	55.2
140	63.6	57.3	5.7	5.7	42.7	51.5	51.5
130	59.1	53.2	5.3	5.3	46.8	47.9	47.9
120	54.5	49.1	4.9	4.9	50.9	44.2	44.2
110	50.0	45.0	4.5	4.5	55.0	40.5	40.5
100	45.5	40.9	4.1	4.1	59.1	36.8	36.8

Monitoring:

1. Blood pressure monitoring:
    a. During the first 24 hours after tPA, monitor BP:
        - Every 15 minutes for 2 hours after starting the infusion, then
        - Every 30 minutes for 6 hours, then
        - Every 60 minutes until 24 hours after starting treatment 3
    b. If systolic blood pressure is >180 mmHg or if diastolic blood pressure is >105 mmHg for 2 or more readings 5 to 10 minutes apart, the following is recommended:
        - **First tier intervention**: Give IV labetalol 10 mg over 1 to 2 minutes. Labetalol may be repeated up to 3 doses every 10 to 20 minutes (doubling doses if needed depending on effect of preceding dose; eg. 1st dose- 10mg, 2nd dose- 20mg, 3rd dose- 40mg, then consider drip)
            - For heart rate<60/minute, use hydralazine 5-20mg intravenous over 1-2 minutes every 20-30 minutes. After second bolus, consider second line intervention
            - Monitor blood pressure and neurologic exam every 15 minutes during treatment and observe for development of hypotension for all 3 tiers of BP interventions

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- **Second tier intervention:** If 3 doses of labetalol or hydralazine bolus or 30 minutes pass without sufficient BP control, the next step should be a nicardipine drip
- **Third tier intervention:** If nicardipine drip fails, then the next step should be a labetalol drip

****To avoid worsening of cerebral ischemia, target BP of 155-175/85-100**.

- Use 0.9% NS **only**, as needed (avoid hypotonic solutions). Initiate fluid hydration in the ED with 250-500 cc bolus followed by 80 cc per hour, except in those patients who have a contraindication (pulmonary edema, renal failure, known CHF)

5. Further management as directed by tele-neuro or accepting neurologist

Intravenous tPA in Acute Ischemic Stroke
Approved FDA use for ***LESS* than 3.0 hours from initial symptoms**

Off-label use for *3 to 4.5 hours (see additional warnings below – requires consent)*

A. Indications

- For patients with NEW symptomatic ischemic stroke with clearly defined *Last Known Well* < 3 hours
- Age 18 or more
- Patient evaluated by tele-neurology and physician, and tPA approved by ED attending (via phone or in person)

B. Contraindications

- CT scan findings of intracranial hemorrhage or major acute infarct (> 1/3 cerebral hemisphere)
- Suspicion of subarachnoid hemorrhage (even if head CT is negative for hemorrhage)
- Significant head trauma or prior stroke in the past 3 months
- Intracranial or intra-spinal surgery within the past 3 months
- History of previous intracranial hemorrhage or large (>10mm) brain aneurysm, vascular malformation or intraparenchymal brain tumor
- Arterial puncture at non-compressible site in previous 7 days
- Known bleeding diathesis **OR**
    1. Current use of oral anticoagulants with INR > 1.7 or PT > 15 seconds
    2. Use of heparin within 48 hours preceding onset of stroke AND prolonged aPTT at time of presentation. Low molecular weight heparin use (i.e.- Lovenox) in the past 24 hours.
    3. If suspected abnormal platelet counts and platelets <100,000
    4. Active internal hemorrhage
    5. Novel oral anticoagulant use in the past 48 hours. If last dose >48 hours, confirm normal renal function [creatinine clearance >50 mL/min] and normal coagulation [aPTT, INR, platelet count, thrombin time or appropriate factor Xa activity assays] before tPA administration.
- Persistent systolic BP >185 mm Hg or diastolic BP >110 mm Hg despite treatment.

- **Patients treated within 3-4.5 hour window warnings**
    - **Age > 80**
    - **Any anticoagulant use (even if INR < 1.7)**
    - **NIHSSS > 25**
    - **History of stroke AND diabetes**

C. Warnings (risks must be weighed against anticipated benefits)

- MI within last 3 months (with normal TTE)
- Current use of oral anticoagulants with INR > 1.5 or PT > 15 seconds
- Major surgery or serious trauma within previous 2 weeks, consider surgical site hemorrhage risk
- Non-disabling, or ~~rapidly improving~~rapidly improving symptoms
- High likelihood of left heart thrombus
- Aortic dissection
- Small or moderate-sized intracranial aneurysm (<10 mm) or vascular malformation. Consider for severe neurologic deficits and disabling symptoms.
- Severe neurological deficit (NIH stroke scale score >22)
- Seizure at symptom onset, particularly with head trauma
- History of IVDU and/or suspicion for endocarditis
- Tox-screen positive for ETOH, cocaine, opiates, or amphetamines (if available, but should not delay tPA protocol)

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- Subacute bacterial endocarditis
- Acute pericarditis
- History of hemorrhagic diabetic retinopathy
- Significant hepatic dysfunction with abnormal INR
- Pregnancy
- Sickle cell disease
- Internal hemorrhage (e.g., GI or urinary tract) < 3 weeks
- Blood glucose < 50 mg/dL

D. Not a contraindication

- Current aspirin, NSAID or antiplatelet drugs (dipyridamole, ticlopidine, clopidogrel)
- History of PUD (not currently active [>3 months])

Treatment of patients who sustain a hemorrhage soon after IV t-PA administration

- STAT call to physician and order for standard labs, check fibrinogen
- Cryoprecipitate 10 units
- Consider aminocaproic acid or tranexamic acid
- Consider platelet transfusion (6-8 units) if available
- Consider FFP transfusion

Last Known Norm	**Blood Glucose**: _____(PTA)_____ **(on-site)** (result) (result)		
Arrival to ED	**Weight in Kg by Scale:**	✓ *Check* or *Time*	**Notes**
Compliance Targets	**Code Stroke Protocol Initiated**		
≤5 min	• Physician, lab and CT called		
	• Code Stroke Panel ordered		
	• Tele-Neuro called or consult		
≤10 min	• MD rapid assessment and NIHSS Assessment		
≤15 min	• Tele-Neurologist or consult responded/case discussed		
	In CT Room		
≤15-25 min	• IV access *(do not delay CT for IV access)*		
	• Labs drawn (*before* scan) *(notify MD if greater than 5 min delay)*		
≤30 min	• CT and CTA scans completed		
	Return to Unit		
	• RN enters wt, ht, and allergies into EMR		
	• **Full** NIH Stroke Scale (physician/RN)		
	• Confirm O2 Saturation greater than 92%. Oxygen at 2-4L by nasal cannula if SpO2 less than 92%		
≤45 min	• NPO until RN Swallow Screen Result:____ *(do **NOT** delay alteplase for Swallow Screen)*		
	• 2nd IV access *(do **NOT** delay alteplase for access)*		
	• ECG, 12-lead *(do **NOT** delay alteplase for ECG)*		
	• CXR *(do **NOT** delay alteplase for CXR)*		
	Thrombolytic Decision Support		
≤55 min	• CT Scan formal reading resulted		
	• PT/INR and platelets resulted		

Time	**RN Init**	**Medication/Tx**
		Oxygen 4L/min, titrate to maintain SpO2 greater than 92%
		IV Normal Saline at 80mL/hr

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	If Thrombolytic (alteplase) to be Given:				
≤55 min	• alteplase order either 1) **entered electronically by MD** OR 2) written order delivered. Confirm dose done by MD and nurse. 0.9mg/kg dosing. 1st 10% bolus				2nd IV Normal Saline Lock
					ASA 300 PR if patient NPO
	• Manager or Physician called for 2nd witness		**Code Stroke called at _____ or alteplase bolus given at_____**		
	• Confirm SBP less than or equal to 185mm Hg, DBP less than or equal to 110 mm Hg				
	• *Only if indicated in next 24 hours*, foley placed *(do **NOT** delay alteplase for foley cath)*				
	• Confirm **verbal** informed consent for alteplase. Get signed consent if possible.				
	• NIHSS by RNs @ care transfer with vitals				
60 min Target:	• **alteplase bolus administered →**		Patient Label		

RN Signature: _____

RN Initials_____

Date_____**Time**_____ _____ **MD** _____

Signature_____

REFERENCES:

Albers GW, Amarenco P, Easton JD, Sacco RL, Teal P. Antithrombotic and thrombolytic therapy for ischemic stroke: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest. 2004 Sep; 126(3 Suppl):483S-512S.

American Heart Association. Guidelines for Cardiopulmonary Resuscitation Emergency Cardiovascular Care. Circulation. 2010, 102 (suppl I): I-210-384.

De Smedt A, De Raedt S, Nieboer K, De Keyser J, Brouns R. Intravenous thrombolysis with recombinant tissue plasminogen activator in a stroke patient treated with dabigatran. Cerebrovasc Dis. 2010; 30:533–534

De Silva DA, Manzano JJ, Chang HM, Wong MC. Reconsidering recent myocardial infarction as a contraindication for IV stroke thrombolysis.<http://www.ncbi.nlm.nih.gov/pubmed/21490319> Neurology 2011;76:1838-40

del Zoppo G, Saver J, Jauch EC, et al. Expansion of the Time Window for Treatment of Acute Ischemic Stroke With Intravenous Tissue Plasminogen Activator. A Science Advisory From the American Heart Association/American Stroke Association. Stroke 2009; 40: 2945.

Jauch, et al. Guidelines for the early management of patients with acute ischemic stroke. Stroke. 2013; 44:870-947

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DEPARTMENT: Acute and Emergency Departments	APPROVED:	Page 1 of 2
SUBJECT: **Suicide Risk Screening and Suicide Precautions**	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 01/2016

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") to be committed to providing a safe environment for patients, students, visitors, and employees. Early identification of patients at risk for suicide is a first step in providing reasonable care and intervention.

PURPOSE:
The purpose of this policy and procedure is to provide necessary safety and health care to patients for whom a reasonable possibility of suicide or danger to others exist.

PROCEDURE:

1. The admitting physician is responsible for assessing the patient's risk for attempting suicide while they are a patient in the facility. If the patient is found to have active suicidal ideation defined as: an existing wish to die accompanied by a plan for how to carry out the death, suicide precautions shall be followed while caring for the patient.

    a. The clinical staff providing care for the patient will document whether or not a patient is presenting with emotional, behavioral, substance and/or alcohol abuse. If a patient appears to present with any of these problems, clinical staff will complete a CIWA (Clinical Institute for Alcohol Withdrawal), a (COWS) clinical opiate withdrawal scale and the psychiatric suicidal assessment at least every 2 hours unless a need to have them completed sooner is necessary.
    b. If the provider or psychiatric assessment indicate the patient has current thoughts of self-harm with a plan, clinical staff will initiate a 5150 (72-hour Involuntary Hold) procedures.
    c. Arrangements for transfer to a psychiatric receiving facility will follow Southern Humboldt Community Healthcare District's 5150 policy and procedure.

2. Implementing Suicide Precautions in Inpatient, Emergency Department and Procedure Areas (Radiology)

    a. Suicide precautions will be implemented immediately once the need is determined. Staff should inform patient that these precautions are being taken in their best interest.
    b. A physician's written order for suicide precautions will be obtained within (2) hours of implementation of suicide precautions.
    c. A physicians order is required for discontinuation of suicide precautions.

3. **Suicide Precautions include:**

    a. Modifications of the patient's environment to increase safety. (Refer to Suicide Risk Safety Checklist and Guideline)
    b. The patient, his/her belongings and assigned room must be as free as possible, of harmful objects. Patients will be placed in hospital gowns with all clothing, jewelry, wallets and phones stored away with a patient sticker on all bags or items. All items will be documented in the patient chart.
    c. All lockers, refrigerators and Carts will be locked. Remove any and all sharp items or cords from monitoring systems unless necessary for medical care.
    d. If the patient needs to use a phone, the patient can write down any numbers from their phone and use the hospital phone while being monitored.
    e. Patients are informed of the need for staff to search their person and their belongings in order to protect the patient from objects that might be potentially harmful. All objects removed from the patient (i.e., scissors, razors, matches, belt) are itemized in the nurses' notes and given to family or next of kin.
    f. Only cordless electric razors are permitted for the patient's use.

g. The patient's visitors are greeted by the staff and informed that potentially harmful gifts (i.e., glass, scissors, and razors) are not to be given to the patient. All safety measures are carried out in a respectful, informative manner in order to minimize the patient's and visitors potential discomfort.
h. Continuous observation by designated staff with documentation every 30 minutes (with no time lapse greater than 30 minutes) including but not limited to level of anxiety, patient activity, treatment plan and/or agitation. Any changes should include a new CIWA, COWS and/or psychiatric assessment.
i. If the patient needs to be transported off the unit, he/she will be accompanied by a tech and/or nurse.
j. When a patient is in the bathroom or shower, a qualified staff will maintain observation.
k. Order a SAFE MEAL TRAY. A Safe Meal Tray which includes: paper plates, plastic ware, no knife, straw and napkin and the tray is to be checked by the RN/LVN/CAN/EMT for unsafe items.
l. Inspect the patient's mouth after administering medication in tablet form to ensure patient has swallowed it. Liquid concentrates preferable.

4. Discharge

a. All patients being discharged from 5150 or those seeking mental health referrals MUST be provided the DHHS (Dept. of Health and Human Services) resource list for Humboldt County for follow up care.
b. Patients who are being discharged should have a final mental health assessment submitted into Healthland prior to discharge.
c. Upon discharge: document any family or friends that will assume responsibility for the patient.
d. Discharge the patient with proper documentation including the advice to consult psychiatrist, mental health clinic and/or primary care physician as well as patient received mental health resource list.
e. Document all items returned to patient and have them sign for them in the logbook that is kept in the locker for 5150 patients.

5. Related SHCHD Policies, Procedures and Resources
72-Hour Involuntary Hold (5150) and Checklist for a Safe Environment

References:
EMS North Coast Emergency Medical Services. "FAQs about 5150 Holds." 22, June 2018.
Joint Commission Standards BoosterPak for Suicide Risk (NPSG.15.01.01). October 2018.
Mitchell, A., Garand, K., Dean, D., Panzak, G., and Taylor, M. (2005). "Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction." *Top Emerg Med.* 2005 Octover; 27 (4): 302-312.
Peate,I. and McGrory, C. "Performing searches on patients: a practical guide." *British Journal of Heathcare Assistants, 2009 Nov.,* 3 (11): 556-58.

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DEPARTMENT: EMERGENCY Department~~SERVICES~~/EDAP	APPROVED:	Page 1 of 4
SUBJECT: ED TRIAGE POLICY	EFFECTIVE DATE: 07/28/2021	SUPERCEDES: 3/28/13

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) to ensure that individuals coming to the hospital for emergency services be evaluated by a triage-qualified Registered Nurse (RN) utilizing the Emergency Severity Index (ESI) Five-Level Triage System.

PROCEDURE:

A. Upon entering ~~into~~ the Emergency Department (ED), a patient will receive an initial triage screening to identify life-threatening conditions and prioritize patients according to acuity.
B. The following steps should occur when making a triage decision:
    1. Determine chief complaint.
    2. Patients requiring immediate life-saving interventions or high-risk patients do not require a detailed physical assessment or a full set of vital signs, in most cases.
    3. Physical examination relative to the patient's chief complaint.
C. Following the initial triage in the ED, the ED nurse will determine the disposition of the triage level based on the following algorithm:
D. Only the assessment necessary to accurately assign a triage level based on the ESI system should be performed in triage and the patient properly assigned to a location.
E. Interventions as defined in the SHCHD ED protocols are to be initiated based on the RN patient assessment.
F. The ESI five-level triage system is based as follows:

ESI Triage Level 1 **Is The Patient Dying?** **Requires Immediate Live-saving Intervention:** **Airway, emergency medications, or other hemodynamic interventions**	**The ESI level-1 patient always presents to the emergency department with an unstable condition. These patients will be taken immediately to the treatment area, the physician is at the bedside and nursing is providing intensive care.** **Examples:** • Intubated pre-hospital • Cardiac Arrest • Respiratory Arrest • Sever Respiratory Distress • SpO_2 <90 • Critically injured trauma patient who presents unresponsive • Overdose with respiratory rate of 6 or less • Severe respiratory distress with agonal or gasping-type respirations • Severe bradycardia or tachycardia with signs of hypoperfusion • Hypotension with signs of hypoperfusion • Trauma patient who requires immediate crystalloid and colloid resuscitation • Chest pain, pale, diaphoretic, blood pressure 70/palp • Weak and dizzy, heart rate=30 • Anaphylactic reaction • Baby that is flaccid • Hypoglycemia with a change in mental status

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	• Unresponsive with a strong odor of ETOH Unresponsiveness is defined as a patient that is either: 1. nonverbal and not following commands (acutely); or 2. Requires noxious stimulus (P or U on AVPU scale). Psychiatric complaint: 1. All suicidal patients 2. Actively hallucinating/hearing voices 3. Delusional and agitated 4. Potential danger to self or others 5. Paranoid

ESI Triage Level 2 **Should the Patient Wait?** **Is this a high-risk situation?** **Or** **Is the patient confused, lethargic or disoriented?** **Or** **Is the patient in sever pain or distress?**	**The ESI level-2 patient is one whose condition could easily deteriorate or who presents with symptoms suggestive of a condition requiring time-sensitive treatment. This is a patient who has a potential major life or organ threat.** **Examples:** • Active chest pain, suspicious for coronary syndrome, stable • History of angioplasty with chest pain, stable vital signs • Severe asthma • Acute epiglottitis • Signs of a stroke, but does not meet Level-1 criteria • Headache, fever, lethargy, rash. Rule out meningitis. • Sudden onset of a headache, no history of headaches • An immunocompromised patient, with a fever. On chemotherapy or post organ transplant or on waiting list • A needle stick in a health care worker • Abdominal pain in the elderly • Gastrointestinal bleeding • Acute arterial occlusion • Signs and symptoms of compartment syndrome • Extremity injury with neurovascular compromise • Testicular torsion, sudden onset of pain • Acute renal failure, unable to be dialyzed • A rule-out ectopic pregnancy, hemodynamically stable • Spontaneous abortion, bleeding and tachycardia with stable blood pressure

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	• Pediatric with vomiting, diarrhea, unable to eat. Exhibiting sunken fontanel, poor skin turgor, lethargy • Pediatric asthma attack with nasal flaring or use of intercostals • Infant less than 28 days with a fever of 100.4°F or 38°C, or greater • Motor vehicle crash with transient loss of consciousness • Stab wound to groin, bleeding controlled, stable vital signs • Sexual assault • Acute urinary retention, in severe distress • Trauma to the eye, sudden partial or full loss of vision, or chemical splash to the eye Psychiatric complaint 1. Panic attack 2. Depressed-no suicidal ideation 3. Intoxicated-cooperative, ambulatory 4. Drug withdrawal

ESI Triage Levels 3,4 and 5 will be based on the number of resources needed to reach a disposition

Labs (blood, urine)	History & physical (including pelvic)
ECG, X-rays CT-MRI-Ultrasound	Point-of-care testing
IV fluid (hydration)	Saline or heplock
IV, IM, or nebulized Medications	PO medications Tetanus immunization Prescription refills
Specialty consultation	Phone call to PCP
Simple procedure=1 (lac repair, Foley cath)	Simple wound care (dressings, recheck)
Complex procedure=2 (conscious sedation)	Crutches, splints, slings

ESI Triage Level 3	**<u>The ESI level-3 patient presents in stable condition. These patients will require 2 or more resources for the clinician to arrive at a disposition.</u>** **<u>Examples:</u>** • Abdominal pain • Chronic migraine headache Procedures requiring conscious sedation 1. Vermilion border laceration 2. Displaced fracture requiring closed reduction prior to splinting Psychiatric complaint

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	1. Anxious-no acute distress 2. Request for medication refill

ESI Triage Level 4	**The ESI level-4 patient presents in stable condition. These patients will require only 1 resource for the clinician to arrive at a disposition.** **Examples:** • Wound requiring incision and drainage • Simple laceration • Urinary tract infection symptoms • Simple extremity injury requiring x-ray

ESI Triage Level 5	**The ESI level-5 patient presents in stable condition. These patients will require no resources for the clinician to arrive at a disposition** **Example:** • Prescription refills • Poison ivy • Dental pain • Ear infection • Routine physical exam

G. IF A PATIENT REFUSES TO CONSENT TO EXAMINATION OR STABILIZING TREATMENT:
1. The Nurse will encourage the patient to receive further medical examination and stabilizing treatment.
2. The Nurse will inform the patient of the risks and benefits of refusal to receive examination and treatment.
3. The Nurse shall take all reasonable steps to secure the written informed refusal of the individual.
4. Should the patient request a transfer to another hospital or care provider.

REFERENCES:

Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care; Version 4. Agency for Healthcare Research and Quality; Advancing Excellence in Healthcare; retrieved 3/2/2020 from: www.ahrq.gov

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DEPARTMENT: Emergency Department	APPROVED:	Page 1
SUBJECT: Valuables and Personal Effects in the Emergency Department	EFFECTIVE DATE: 07/28/2021	SUPERSEDES: 08/01/2020

Policy:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) that it does not assume responsibility for valuables kept by the patient, nor for the loss or damage of personal belongings not deposited in a hospital valuables envelope. Personal effects will be placed in a "belongings" bag and labeled with the patient's identification. Valuables will be bagged, labeled with the patient's identification, and locked at the Nurses' station if patient is unconscious, no relatives are present, or if the patient expires.

PROCEDURE:

1. For the alert, conscious, non-critical patient, personal belongings are placed in a labeled bag or envelope and kept with the patient and are the patient's responsibility. If the patient is sent to x-ray, property is kept with the patient on the cart, wheelchair, or hand carried.

2. If the patient is unconscious and no relatives are present, valuables should be inventoried by two nursing staff members, bagged, labeled and locked in the double lock drawer in the Emergency Room. This should be noted on the patient's chart.

3. Medications brought from home that are not approved for patient use shall be sent home with the patient's family member or designee. If the medications cannot be removed from the Emergency Department by the patient's family or designee, the medications should be treated and stored as valuables.

4. If the patient is admitted to the hospital:

   a. All effects are placed in a labeled bag and returned to the patient.

5. All valuables should be returned to the family or locked at the Nurses' Station and so noted on the patient's chart.

6. If the patient is transferred to another facility:

   a. All effects are placed in a labeled bag and given to the family or the ambulance attendants.

   b. All valuables should be returned to the family or locked at the Nurses' Station and so noted on the patient's chart.

7. If the patient is dead on arrival (DOA) or expires, the personal effects and valuables are given to the family except in a coroner's case. In a coroner's case the personal effects are labeled and given to the coroner. In each instance the disposal of the personal effects is noted on the patient's chart.

8. If the patient is in custody of the Humboldt County Sheriff or California Highway Patrol:

   a. All belongings shall be placed in a "belongings" bag and labeled.

   b. The personal belongings shall be released to the Humboldt County Sheriff Deputy or the California Highway Patrol Officer and so noted on the Emergency Room record.

References:

Perney, S. P., Croce, B. C., & Anderson, J. A. (2004). Healthcare security and emergency management. The newsletter of disaster planning, crime and loss prevention, Vol. 3(No. 9), 6–9. https://www.hcpro.com/content/41759.pdf

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