



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Department:	Emergency Department
Policy Name:	Helipad
Policy Number	678-41
Effective Date:	May 2013
Approved by:	Nancy Pitcock

Policy Origin Date: 5/07

Policy Statement: St. Vincent Anderson Regional Hospital in collaboration with PHI Air Medical, also operating under the name Stat Flight will provide a safe environment for patients, staff and crew members while performing operational missions and training.

Definitions:

1. St. Vincent Anderson Regional Hospital Heli-stop is located on the roof of the Emergency Department and does not include a hangar or fueling station. Securing of the PHI Air Medical aircraft at the Heli-stop shall be in accordance with existing PHI Air Medical policies.
2. All PHI Air Medical flight crew members and hospital staff who will be accessing the heli-stop must have documented training on how to activate the fire foam suppression system in the event of an aircraft fire and manual activation is required.
3. PHI Air Medical flight crew members operate under Saint Vincent Hospital Supervising Hospital Certification under the license of their designated medical director.
4. Heli-stop access is strictly limited to person(s) that have received training pertinent to the operations and safety of a rotor wing aircraft. This training will be conducted and documented by the PHI Air Medical Staff and kept in the associates files by the manager of the department.
5. Person(s) assisting the flight crew with the loading or unloading of a patient will do so **only at the request** of the PHI Air Medical staff based on their need and assessment of the transport conditions. At no time shall any person(s) be allowed to approach or enter a PHI Air Medical aircraft unless accompanied by an authorized PHI Air Medical employee. Hospital staff shall remain in the heli-stop entryway with the patient until the flight crew is ready to escort them to and from the aircraft.
6. A minimum portable 20-lb Ansul cartridge fire-extinguisher will be kept in the upstairs elevator access area and readily accessible at all times. Personnel must be trained on the use of this extinguisher prior to assisting with any patient loading procedure.
7. In the event of a catastrophic event, such as a crash involving the aircraft while on the heli-stop, no hospital personnel should attempt to approach the aircraft for any reason until all parts of the aircraft have come to a complete stop.

8. Daily checks of the hospital gurney being utilized for patient transport onto the heli-stop shall be checked and documented by the PHI Air Medical staff to ensure that the O2 source has no less than 500 lbs of oxygen available with an appropriate regulator featuring a 50 psi port.
9. Daily inspection of the St. Vincent Anderson Regional Hospital heli-stop and surrounding area will be performed by PHI Air Medical flight crew members to look for debris or any other materials that may cause a safety hazard to the aircraft. Deficiencies with pad or walkway lighting, pad surface or heli-stop structure, or the surrounding structural lighting must be reported immediately to Saint John's Health System Engineering department at 646-8271.
10. Elevator and stairwell access will be kept locked at all times to prevent emergency department patients or visitors from entering and accidentally gaining access to the roof. Keys must be kept secure by flight crew members at all times. Loss of these keys must be reported to the PHI Air Medical base manager and St. Vincent Anderson Regional Hospital Security for replacement.

TRAINING:

1. PHI Air Medical staff shall conduct training for hospital associates who will be accessing the heli-stop. The training will be done on an annual basis and additionally at the request of the hospital. The training will include but is not limited to:
 - a. Loading and unloading procedures
 - b. ELT activation
 - c. Fuel spill procedures
 - d. Fire safety procedures
 - e. Emergency shut down of the aircraft
 - f. Use of Ansul cartridge fire extinguisher
2. Documentation of all training provided to Saint. John's associates will be given to hospital management for the purposes of their recordkeeping. Scheduling of heli-stop safety classes will be done through the base safety representative.





St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Trauma Operating Room Response and Equipment

St. Vincent Anderson Regional Hospital's Operating Room (OR) is committed to providing the highest level of surgical care to trauma patients by providing staffing twenty four (24) hours a day three hundred and sixty five (365) days a year. A surgical call team with a 30 minute response time will be available during those times when an in-house team is not available. Anesthesia coverage will be provided under the same parameters.

The available OR trauma supplies and equipment are as follows:

- Case carts with sterile supplies and instrument trays
 - Exploratory laparoscopy
 - Exploratory laparotomy
 - C-section
 - Chest trauma
- Level 1 Rapid Infuser
- Neptune high capacity suction machine
- We also have mobile carts with specialty supplies for emergency procedures for the following specialties:
 - Neurosurgery
 - Vascular
 - Urology
- Hotline fluid warmers
- Bair Hugger
- Multiple instruments in sets or single wrapped or peel pack to allow adapting surgical set-up to accommodate all surgical procedures.
- Cautery
- Crash cart with defibrillator and external pacing
- Fracture table
- Orthopedic major and minor instrumentation



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Surgery Scope of Care

The main Operating Room (OR) serves all who present in need of care. This is a diverse population including newborns, infants, adolescents, adults, and geriatric patients of varying ethnicity representing many cultures and religious affiliations. Care is provided for trauma, cardiovascular, orthopedics including total joints, urology, neurological, gynecological, thoracic, ear, nose, throat, arthroscopy, EGD and colonoscopy, and general surgery.

The Surgery Department is committed to:

- Provision of high quality surgical care as evidenced by patient outcomes.
- Provision of patient centered care that addresses the patients' physical and spiritual needs.
- Provision of cost effective surgical care through supply acquisition utilizing Ascension supply chain vendor contracts.
- Provision of associate education to insure highly trained personnel in all Registered Nurse and Certified Surgical Technologist roles for all surgical procedures.
- Provision of a safe environment for all patients and surgical associates through ongoing monitoring of the facility and processes.
- Facilitate continual improvements through collaborative efforts including all care delivery partners.
- Standardize all processes for improved efficiency and cost effectiveness utilizing LEAN principles.

Leadership:

Surgical Services is managed by Nursing in a collaborative relationship with Surgeon and Anesthesia leadership. The surgical department consists of Pre-Admission Testing (PAT), Pre-Operative Services, the Operating Room (OR), Post Anesthesia Care Unit (PACU), Phase 2 Recovery, and Sterile Processing. The six (6) OR rooms in the main operating suite provides services twenty-four (24) hours a day three hundred and sixty five (365) days a year.

Staffing:

Surgery Services department associates include Schedulers, a Senior Administrative Assistant, Multi-Task Technicians (MTT), Certified Surgical Technologists (CST), Licensed Practical Nurse (LPN), Registered Nurse (RN), Practice Facilitator (PF), and Director Perioperative Services.

After initial scheduling of a procedure by the Surgeon or his designee the patient is contact by PAT associates to obtain a Health Assessment History (HAH). This patient health information is reviewed by Anesthesia prior to the day of surgery. On the day of surgery the patient is admitted to the Pre-Operative Services area and an RN conducts a re-assessment of the patients health status. Nurse to Patient ratios are determined by patient condition and need. Unit staffing varies daily and is dependent on number of procedures scheduled, type and complexity of procedures scheduled, skillset of assigned associates, and other patient factors identified by the pre-admission process. The Practice Facilitator and Director Perioperative Services make staffing assignments collaboratively. Supplemental staffing is provided through utilization of on-call or overtime hours.

Surgical Services utilizes the AORN Standards and Recommended Practices, ASPAN Standards, SGNA Standards, and AMMI Standards as the basis for our care delivery. We use the PNDS as the standard

language for perioperative nursing practice and education. We utilize this standard language for all patient care documentation.

Perioperative Nursing staffing includes:

<u>Department</u>	<u>Position</u>	<u>Hours</u>	<u>FTE</u>
Sterile Processing	Manager	Variable/Salaried	1.0
	Team Lead	0600-1430	1.0
	Team Lead	1400-2230	1.0
	Team Lead	2200-0630	1.0
	Instrument Tech	0700-1530	3.0
	Instrument Tech	1500-2330	3.0
	Instrument Tech	2300-0730	2.0
		Total FTE	12.0
Surgery Services	Director	Variable/Salaried	1.0
	Practice Facilitator	Variable/Hourly	2.0
	RN	Variable/Hourly	16.9
	RN	On-Call/Salaried	1.0
	CST	Variable/Hourly	5.5
	MTT	Variable/Hourly	3.0
	Senior Administrative Assistant	0730-1600	1.0
	Scheduler	0830-1700	1.5
		Total FTE	32.9

Associate Job Requirements:

<u>Position</u>	<u>Requirement</u>
RN	Current Indiana license
LPN	Current Indiana license
CST	Certification
MTT	High school diploma/GED
Senior Administrative Assistant	High school diploma/GED
Scheduler	High school diploma/GED

- All associates are required to complete annual competencies and mandatory education through the SEED web-based training.
- All associates receive annual performance appraisals including success plans if need is indicated.
- All associates attend infection control program annually.
- All associates attend annual safety training.
- All patient care personnel will maintain BLS certification.
- Patient care RN's are ACLS and PALS certified.
- All associates must receive Flu shot annually.

Professional Practice:

Our professional practice model is *Relationship-Based Care*. This model is supported by a council structure that includes resources for research, nursing practice, quality, education, and leadership. The core of this structure is the Unit Based Councils. In Surgery Services the Practice Council consists of RN, CST, MTT, Nursing Educator, and leadership representatives. This Council is chaired by an RN representative and has shared decision-making responsibility regarding practice issues within the care delivery setting.

The Surgery Department and organization provides an environment wherein nurses have a decision-making voice regarding practice, quality, and safety of nursing care as delivered to our patients. Outcomes are measured utilizing Nurse-sensitive indicators as described by the National Database for Nursing Quality Indicators, the HCAHPS survey database, patient satisfaction scores as provided by Professional Research Consultants, Inc., and by internal associate satisfaction surveys.

Performance Improvement:

The Surgery Department uses a combination of performance improvement processes. All patient care events and near misses are reviewed to identify areas of potential intervention through process improvement, training, or associate accountability. Process improvement concerns are addressed by a combination of the Practice Council and leadership. The OR Educator and leadership address training issues. Leadership addresses accountability issues. Ad hoc members of the Practice Council include all interdisciplinary partners who collaboratively support care delivery.

The Surgery Department conducts daily Safety Huddles. All associates are invited to attend to present concerns related to care delivery, safety, or patient satisfaction. Sterile Processing and TriMedx have daily representation to present any equipment or instrumentation concerns related to patient care delivery.

Daily walk-through of the clinical areas to identify patient care delivery or safety concerns are conducted by leadership and weekly rounding is conducted by a collaborative group including Quality, Infection Control, Environmental Services, Engineering, and Supply Chain on a rotating basis.

Competency Assurance Plan

Annual competencies are identified each year and designated for mandatory completion by associates. These competencies are ranked using a high risk/low volume, high risk/high volume, problem-prone priority system to assure that appropriate skills are maintained. Examples: Fire safety, malignant hyperthermia.

- I. Overview: Competency assessment is an ongoing process that assures that every associate remains competent in their area of expertise through their employment. Quality delivery of care is dependent on every member of the surgical team being competent in all aspects of their contribution to patient care delivery.
- II. Definition: Com.pe.tence – (noun: competency) the ability to do something successfully or efficiently. (synonyms: capability, ability, proficiency, expertise, skill, prowess, mastery)
- III. Responsibility: Department leadership maintains responsibility for assuring the competency of all department associates. Competencies are assessed by department Director, Educator, Practice Facilitators, preceptors, and all experienced staff.
 - Each associate is accountable for insuring his/her own individual competency through participation in continuous educational opportunities and staying informed of current, relevant professional issues and scientific advances in their area of expertise.
 - CSTs will complete and document CEUs required to maintain certification.
- IV. Mechanisms: Mechanisms used to assure competence.
 - Licensure/Certification

- Hospital orientation
 - Unit specific orientation
 - Job competency checklist
 - Annual competency checklist
 - Population served competency
 - In-service education
 - Continuing education
 - Annual mandatory education
- V. Annual competency assurance:
- Annual skills assessment
 - Associate learning needs survey
 - Supply Chain inventory changes
 - Technology updates
 - Changes in laws and/or regulations
 - Changes in professional Standards and Recommendations.
 - High risk/low volume procedures
 - High risk/high volume procedures
 - Problem prone procedures
 - Patient satisfaction indicators
 - Critical incident indicators
 - Safety event indicators
 - Mission effectiveness
 - Fiscal responsibility



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Surgery Department Call Coverage

Purpose:

To provide coverage for non-staffed hours in Surgery Services and to supplement staffing to accommodate add-on and emergency procedures.

Area:

Pre-Admission Testing, Pre-Operative Admissions Unit, Operating Room, Post Anesthesia Care Unit, and Sterile Processing.

Guidelines:

- All associates agree to accept call as part of their employment.
- Orienteer will be assigned buddy call with their preceptor beginning immediately upon hire.
- Individual call will be assigned upon completion of orientation.
- Response time for call is twenty (20) minutes.

Compensation:

- Refer to Human Resources compensation policies.

Pagers:

- Pagers will be provided for all individuals who are assigned call.

Call assignments:

- OR
 - Call 1 – RN
 - Call 2 – CST
 - Call 3 – CST
 - Call 4 – RN
 - Administrative call – RN (Director, Manager, Practice Facilitator)
 - Hours
 - Sunday – Friday 7p-7a
 - Saturday 7a-7a
 - Sunday 7a-7p
- PACU
 - Call 1 – RN
 - Call 2 – RN
 - Sunday – Friday 7p-7a
 - Saturday 7a-7a
 - Sunday 7a-7p
- Endoscopy
 - Call 1 – RN
 - Call 2 – RN
 - Sunday – Friday 7p-7a
 - Saturday 7a-7a
 - Sunday 7a-7p
- Holiday call coverage will be assigned on a rotating basis. Holiday coverage will be comparable to Saturday coverage and will be compensated consistent to Human Resources policy.

Call Rotation:

- Call will be assigned equally to all individuals within their job classification.
- Call will not be assigned during approved vacations.
- When on military duty, maternity leave, educational seminars, and Leave of Absence volunteers will be sought first. If no volunteers shift will be assigned on equal rotating basis.
- Call shifts may only be traded to individual with same skillset.
- Call-off for assigned shift – individual who covers shift will have option of having their next assigned call shift reassigned to individual who called off.



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Commitment of Anesthesia Services

Anesthesiology Services at St. Vincent Anderson Regional Hospital are committed to providing care to the injured patient by ensuring an anesthesiologist is on call and promptly available twenty four hour (24) hours per day. An anesthesiologist liaison has been designated to the Trauma Program and will attend at least 50 % of the multidisciplinary peer review meetings.

9/30/13

AbdulRahman Kahif, M.D.
Chief of Anesthesia Services
St. Vincent Anderson Regional Hospital

St. Vincent Anderson Regional Hospital

September 2013 Anesthesia Call Schedule

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	2	3	4	5	6	7	8
Call	Alexandrov	Brown	Aslam	Brown	Ingersoll	Rahman	Aslam
Back up		Brown	Ingersoll	Vu	Aslam		Aslam
Locum							
Vacation							
Off							
	9	10	11	12	13	14	15
Call	Vu	Alexandrov	Brown	Ingersoll	Rahman	Aslam	Aslam
Back up	Brown	Ingersoll	Rahman	Vu	Alexandrov		Aslam
Locum							
Vacation							
Off							
	16	17	18	19	20	21	22
Call	Alexandrov	Brown	Ingersoll	Rahman	Aslam	Vu	Vu
Back up	Ingersoll	Rahman	Aslam	Alexandrov	Brown		3
Locum							
Vacation							
Off							
	23	24	25	26	27	28	29
Call	Brown	Ingersoll	Rahman	Aslam	Vu	Brown Alexandrov	Brown Alexandrov
Back up	Rahman	Aslam	Vu	Brown	Ingersoll		
Locum							
Vacation							
Off							
	30						
Call	Ingersoll						
Back up	Aslam						
Locum							
Vacation							
Off							

October 2013 Anesthesia Call Schedule

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
		1	2	3	4	5	6
Call		Rahman	Aslam	Vu	Brown Alexandrov	Alex Brown	Alex Brown
Back up		Vu	Alexandrov	Ingersoll	Rahman		5
Locum					Aslam		
Vacation							
Off							
	7	8	9	10	11	12	13
Call	Rahman	Aslam	Vu	Alexandrov	Alex Brown	Brown Ingersoll	Brown Ingersoll
Back up	Vu	Alexandrov	Brown	Rahman			6
Locum					Kush		
Vacation							
Off							
	14	15	16	17	18	19	20
Call	Aslam	Vu	Alexandrov	Brown	Ingersoll	Rahman	Rahman
Back up	Alexandrov	Brown	Ingersoll	Aslam	Vu		1
Locum				Kush			
Vacation							
Off							
	21	22	23	24	25	26	27
Call	Vu	Alexandrov	Brown	Ingersoll	Aslam Aslam	Aslam	Aslam
Back up	Alex Brown	Ingersoll	Rahman	Vu	Brown Alexandrov		2
Locum							
Vacation							
Off							
	28	29	30	31			
Call	Alexandrov	Brown	Ingersoll	Rahman			
Back up	Ingersoll	Rahman	Aslam	Alexandrov			
Locum		Aslam					
Vacation							
Off							

November 2013 Anesthesia Call Schedule

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
					1	2	3
Call					Aslam	Vu	Vu
Back up					Brown		3
Locum							
Vacation							
Off							
	4	5	6	7	8	9	10
Call	Brown	Ingersoll	Rahman	Aslam	Vu	Alexandrov	Alexandrov
Back up	Rahman	Aslam	Vu	Brown	Ingersoll		4
Locum							
Vacation							
Off							
	11	12	13	14	15	16	17
Call	Ingersoll	Rahman <i>Alex</i>	Aslam	Vu	Alexandrov	Rahman	Rahman
						(for Nov 30 & Dec 1)	
Back up	Aslam	Vu	Alexandrov	Ingersoll	Brown		5
Locum							
Vacation							
Off							
	18	19	20	21	22	23	24
Call	Ingersoll	Aslam	Vu	Alexandrov	Rahman	Ingersoll	Ingersoll
	*				*		
Back up	Vu	Alexandrov	Rahman	Brown	Aslam		6
Locum							
Vacation							
Off							
	25	26	27	28	29	30	1-Dec
Call	Aslam	Vu	Alexandrov <i>Kash</i>	Brown	Brown	Brown	Brown
					*	(for Nov 16 & 17)	
Back up	Vu	Ingersoll	Aslam				1
Locum							
Vacation							
Off							

December 2013 Anesthesia Call Schedule

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	2	3	4	5	6	7	8
Call	Vu	Alexandrov	Brown	Ingersoll	Rahman	Aslam	Aslam
Back up	Brown	Ingersoll	Rahman	Vu	Alexandrov		2
Locum							
Vacation							
Off							
	9	10	11	12	13	14	15
Call	Alexandrov	Brown	Vu (for Jan 1)	Rahman	Aslam	Vu	Vu
Back up	Ingersoll	Rahman	Aslam	Alexandrov	Brown		3
Locum							
Vacation							
Off							
	16	17	18	19	20	21	22
Call	Brown	Ingersoll	Rahman	Aslam	Vu	Alexandrov	Alexandrov
Back up	Rahman	Aslam	Vu	Brown	Ingersoll		4
Locum							
Vacation							
Off							
	23	24	25	26	27	28	29
Call	Aslam (for Dec 31)	Rahman	Rahman (for Dec 30)	Vu	Alexandrov	Brown	Brown
Back up	Ingersoll			Alexandrov	Aslam		5
Locum							
Vacation							
Off							
	30	31	1-Jan	2-Jan	3-Jan	4-Jan	5-Jan
Call	Aslam (for Dec 25)	Ingersoll (for Dec 23)	Ingersoll (for Dec 11)	Alexandrov	Brown	Ingersoll	Ingersoll
Back up	Alexandrov	Aslam		Vu	Rahman		6
Locum							
Vacation							
Off							



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Critical Care Physician Coverage

The Critical Care physicians at St. Vincent Anderson Regional Hospital are committed to providing care to the injured patient and are in house or promptly available twenty four hours a day. Care of the critically injured patient is continuously evaluated through the Performance Improvement and Patient Safety Program.

Joseph C. Baer, FACS
Trauma Medical Director
St. Vincent Anderson Regional Hospital

9/20/13

Date

David C. Mares, MD
Chief of Inpatient Medicine
St. Vincent Anderson Regional Hospital

9-24-2013

Date

Medical Specialists of Madison Co., P.C.
 Thomas Bright, MD, David Mares, MD, Pablo Molina, MD, Alfredo Vazquez, MD
 Brandon Aiman, PA-C, Stephanie Wilson, NP-C

June

Sun	Mon	Tue	Wed	Thu	Fri	Sat
**	**	**	**	*30 Dr Mares	*31 Dr Molina	1 Dr Molina
2 Dr Molina	3 Dr Mares Dr Vazquez off	4 Dr Vazquez	5 Dr Mares	6 Dr Molina Dr Mares off	7 Dr Vazquez Dr Mares off	8 Dr Vazquez Dr Mares off
9 Dr Vazquez	*10 Dr Mares Dr Vazquez off	*11 Dr Vazquez	*12 Dr Mares Dr Mares SC	*13 Dr Molina	*14 Dr Mares Dr Molina off	15 Dr Saltagi
16 Dr Saltagi	*17 Dr Molina Dr Mares off	*18 Dr Vazquez Dr Mares off	*19 Dr Molina Dr Mares off	*20 Dr Vazquez Dr Mares off	*21 Dr Molina Dr Mares off	22 Dr Vazquez
23 Dr Molina	24 Dr Mares Dr Vazquez off	25 Dr Molina Dr Vazquez off	26 Dr Mares Dr Vazquez off Dr Molina SC	27 Dr Vazquez	28 Dr Mares Dr Molina off	29 Dr Mares
30 Dr Mares	Dr Vazquez off: June 3 rd , June 10 th and June 24 th - June 26 th Dr Mares Vacation: June 17 th --- June 21 st , SouthernCare June 12 th Dr Molina off: June 14 th , SouthernCare June 26 th , off June 28 th Stephanie out: June 13 th afternoon					
						** See ** *Changes *

2013

1.11.13-0536

Medical Specialists of Madison Co., P.C.
 Thomas Bright, MD, David Mares, MD, Pablo Molina, MD, Alfredo Vazquez, MD
 Brandon Aiman, PA-C, Stephanie Wilson, NP-C

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 Dr Vazquez Dr Molina SC	2 Dr Molina	3 Dr Mares Dr Molina off	4 Dr Mares
5 Dr Mares	6 Dr Molina Dr Vazquez off	7 Dr Mares	*8* Dr Molina	9 Dr Mares	*10* Dr Vazquez Dr Mares off	11 Dr Saltagi
12 Dr Saltagi	13 Dr Mares Dr Molina off	14 Dr Vazquez Dr Molina off Dr Mares, Brandon & Stephanie-OUT	15 Dr Mares Dr Mares SC Dr Molina off Stephanie off	16 Dr Vazquez	17 Dr Molina Dr Mares off	18 Dr Molina
19 Dr Molina	20 Dr Mares Dr Vazquez off	21 Dr Vazquez	22*** Dr Molina	23*** Dr Mares	24 Dr Vazquez Dr Molina off	25 Dr Vazquez
26 Dr Vazquez	27 OFFICE CLOSED Dr Molina Brandon Vacation	28 Dr Vazquez Brandon Vacation	29** Dr Vazquez Dr Molina SC Brandon Vacation	30** Dr Molina Brandon Vacation	*31 Dr Mares Brandon Vacation	*** See Changes

Dr Molina: OUT May 3rd, May 13th thru May 15th & May 24th, SouthernCare May 1st & May 29th
 Dr Vazquez: OUT May 6th & May 20th ---- Dr Mares: OUT May 10th, May 14th & May 17th, SouthernCare May 15th
 Stephanie: OUT May 14th & May 15th *****Brandon: Out May 14th, Vacation May 28th thru May 31st

2013

THE OFFICE WILL BE CLOSED MAY 27, 2013 for Memorial Day

6646-8536

Thomas P Bright, MD - David C Mares, MD - Pablo E Molina, MD - Alfredo Vazquez, MD - Brandon Aiman, PA-C - Stephanie Wilson, NP-C
 Medical Specialists of Madison Co., P. C.

Sun	Mon	Tue	Wed	Thu	Fri	Sat	
	1 Dr Vazquez Dr Mares Out Dr Molina Out	2 Dr Saltagi Dr Mares Out Dr Molina Out	3 Dr Saltagi Dr Mares Out Dr Molina Out	4 Dr Vazquez Dr Molina SC-Out Dr Mares Out	5 Dr Saltagi Dr Mares Out Dr Molina Out	6 Dr Saltagi Dr Mares Out Dr Molina Out	
7 Dr Saltagi Dr Mares Out Dr Molina Out	8 Dr Vazquez	9 Dr Mares	10 Dr Vazquez	11 Dr Molina	12 Dr Vazquez Dr Mares Out	13 Dr Vazquez	
14 Dr Vazquez	15 Dr Mares Dr Molina Out	16 Dr Vazquez	17 ***** Dr MOLINA Dr Mares SC	18 ***** Dr MARES	19 Dr Mares Dr Vazquez Out	20 Dr Mares Dr Vazquez Out	
21 Dr Mares Dr Vazquez Out	22 Dr Molina Dr Vazquez Out	23 Dr Mares Dr Vazquez Out	24 Dr Molina Dr Vazquez Out	25 Dr Mares Dr Vazquez Out	26 Dr Molina Dr Vazquez Out	27 Dr Molina Dr Vazquez Out	
28 Dr Molina Dr Vazquez Out	29 Dr Mares Dr Vazquez Out	30 Dr Molina Dr Vazquez Out	***** CHANGES MADE DR MOLINA on CALL 04/17/2013 DR MARES on CALL 04/18/2013				2013
Dr Mares: Vacation 04/01/13- 04/07/13, Out 04/12/13, SouthernCare 04/17/13 Dr Molina: Vacation 04/01/13- 04/07/13, SouthernCare 04/04/13, Out 04/15/13 Dr Vazquez: Vacation 04/19/13-04/30/13 Brandon out 04/01/2013							

646-836



**St. Vincent
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Commitment of Radiology

Northwest Radiology at St. Vincent Anderson Regional Hospital is committed to providing care to the injured patient by providing radiology services twenty four hours per day.

Joseph C. Baer, FACS
Trauma Medical Director
St. Vincent Anderson Regional Hospital

9/20/13

Date

Michael Conley, MD
Chief of Radiology
St. Vincent Anderson Regional Hospital

9/27/2013

Date



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Medical Imaging Trauma Activation Response Policy

The Medical Imaging Department at St. Vincent Anderson Regional Hospital is committed to providing immediate care to the injured patient and will respond to all Trauma Alert and Trauma Code 1 activations as part of the multidisciplinary response trauma team.

Purpose:

Establish expectations and processes for medical imaging technologist working with the Emergency Department and providing prompt imaging services for the injured patient.

Policy:

Medical imaging will:

- a. Respond promptly to Trauma Alert and Trauma Code 1 activations when announce overhead.
- b. Prepare necessary equipment and supplies
- c. Take portable x-ray machine and supplies to the Emergency Department
- d. Cover digital detectors or CR cassettes with plastic to prevent damaging and/or exposure to blood or body fluids.
- e. Wear protective apparel prior to entering the trauma room including but not limited to aprons, gowns, gloves, head cover, shoe cover, mask and eye shields to prevent exposure.
- f. Arrive prepared to image the trauma patient within 15 minutes of activation.

CT Technologist will:

- a. Discuss with trauma team regarding when the patient should be transported to CT.
- b. Give trauma patient priority.
- c. Immediately prepare for the incoming trauma patient by loading the necessary supplies and preparing the unit as appropriate.
- d. Wear protective apparel prior to entering the trauma room including but not limited to aprons, gowns, gloves, mask and eye shields to prevent exposure.

Emergency Department staff will:

- a. Prepare patient and transport to CT scanner at the appropriate time ensuring prompt, timely care of the injured patient.

Medical imaging and CT staff will:

- a. Obtain CT and radiology images
- b. Send images to PACS
- c. Complete study in RIS
- d. Designate the images as STAT on PACS
- e. Designate images as "call report"
- f. Notify radiologist of the trauma procedure

Saint Vincent Anderson Regional Hospital

PLAN FOR THE PROVISION OF PATIENT SERVICES 2013

Medical Imaging Diagnostic Medical Imaging

DEPARTMENTAL MISSION STATEMENT:

The mission of the Medical Imaging Department is to provide quality patient care and diagnostic imaging services to the community utilizing the latest technology and sophisticated diagnostic equipment.

The Medical Imaging Staff is comprised of highly trained professionals who strive to provide these services in a Christian environment with respect for the dignity and confidentiality of those served.

SCOPE OF SERVICES PROVIDED:

Medical Imaging is a full service department providing diagnostic radiographs, Fluoroscopy procedures, portable exams, C-arm exams (surgery/pain clinic) (Surgery Center, Central Indiana Orthopedics, and main surgery) and minor special procedures. The Medical Imaging Department of Saint Vincent Anderson Regional Hospital is a professional division directly responsible to the Vice President of Operations. It provides diagnostic radiology procedures to the patient for the referring physician. These procedures are in accordance with all state and federal regulations and all hospital and medical staff procedures.

PATIENT CARE

Types of patients served:

- Inpatients
- Outpatients
- E.D. patients

Most frequent conditions treated:

- Providing Diagnostic Radiology procedures.
- Supporting physicians in patient management.

Patient populations served:

- | | |
|-----------------------------|----------------------------|
| - Newborn (Birth –6 months) | - School age (6-12 years) |
| - Infant (6 months-1 year) | - Adolescent (12-18 years) |
| - Toddler (1-3 years) | - Adult (18-75 years) |
| - Pre-school (3-6 years) | - Geriatric (75 years +) |

Methods used to assess patient care needs:

- Health Assessment & History Form
- Physician's order
- Departmental protocol:
- Legal requirements:
- Departmental policy:

Services/procedures performed to meet assessed patient care needs: (What does staff do to, for, or with patients and their significant others.)

- Review physician's order for appropriateness of exam
- Review patient history with patient and record pertinent data on request
- Review procedure with patient and/or significant other
- Comfort patient with warm blanket if necessary
- Contact ancillary services when special needs are assessed such as case management etc.

Complexity of patient care provided:

- Primary
- Simple
- Complex

Medical Imaging Hours of departmental operation:

24 hours per day, 7 days per week.

STAFF:

Knowledge and skill level:

Radiologists-Board certified. Currently licensed in the State of Indiana.

Radiologic Technologist-Hold an Associates or BS Degree or a certificate from an AMA approved school of radiologic technology. All radiologic technologists are certified by the American Registry of Radiologic Technologists and are licensed by the Indiana State Department of Health.

Radiology Nurses-RN's hold an AS or BS degree from an accredited college or diploma from an approved school and are licensed by the State of Indiana. ACLS certification.

Medical assistants and administrative assistants –successful completion of on the job training.

Staffing Plan

The diagnostic section of Medical Imaging is staffed by medical imaging technologists, senior techs, manager, RN, medical imaging assistants, and administrative assistants.

Budgeted

Medical Imaging Technologist (all shifts) – 11.3
Senior technologists (1 days/ 1 evenings) – 2.0
Manager Medical Imaging – 1.0 - days
Medical Imaging Assistants – 3.0 - days
Administrative Assistants – 3.0 - days
RN – 1.0 days

Availability:

North West Radiologists

Board certified radiologists (2), (1) scheduled at Erskine building and (1) in the main hospital 5 days per week from 8:00 a.m. to 4:30 p.m. Monday through Friday.
Radiologists provide Nighthawk services from 4:30pm- 8:00am Monday – Friday and 24 hours on weekends.

Radiologic Technologists are available within the department 24 hours per day.

SUPPORT SERVICES:

Support services used or available for use, by the department:

- Administration
- Biomedical Engineering
- Infection Control
- Case Management
- Center for Spiritual Care
- Corporate Education/Library
- LEAN
- Associate Health Services
- SPD
- Environmental Services
- Financial Management
- Dietary
- Health Information Management
- Human Resources
- Information Resources
- Corporate Communications
- Planning and Marketing
- Printing and Mailing Center
- Purchasing
- Engineering Services
- Telecommunications
- Volunteer Services

Associated clinical services used by the department:

- Cardiac Cath. Lab
- Cardiac Rehab/Wellness
- Neurology
- Center for Spiritual Care
- Rehabilitation
- Pharmacy
- Pre-Admissions
- Radiation Oncology
- Respiratory Care

- Chemotherapy

- Laboratory

Collaborative relationships that exist with other departments:

- Anderson Center
- Bennett Rehabilitation Center
- Birthing Center 2S
- Children's Clinic
- Chemo/Radiation Therapy
- Critical Care/Telemetry
- Respiratory Care

- Home Health Care and Hospice
- Medical Services, 5S, 6S
- Occupational Medicine Center
- Surgery Center, Surgery 3 S

RECOGNIZED STANDARDS OR PRACTICE GUIDELINES USED:

The Medical Imaging department has implemented and maintains all requirements and suggested practice guidelines as per OSHO, HCFA, SDOH, JCAHO, ACR

Prepared by: Craig Mitchell, MBA, RT

Date prepared: 2013

Reviewed by Vice President: _____

Date reviewed: _____

Saint Vincent Anderson Regional Hospital

PLAN FOR THE PROVISION OF PATIENT SERVICES

2013

Medical Imaging CT

DEPARTMENTAL MISSION STATEMENT:

The mission of the Medical Imaging department is to provide quality patient care and diagnostic imaging services to the community utilizing the latest technology and sophisticated diagnostic equipment.

CT associates are comprised of highly trained professionals who strive to provide these services in a Christian environment with respect for the dignity and confidentiality of those served.

SCOPE OF SERVICES PROVIDED:

The CT department is a full service department providing CT of the head, abdomen, pelvis, spine and ortho. The CT department of Saint Vincent Anderson Regional Hospital is a professional division directly responsible to the Vice President of Operations. The department provides CT diagnostic procedures to the patient for the referring physician. These procedures are in accordance with all state and federal regulations and all hospital and medical staff procedures.

PATIENT CARE

Types of patients served:

- Inpatients
- Outpatients
- E.D. patients

Most frequent conditions treated:

- Providing Diagnostic CT procedures.
- Supporting physicians in patient management.

Patient populations served:

- Newborn (Birth –6 months)
- Infant (6 months-1 year)
- Toddler (1-3 years)
- Pre-school (3-6 years)
- School age (6-12 years)
- Adolescent (12-18 years)
- Adult (18-75 years)
- Geriatric (75 years +)

Methods used to assess patient care needs:

- Health Assessment & History Form
- Physician's order
- Departmental protocol:
- Legal requirements:
- Departmental policy:
- Other:

Services/procedures performed to meet assessed patient care needs: (What does staff do to, for, or with patients and their significant others.)

- Review physician's order for appropriateness of exam
- Review patient history with patient and record pertinent data on request
- Review procedure with patient and significant other
- Comfort patient with warm blanket if necessary
- Contact ancillary services when special needs are assessed such as case management etc.

Complexity of patient care provided:

- Primary
- Simple
- Complex

CT Hours of departmental operation:

24 hours per day, 7 days per week.

STAFF:

Knowledge and skill level:

Radiologists-Board certified. Currently licensed in the State of Indiana.

CT Technologist-Hold an Associates or BS Degree or a certificate from an AMA approved school of radiologic technology. All CT technologists are certified by the American Registry of Radiologic Technologists and are licensed by the Indiana State Department of Health. CT Technologists can specialize in CT (Registered CT Technologist).

Radiology Nurses-RN's hold an AS or BS degree from an accredited college or diploma from an approved school and are licensed by the State of Indiana. ACLS certification.

Medical assistants and administrative assistants - --successful completion of on the job training.

Staffing Plan

The CT diagnostic section of Medical Imaging is staffed by CT technologists, senior techs, manager, RN, medical imaging assistants, and administrative assistants.

Budgeted

CT Technologist (all shifts) – 7
Senior technologists - 2 (1 days/ 1 evenings)
Manager Medical Imaging – 1.0 - days
Medical Assistants – 3.0 - days
Administrative Assistants – 3.0 - days
RN – 1.0 - days

Availability:

North West Radiologists

Board certified radiologists (2), (1) scheduled at Erskine building and (1) in the main hospital 5 days per week from 8:00 a.m. to 4:30 p.m. Monday through Friday.
Radiologists provide Nighthawk services from 4:30pm- 8:00am Monday – Friday and 24 hours on weekends.

CT Technologists are available within the department 24 hours per day.

SUPPORT SERVICES:

Support services used, or available for use, by the department:

- Administration
- Biomedical Engineering
- Infection Control
- Case Management
- Center for Spiritual Care
- Corporate Education/Library
- LEAN
- Employee Health Services
- Environmental Services
- Engineering Services
- Financial Management
- Dietary
- Health Information Management
- Human Resources
- Information Resources
- Corporate Communications
- Planning and Marketing
- Printing and Mailing Center
- Purchasing
- SPD

Associated clinical services used by the department:

- Cardiac Cath. Lab
- Cardiac Rehab/Wellness
- Cardio-Pulmonary & Neurology
- Pharmacy
- Pre-Admissions
- Radiation Oncology



CRITICAL CARE AREA

The Critical Care Area of Saint John's Health System is a 20 bed combined unit caring for Critical Care, Progressive Care and Telemetry patients. The care model for Critical Care patients is Primary Care, while the care model for Progressive Care and Telemetry patients is a modified Primary Care, with RN staff assisted by Multi-task technicians (MTT's), who assist the RN staff with patient hygiene, transport, blood draws, ecg's, clerical and other aspects of patient care.

The Critical Care Area also provides care to patients seen in the Pulmonary Outpatient Clinic setting. Outpatients come to the Critical Care Area for procedures performed by the pulmonary care specialists and include, but are not limited to, thoracentesis, paracentesis, pleurex drain placement, removal and education, midline placement and removal, etc. The clinic averages 12 to 14 patient visits a week.

The Critical Care Area also provides care to medical/surgical patients requiring insertion of tunneled dialysis catheters, which are inserted by the pulmonary care specialists at the bedside. The patient's recovery time and initial dialysis treatment are performed in Critical Care, with the patient returning to the medical/surgical unit upon completion of their dialysis. Initial dialysis treatment of patients with new, but existing dialysis catheters, is done in the Critical Care Area until it is known how the patient will respond, and then the patient returns to the medical/surgical floor on completion of their dialysis treatment.

PATIENT ROOMS

Patient Rooms 1121 to 1129 are designated for Telemetry and Progressive Care patients.

Patient Rooms 1101-1111 are designated for Critical Care, and may be used for Progressive Care and Telemetry patients.

Patient Room 1112 is designated for outpatient use.

All rooms have hardwired (central) monitor capability with monitors in the patient rooms and telemetry capability. All patient monitors can be viewed at both back and front nurses' stations.



STAFFING GUIDELINES FOR THE CRITICAL CARE AREA OF SAINT JOHN'S HEALTH SYSTEM

EXPECTATION: Assignments will be made focusing on the need (acuity) of the patients, families, and the available resources (nursing experience, competency, staff mix), cost of delivery of care, and the flexibility to adjust staffing as needs change.

Nurse to Patient Ratio:

Critical Care Patient: 2 Patients to 1 RN

Progressive Care/Telemetry Patient: 4 Patients to 1 RN

Medical Patient Holds: 5 Patients to 1 RN

BE CREATIVE

USE CRITICAL THINKING SKILLS

DEVELOP A PLAN OF CARE FOR THE CRITICAL CARE AREA



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Critical Care Unit Equipment

- ZOLL monitoring system
- Difficult intubation supplies
- Portable bedside ultrasound
- 2 fiber laryngoscopes
- IO insertion kit
- Hemodialysis catheter kit
- 3 Code Carts
- 1 pediatric respiratory cart
- Procedure Cart
- Respiratory Cart
- Transvenous pacemaker
- Peripheral Nerve Stimulator
- Portable over bed Gantry lift
- Hardwired Datascope monitors in all 21 rooms (HR, BP, RR, SPO2, Art, CVP, HD monitoring of Swans, charting integration)
- Level One Rapid Infuser available to us from OR
- Glidascope available to us from OR or ED



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Department	Critical Care Area
Policy Name	Admission/Discharge Criteria for Critical Care
Effective Date	September 2013
Approved by	Critical Care Committee

Policy Origin Date: 8/1975

Policy Statement: Criteria will be established by the Critical Care Committee for the admission/discharge of Critical Care patient.

Definition:

1. The Critical Care Committee is composed of a Chairman, at least five (5) other appointed members of the medical staff, non-voting representatives of the Health System Administration, Critical Care Nursing, and Nursing Administration.
2. The Critical Care unit is provided for the care of the seriously ill patient or for those patients requiring intense monitoring during the acute phase of illness.
3. Patient will be admitted to the Critical Care unit utilizing but not limited to the following criteria:
 - a. Priority I
 - i. Critically ill
 - ii. Unstable
 - iii. Receiving intensive treatment only available in the Critical Care area, i.e., intensive cardiac monitoring, ventilator management, pulmonary artery monitoring, arterial line monitoring, titration of vasoactive drugs.
 - b. Priority II
 - i. Not critically ill
 - ii. Stable
 - iii. Requires intensive monitoring and at risk of needing immediate treatment, i.e., uncomplicated MI, thrombolytic therapy, post-op from major elective surgery.
 - c. Priority III
 - i. Critically III
 - ii. Unstable
 - iii. Is "no code" and receiving intensive therapy
4. In the event that a Critical Care bed is needed and all Critical Care beds are occupied, the manager, director, administrative director, or designee will evaluate the patient according to the prioritization listed. The attending physicians will be contacted to determine the feasibility of transferring a patient who is less critically ill.

5. The Chairman of the Critical Care Committee will be utilized to assist in making triage decision in the event a Critical Care bed is needed and all attending physicians report non-transferrable patients. The manger, director, administrative director on duty, or designee will assist in this process. Priority lists from Definition #2 will be utilized.
6. Patients admitted to Critical Care will be evaluated by their attending physician or designee immediately prior to admission or within a timeframe designated by the Critical Care Committee (4 hours).
7. The Pulmonary/Critical Care physician on call or the Cardiologist on call will be contacted in the event the attending physician or designee is unavailable to the nursing staff regarding a patient in the Critical Care area.
8. Transfer/Discharge from the Critical Care area will be by physician order. Those physicians no longer meeting admission criteria will be considered for transfer/discharge. Transfer/discharge criteria includes but is not limited to:
 - a. Remains critically ill but requires procedures/care not provided by this institution.
 - b. Maintains stable airway.
 - c. Does not require mechanical ventilator support except as long term therapy, i.e. home ventilator therapy.
 - d. Stable hemodynamically
 - e. Does not require actively titrated intravenous vasoactive therapy.
 - f. Does not require invasive monitoring.
9. A telemetry patient will be admitted to the last available Critical Care bed.
10. In the event that a Critical Care bed is not available, Critical Care patients may be held in the Recovery Room or in the Emergency Department until the time a bed becomes available. Critical Care standards will apply.

ACTION STEPS:

ADMISSION

1. The attending physician or designee will:
 - a. Determine medical necessity of admission to Critical Care.
 - b. Document order on medical record.
 - c. Notify Admissions of the need for a Critical Care bed.
 - d. Write admission orders prior to admission or immediately following admission.
 - e. Evaluate patient within a timeframe established by the Critical Care Committee.
2. Admitting and/or Administrative Director will:
 - a. Notify the Critical Care unit of the need for a bed.
 - b. Facilitate the admission process.
 - c. Assist in evaluating and prioritizing patient in the event of a Critical Care bed shortage.
 - d. Contact the Critical Care Committee Chairman as necessary regarding triaging patients for transfer or evaluation after admission.

3. Nursing Management will:
 - a. Facilitate the admission process.
 - b. Assist in evaluating and prioritizing patients in the event of a Critical Care bed shortage.
 - c. Contact the Critical Care Committee Chairman as necessary regarding triaging patients for transfer or evaluation after admission.

TRANSFER/DISCHARGE

1. The attending physician will:
 - a. Document a written order for discharge or transfer in the medical record.
2. Critical Care staff will:
 - a. Communicate concerns regarding transfer criteria to the attending physician, manager, director, or administrative director.
 - b. Communicate the order for transfer/discharge to Admissions.
 - c. Notify patient and family of transfer/discharge.
 - d. Provide report by telephone to the receiving unit or facility.
 - e. Refer to Administrative Policy ADMIN-168 "Patient Transfers".



Department:	Critical Care Area
Policy Name:	Admission/Discharge Criteria for Progressive Care
Policy Number	
Effective Date:	
Approved by:	

Policy Origin Date: 6/05

Date Policy or Revision Becomes Effective:

Policy Statement: Criteria will be established by the Critical Care Committee for the admission/discharge of patients to Progressive Care within the Critical Care Area.

Scope: Critical Care Area

Definitions:

1. Progressive Care within the Critical Care Area exists to provide a place for the monitoring and care of patients with multi-system, moderate or potentially severe physiologic instability. The Progressive Care Patient's needs fall along the less acute end of the Critical Care continuum, but requires more than is available from the medical floor.
2. The Critical Care Committee is composed of a Chairman, at least five (5) other appointed members of the medical staff, non-voting representative of the Health System Administration, Critical Care Nursing, and Nursing Administration.
3. The Critical Care Committee and Nursing Administration will evaluate procedures, make recommendations for the operation of this area, and have general authority over admission and discharge criteria for this area.
4. Criteria for admission to Progressive Care within the Critical Care Area include, but are not limited to:
 - A. **Cardiac System**
 1. Hemodynamically stable myocardial infarction.
 2. Any hemodynamically stable dysrhythmia. Medical conditions which place the patient at significant risk for arrhythmias.
 3. Titration of cardio-active intravenous medications, ie, nitroglycerin, dobutamine, amiodarone.
 4. Hypertensive urgency without evidence of end-organ damage.

- B. **Pulmonary System**
 - 1. Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and/or nasal positive airway ventilation.
 - 2. Patients who require frequent vital signs or aggressive pulmonary physiotherapy.
- C. **Neurological Disorders**
 - 1. Patients with established, stable stroke who require frequent neurologic assessments or frequent suctioning and turning.
 - 2. Patients with chronic but stable neurologic disorders who require frequent nursing intervention.
 - 3. Stable cervical spinal cord injured patients.
- D. **Drug Ingestion and Drug Overdose**
 - 1. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable.
- E. **Gastrointestinal (GI) Disorders**
 - 1. GI bleeding with minimal orthostatic hypotension responsive to fluid therapy.
 - 2. Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs.
 - 3. Acute liver failure with stable vital signs.
- F. **Endocrine**
 - 1. Diabetic ketoacidosis patients requiring constant intravenous infusion of insulin, or frequent injections of regular insulin during the early regulation phase after recovery from diabetic ketoacidosis.
 - 2. Thyrotoxicosis, hypothyroid state requiring frequent monitoring.
- G. **Surgical**
 - 1. The postoperative patient who is hemodynamically stable but requires closer monitoring during the first 24 hours.
- E. **Miscellaneous**
 - 1. Appropriately treated and resolving early sepsis without evidence of shock or secondary organ failure.
 - 2. Patients requiring closely titrated fluid management.
 - 3. Any patient requiring frequent nursing observation or extensive time requirement for wound management who does not fall under the above categories may be considered for admission (example: Addison's disease, renal failure, delirium tremens, hypercalcemia).
- 4. Patients who are usually NOT appropriate for admission to Progressive Care include:
 - A. Complicated acute myocardial infarction with temporary pacemaker, angina, hemodynamic instability, significant pulmonary edema or significant ventricular dysrhythmias.
 - B. Patients with acute respiratory failure who are recently intubated or at imminent risk of requiring intubation.

- C. Patients requiring invasive hemodynamic monitoring with a pulmonary artery or left atrial catheter.
 - D. Patients in status epilepticus.
 - E. Patients with catastrophic brain illness or injury who are not to be resuscitated and are not candidates for organ donation.
 - F. Patients from whom aggressive modalities of care are being withheld or have been withdrawn, such that they are receiving only comfort measures.
5. A Progressive Care bed will not be utilized as a Critical Care bed in the occurrence of a Critical Care Bed Shortage, nor will a Progressive Care patient be admitted to the last available Critical Care Bed.
 6. Patients admitted to Progressive Care will be evaluated by their attending physician or designee within a timeframe designated by the Critical Care Committee. (6 hours)
 7. In the event a Progressive Care bed is needed and all Progressive Care beds are occupied, the manager, director, administrative director or designee will evaluate the patients according to the admission criteria. The attending physicians will be contacted to determine feasibility of transferring a patient who requires less monitoring.
 8. The Chairman of the Critical Care Committee will be utilized to assist in making triage decisions in the event a Progressive Care bed is needed and all attending physicians report their patient non-transferable. The manager, director, administrative director on duty, or designee will assist in this process.
 9. The Pulmonary/Critical Care physician on call or the Cardiologist on call will be contacted in the event the attending physician or designee is unavailable to the nursing staff regarding a patient in the Progressive Care area.
 10. Dismissal/Discharge from Progressive Care will be by physician order. Those patients no longer meeting admission criteria will be considered for discharge/transfer.
Transfer/Discharge Criteria includes:
 - A. When a patient's physiologic status has stabilized and the need for intensive patient monitoring is no longer necessary and the patient can be cared for on a medical unit.
 - B. When a patient's physiological status has deteriorated and active life support is required, or highly likely the patient will be transferred to a Critical Care bed.

Action Steps:

1. **ADMISSION**

A. The attending physician or designee will:

1. Determine medical necessity of admission to Progressive Care in the Critical Care
2. Document order on medical record.
3. Notify Admissions of the need for a Progressive Care bed.
4. Write admission orders prior to admission or immediately following admission.
5. Evaluate patient within a timeframe established by the Critical Care Committee.

B. Administrative Director or designee will:

1. Notify the Critical Care Unit of the need for a Progressive Care bed.
2. Facilitate the admission process.
3. Assist in evaluating and prioritizing patients in the event of a Critical Care/ Progressive Care bed shortage.
4. Contact the Critical Care Committee Chairman as necessary regarding triaging patients for transfer or evaluation after admission.

C. The Critical Care/Progressive Care nursing staff will:

1. Coordinate the admission process per policy.
2. Notify the administrative director of possible transfers.
3. Contact attending physicians for possible transfers in a bed shortage.
4. Notify the manager, director, and or administrative director if attending physician has not evaluated the patient within the timeframe designated by the Critical Care Committee.

2. **TRANSFER/DISCHARGE**

A. The attending physician will:

1. Document a written order for discharge or transfer in the medical record.

B. The Critical Care/ Progressive Care staff will :

1. Communicate concerns regarding transfer criteria to the attending physician, manager and/or administrative director.
2. Notify patient and family of transfer/discharge.
3. Provide report by telephone to the receiving unit or facility.
4. Refer to Administrative policy 949-168 "Patient Transfer".

**Saint John's Health System
Critical Care Area**

Policy Title: Admission/Discharge Criteria for Telemetry
Policy Number: 640-002

Policy Origin Date: 6/79

Date Policy or Revision Becomes Effective: 3/02

Policy Statement:

Criteria will be established by the Critical Care Committee for the admission/discharge of patients to the Telemetry unit.

Scope: Critical Care Area

Definitions:

1. The Telemetry unit exists to provide continuous cardiac monitoring for patients who do not require intensive or invasive monitoring.
2. The Critical Care Committee is composed of a Chairman, at least five (5) other appointed members of the medical staff, non-voting representative of the Health System Administration, Critical Care Nursing, and Nursing Administration.
3. The Critical Care Committee and Nursing Administration will evaluate procedures, make recommendations for the operation of this area, and have general authority over admission and discharge criteria for this area.
4. Criteria for admission to the Telemetry unit include but are not limited to:
 - A. Exhibited arrhythmias
 - B. Medical conditions which place the patient at significant risk for arrhythmias.
 - C. Titration of cardio-active intravenous medications, i.e., nitroglycerin, dobutamine, amiodarone.
 - D. Short stay observation patients admitted for the following conditions:
 - i. Scheduled procedure (i.e., cardioversion, permanent pacemaker placement)
 - ii. Chest pain
 - iii. Unstable angina
 - iv. Angina pectoris
 - v. Syncope
5. Patients with arrhythmias that are not to be treated will not be admitted to the Telemetry unit.
6. A Telemetry bed will not be utilized as a Critical Care bed in the occurrence of a Critical Care bed shortage.
7. Patients requiring active titration of vasoactive intravenous medications (dopamine, epinephrine, nitroprusside) will not be admitted to the Telemetry unit.
8. Patients admitted to the Telemetry unit will be evaluated by their attending physician or designee within a timeframe designated by the Critical Care Committee. (12 HOURS)

9. In the event that a Telemetry bed is needed and all Telemetry beds are occupied, the manager, director, administrative director, or designee will evaluate the patients according to the admission criteria. The attending physicians will be contacted to determine feasibility of transferring a patient who requires less monitoring.
10. The Chairman of the Critical Care Committee will be utilized to assist in making triage decisions in the event a Telemetry bed is needed and all attending physicians report their patient non-transferable. The manager, director, administrative director on duty, or designee will assist in this process.
11. The Pulmonary/Critical Care physician on call or the Cardiologist on call will be contacted in the event the attending physician or designee is unavailable to the nursing staff regarding a patient in the Telemetry area.
12. Dismissal/Discharge from the Telemetry area will be by physician order. Those patients no longer meeting admission criteria will be considered for discharge/transfer. Transfer/Discharge criteria includes but are not limited to:
 - A. Stabilization of arrhythmia.
 - B. Monitoring is no longer necessary.
 - C. Arrhythmia continues but will no longer be treated.

Action Steps:

1. **ADMISSION**

- A. The attending physician or designee will:
 - i. Determine medical necessity of admission to Telemetry.
 - ii. Document order on medical record.
 - iii. Notify admissions of the need for a Telemetry bed.
 - iv. Write admission orders prior to admission or immediately following admission.
 - v. Evaluate patient within a timeframe established by the Critical Care Committee.
- B. Admitting and/or the Administrative Director will:
 - i. Notify the Telemetry unit of the need for a bed.
 - ii. Facilitate the admission process.
 - iii. Assist in evaluating and prioritizing patients in the event of a Telemetry bed shortage.
 - iv. Contact the Critical Care Committee Chairman as necessary regarding triaging patients for transfer or evaluation after admission.
 - v. Contact the Critical Care Committee Chairman or Cardiology Section Chairman for evaluation of patient in the event the attending physician is unavailable.
- C. The Telemetry nursing staff will:
 - i. Coordinate the admission process per policy.
 - ii. Notify the manager, director, and/or administrative director of possible transfers.
 - iii. Contact attending physicians for possible transfers in a bed shortage.
 - iv. Notify the manager, director, and/or administrative director if attending physician has not evaluated patient within timeframe designated by the Critical Care Committee.

2. TRANSFER/DISCHARGE

A. The attending physician will:

i. Document a written order for discharge or transfer in the medical record.

B. Telemetry staff will:

i. Communicate concerns regarding transfer criteria to the attending physician, manager, director, and/or administrative director.

ii. Communicate the order for transfer/discharge to admissions.

iii. Notify patient and family of transfer/discharge.

iv. Provide report by telephone to the receiving unit or facility.

v. Refer to Administrative policy 949-168 "Patient Transfer".

Key Words:

Forms or Documents to be Electronically Linked to Policy:

Other Forms/Documents:

Competency:

Educode Module:

Administrative or Departmental Forms replaced or eliminated:

Related Policies:

<u>Policy Type/Department Name</u>	<u>Policy #</u>	<u>Policy Title</u>
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Administrative or Departmental Policies Eliminated:

Policy Owner (by title/function): Manager, Critical Care

Policy Reviewers (by title/function): Manager, Critical Care

Policy Approvers (medical staff and/or health system committee):

Director, Specialty Services

Regulatory Standards (list specific reference for each that apply):

- **Associated JCAHO Standards:**
- **State Department of Health Standards:**
- **HCFA Standards:**
- **Professional Association Standards:**
- **Other:**

CRITICAL CARE

definition:

The Critical Care Unit is provided for the care of the seriously ill patient or for those patients requiring intensive monitoring during the acute phase of illness.

ADMISSION CRITERIA

Priority I

Critically ill
Unstable

Receiving intensive treatment only available in Critical Care Area, ie., intensive cardiac monitoring ventilator management, pulmonary artery monitoring, arterial line monitoring, titration of vasoactive drugs, dialysis.

Priority II

Not critically ill
Stable

Requires intensive monitoring and at risk of needing immediate treatment, ie., uncomplicated MI thrombolytic therapy, post-op from major elective surgery

Priority III

Critically ill
unstable

Is "No Code" and receiving intensive therapy

Patients admitted to Critical Care will be evaluated by their attending physician or designee immediately prior to admission or within 4 hours.

TELEMETRY

definition:

Telemetry in the Critical Care Area exists to provide continuous cardiac monitoring for patients who do not require intensive or invasive monitoring.

ADMISSION CRITERIA

Exhibited arrhythmias

Medical conditions which place the patient at significant risk for arrhythmias

Titration of cardio-active intravenous medications, ie., nitroglycerin, infusion of dobutamine, amiodarone, low dose dopamine, etc
Short Stay Observation Patients admitted for the following conditions:

scheduled procedure (cardioversion, permanent pacemaker, etc)
chest pain
angina pectoris
unstable angina
syncope

Patients who are not appropriate for admission to Telemetry include

Patients requiring active titration of vasoactive intravenous medications (dopamine, epinephrine, nitroprusside, etc)
Patients with multi system moderate or potentially severe physiologic instability
Patients with arrhythmias that are not to be treated

Patients admitted to Telemetry will be evaluated by their attending physician or designee immediately prior to admission or within 12 hours.

PROGRESSIVE CARE

definition:

Progressive Care within the Critical Area exists to provide a place for the monitoring and care of patients with multi-system moderate or potentially severe physiologic instability. The Progressive care patient's needs fall along the less acute end of the Critical Care continuum, but requires more than is available from the medical floor.

ADMISSION CRITERIA

PATIENTS WHO ARE NOT APPROPRIATE FOR ADMISSION TO PROGRESSIVE CARE INCLUDE
Complicated acute myocardial infarction with temporary pacemaker, angina, hemodynamic instability, significant pulmonary edema or significant ventricular dysrhythmias
Patients with acute respiratory failure who are recently intubated or at imminent risk of requiring intubation
Patients requiring invasive hemodynamic monitoring with a pulmonary artery or left atrial catheter.
Patients in status epilepticus
Patients with catastrophic brain illness or injury who are not to be resuscitated and are not candidates for organ donation
Patients from whom aggressive modalities of care are being withheld or have been withdrawn, such that they are receiving only comfort measures.

PATIENTS WHO ARE NOT APPROPRIATE FOR ADMISSION TO PROGRESSIVE CARE INCLUDE
GI bleeding with minimal orthostatic hypotension responsive to fluid therapy
Variceal bleeding without evidence of bright red blood by gastric aspirate and stable vital signs
Acute, mild liver failure with stable vital signs
Endocrine
Diabetic ketoacidosis patients requiring constant intravenous infusion of insulin or frequent injections of regular insulin during the early regulation phase after recovery from diabetic ketoacidosis
Surgical
The postoperative patient who is hemodynamically stable but requires closer monitoring during the first 24 hours.
Miscellaneous
Appropriately treated and resolving early sepsis without evidence of shock or secondary organ failure
Patients requiring closely titrated fluid management
Any patient requiring frequent observation or extensive time requirement for wound management who does fall

Cardiac System
Hemodynamically stable myocardial infarction
Any hemodynamically stable dysrhythmia or medical conditions which place the patient at significant risk for arrhythmias
Titration of cardio-active intravenous medications, ie, nitroglycerin, infusion of dobutamine, amiodarone, low dose dopamine, etc.
Hypertensive urgency without evidence of end-organ damage
Pulmonary System
Hemodynamically stable patients with evidence of compromised gas exchange and underlying disease with the potential for worsening respiratory insufficiency who require frequent observation and or nasal positive airway ventilation without impending progression to mechanical ventilation
Patient who require frequent vital signs or aggressive pulmonary physiotherapy.
Neurological Disorders
Patients with established, stable stroke who require frequent neurologic assessments or frequent suctioning and turning
Patients with chronic but stable neurologic disorders who require frequent nursing intervention
Stable cervical spinal cord injured patients
Drug Ingestion and Drug Overdose
Any patient requiring frequent neurologic, pulmonary or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable

PATIENTS WHO ARE NOT APPROPRIATE FOR ADMISSION TO PROGRESSIVE CARE INCLUDE
Patients admitted to Progressive Care will be evaluated by their attending physician or designee immediately prior to admission or within 6 hours

PATIENTS WHO ARE NOT APPROPRIATE FOR ADMISSION TO PROGRESSIVE CARE INCLUDE
under the above categories may be considered for admission, ie., Addison's disease, renal failure, delirium tremens, hypercalcemia, etc.

STANDARD PATIENT CARE: CRITICAL CARE

DEFINITION: NURSING CARE GIVEN TO ANY PATIENT WHO IS CRITICALLY ILL AND REQUIRES CONSTANT NURSING SUPERVISION AND MONITORING.

CHECK AND ASSESS

EVERY TWO HOUR AND PRN MULTI-SYSTEM ASSESSMENT WHICH WILL INCLUDE:

- MENTAL STATUS / NEURO ASSESSMENT
- ASSESSMENT OF PAIN STATUS
- AUSCULTATION OF BREATH SOUNDS
- AUSCULTATION OF HEART SOUNDS
- AUSCULTATION OF BOWEL SOUNDS
- ASSESSMENT OF PERIPHERAL PULSES AND PERFUSION
- ASSESSMENT OF URINE OUTPUT ON PATIENTS WITH AN ANCHORED CATHETER
- VITAL SIGN MEASUREMENT (BLOOD PRESSURE, HEART RATE, RESPIRATORY RATE, PULSE OXIMETRY)
- ASSESSMENT OF HEMODYNAMIC PARAMETERS IF PULMONARY ARTERY CATHETER IS PRESENT
- IV SITE PATENCY
- OXYGEN THERAPY

EVERY FOUR HOUR AND PRN ASSESSMENT OF:

- TEMPERATURE
- SKIN INTEGRITY
- FEEDING TUBE RESIDUALS WHEN FEEDINGS ARE RUNNING
- FEEDING TUBE PLACEMENT AND PATENCY

EVERY SHIFT AND PRN ASSESSMENT OF:

- CARDIAC RHYTHM
- CHANGES IN APPETITE
- BOWEL AND BLADDER FUNCTIONS
- NG TUBE PLACEMENT AND PATENCY

DAILY ASSESSMENT:

- TOTAL I & O
- WEIGHT

PROVIDE:

- ASSISTANCE WITH PERSONAL HYGIENE AS INDICATED
- SKIN CARE Q SHIFT AND PRN
- PROPER EXERCISE AND/OR ACTIVITY AS ORDERED
- PATIENT SAFETY NEEDS (UPPER SIDERAILS UP, CALL LIGHT WITHIN REACH, PROPER LIGHTING, IDENTIFICATION BEFORE TREATMENT)
- PATIENT PRIVACY
- EDUCATION/INSTRUCTION TO PATIENT, FAMILY, OR SIGNIFICANT OTHER
- MEDICATIONS AND TREATMENTS AS ORDERED
- EMERGENCY CARE
- FOR PATIENT COMFORT
- TIME TO MEET PATIENT'S PSYCHOLOGICAL NEEDS

INITIATE:

- CONTINUOUS PULSE OXIMETRY
- CONTINUOUS CARDIAC MONITORING
- MORE FREQUENT ASSESSMENT OF VITAL SIGNS
- MAINTENANCE OF INVASIVE LINES (ARTERIAL, PULMONARY ARTERY,ARTERIAL SHEATHS) PER POLICY
- IV PLACEMENT AND MAINTENANCE. ALL CRITICAL CARE PATIENTS WILL HAVE A FUNCTIONING IV/SALINE LOCK.
- IV SITE CARE PER POLICY
- IV TUBING CHANGES PER POLICY
- FOLEY CARE DAILY
- DISCHARGE PLANNING
- I & O EVERY 8 HOURS (TOTALING)
- STANDARD PRECAUTIONS
- COMMUNICATION WITH PHYSICIAN REGARDING CHANGES IN PATIENT CONDITION
- EMERGENCY CARE AS INDICATED
- SOCIAL SERVICE CONSULT
- CONSULT WITH CHAPLAINCY

ENCOURAGE

- FAMILY AND/OR SIGNIFICANT OTHER'S INVOLVEMENT IN CARE AS INDICATED
- PATIENT AND VISITORS TO FOLLOW STANDARD PRECAUTIONS AS INCICATED

EXCEPTIONS TO THE STANDARD TO BE CHARTED

REFERENCE: AACN STANDARDS OF CARE FOR CRITICAL CARE
5/98

STANDARD PATIENT CARE: PROGRESSIVE CARE

DEFINITION: NURSING CARE GIVEN TO ANY PATIENT REQUIRING EXTERNAL CARDIAC MONITORING WITH MULTI-SYSTEM, MODERATE OR POTENTIALLY SEVERE PHYSIOLOGIC INSTABILITY WHOSE NEEDS FALL ALONG THE LESS ACUTE END OF THE CRITICAL CARE CONTINUUM, BUT REQUIRES MORE THAN IS AVAILABLE FROM THE MEDICAL FLOOR.

CHECK AND ASSESS:

EVERY FOUR HOUR AND PRN MULTI-SYSTEM ASSESSMENT WHICH WILL INCLUDE:

- MENTAL STATUS / NEURO ASSESSMENT
- ASSESSMENT OF PAIN STATUS
- AUSCULTATION OF BREATH SOUNDS
- AUSCULTATION OF HEART SOUNDS
- AUSCULTATION OF BOWEL SOUNDS
- ASSESSMENT OF PERIPHERAL PULSES AND PERFUSION
- VITAL SIGN MEASUREMENT (TEMPERATURE, BLOOD PRESSURE, HEART RATE, RESPIRATORY RATE)
- ASSESSMENT OF URINE OUTPUT ON PATIENTS WITH AN ANCHORED CATHETER
- IV SITE PATENCY
- OXYGEN THERAPY
- SKIN INTEGRITY
- FEEDING TUBE RESIDUALS WHEN FEEDINGS ARE RUNNING
- FEEDING TUBE PLACEMENT AND PATENCY

EVERY SHIFT AND PRN ASSESSMENT OF:

- CARDIAC RHYTHM
- CHANGES IN APPETITE
- BOWEL AND BLADDER FUNCTIONS
- NG TUBE PLACEMENT AND PATENCY

DAILY ASSESSMENT:

- TOTAL I & O
- WEIGHT

PROVIDE:

- ASSISTANCE WITH PERSONAL HYGIENE AS INDICATED
- SKIN CARE Q SHIFT AND PRN
- PROPER EXERCISE AND/OR ACTIVITY AS ORDERED
- PATIENT SAFETY NEEDS (SIDERAILS UP, CALL LIGHT WITHIN REACH, PROPER LIGHTING, IDENTIFICATION BEFORE TREATMENT, KOPS SCORE AND INTERVENTION)
- PATIENT PRIVACY
- EDUCATION/INSTRUCTION TO PATIENT, FAMILY OR SIGNIFICANT OTHER
- MEDICATIONS AND TREATMENTS AS ORDERED
- EMERGENCY CARE
- FOR PATIENT COMFORT
- TIME TO MEET PATIENTS PSYCHOLOGICAL NEEDS

INITIATE:

- CONTINUOUS PULSE OXIMETRY AS INDICATED
- CONTINUOUS CARDIAC MONITORING
- MORE FREQUENT ASSESSMENT OF VITAL SIGNS
- IV PLACEMENT AND MAINTENANCE. ALL PROGRESSIVE CARE PATIENTS WILL HAVE A FUNCTIONING IV/SALINE LOCK
- IV TUBING CHANGES PER POLICY
- FOLEY CARE EVERY SHIFT
- DISCHARGE PLANNING
- I & O EVERY 8 HOURS (TOTALING)
- STANDARD PRECAUTIONS
- COMMUNICATION WITH PHYSICIAN REGARDING CHANGES IN PATIENT CONDITION
- EMERGENCY CARE AS INDICATED
- SOCIAL SERVICE CONSULT
- CONSULT WITH CHAPLAINCY

ENCOURAGE:

- FAMILY AND/OR SIGNIFICANT OTHER'S INVOLVEMENT IN CARE AS INDICATED
- PATIENT AND VISITORS TO FOLLOW STANDARD PRECAUTIONS AS INDICATED

REFERENCE: AACN STANDARD OF CARE FOR CRITICAL CARE

601-??-598 STANDARD PATIENT CARE: PROGRESSIVE CARE

STANDARD PATIENT CARE: TELEMETRY

DEFINITION: NURSING CARE GIVEN TO ANY PATIENT REQUIRING EXTERNAL CARDIAC MONITORING.

CHECK AND ASSESS:

EVERY FOUR HOUR AND PRN MULTI-SYSTEM ASSESSMENT WHICH WILL INCLUDE

- MENTAL STATUS / NEURO ASSESSMENT
- ASSESSMENT OF PAIN STATUS
- AUSCULTATION OF BREATH SOUNDS
- AUSCULTATION OF HEART SOUNDS
- AUSCULTATION OF BOWEL SOUNDS
- ASSESSMENT OF PERIPHERAL PULSES AND PERFUSION
- VITAL SIGN MEASUREMENT (TEMPERATURE, BLOOD PRESSURE, HEART RATE, RESPIRATORY RATE, PULSE OXIMETRY,)
- IV SITE PATENCY
- OXYGEN THERAPY
- SKIN INTEGRITY
- FEEDING TUBE RESIDUALS WHEN FEEDINGS ARE RUNNING
- FEEDING TUBE PLACEMENT AND PATENCY

EVERY SHIFT AND PRN ASSESSMENT OF:

- CARDIAC RHYTHM
- CHANGES IN APPETITE
- BOWEL AND BLADDER FUNCTIONS
- NG TUBE PLACEMENT AND PATENCY

DAILY ASSESSMENT:

- TOTAL I & O
- WEIGHT

PROVIDE:

- ASSISTANCE WITH PERSONAL HYGIENE AS INDICATED
- SKIN CARE Q SHIFT AND PRN
- PROPER EXERCISE AND/OR ACTIVITY AS ORDERED
- PATIENT SAFETY NEEDS (UPPER SIDERAILS UP, CALL LIGHT WITHIN REACH, PROPER LIGHTING, IDENTIFICATION BEFORE TREATMENT)
- PATIENT PRIVACY
- EDUCATION/INSTRUCTION TO PATIENT, FAMILY, OR SIGNIFICANT OTHER
- MEDICATIONS AND TREATMENTS AS ORDERED
- EMERGENCY CARE
- FOR PATIENT COMFORT
- TIME TO MEET PATIENT'S PSYCHOLOGICAL NEEDS

INITIATE:

- CONTINUOUS PULSE OXIMETRY AS INDICATED
- CONTINUOUS CARDIAC MONITORING
- MORE FREQUENT ASSESSMENT OF VITAL SIGNS
- IV PLACEMENT AND MAINTENANCE. ALL TELEMETRY PATIENTS WILL HAVE A FUNCTIONING IV/SALINE LOCK.
- IV SITE CARE PER POLICY
- IV TUBING CHANGES PER POLICY
- FOLEY CARE DAILY
- DISCHARGE PLANNING
- I & O EVERY 8 HOURS (TOTALING)
- STANDARD PRECAUTIONS
- COMMUNICATION WITH PHYSICIAN REGARDING CHANGES IN PATIENT CONDITION
- EMERGENCY CARE AS INDICATED
- SOCIAL SERVICE CONSULT
- CONSULT WITH CHAPLAINCY

ENCOURAGE

- FAMILY AND/OR SIGNIFICANT OTHER'S INVOLVEMENT IN CARE AS INDICATED
- PATIENT AND VISITORS TO FOLLOW STANDARD PRECAUTIONS AS INCICATED

EXCEPTIONS TO THE STANDARD TO BE CHARTED

REFERENCE: AACN STANDARDS OF CARE FOR CRITICAL CARE
5/98

601-43-598 Standard Patient Care: Telemetry



Blood Bank and Laboratory Services

Mid America Clinical Laboratories blood bank at St. Vincent Anderson Regional Hospital is available twenty four (24) hours a day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells and fresh frozen plasma to meet the needs of injured patients. Minimum inventory is as follows:

Red Blood Cells	67
Frozen Plasma	24

Further, laboratory services are available twenty four (24) hours per day.

Sarah Asnicar

9-24-13

Sarah Asnicar

Laboratory Coordinator

Mid America Clinical Laboratories at St. Vincent Anderson Regional Hospital



SECTION #1: WHO DO YOU SERVE/WHAT DO YOU DO?

Mid America Clinical Laboratories at St. Vincent Anderson Regional Hospital perform stat and limited routine testing 24 hours/day, 7 days/week, as necessary, for appropriate patient care. Testing is performed on inpatients, outpatients and designated outreach patients choosing St. Vincent Anderson Regional Hospital as their resource for healthcare. These testing services provide information to physicians and healthcare providers to identify and diagnose illness, develop effective treatment and maintain wellness. Available technology and staff proficiency meet medical staff requirements for the range of services provided from birth through the end stages of life. Our mission is to be the leading Indiana provider of quality clinical laboratory services achieved through the expertise, commitment, and creativity of our associates.

SECTION #2: DEPARTMENTAL GOALS

- We maintain a quality assurance plan to provide the highest quality services possible to our patients and clinicians in a patient-centered environment. This includes accurate patient and specimen identification throughout specimen collection, transport of specimens, testing of specimens and reporting of patient test results. Example monitors include:
 - Turnaround Times—STAT orders for critical tests are targeted for result availability within 30 minutes for emergency department (ED) requests and within 40 minutes for non-ED requests. Critical tests include CBC, Automated Differential, Hemoglobin, Hematocrit, PT, PTT, Basic Metabolic Panel, Complete Metabolic Panel, Lipase, Amylase, Magnesium, and Electrolytes. An expanded test menu is offered with a turnaround time of 40 minutes. STAT outpatient orders for tests performed on site have a turnaround time goal of one hour or less from receipt in the laboratory.
 - Communication of STAT and critical (life threatening or life altering) patient test results to the clinicians in a timely manner (≤ 15 minutes of availability)
 - Identification, communication and correction of errors in a timely manner
 - Test order accuracy
 - Test accuracy—Proficiency testing performance of 99.3% or greater percent acceptable
 - Blood component wastage and appropriateness of order
 - Specimen Acceptability
 - Blood Culture Contamination (Rate of < 2.5 %)

SECTION #3: DESCRIBE HOW THE DEPARTMENT OPERATIONS ARE MANAGED

Mid America Clinical Laboratories determines and oversees policies and standard operating procedures from its headquarters located at the Regional Laboratory in Indianapolis. It is administered by a General

Manager and CEO. A board-certified pathologist serves as Medical Director and directs all laboratory activities, providing medical and technical support services. There is a Vice President of Hospital Laboratory Operations and a Quality Assurance and Safety Officer. Within the laboratory at the St. Vincent Anderson Regional Hospital Laboratory, services are administered by a pathologist as Medical Director, a laboratory director and laboratory technical coordinators.

The clinical laboratory is located on the first floor, south tower and operates 24 hours/day, seven days/week.

SECTION #4: LIST THE DEPARTMENT STAFFING PLAN; INCLUDE ALL JOB TITLES

The following lists describe the staffing plans for the laboratory services at the MACL laboratory at St. Vincent Anderson Regional Hospital.

- **Pathologists.** All are employed by AmeriPath and are qualified physicians with board certification in pathology.
- **Administrative Staff.** All hold Baccalaureate degrees in Medical Technology, Cytotechnology or other related laboratory health science field, MT (ASCP) or equivalent required. All are qualified as Technical Supervisors under the Clinical Laboratory Improvement Amendments (CLIA).
 - Director, Hospital Based Laboratories
 - Technical Coordinator, Hospital Labs
- **1st Shift (Day Shift) Operations Staff**
 - Lead Medical Technologist
 - Medical Technologist
 - Laboratory Assistant 2
 - Laboratory Assistant 1
 - Hospital Based Laboratory (HBL) Phlebotomist/Laboratory Assistant
 - Patient Care Provider (Phlebotomist)
- **2nd Shift (Evening Shift) Operations Staff**
 - Lead Medical Technologist
 - Medical Technologist
 - Laboratory Assistant 2
 - Patient Care Provider (Phlebotomist)
- **3rd Shift (Night Shift) Operations Staff**
 - Medical technologist
 - Patient Care Provider (Phlebotomist)
- **Staffing Decisions**
 - Staffing decisions are made by the Technical Coordinator and Lead Medical Technologist. Criteria for staffing is workload and its effect on test report turnaround time demands utilizing staff that meet qualifications by regulatory agencies (CMS [CLIA] and College of American Pathologists [CAP]).
 - Variations in staffing requirements are caused by fluctuations in demand for laboratory services. This is related directly to hospital census (bed occupancy), outpatient visits and work brought to the laboratory from approved outreach clients.
 - These variations are addressed on a day-to-day basis by the laboratory management team. Additional needs may be met by expanding the schedules of part-time staff and the use of overtime as necessary.

- **Describe how patient care is delivered in your area**
 - Patient care is delivered by providing tests results and information required to move patients through the healthcare system from initial assessment to diagnosis, treatment and continued maintenance of health. Nurses and phlebotomists collect specimens, qualified laboratory staff performs specimen analysis and pathologists provide consultative and diagnostic services to physicians and other healthcare providers.

SECTION #5: WHAT ARE OUR MINIMUM REQUIREMENTS FOR STAFF EMPLOYED IN YOUR AREA?

- **Pathologists.** Pathologists are AmeriPath associates. They are, at a minimum, M.D., Board Certified Pathologists who meet CLIA Laboratory Medical Director requirements.
- **Administrative Staff.** All are required to hold a Baccalaureate Degree in Medical Technology, Cytotechnology or other related laboratory health science field, be a registered Medical Technologist, MT(ASCP) or equivalent and meet requirements defined in CLIA.
- **Technical Coordinators.** All are required to hold a Baccalaureate Degree in Medical Technology, Cytotechnology or other related laboratory health science field. MT (ASCP) required or equivalent and meet requirements defined in CLIA.
- **Lead Medical Technologist.** Certification as a Medical Technologist, MT (ASCP), CLS (ASCP), MLT (ASCP), (AMT) or equivalent. All are required to hold a Baccalaureate Degree in Medical Technology or Laboratory Science and meet Technical or General Supervisor requirements defined in CLIA.
- **Medical Technologist.** Certification as a Medical Technologist (e.g., MT (ASCP), CLS (ASCP), MLT (ASCP), (AMT)) or equivalent. Must hold a Baccalaureate Degree in Medical Technology or Laboratory Science, or an Associates Degree in Laboratory Science, or meet the education and experience requirements defined by CLIA.
- **Laboratory Assistant 2.** A high school diploma or GED is required. Three to six months experience in a healthcare-oriented environment performing phlebotomy/clerical and technical functions.
- **Laboratory Assistant 1.** A high school diploma or GED is required. Prefer three to six months experience in a healthcare-oriented environment performing phlebotomy/clerical and technical functions.
- **Hospital Based Laboratory (HBL) Phlebotomist/Laboratory Assistant.** A high school diploma or GED is required. Prefer experience in a healthcare oriented environment performing clerical and phlebotomy functions.
- **Patient Care Provider.** A high school education or equivalent; training or certification in phlebotomy, minimum of a training course in phlebotomy or demonstrated competency performing venipuncture on all types of patients including geriatric, pediatric and chronically ill.

SECTION #6: WHO HELPS YOU SUPPORT YOUR CUSTOMERS?

- AmeriPath provides the medical director of laboratories and staff pathologists who perform the duties of clinical consultant to the medical staff.
- Indiana Blood Center provides blood products and consultation services for complex antibody identification.

- MACL network-level service departments such as Information Technology, Compliance, Quality Assurance and Safety, Logistics, and Purchasing. MACL network-level Best Practice Teams provide guidance and support in technical and patient service areas.
- Laboratory staff participate in the following St. Vincent Anderson Hospital Committees:
 - Pharmacy and Therapeutics Committee
 - Chest Pain Certification Committee
 - Stroke Certification Committee
 - Infection Control Committee
 - Executive Leadership Team
 - Regulatory Readiness Committee
 - Blood Utilization Committee

SECTION #7: BRIEFLY DESCRIBE HOW PERFORMANCE IMPROVEMENT IS INCORPORATED INTO YOUR AREA.

- Mid America Clinical Laboratories (MACL) has a Quality Management Program that is structured to systematically monitor, evaluate and improve the quality and appropriateness of our involvement in patient care. This program incorporates MACL quality priorities and goals, client hospitals' quality and patient safety priorities and goals, the Collage of American Pathologists' (CAP) patient safety goals, and includes the Clinical and Laboratory Standards Institute (CLSI) Quality Systems Essentials (QSEs).
- The scope of this policy (QA.GEN.1.0) applies to all MACL associates and facilities. All aspects of the laboratory's role in patient care are integrated into this program—preanalytic, analytic, and postanalytic. The Quality Assurance Resource team (QART) reviews quality management (QM) activities quarterly and the QM plan annually for effectiveness. Activities of this plan are shared, as appropriate, with client hospitals at least annually. An overview of quality management (QM) activities is given to the MACL board quarterly; partner hospital networks have board representation.
- MACL's Commitment to Quality. We maintain a quality assurance plan that objectively evaluates our service quality so that we continue to provide the highest quality services possible to our patients and clinicians in a patient-centered environment. For our patient population, being patient centered requires attention to a caring and innovative environment and accurate and timely test results. We intend to identify and correct problems before or as they occur. To ensure quality service we commit to these guidelines:
 - We use CAP, an external accreditation body, to evaluate our patient care quality.
 - We routinely evaluate and document associate performance.
 - We use a safety program to protect our clients, staff, community and environment.
 - Our policies and procedures are written and always available to laboratory associates.
 - We use checklists to ensure performance of scheduled activities and duties.
 - We use and document correct patient preparation and specimen collection and handling techniques.
 - We use and document instrument maintenance and internal quality control programs to ensure high-quality assay and instrument performance.
 - We perform regular systematic reviews of our services to identify area where improvements can be made.

SECTION #8: COMPETENCY ASSURANCE PLAN

A. OVERVIEW:

Competency Assessment is an ongoing process to document that an associate remains at an acceptable level of performance. The provision of quality patient care delivery is dependent upon all associates being assessed and evaluated for competence on a periodic basis.

B. DEFINITION:

Competence refers to having the essential knowledge, skills and ability to perform a job assignment as trained according to procedural specifications. Competency assessment is an objective evaluation that assures a person continues to perform job assignments accurately, proficiently, and according to established standards.

C. RESPONSIBILITY:

The Medical Director ensures that policies and procedures are established for monitoring individuals to assure that they are competent to perform the job assignment they have been given. The Technical Consultant or Technical Supervisor evaluates the competency of all testing personnel and assures that the staff maintains their competency to perform test procedures and report test results promptly, accurately and proficiently.

D. MECHANISMS:

Mechanisms for assessing, evaluating and assuring competence are as follows:

- Educational requirements
- Certification
- Department Specific Orientation
- Job Competency checklist
- Annual Competency review
- Mandatory requirements for continuing education
- Direct observation of job duty performance
- Monitoring the recording and reporting of patient test results, including critical results
- Review of worksheets, quality control records, proficiency testing results and preventive maintenance records



MACL Minimum Inventory

BB.GEN.2.0 Minimum Inventory

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

MINIMUM INVENTORY PER SITE

• **St. Vincent - Indianapolis**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	100	40	100	20	15	6			
RINF	4	4	4						All CMV Negative & prestorage leukoreduced.
Plasma	20		30		10		20		
Cryo	4 pools		4 pools		4 pools		10 single cryo 4 pools		*Pools =pool of 5 units
Platelets	<ul style="list-style-type: none"> • 4 Platelet pheresis, any type for general population. • 2 A+/= platelet pheresis, for trauma • 1 AB +/- or A+/, CMV negative, for neonatal use. 								2 platelet phereis for general population to be CMV negative
Rh Immune Globulin	25 vials								

• **St. Vincent – Women's**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	8	10	6					
RINF		4							CMV Neg, LR, IRR
Plasma			8		2		4 adult 8 pedi		
Cryo			1 pool				5 single		
Platelets	1 A or AB								
Rh Immune Globulin	25 vials								



Minimum Inventory

• **St. Vincent - Jennings**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	6	2					

• **St. Vincent Salem**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	8	4					
Rh Immune Globulin	2-5 vials								

• **St. Vincent – Fishers (North East Medical Center)**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL		4*							2 CMV neg & Irr
Rh Immune Globulin									

• **St. Vincent - Carmel**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	4		2	0	0	
RNF		1							
Plasma	4		4		6 - 1 AB infant				
Cryo	5		5						
Rh Immune Globulin	2 boxes of 10 vials each								

• **St. Vincent - Mercy**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	7	4					
Plasma							6		
Rh Immune Globulin	4								

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MACL Minimum Inventory

• **St. Vincent - Randolph**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	4	3	4	2	1	1			
Plasma							4		
Rh Immune Globulin	10								

• **IOH**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	5	6	6	4					
Plasma							6		

• **St. Vincent - Dunn**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	4*	6	4					• 2 CMV neg
Plasma							4		
Rh Immune Globulin									

• **St. Vincent - Anderson**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	22	6	22	6	5	2	2	2	
Plasma	6		6		6		6		
Rh Immune Globulin	10								

• **St. Vincent - St. Joseph Kokomo**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	4	10	4	2				
Plasma	6		6		4		4		
Rh Immune Globulin									



MACL Minimum Inventory

• **Community North**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	25	10	25	4					
RINF		1							<5 days, CMV=,LR,IRR pedi bags attached
Plasma	20		20		8		8 (at least one unit of ped plasma)		
Cryo			10 or 2 pools of 5				1 single or 1 pool		
Platelets	1 AB or A Rh neg or positive								CMV=,LR,IRR, pedi bags attached

• **The Indiana Heart Hospital**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	6	4					
Plasma	20		20		4		4		
Cryo	4		4		4				
Platelets	2*								

* 2 units of apheresis platelets will be kept on site Monday-Friday during normal surgical hours (6:30am-5pm). After normal hours, weekends and holidays a minimum of one unit will be kept on hand, if supply is available. Standing order of platelets is delivered on the following time table: Monday 2 units, Tuesday and Wednesday 3 units, Friday 1 unit. If patients are stable and the need is not emanate for the use of platelets, in order to conserve the product, the blood bank will not order additional units of platelets to arrive before the standing order.

• **Community Hospital East**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	20	10	20	10					
Plasma	10		10		10		10		
Cryo			2 pools						
Platelets	1 apheresis available except for Sunday								

• **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.



MACL Minimum Inventory

- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

WRITTEN BY: Beth Hughes

IMPLEMENTATION DATE: Jan 2000

St. Vincent Anderson Hospital
TAT

Test Criteria	Test Category	Data Entry	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	YTD	Q1: Jan-March	Q2: April-June	Q3: July-Sept	Q4: Oct-Dec
STAT ER	CBC, auto diff, Hgb, Hct, PT, PTT, BMET, CMET, LIPA, AMY, MG, LYLES	Test volume	3205	3341	4470	3322	3734	3275	3433	3602					28382	11016	10331	7035	0
Goal	90% resulted within 30 minutes of receipt	% at criteria	94%	94%	94%	93%	95%	95%	93%	92%					94%	94%	92%		0
	# meeting goal	calculation	3022	3135	4188	3104	3540	3103	3185	3312	0	0	0	0	26589	10345	9747	6497	0
STAT ER	TAT for RRL tests on List *	Test volume	1726	1919	2235	2005	2035	1728	1948	1956					15552	5880	5768	3904	0
Goal	90% resulted within 45 minutes of receipt	% at criteria	97%	97%	96%	98%	97%	98%	98%	96%					97%	96%	97%	97%	
		calculation	1666	1858	2134	1961	1969	1690	1905	1878	0	0	0	0	15060	5658	5620	3783	0
STAT Exclude ER	CBC, auto diff, Hgb, Hct, PT, PTT, BMET, CMET, LIPA, AMY, MG, LYLES	Test volume	423	450	546	487	525	445	454	521					3851	1419	1457	975	0
Goal	90% resulted within 40 minutes of receipt	% at criteria	96%	98%	94%	97%	93%	97%	97%	93%					95%	96%	95%	95%	
	# meeting goal	calculation	405	440	512	470	487	433	442	487	0	0	0	0	3676	1357	1390	929	0
Troponin I TAT																			

St. Vincent Anderson Hospital

TAT

Test Criteria	Test Category	Data Entry	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	YTD	Q1: Jan-March	Q2: April-June	Q3: July-Sept	Q4: Oct-Dec	
Troponin I TAT																				
Troponin	Total # of tests ordered	Raw Data #	591	646	740	670	696	671	668	676					5358	1977	2037	1344	0	
Goal	Expected TAT w/in 30 minutes of receipt to report	Average TAT reported in minutes	29	28	29	28	29	28	29	29					29	29	28	19	0	



MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

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MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

I. Mission

Our mission is to be the leading Indiana provider of quality clinical laboratory services achieved through the expertise, commitment, and creativity of our associates.

II. Scope of Services

Laboratory Testing Facilities

Mid America Clinical Laboratories includes a network of Hospital-Based Laboratories, Laboratory Service Centers, Point-of-Care Testing (POCT) services, and a Regional Reference Laboratory.

Hospital-Based Laboratories—The Hospital-Based Rapid Response Laboratories (RRL) perform stat and some routine testing 24 hours a day, 7 days a week, as necessary for appropriate patient care at each hospital location. Testing at these laboratories includes the following disciplines:

- Chemistry
- Coagulation
- Hematology
- Immunohematology (Blood Bank)
- Rapid and Routine Microbiology
- Urinalysis

Regional Reference Laboratory—The Regional Reference Laboratory performs routine and esoteric testing in the following clinical pathology disciplines:

- Chemistry
- Coagulation
- Gynecologic Cytology
- Hematology
- Immunohematology (Blood Bank)
- Immunology



MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

- Microbiology (including Bacteriology, Mycology, Virology, Parasitology and Mycobacteriology)
- Molecular Diagnostics
- Urinalysis

Much of the testing at the Regional Reference Laboratory is performed overnight, to better support patient care by allowing at most 24-hour turnaround time for most routine, and some esoteric tests. Hours of service vary by department or testing area. This facility may be contacted through Customer Services.

Point-of-Care Testing—Point-of-Care Testing is performed and/or managed in many locations, including hospital patient care units, emergency departments, outpatient clinics, surgery centers and MACL Patient Care Centers (PCCs). MACL provides POCT oversight management or assistance to hospital clients to ensure all regulatory requirements are met. These services include: selection of POCT devices, training, review of data, performance of linearity/correlation studies, procedures, logs, investigation of new methods, proficiency testing selection and review, etc. A certified medical technologist and several POCT service representatives staff the department to support this program.

Laboratory Accreditation and Quality Assurance—MACL is accredited by the College of American Pathologists (CAP) and, for the St. Vincent Indianapolis Blood Bank, the American Association of Blood Banks (AABB). Both the CAP and the AABB are deemed accrediting agencies for the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Clinical Laboratory Improvement Amendments (CLIA), which is the set of Federal regulations covering clinical laboratory practices. Additionally, MACL services are monitored and approved by the Indiana State Department of Health (ISDH) and the Food and Drug Administration (FDA).

Board-certified pathologists direct all laboratory activities, providing medical and technical support services on a full-time basis. Well-trained and competent medical technologists, cytotechnologists, analytical scientists, medical laboratory technicians, and lab assistants enable MACL to provide precise and accurate test results. Day-to-day quality and accuracy are assured by internal quality control and external proficiency testing programs, as well as extensive competency assessment protocols. A comprehensive quality management program provides both guidance and monitoring of testing quality and service effectiveness.

Safety—MACL complies with all applicable safety and environmental requirements established by federal, state and local authorities (eg, OSHA, EPA, IDEM, ISDH).



MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

Results Reporting Services—In accordance with regulations governing clinical laboratories and in order to maintain the confidentiality of personal health information, it is MACL policy to release test-related information only to the person who requested the test or to that person's representative.

Computer generated reports are charted in the hospitals or sent to physician offices or outside facilities by the best available means of communication: electronically, by courier, or by mail.

Reference ranges (normal ranges) with interpretation of results as indicated will be included on each patient test report. Because of continuing improvements in methodology and expanding knowledge in clinical interpretation, reference ranges do not remain static in a progressive laboratory. Each report will carry current reference ranges for the specific test.

Alert or critical results are flagged in the laboratory computer system when they exceed the verification range. All alert values are telephoned to the nursing unit or the physician. For those tests with established turnaround times, the laboratory will evaluate the urgency of the test result requested and notify the appropriate nursing unit or physician.

Turnaround times for STAT tests performed on site at the Hospital Based RRLs will be one hour or less from receipt in the laboratory. Turnaround times for routine tests performed by the Regional Reference Laboratory will be less than 16 hours. Most microbiology testing, esoteric testing, and gynecologic cytology will be available in 48 to 72 hours; dependent upon methodology. When appropriate, microbiology preliminary reports are often available after 24 hours.

Rapid Response Laboratory (RRL) Test Availability—Rapid Response Laboratory test menus vary slightly, dependent upon the needs of the facility's patient population and service mix. STAT orders for testing are targeted for result availability within 30 minutes for emergency department (ED) requests and 45 minutes for non-ED requests. The basic RRL test menu includes the tests shown in the table below. Again, this menu varies based on facility need due to patient population and service mix (eg, a facility offering transplant services may require the ability to monitor some transplant drug concentrations in their patients, another location may service patients who do not require some of the tests listed, such as gentamicin).



MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

Rapid Response Laboratory (RRL) Sample Test Menu		
Acetaminophen	CPK	Occult Blood, Gastric
Acetone	Creatinine	Osmolality, Blood/Urine
Alanine Aminotransferase (ALT)	Crossmatch	Phosphorus
Albumin	D-Dimer	Platelet Count
Alcohol	Digoxin	Potassium, Serum/Plasma/Blood
Alkaline Phosphatase	Dilantin	Protein, Total, Blood
Ammonia	Direct Antiglobulin Test	Protein, Total, CSF
Amylase	Drug Screen, Urine (Triage)	Protime (PT, Prothrombin Time) -
Antibody Screen	Electrolyte Panel, Blood	PTT (Partial Thromboplastin Time)
Antibody Screen, prenatal	Gentamicin	RBC Count
Aspartate Aminotransferase (AST)	Glucose, Blood	Renal Function Panel
Bacterial Vaginosis (BV)	Glucose, CSF	Respiratory Syncytial Virus (RSV)
Basic Metabolic Panel (BMET)	Glucose, Post Prandial, 2 hour	Rh Typing (includes weak D)
Bilirubin, Direct	Glucose Tolerance (various)	Salicylate
Bilirubin, Direct-Neonatal	Gram Stain	Sedimentation Rate
Bilirubin, Total	Group A Strep Screen	Sodium, Blood
Bilirubin, Total-Neonatal	HCG, Qualitative, Blood	Specific Gravity, Urine
Blood Type	HCG, Qualitative, Urine	Tegretol/Carbamazepine
BNP	HCG, Quantitative, Serum	Trichomonas Rapid Test (TRS)
BUN	Hematocrit	Trich Prep
Calcium	Hemoglobin	Troponin I
Calcium, Ionized	Hepatic Panel	Type and Crossmatch
Carbon Dioxide (CO ₂)	HIV 1/2 (Suds) Needlestick Protocol	Uric Acid, Blood
Carbon Monoxide (CO)	India Ink Prep	Urinalysis (UA)
CBC (no Differential)	Influenza A & B	Urinalysis Microscopic
CBC with Differential	Iron, Total	Urine, Ketone
Cell Count, Body Fluid	Lactic Acid, Blood	White Blood Cell Count
Cell Count, CSF	LDH	
Cell Count, Joint Fluid	Lipase	
Chloride	Magnesium	
CKMB	Mono Screen	
<i>Clostridium difficile</i> —Rapid	Myoglobin	
Comp. Metabolic Panel (CMET)	Occult Blood, Fecal	

Client Services

MACL recognizes that the laboratory's quality is defined by both technical and service quality. We will continually strive to understand, respond to, and meet the needs of our clients by functioning as their advocate; recognizing and responding to service opportunities and facilitating resolution.

The Client Services Department is available:

Monday – Friday	24 hours/day
Saturday	12:00 AM – 3:30 PM (RRLs take calls after 3:30 PM)
Sunday and Holidays	7:00 AM – 3:30 PM (Closed Christmas Day; RRLs take calls after 3:30 PM)



MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

Client Services addresses all customer inquiries relative to specimen requirements, test results, test information, and duplicate reports or report retransmission, along with other questions and concerns.

Courier Services/Specimen Pick-up

Courier service is designed to meet the needs of our customers for specimen pick-up, and report and supply delivery to hospitals, clinics, physician offices, and nursing facilities throughout our service area.

Patient Care Centers

MACL has more than 20 Patient Care Center (PCCs) throughout Central Indiana. In addition to these locations, outpatient draw sites are located in many of our affiliated hospital locations. Hours for the hospital-based PCC locations are, at minimum, Monday-Friday 8 AM to 5 PM; some locations have Saturday hours. Information on specific locations is available through Client Services and the MACL webpage (www.maclonline.com) These PCCs are staffed with Phlebotomists who are required to complete competencies in age-specific training in phlebotomy and specimen preparation, including annual recertification in all areas. All associates undergo extensive compliance training, which includes coverage of HIPAA requirements.

Beyond these MACL-specific PCC locations, we have numerous in-office phlebotomists placed in clinics and physician practices throughout Central Indiana.



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Commitment of Surgery Services Department

St. Vincent Anderson Regional Hospital's Operating Room (OR) is committed to providing the highest level of surgical care to trauma patients by providing staffing twenty four (24) hours a day three hundred and sixty five (365) days a year. A surgical call team with a 30 minute response time will be available during those times when an in-house team is not available. Anesthesia coverage will be provided under the same parameters.

The Post Anesthesia Care Unit (PACU) is an integrated part of the Surgery Services department. This combined unit adheres to the same standards and the same commitment of providing safe, high quality, cost effective care to all surgical patients twenty four (24) hours a day, three hundred and sixty five (365) days a year. This patient care will be provided through a combination of in-house and on-call coverage consistent with OR coverage hours. PACU services will be provided to all in-patient and outpatient surgical patients requiring Phase I recovery. Services will also be provided as required for patients needing Phase I recovering after Radiology and Cardiology procedures.

9.30.2013

Duane Cox, RN, MBA
Director Perioperative Services
St. Vincent Anderson Regional Hospital

Date



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Post-Anesthesia Care Unit

The Post Anesthesia Care Unit (PACU) is an integrated part of the Surgery Services department. This combined unit adheres to the same standards and the same commitment of providing safe, high quality, cost effective care to all surgical patients twenty four (24) hours a day, three hundred and sixty five (365) days a year. This patient care will be provided through a combination of in-house and on-call coverage consistent with OR coverage hours. PACU services will be provided to all in-patient and outpatient surgical patients requiring Phase I recovery. Services will also be provided as required for patients needing Phase I recovering after Radiology and Cardiology procedures.

The following equipment is available for the PACU patient's care:

- Adult code cart
- Pediatric code cart
- Level 1 Rapid Infuser
- Hotline fluid warmer
- Baer Hugger
- Cardiac monitor
- Ventilator support
- O₂
- Suction
- B/P monitoring
- Temp monitoring



St. Vincent Anderson Regional Hospital

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In Patient Therapy Services

765/646-8168 or 765/646-8169

- **Physical Therapy is able to meet the needs of the following patient types:**
 - Neuro,
 - Orthopedic, (including after care for total joint replacements, major multiple fractures...etc.)
 - Pulmonary/cardiac debility,
 - General debility services

- **Occupational Therapy is able to meet the needs of the following in patient types:**
 - Neuro,
 - Orthopedic, (including after care for total joint replacements, multiple fractures...etc.)
 - Pulmonary/cardiac debility,
 - General debility services
 - Lymphedema Program

- **Speech/Language Pathology Services: Adult and pediatric**
 - Speech-language disorders,
 - Aural rehabilitation,
 - Cognitive rehabilitation,
 - Voice disorders/ vocal cord dysfunction
 - Dysphagia services:
 - Swallow Function Video evals (SFV)
 - Fiber-optic endoscopic swallow treatment (FEES)
 - Vital Stim: E-stim treatment to the swallowing muscles

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St. Vincent Anderson Regional Hospital

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Bennett Rehabilitation Center

Madison County's only inpatient intensive rehabilitation center

Established in 1988

765/608-2661 (Referrals)

765/646-8368(Nurses Station)

765/646-8530(Gym)

- This acute in patient rehabilitation program is led by a board-certified physiatrist, a doctor specializing in physical medicine.
- Medical Director and Physiatrist, Bianca Ainhorn, MD
 - 8450 Northwest Blvd., Indianapolis, IN
 - 4 MD visits/week along with 24/7 on call for medical management
 - Primary contact: 317/393-2861, pager
- 13 bed unit located on the 2nd floor of St. Vincent Anderson Regional Hospital
- Referrals and Admissions accepted 24/7
- Medical supervision by RN's 24 hours per day
- Intensive Physical, Occupational, and Speech Language Pathology Therapy services provided at a minimum of 3 hours of therapy/day (5 out of 7 days/week)
- Patient must require 2 therapies for higher function
- Intensive Therapy services offered 7 days/week
- A Licensed Social Worker is consulted on all patients. This team member specializes in discharge planning, including assisting the patient and family with acquiring equipment or scheduling outpatient or home services after they leave Bennett.
- Technology utilized to promote improved functional skills including: BioNess L300, orthoses, and the LiteGait Body Weight Support System.
- Other Intensive Medical Services:
 - 24/7 Hospitalist Program
 - Able to consult any other MD specialties for patients while in the acute rehabilitation setting. (i.e. Neuro, Cardiac, Urology, Renal...etc.)
 - Certified Wound/Ostomy Nursing services
 - In patient Dialysis provided on the rehab unit
 - All in patient hospital services are able to be offered to patients in the intensive rehab setting (i.e. Lab, Radiology, Pharmacy, Dietary...etc.)
- Bennett Rehabilitation is able to meet the intensive medical/rehabilitation needs of patients in the following diagnostic categories which may be secondary to trauma:
 - Stroke: All diagnoses stating stroke, cerebrovascular accident, cerebral thrombosis, and any late effects of the above conditions.
 - Spinal Cord Injury: Paralysis, quadriplegia, paraplegia, CNS damage or any residuals due to an injury or spinal trauma.
 - Amputation: Amputations of an extremity which are traumatic or stemming from medical necessity secondary to trauma.

- Major Multiple Trauma: Any patient with residuals or conditions originating from an external cause where the patient sustains two (2) or more major injuries to the musculoskeletal, vascular and/or neurological systems.
- Hip Fracture: Any residual or late effect due to a hip fracture. (pathological or traumatic)
- Traumatic Brain Injury: Any residual or late effect due to a closed or open head injury or to a head surgery.
- Burns: Any residuals (such as contractures) stemming from burns (30% of the body surface)
- Acute Debility (Medical/Cardiac/Pulmonary)



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

The Carl D. Erskine Outpatient Rehabilitation Centers

2020 Meridian Street, Suite 170, Anderson, IN 46016

2602 Enterprise Drive, Anderson, IN 46013

Centralized Scheduling Phone (765) 608-3970 Ext 1 Fax (765) 608-3909

List of Services

>Orthopedic Rehabilitation:

2 Board Certified Orthopedic PTs
Pre- and post-op

>Spine Rehabilitation: back and neck pain specialty:
includes McKenzie TX

>Certified Hand Therapy Specialists

>Sports Medicine Rehabilitation

>Augmented Soft Tissue Mobilization (ASTYM)

>Orthotic Assessment and Fabrication: custom shoe
inserts, foot orthoses, hand/arm splints

>Chronic Pain Rehabilitation

Treatment of fibromyalgia, arthritis, and other pain
conditions

>Aquatic/Pool Therapy

>Regional Balance Center Services

Vestibular Rehabilitation
Assessment & treatment of dizzy patients
Includes computerized balance assessment
Herdman Certified Vestibular Rehab Physical
Therapist
Balance Improvement Therapy
Home Assessments/Recommendations
Falls Risk Assessment

>Cancer Rehabilitation: PT, OT, Speech specializing in the treatment of patients undergoing chemo/radiation TX.

Manual soft tissue TX, lymphatic drainage TX, head and neck cancer TX, swallowing and voice TX, and pelvic/perineal
cancer TX. Functional Restoration for cancer related debilities.

>Wound/Ostomy Care Center:

Certified Wound/Ostomy
Registered Nurse Specialist's assessment and
treatment of all types of wounds and ostomy needs.

>Speech/Language Pathology Services: Adult and pediatric
Speech-language disorders, aural rehabilitation, cognitive
rehabilitation, voice disorders/ vocal cord dysfunction

Dysphagia services:

Swallow Function Video evals (SFV)
Fiber-optic endoscopic swallow TX (FEES)
Vital Stim: E-stim TX to the swallowing muscles

>Lymphedema Program: Certified Manual Lymph
Drainage Therapist

>Stroke/Neurological Rehabilitation Services:

Certified Traumatic Brain Injury PT/OT

Bioness: L300 e-stim treatment for drop foot post
CNS dysfunction

Supported Harness & Neurocom Equipment

SAEBO Flex Orthoses: Improve hand function in
stroke patients

>Pediatric Rehabilitation- PT, OT, and Speech

Development delays, post surgery, post injury

>Women's Health Rehabilitation Services

Continence Rehabilitation: bladder & bowel

Pelvic Health Rehabilitation

Post breast surgical/radiation therapy services

Osteoporosis Treatment: posture, pain, functional
restoration

>Industrial Rehabilitation Program:

Assessment and Treatment of Injured Workers

Functional Capacity Evaluations

Work Conditioning and injury prevention education

>Audiology Services

Complete diagnostic services

Hearing aids, repairs, and batteries

Tinnitus evaluations

Central auditory processing evaluations

VNG and CDP testing/interpretation



St. Vincent Anderson Regional Hospital

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SCOPE OF CARE/SERVICE

Respiratory Care

The *Respiratory Care Department* provides twenty-four hour service under the direction of licensed pulmonologists to patients with cardio-pulmonary disorders ranging from the neonate to the elderly. Services include diagnostic testing, therapeutics, monitoring, ventilation, and airway maintenance. This department services outpatients, inpatients, emergency room patients and patients on Bennett Rehabilitation.

The Respiratory Care Department offers rehabilitative services to COPD patients Monday through Friday.

An Asthma Clinic provides education and evaluation of patients with a diagnosis of asthma.

Smoking cessation classes are offered to those choosing to quit.

Registered Respiratory Therapists are part of the Trauma Team, Code Blue Team, Code Pink Team, and the Rapid Response Team. All therapists are certified in BLS, ACLS, NRP, and PALS.

The Respiratory Care staff includes Certified Respiratory Therapists, Registered Respiratory Therapists, Certified Asthma Educators, Certified Pulmonary Function Technologist and Neonatal-Pediatric Specialists.



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Staffing Plan CY 2013-2014

Cost Center/Location: 7180 Respiratory Care

Shifts	Job Classes	Absolute Minimum	Operational Minimum	Operating Norm
Day	Registered Respiratory Therapist (RRT)	Two credentialed therapist	Two credentialed therapist	Three – four credentialed therapist
	Certified Respiratory Therapist (CRT)	An additional person (director or designee) is on call 24 hours a day seven days a week.	An additional person (director or designee) is on call 24 hours a day seven days a week.	An additional person (director or designee) is on call 24 hours a day seven days a week.
Evening	Registered Respiratory Therapist (RRT)	Two credentialed therapist	Two credentialed therapist	Three – four credentialed therapist
	Certified Respiratory Therapist (CRT)	An additional person (manager or designee) is on call 24 hours a day seven days a week.	An additional person (manager or designee) is on call 24 hours a day seven days a week.	An additional person (manager or designee) is on call 24 hours a day seven days a week.
Night	Registered Respiratory Therapist (RRT)	Two credentialed therapist	Two credentialed therapist	Three credentialed therapist
	Certified Respiratory Therapist (CRT)	An additional person (director or designee) is on call 24 hours a day seven days a week.	An additional person (director or designee) is on call 24 hours a day seven days a week.	An additional person (director or designee) is on call 24 hours a day seven days a week.

Factors which increase staffing (Volume variables, special functions, weather, etc.) :

Increase number of therapy orders and/or increased number of ventilator patients.

Contingency Plan for departmental staffing catastrophe:

Call in on call therapist.

Increase staff by use of registry, critical staffing pay plan, and/or agency staff.

Notify Medical Director

Cancel Pulmonary Rehabilitation and Pulmonary Function Testing, use therapist to provide therapy.

Approved By: _____

Date: 2/01/2013

HOSPITAL PROCUREMENT AGREEMENT
(ORGAN)

This Hospital Procurement Agreement (Organ) ("Agreement") is made this 1st day of January, 2013, between St. Vincent Anderson Regional Hospital ("Hospital") and Indiana Organ Procurement Organization, Inc. ("IOPO").

RECITALS

A. IOPO is an Indiana nonprofit corporation and is a freestanding Organ procurement organization (within the meaning of 42 C.F.R. § 413.200 and § 486.302) which is the federally qualified Organ procurement organization designated for the donation service area within the State of Indiana in accordance with Section 371 of the Public Health Service Act (42 U.S.C. § 273) ("Donation Service Area");

B. IOPO is a member of the Organ Procurement and Transplantation Network ("OPTN") established under Section 372 of the Public Health Service Act (42 U.S.C. § 274), the nonprofit corporation composed of transplant centers, organ procurement organizations, and histocompatibility laboratories, with the purpose of increasing the availability and access to donor organs;

C. OPTN is administered by the United Network for Organ Sharing ("UNOS"), a nonprofit corporation, which, as the OPTN contractor, manages the national Organ transplant waiting list, manages clinical data in a secure environment, works to improve the quality processes of OPTN, and facilitates the Organ allocation, matching and placement process for human Organ transplants;

D. The purposes of IOPO are to perform and coordinate the identification of donors, the retrieval, procurement, preservation and transportation of Organs for transplantation to work with the OPTN and UNOS in the allocation and placement of Organs available for transplant, and to educate medical personnel and the general public regarding donation and transplantation issues;

E. Hospital participates in the Medicare and Medicaid program and desires to be in compliance with Section 1138 of the Social Security Act (42 U.S.C. § 1329b-8) and the rules of the Centers For Medicare and Medicaid Services ("CMS") for hospital conditions of participation in Medicare and Medicaid programs (42 CFR Part 482.45);

F. Hospital is located within the Donation Service Area of IOPO;

G. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in Hospital; allowing families of Potential Donors to be informed of the potential for Organ, Tissue, or Eye donation; and maintaining Potential

Donors under the direction and guidance of IOPO while necessary determinations of medical suitability, testing and placement of Organs can take place. Hospital agrees to cooperate with IOPO in supporting a patient's right to donate Organs, Tissue and Eyes when an appropriate declaration of gift has been made by the patient, even if that declaration of gift is contrary to the wishes of the next of kin, and, allowing IOPO to appropriately approach all families of medically suitable Potential Donors in order to obtain the consent to donate Organs, Tissue and Eyes, when appropriate, for suitable Potential Donors under eighteen years of age or where no declaration of gift can be found. Hospital hereby requests that IOPO recover all Organs from Donors who die within Hospital that are determined to meet the requirements of medical suitability; and

H. In situations where organs, tissue and eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consents, procurement may proceed for medical or dental education, research, the advancement of medical or dental science, or therapy.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants contained herein and for other good and valuable consideration, the parties hereby agree as follows:

1. Definitions. For purposes of this Agreement, the following words shall have the meanings indicated herein:

a) "Brain Death" shall mean the condition of death occurring when increased intracranial pressure is sufficient to impede the flow of blood into the brain causing cellular death of the brain tissue and/or herniation; characterized by the absence of electrical activity in the brain, blood flow to the brain, and brain function as determined by the clinical assessment of responses therefor, resulting in complete, irreversible cessation of all functions of the entire brain, including the brain stem.

b) "Clinical Indicators" shall mean the following criteria for a patient with severe, acute brain injury and (i) who requires mechanical ventilation; (ii) is in an intensive care unit, critical care unit or emergency department; (iii) has clinical findings consistent with a Glasgow Coma Score that is less than a threshold of 5, absent central nervous system depressants or an induced coma, or for whom the attending physicians are evaluating a diagnosis of brain death, or for whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's or guardian's decision.

c) "Conversion Rate" shall mean the number of Potential Donors meeting the medical suitability requirements of IOPO, who actually donate Organs compared to all eligible Organ Donors who die in Hospital, including those for whom consent to donate is not obtained, expressed as a percentage.

- d) "Designated Requestor" shall mean an individual designated by the Hospital or IOPO and trained to handle or participate in the donation consent process, who has completed a course offered or approved by IOPO or, in conjunction with a local Tissue and Eye bank, regarding the methodology for approaching the family or person responsible for a Potential Donor and requesting Organ, Tissue or Eye donation.
- e) "Donation After Circulatory Death" ("DCD") shall mean an Organ donation process with a patient who has suffered a non-survivable brain injury or cardiac event such that patient death would be imminent subsequent to the removal of mechanical support for circulatory and respiratory functions. A Donor After Circulatory Death means an individual who donates Organs after his or her heart has irreversibly stopped beating and may be termed a non-heart beating systolic Donor. Any Hospital patient who is consented for Donation After Circulatory Death shall be transferred to an accepting facility capable of supporting DCD protocols and with whom Hospital has an agreement to accept a DCD donor per Hospital policy developed jointly with IOPO
- f) "Donor" or "Potential Donor" shall mean any person who dies in circumstances (causes and conditions of death, and age at death) that are generally acceptable for donation of at least one vascularized Organ, Tissue or Eye; the Potential Donor can be identified in a timely manner; and where proof of the patient's declaration to donate an anatomical gift can be obtained; or, absent such a declaration to donate, permission for donation can be obtained from the family or other legal guardian.
- g) "Eye" or "Eyes" shall mean the whole eye or portions of the human eye, including the cornea, corneal tissue, sclera, and vitreous.
- h) "Family Services Coordinator" shall mean an employee of IOPO trained in obtaining consent for Organ, Tissue and Eye donations.
- i) "Imminent Death" shall mean the time when an individual's death is reasonably expected utilizing the criteria enumerated for Clinical Indicators.
- j) "Organ" shall mean a human kidney, heart, lung, pancreas, liver, or intestine (or multivisceral Organs when transplanted at the same time as an intestine).
- k) "Procurement Transplant Coordinator" or "PTC" shall mean an employee of IOPO trained in coordinating the process of Organ donation and procurement.
- l) "Timely Referral" shall mean a telephone call by Hospital notifying IOPO of an Imminent Death, in sufficient time to give IOPO an adequate opportunity to begin assessment of a Potential Donor prior to the withdrawal of, or discussion with family or guardian regarding, any life-sustaining therapies (i.e., medical or pharmacological support) and as soon as it is anticipated a patient will meet the criteria for Imminent Death agreed by the OPO and Hospital or as soon as possible after a patient meets the criteria for Imminent Death agreed to by the OPO and Hospital.

m) "Tissue" shall mean other transplantable and non-transplantable tissues of the human body, excluding Organs, and including but not limited to whole heart for heart valves, vascular tissue, connective tissues, skin and bones.

2. Notice of Donor Availability and Consent. Hospital shall, consistent with applicable laws and regulations, cooperate with IOPO in the recovery of Organs donated from patients who die in the Hospital. Hospital shall cooperate with IOPO to prepare and implement appropriate policies that support the mechanism of the donation of Organs.

a) Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), or based on Clinical Triggers, in the Hospital. In addition, Hospital shall provide Timely Referral to IOPO or the named donee, if any, when Hospital becomes aware that a person in transit to Hospital is identified as a Potential Donor. IOPO shall preliminarily determine, based upon medical and patient information provided by Hospital, the medical suitability of each Potential Donor for Organ, Tissue and Eye donation according to requirements utilized by IOPO, and the appropriate tissue and eye banks serving Hospital.

b) The determination of death for a Potential Donor shall be made by the Donor's attending physician or by the physician responsible for certifying death at the Hospital. Such physician shall not participate in any procedure relating to removal or transplantation of any Organs, Tissues, or Eyes. IOPO shall not participate in the determination of death of any potential Organ, Tissue or Eye Donor. Notification of a determination of death shall be written into the patient's chart upon pronouncement. IOPO shall verify the determination of death according to applicable State and federal laws prior to proceeding with any anatomical recovery.

c) Hospital shall allow IOPO to determine the medical suitability of any Potential Donor and to use such portable laboratory equipment as may be necessary to facilitate such determination.

d) Hospital shall ensure, in collaboration with IOPO and consistent with federal and state laws, rules and regulations, that a patient's right to donate Organs, Tissues, and Eyes is fulfilled when appropriate declaration of gift is noted, or that the family of each Potential Donor, or person legally responsible for a Potential Donor, is informed of the potential to donate Organs, Tissues, and Eyes, or to decline to donate when the appropriate declaration of gift cannot be found. When a family member or person legally responsible for a Potential Donor is informed about the procedures for making a gift of Organs, Tissue or Eyes, the fact that the family member or representative was so informed shall be noted in the Potential Donor's medical chart. Hospital and IOPO shall encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of Potential Donors.

e) IOPO and Hospital shall act in good faith to support a patient's right to donate, and fulfill a patient's wishes to donate anatomical gifts in accordance with the

Indiana Uniform Anatomical Gift Act, Indiana Code 29-2-16-2 et seq. (the "Act"). The Act prevents a patient's family from altering a gift declared in writing by an individual under the provisions of the Act. Under the provision of the Act, IOPO shall attempt to obtain any documentation of patient's declared decision to donate, including applicable designations on an individual's driver's license, which may be determined from the Bureau of Motor Vehicles registry or the Donate Life Indiana registry and honor such request in accordance with applicable requirements of law.

f) IOPO shall determine whether a Potential Donor has made a written anatomical gift, and, if so, whether the Potential Donor has subsequently revoked the anatomical gift in writing, in consultation with the family or guardian of the Potential Donor and with any other sources that are reasonably available, and any information received by IOPO shall be provided by IOPO to Hospital, the attending physician, and the physician who certified the Potential Donor's death if there is not an attending physician, and must be documented in the Donor's medical chart.

g) Designated Requestor shall work cooperatively with a Family Services Coordinator in requesting consent for any potential anatomical donation from a Potential Donor's family, when no declared intent by the Potential Donor can be found. If Hospital has actual notice of contrary intent in writing by a Potential Donor, or that the potential donation is opposed by a member of the Potential Donor's family or guardian, which member is of the same or prior class under Indiana law as the family member or guardian granting the consent, Hospital shall notify IOPO of such contrary intent. This shall not prevent IOPO from presenting options for donation to a Potential Donor's family members or guardian.

h) In the event that Organs, Tissue or Eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consent, procurement and all examinations necessary to assure suitability may proceed for donation for medical or dental research or education, the advancement of medical or dental science, or therapy.

3. Organ Procurement. The procedures undertaken to procure donated Organs shall be supervised by PTC, or other professional procurement personnel, provided by and or contracted by IOPO, with specialized training in transplantation, Donor evaluation and management and Organ preservation, to coordinate Organ procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ procurement personnel perform such activities. Hospital agrees to grant access, on an emergency basis in accordance with its Medical Staff rules and regulations, to physicians and other Organ procurement personnel participating in the procurement procedures, case management, and all ancillary activities. Hospital and IOPO agree to cooperate in complying with reasonable requirements of other health care providers and payors in connection with Organ procurement pursuant to the terms of this Agreement.

4. IOPO Obligations. IOPO, consistent with its purposes of performing and coordinating the retrieval, preservation and transportation of Organs will follow the system of locating

prospective recipients pursuant to the rules of the OPTN for available Organs, and educating medical personnel regarding donation issues, shall:

- a) provide twenty-four (24) hour availability of a qualified IOPO staff member or PTC to evaluate and determine the medical suitability for Organs from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ recovery, provide technical assistance during recovery and initiate Organ preservation and recovery;
- b) provide a Family Services Coordinator or other qualified IOPO staff member to appropriately inform the family of a Potential Donor of the right to donate or to decline to donate, to seek to obtain consent for donation from the family or person legally responsible in accordance with applicable law, and with discretion and sensitivity to the family or legal guardian.
- c) provide in-service training for Hospital personnel involved in Organ donations;
- d) educate Hospital personnel regarding donation and transplantation issues;
- e) if requested, approve or provide on at least an annual basis a course in the methodology for approaching Potential Donor families and requesting Organ donation for the purposes of training Hospital personnel to become Designated Requestors, which training shall also be designed in conjunction with the tissue and eye bank community, if Hospital chooses to use Hospital personnel to perform such tasks;
- f) provide a physician or other qualified and trained personnel to assist in the medical management of the Potential Donor during the time of actual procurement of Organs and provide assistance to physicians who are members of the Medical Staff of Hospital to provide such services, and IOPO's Medical Director shall provide oversight and assistance in the clinical management of a Potential Donor when the Hospital physician on call is unavailable;
- g) ensure that IOPO personnel and IOPO contractors providing services under this Agreement are trained in the proper methods necessary for Donor screening, determining medical suitability, requesting consent for donation, procurement, transportation and preservation of Organs, efficient placement of Organs, and oversight of Organ recovery;
- h) determine whether there are conditions that may influence or affect the medical suitability and acceptance of a Potential Donor;
- i) to the extent reasonably practical, obtain the medical and social history of a Potential Donor;
- j) review the medical chart of a Potential Donor and perform a physical examination of a Potential Donor;

- k) using the protocols and procedures developed and adopted by Hospital, in consultation with Hospital's designated Tissue recovery agency and Eye recovery agency, determine whether a Potential Donor whose death is imminent or who has died, is medically suitable for Tissue or Eye donation;
- l) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;
- m) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ recovery;
- n) if IOPO recovers Organs from a DCD Donor, IOPO shall maintain and follow protocols for evaluating DCD Donors; for withdrawal of support, including the relationship between the time of consent to donation and the withdrawal of support; the use of medications and interventions not related to the withdrawal of support; the involvement of family members prior to Organ recovery; and criteria for the declaration of death and time period that must elapse prior to Organ recovery;
- o) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs after their procurement;
- p) utilize Organs procured at Hospital in accordance with the rules and requirements of OPTN and UNOS, and requirements of law, to recipients deemed suitable in accordance with sound medical practice;
- q) if requested by Hospital, provide Hospital with information as to the eventual disposition of all Organs procured at the Hospital;
- r) reimburse Hospital at a rate consistent with national organ procurement standards that are reasonable and customary for the Indiana region as determined by American Medical Bill Review ("AMBR"), for all costs associated with procurement of Organs from Donors preliminarily approved as medically suitable from and after the time of death of the Donor is determined and proper consent is obtained, in accordance with existing applicable CMS regulations;
- s) pay private physicians not otherwise compensated through Hospital for reasonable and customary procurement fees for services related to procurement activities, unless IOPO and a physician have entered into a separately negotiated agreement for charges related to procurement activities;
- t) make arrangements for histocompatibility tissue testing and testing for potentially transmittable diseases according to the current standards of practice to determine the medical acceptability of the donated Organs for the purposes intended, which shall be performed by a laboratory that is certified in the appropriate specialty or subspecialty of service and meeting the requirements specified by UNOS, in accordance with the

guidelines specified by the Center for Disease Control and other applicable laws and regulations;

u) send complete documentation of Donor information including Donor's blood type and other vital data necessary to determine compatibility for purposes of transportation, the complete record of Donor's management, documentation of consent, documentation of the pronouncement of death, and documentation regarding determining Organ quality to the Transplant Center that will utilize each Organ; and two individuals, one of whom must be an IOPO employee, must verify that the documentation that accompanies an Organ is correct;

v) conduct reviews, on at least a monthly basis, of death records in every Medicare and Medicaid participating hospital in its Donation Services Area that has a Level I or Level II trauma center or 150 or more beds, a ventilator and an intensive care unit (unless the hospital has a waiver to work with an Organ procurement organization other than IOPO), with the exception of psychiatric and rehabilitation hospitals; to make an assessment of the medical charts of deceased patients to evaluate the potential for Organ donation; and in the event that missed opportunities for donation are identified, IOPO, working with Hospital, shall implement actions reasonably necessary to improve performance in identifying such opportunities;

w) establish written policies to address the process for identifying, reporting, thoroughly analyzing and preventing adverse events that may occur during the Organ donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ donation;

x) maintain a toll-free telephone number (800-356-7757) to facilitate the central referral of Organ, Tissue and Eye donations within the IOPO Donation Service Area; and

y) either directly or through a contract with an answering service, shall cause Organ donation referrals to be referred to IOPO and its on-call staff, shall cause referrals for Tissue and Eye donation to be referred to the appropriate agency having an agreement with Hospital for handling such donations; and shall cooperate with the tissue banks with which Hospital has an agreement to ensure that referrals are screened for Tissue and Eye donation potential and to cooperate in obtaining consent for Tissue and Eye donations.

5. Additional Hospital Obligations. In addition to those obligations set forth in Section 2 of this Agreement, Hospital shall:

a) comply with the requirements of Section 1138 of the Social Security Act (42 U.S.C. § 1320b-8) and the regulations of the Centers for Medicare and Medicaid Services; all anatomical gift legislation of the State of Indiana; and other legal requirements applicable to Organ donation;

- b) allow IOPO to use ancillary laboratory facilities, other than any available at Hospital, for tests of Organ function, blood typing, and other indicated clinical studies of Potential Donors as directed or requested by IOPO;
- c) maintain certification of Hospital laboratory testing under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") and regulations of the Centers for Medicare and Medicaid Services, 42 C.F.R. Part 493.
- d) in a timely manner provide intensive care or other clinical support for optimum maintenance of Potential Donors prior to Organ procurement, to follow procedures and protocols as specified by IOPO for Organ procurement; and work cooperatively with IOPO in the optimum maintenance of Potential Donors while necessary testing and placement of potential donated Organs takes place;
- e) shall adopt a protocol for DCD Donors, and notify IOPO of Hospital's DCD protocol, and to take all steps required under such protocol for determinations of death as provided in subsection 5. (f) below;
- f) in a timely manner provide physicians to determine the death of Potential Organ Donors in compliance with applicable state law and in accordance with standard medical practice;
- g) work cooperatively with IOPO on providing access to Potential Donor medical records, in providing appropriate access to Hospital's information system;
- h) provide IOPO with wired or wireless secure high-speed internet connection within the Hospital, at no charge to IOPO, for the purpose of facilitating the evaluation, maintenance, recovery, placement, and medical charting of Donors, in order for IOPO to provide Donor information to UNOS, and, if Hospital cannot provide a high speed Internet connection, Hospital agrees to work with IOPO to make the best alternative Internet connection available, which could include wireless Internet access cards or a dial-up connection;
- i) provide an operating room with staff if needed (including surgical, anesthesia, and nursing) and materials deemed appropriate by IOPO for performing cadaveric Organ recovery, and assistance in performing all reasonably necessary tests and examinations, and if Hospital does not have appropriate operating room facilities, to follow procedures and protocols as specified by IOPO until such time as a potential Donor can be transported to another medical facility with appropriate facilities;
- j) provide an itemized bill of all services for each Organ Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ Donor, or person financially responsible for payment of the expenses for medical and surgical care for the Donor, is not charged or billed for expenses related to Organ donation; and to furnish to IOPO, upon request, an itemized statement of expenses billed to the Donor family or other

responsible party, relating to the Donor's medical and surgical care and treatment to confirm that no such charges or bills were remitted;

k) work cooperatively with IOPO in the education of Hospital staff and the community regarding donation issues;

l) enter a notation in a patient's chart when Timely Referral is provided to IOPO;

m) cooperate with IOPO and provide the assistance of at least one qualified Hospital employee to assist in verifying that documentation, including Donor blood type and other vital data necessary to determine compatibility for purposes of transplantation, specified in subsection 4. (u) of this Agreement that accompanies an Organ to a Transplant Center is correct;

n) cooperate with IOPO in performing death record reviews as specified in subsection 4. (v) of this Agreement; and, if required, to cooperate with IOPO in implementing actions deemed reasonably necessary to improve the opportunities for identifying Potential Donors;

o) cooperate with IOPO in identifying, reporting, analyzing and preventing adverse events that may occur during Organ donation at Hospital, as specified in subsection 4(u) of this Agreement, and cooperate with IOPO in taking all steps deemed reasonably necessary to prevent the repetition of adverse events during Organ donation at Hospital; and

p) prepare and implement written policies supporting a program for monitoring the effectiveness of its Organ donation and procurement program by collecting and analyzing records regarding Potential Donors and referrals to IOPO, and Hospital's Conversion Rate data, and, where possible, taking steps to improve the Conversion Rate

6. Retention and Access to Records. In accordance with the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395x(v)(I) and regulations thereunder, IOPO and Hospital agree that each shall retain and for four years after services are furnished by either hereunder, shall allow the Comptroller General of the United States and the United States Department of Health and Human Services, and their duly authorized representatives, access to this Agreement and to such of the books, documents and records of each as are necessary to verify the costs of services performed hereunder, provided that the said access is required by the cited law and regulations and further provided that the request for access complies with the procedural requirements of those regulations.

7. Independent Contractors. In the performance of all obligations hereunder, the relationship of Hospital and IOPO shall be that of independent contractors, and neither shall be deemed to be the partner or agent of the other, and no party shall withhold or in any way be responsible for the payment of any federal, state, or local income or occupational taxes, F.I.C.A. taxes, unemployment compensation or workers compensation contributions, or any other payments for or on behalf of any other party or any person on the payroll of any other party.

8. Professional Liability. IOPO and Hospital shall each, at all times, qualify and comply with the procedures to be and remain qualified health care providers pursuant to the Indiana Medical Malpractice Act, as amended, Indiana Code § 34-18-1-1 et seq. and shall maintain professional malpractice liability insurance coverage or other qualifying financial responsibility in accordance with the applicable liability limits or securities as specified therein, and pay the annual surcharges levied by the Indiana Department of Insurance.
9. Indemnification. Hospital and IOPO shall protect, defend, indemnify and hold harmless the other party from and against all claims, losses, demands, damages and causes of action, including reasonable attorney fees arising or in any way resulting from the indemnifying party's willful or negligent acts or omissions or the acts of the indemnifying party's agents or employees, in providing services pursuant to this Agreement. Said indemnification shall be limited to the maximum exposure permitted under Indiana Code § 34-18-1-1 et seq., unless insurance coverage in a greater amount is possessed by the indemnifying party.
10. Governing Law. This Agreement shall be controlled by and construed under, the laws and regulations of the State of Indiana and applicable federal laws and regulations.
11. Compliance with Social Security Act. The parties agree that all provisions of this Agreement shall be interpreted in such a manner as to comply with the requirements of Section 1138 of the Social Security Act, as added by Section 9318 of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. § 1320b-8), and rules or regulations adopted pursuant to that law relating to Organ procurement.
12. Confidentiality of Patient Records. The parties agree to maintain the confidentiality of patient records pursuant to state and federal laws and regulations. However, to the extent permissible, the parties agree to cooperate in the exchange of information and records as may be necessary to carry out the terms of this Agreement, including obtaining information for inclusion in any IOPO originated donation chart as required by federal law. IOPO may disclose Donor medical and patient information to physicians providing treatment for Organ recipients, to Transplant Centers receiving Organs, Tissue and Eyes, to the local coroner, and as may otherwise be required by applicable laws or regulations. IOPO may disclose medical and billing information to institutions providing reimbursement of expenses related to Organ donation and procurement.
13. Termination. This Agreement shall remain in effect until terminated by either party. Termination may be made by either party upon 90 days prior written notice to the other.
14. Waiver. The failure of any one party hereto to enforce any breach or to enforce any lack of performance of any covenants or obligations contained herein shall not constitute the waiver of that breach or of any similar subsequent breach of this Agreement.

15. Amendment. This Agreement represents the entire agreement between the parties hereto, and supersedes any prior stipulation, agreement, or understanding of the parties, whether oral or written. Any modification of this Agreement shall be invalid unless stated in writing and signed by both parties hereto.

16. Notice. All communications, notices and demands of any kind which either party may be required or desires to give or serve upon the other party shall be made in writing and sent by registered or certified mail, postage prepaid, return receipt requested, to the following addresses:

Hospital:

Thomas J. Vanosdol, Chief Executive Officer
St. Vincent Anderson Regional Hospital
2015 Jackson Street
Anderson, IN 46016

IOPO:

Kelli Hanner, COO
Indiana Organ Procurement Organization, Inc.
3760 Guion Rd
Indianapolis, IN 46222

Either party hereto may change its address specified for notices herein by designating a new address in accordance with this paragraph.

17. Separable Provisions. If any provisions hereof shall be, or shall be adjudged to be, unlawful or contrary to public policy, then that provision shall be deemed to be null and separable from the remaining provisions hereof, and shall in no way affect the validity of this Agreement.

18. Discrimination. The parties hereby warrant that each party is and shall continue to be in compliance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. No person shall, on account of race, color, religious creed, national origin, ancestry, sex, handicap or age be unlawfully excluded from participation in any program sponsored by either of the parties of this Agreement.

19. Debarment. IOPO and Hospital each represents and warrants to the other, that neither it nor any of its affiliates, officers, directors, subcontractors, or employees, is barred from participating in federal or state health care programs, or has been convicted of a criminal offense with respect to health care reimbursement. IOPO and Hospital shall notify the other immediately if the foregoing representation becomes untrue, or if it is notified by the Office of the Inspector General of the Department of Health and Human Services or other enforcement agencies that an investigation of IOPO or Hospital has begun which could lead to a sanction, debarment, or conviction.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

ST. VINCENT ANDERSON
REGIONAL HOSPITAL

By: 
Printed: Thomas J. Vanosdol
Its: Chief Executive Officer
Date: 11/12/12

“HOSPITAL”

INDIANA ORGAN PROCUREMENT
ORGANIZATION

By: 
Printed: Kellie Hanner
Its: Chief Operating Officer
Date: 11-6-12

“IOPO”

G:\NOPO\HospAgmts\OrganProcureAgmt-2006-12-08

Current Status: Active

PolicyStat ID: 497920



*St. Vincent
Anderson Regional Hospital*

Effective Date: 01/1989
Approved Date: 07/2013
Last Revised: 07/2013
Expires: 07/2016

Author: Reilly, Sister Kathleen: Vice
President of Mission

Policy Area: Mission

References:

Applicability: St. Vincent Anderson Regional
Hospital :

St. Vincent Anderson Regional
Hospital (stvanderson)

Organ and Tissue Donation - ADMIN-084

POLICY STATEMENT:

St. Vincent Anderson Regional Hospital, with Medical Staff participation, and using discretion and sensitivity with respect to the circumstances, views and beliefs of individuals, facilitates organ/tissue donation by referring potential candidates to a recovery agency either at the time of death or when death is imminent.

DEFINITIONS:

- A.
 1. This policy is in compliance with Federal Regulation 42 CFR 482.45, CMS Conditions of Participation for hospitals.
 2. Organ means a human kidney, heart, lung, pancreas, liver, small intestine and any other solid human organ.
 3. Tissue means other tissues of the human body, excluding organs and including, but not limited to, corneas, eyes, heart valves, skin, bone, veins, arteries, tendons, and fascia.
 4. Imminent death refers to those situations when a patient has experienced a non-survivable brain injury requiring ventilation (CVA, trauma, anoxia, tumor) has a GCS of 5 or less, and death is likely to occur.
 5. Brain Death – An individual may be pronounced dead by the physician (refer to Brain Death Policy #ADMIN-147) when:
 - a. The individual has sustained irreversible cessation of the entire brain, including the brain stem, as determined in accordance with St. Vincent Anderson Brain Death Policy.
 - b. Notification of IOPO must be done prior to discussion of terminal wean and prior to the withdrawal of support (Vasopressors and Ventilator).
- B. Donation after Circulatory Death (DCD) allows for the recovery of liver, pancreas, kidneys and tissues from patients who have suffered a devastating non-recoverable illness or injury and are vent dependent, but do not meet brain death criteria. This type of donation is offered to families only after the decision has been made to remove the patient from life support. Recovery of organs takes place after the patient has been declared dead based on the absence of all cardiovascular and respiratory function. This type of donation is also often referred to as non-heart beating organ donation (NHBD). IOPO Clinical pathways phase 1 through 7 and donor management guidelines will be used and are available in a three ring binder in ER, Critical Care, OR and in the Administrative Director's office.
- C. St. Vincent Anderson has signed agreements with the following organ/tissue recovery agencies that have formed an alliance called INDIANA DONOR ALLIANCE (IDA) to assist with referrals via one call to 1-800-356-7757.

1. Indiana Organ Procurement Organization, Inc. (IOPO)
 2. Indiana Lions Eye Bank (ILEB)
- D. Appropriate medical care is provided as indicated, without regard to whether an anatomical gift is under consideration.
- E. Determination of suitability for organ recovery after discontinuation of life support and subsequent cardiac arrest (DCD) and heart beating organ donation after brain death has been confirmed, can only be made after medical evaluation by IOPO. Early contact with IOPO prior to discontinuation of life support is essential.
- F. Medical suitability is determined by the recovery agency, who informs St.Vincent Anderson which organs/tissue may be donated at the time of death.
- G. Under Indiana's Uniform Anatomical Gift Act (UAGA), if a person is medically suitable for donation and knowledge of the donors' legal declarations of an anatomical gift may include, but not be limited to a government issued driver's license or identification card or, through documentation from an appropriate anatomical gift registry. A drivers license that is suspended, revoked or expired does not change the validity of the declaration of gift. Upon determination by the Organ Procurement Organization that a declaration of gift is valid, no further approval is required from the patient, patient's next of kin, agent or POA in order to proceed with the donation of organs and/or tissue. If no declaration has been made, then consent must be obtained. Notify the Administrative Director in the event the patient's family needs further explanation.
- H. A Designated Requester is a hospital associate trained in accordance with CMS regulations who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ, tissue, and eye donations. The Center of Spiritual Care chaplains in partnership with Indianan Lions Eye and Tissue Bank are the designated requester for cornea and tissue.
1. ***In all cases of potential organ donation, IOPO is the designated requester. Discussion about potential organ donation should not be initiated by chaplain, physician, or nurse.***
- I. Attending Physician - The physician who has primary responsibility for the medical care or treatment of the patient. If a patient is pronounced dead on arrival in the Emergency Room or did not have an attending physician before death, the attending physician shall be the physician who pronounces death.
- J. In some situations, where the death does not occur in the hospital and the body is taken directly to the morgue, the coroner may request assistance of Chaplain/Designated Requester regarding tissue referral.
- K. The Donor Council is an interdisciplinary group that includes representatives from IOPO and Indiana Lions Eye Bank, whose goal is to simplify the donation process, educate the caregivers of donation processes, work to improve referrals and actual donations, arrange designated requester training or re-training through one of the procurement organizations and evaluate the needs of the organization as they relate to donation.
- L. The Donor Flag will be flown for 48 hours following an organ donation at St.Vincent Anderson. The administrative director will notify security during the day shift, Monday - Friday, to let them know the flag should be flown. If the donation occurs on the weekend or night shift, the flag will be flown the next business day.

ACTION STEPS:

Determine patient's condition

- A.
 1. Cardiac Death (no heartbeat) - tissue and eye donor candidate
 2. Donation after Circulatory Death (DCD) candidate
 3. Imminent or Brain Death - organ, tissue, and eye donation

CARDIAC DEATH:

- A. 1. **Administrative Director/Nursing will:**
- a. Determine cardiac death (no heartbeat) status.
 - b. Notify the Center for Spiritual Care and the Administrative Director of the death.
- B. **Chaplain will:**
1. Call Indiana Donation Alliance at 1-800-356-7757.
 - a. Follow the operator's instructions.
 - b. Receive call from a donation coordinator.
 - c. Coordinate review of patient's medical history to determine suitability for donation.
 - d. Call funeral home according to family wishes, informing them of donor status and arrangements for procurement.
 2. Inform the Coroner of donor possibility to obtain his consent.
 3. Transplant coordinators will go to the unit where the death occurred to review medical record and determine what copies are needed. Copies of the medical record will not be sent to the morgue.
- C. **A Designated Requester will:**
1. Determine whether deceased was a registered donor.
 2. If yes, representative from ILEB will discuss options with the family.
 3. If not a registered donor, follow steps below.
 4. Offer the possibility of tissue/eye donation with the next of kin (legal) once the tissue/eye bank representative has determined suitability
 5. An anatomical gift of a decedent's body or part for the purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who are reasonably available, in the order of priority listed:
 - a. An agent of the decedent at the time of death who could have made an anatomical gift as described in donor choice law.
 - b. The spouse of the decedent.
 - c. Adult children of the decedent.
 - d. Parents of the decedent
 - e. Adult siblings of the decedent.
 - f. Adult grandchildren of the decedent.
 - g. Grandparents of the decedent.
 - h. An adult who exhibited special care and concern for the decedent.
 - i. A person acting as the guardian of the decedent at the time of death.
 - j. Any other person having the authority to dispose of the decedent's body.
- D. Obtain consent
- E. Uphold registered donor's wishes regarding tissue/eye donation.
- F. If not a registered donor, a designated requester will approach the family for a donation decision.
- G. If family does not consent, document response on the "Death Dismissal Record."

- H. If consent is obtained, acquire family signatures witnessed by another on "*Anatomical Gift Consent Form.*"
- I. Chaplain or nurse will complete tissue/eye donation section on *Death Dismissal Record.*

Imminent or Brain Death:

Facilitate early referral of potential organ donors:

Physician, Nurse or Chaplain may begin the referral process only by calling the Indiana Donation Alliance. Do not discuss organ donation with the family.

Physician or Nurse will:

- A. Identify patients with imminent or potential brain death status (See Brain Death Policy ADMIN-147v2) utilizing the following clinical indicators for potential organ donors:
 - 1. All ventilated brain injured patients (CVA, trauma, anoxia, or tumor)
 - 2. Glasgow coma scale of 5 or less.
 - 3. Prior to discussion of terminal wean.
 - 4. Prior to withdrawal of support (vasopressors and ventilator)
 - a. If not a suitable donor, document agency, date time, procurement coordinator's name, and reason.
 - b. If a suitable donor, the IOPO coordinator will make arrangements to come to St.Vincent Anderson to evaluate status of patient and speak to patient's family
- B. Notify administrative director.
- C. Work with Indiana Donation Alliance staff to provide donor opportunity.
- D. Notify Chaplain of pending donation status, if not already involved.

Donation After Circulatory Death (DCD)

Physician or Nurse may begin the referral process by calling the Indiana Donation Alliance.

Physician/Nurse or Administrative Director will:

- A. Contact IOPO if clinical indicators for referral exist:
 - A. Patient has an irreversible, severe, neurological illness or injury with no hope for survival but does not meet brain death criteria
 - B. The family, in consultation with the attending physician has made the decision to withdraw life support. This discussion is to be documented in the patient's medical record.
 - C. The patient has been on mechanical ventilation and is not expected to maintain a sustainable respiratory effort without mechanical support.
 - D. The cause of death is known.
 - E. In the opinion of the attending physician, cardiopulmonary death will likely occur within one hour following withdrawal of hemodynamic and respiratory support.
 - F. Postpone discussion of donation with family until suitability is determined.
 - G. Withdrawal of respiratory support will only occur in the operating suite. IOPO and the transplant team will be on site and available prior to withdrawing of support, but will not participate during the removal of life support. The following procedure will be utilized:
 - 1. The Critical Care RN will administer Heparin 300 units/kg IV push

2. The Critical Care RN or RT will withdraw ventilator support and will discontinue IV medications excluding medications for comfort. Cardiac monitoring will be maintained.
- H. For the purpose of certification of death, the following will be confirmed by the attending physician:
1. Confirm electrode placement
 2. Absence of palpable pulse by physician exam or Doppler flow
 3. Apnea via auscultation of breath sounds.
 4. Completely unresponsive to stimuli
 5. Five minutes of any of the following rhythms confirmed in two leads: Asystole, Vfib, or Pulseless Electrical Activity
 6. Pupils fixed and dilated
If the patient does not deteriorate to death within the designated time of 60 minutes or at the discretion of the transplant surgeon, the donation will not proceed and comfort measures will be maintained. The patient will be moved to Critical Care if they do not deteriorate to death within one hour.
- I. A debriefing will be available immediately after the DCD case, coordinated by Spiritual Care and the Administrative Director for staff actively involved in the donation process
- J. Every DCD case will be reviewed at a later date by a group which may include :
1. IOPO Coordinator
 2. Attending Physician
 3. Critical Care Primary Nurse
 4. Manager of Center for Spiritual Care
 5. Manager of Surgical Services
 6. Director of Quality
 7. Manager of Critical Care
 8. Director of the Emergency Department
 9. Donor Council

The purpose of the case review is to identify problems and complications, potential or real, and recommend changes toward their solution

Registration of Donation after Circulatory Death (DCD) Donors only.

Nursing Personnel will:

- A. Notify Patient Access that a patient has died and will be an organ donor.
 1. Provide date and time of death.
 2. Provide current registration number and medical record number.
- B. Complete discharge process for current inpatient account as per policy when death occurs.

Patient Access Personnel will:

- A. Register the donor patient creating a new medical record number.
 1. Print the face sheet from the patient's current inpatient stay (stay during which the patient died) to use as a reference for information when completing the donor registration.
 2. Register the donor patient through the "Register Temporary Patient" Pathway.
 - Enter in the acc Ind field "O" and the date/time of death.

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- Erase the guarantor and enter the name as Agency, IOPO
 - Enter address: 3760 Guion Road, Indianapolis, IN 46222
 - Enter telephone # 888-275-4676
1. Erase all emergency contact fields and enter "N" in relation to patient field.
 2. Insurance Data Screen
 3. Enter the code for IOPO
 4. List the COB as "1"
 5. Allow subscriber information to be the patient
 6. Enter a patient type of "O"
 7. Enter a hospital service of "XSS"
 8. Enter clinic code of "ADMT"
 9. Enter physician with the original attending physician for this patient
 10. Enter Reg priority of "R"
 11. Enter Reg source of "RP"
 12. Enter Complaint as "Organ Procurement"
 13. List date and time as one minute after death
 14. Place patient in bed 1112 in Critical Care (The patient will be listed in two beds until the donation process is complete.)
1. Print face sheet and bracelet and send to Critical Care.
 - a. Contact HIM (8422 leave voice mail if needed) and request the two medical records be merged following donation.

Attachments:



601- 27.pdf



768- 6.pdf

Approver	Date
Cynthia L. Ruffer: Director of Quality, Risk and Regulatory Readiness	04/2013
Stacy Austin: Nursing Educator	06/2013
Cynthia L. Ruffer: Director of Quality, Risk and Regulatory Readiness	07/2013

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*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Diversion Policy

St. Vincent Anderson Regional Hospital is committed to providing care to care to the injured patient and affirm we will not be on diversion status more than five percent (5%) of the time.

Nancy G Pitcock

Nancy Pitcock, RN, BSW, MSN
Chief Nursing Officer

9/25/13

Date



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Diversion Activation Policy

Diversion is initiated only when safe patient care becomes a concern due to specific patient care areas at maximum capacity, depletion of available staff or unavailability of medical equipment necessary to provide specialized care of diagnostics. Patient care and safety is the central consideration in all diversion decisions.

Neuro-diversion has been initiated at St. Vincent Anderson Regional Hospital during the past twelve months due to CT down time. In these cases, our back up CT located at the Erskine Ambulatory Services Building was staffed and used for patients in need of CT that arrived by means other than EMS.

Kathi Wasilewski 9/29/13

Kathi Wasilewski, RN, MA, CEN
Director Emergency Services

Date

Saint Johns Health System Ambulance Diversion Record

Type of Event:

ED Overcrowding

CT Scanner

Physical Plant Disruption

Date of Diversion: 02/21/13 Time: 1721 Administrative Representative Chick Henderson

ED Manager notified _____ ED Physician Dr. Link & Dr. Kyle

Reason(s) ED diversion was initiated: (detailed explanation to include number and types of patients in the ED) AT Scanner not working

Steps taken to access additional staff and/or resources: AT @ ER Skine - Staffed until off diversion.

Diversion Notification Phone Numbers	ON DIVERSION Person Contacted	Time	Initials	OFF DIVERSION Person Contacted	Time	Initials
Community Hospital Anderson Administrative Representative 298-4212	Lisa	1723	MS	Nichelle	2010	MS
City of Anderson Dispatch 648-6775	Allison	1724	MS	Bradley	2010	MS
Madison County Dispatch 642-0221	Shelia	1725	MS	Shelia	2014	MS
EM/MS of Anderson 644-1717	Laura	1725	MS	Robert	2015	MS
Rural Metro Anderson 644-2800	Jess	1726	MS	Jess	2015	MS
Delaware County / Salem Township 747-7878	Dudley	1726	MS	Lon	2015	MS
Henry County 765-529-4901	Jim	1727	MS	Tullman	2017	MS

These calls must be made when initiating and discontinuing diversion status

Saint Johns Health System Ambulance Diversion Record

Type of Event: ED Overcrowding CT Scanner Physical Plant Disruption

Date of Diversion: 5/16/13 Time: 0715 Administrative Representative Nancy Brooks

ED Manager notified Kathy Kotal ED Physician Burke

Reason(s) ED diversion was initiated: (detailed explanation to include number and types of patients in the ED) _____

Steps taken to access additional staff and/or resources: Maintenance on scanner
CT Scanner available @ ER/ERsine Building

Diversion Notification Phone Numbers	ON DIVERSION Person Contacted	Time	Initials	OFF DIVERSION Person Contacted	Time	Initials
Community Hospital Anderson Administrative Representative 298-4242	<u>Yves</u>	<u>0715</u>	<u>TW</u>	<u>Yves</u>	<u>0930</u>	<u>NSP</u>
City of Anderson Dispatch 648-6775	<u>Sue</u>	<u>0710</u>	<u>NSP</u>	<u>Sue</u>	<u>0945</u>	<u>NSP</u>
Madison County Dispatch 642-0221	<u>China</u>	<u>0720</u>	<u>NSP</u>	<u>China</u>	<u>0946</u>	<u>NSP</u>
EMAS of Anderson 644-1717	<u>Cathy</u>	<u>0720</u>	<u>NSP</u>	<u>Cathy</u>	<u>0946</u>	<u>NSP</u>
Rural Metro Anderson 644-2800	<u>Grampur</u>	<u>0730</u>	<u>NSP</u>	<u>Mark</u>	<u>0946</u>	<u>NSP</u>
Delaware County / Salem Township 747-7878	<u>Randy</u>	<u>0721</u>	<u>NSP</u>	<u>Yves</u>	<u>0946</u>	<u>NSP</u>
Henry County 765-354-2281	<u># Overcrowding</u>	<u>0721</u>	<u>NSP</u>	<u>Yves</u>	<u>0946</u>	<u>NSP</u>

Alexandra 724-3000
These calls must be made when initiating and discontinuing diversion status

Saint Johns Health System Ambulance Diversion Record

Type of Event: ED Overcrowding DCT Scanner Physical Plant Disruption

Date of Diversion: 7/18/13 Time: 1620 Administrative Representative: MJ Swelton

ED Manager notified: Andrea / Kimberly ED Physician: Roger Wagner

Reason(s) ED diversion was initiated: (detailed explanation to include number and types of patients in the ED) _____

Steps taken to access additional staff and/or resources: CIC ERSKINE - STAFF AVAILABLE - OPEN

Diversion Notification Phone Numbers	ON DIVERSION			OFF DIVERSION		
	Person Contacted	Time	Initials	Person Contacted	Time	Initials
Community Hospital Anderson Administrative Representative 298-4242	Miris	1620	MS	Chris	1836	MS
City of Anderson Dispatch 648-6775	Bradly	1621	MS	Bradly	1830	MS
Madison County Dispatch 642-0221	Rechel	1621	MS	14	1831	MS
EMAS of Anderson 644-1717	Jessy	1621	MS	Kyra	1832	MS
Rural Metro Anderson 644-2800	Amber	1622	MS	Amber	1832	MS
Delaware County / Salem Township 747-7878	Gunner	1622	MS	Sen	1833	MS
Henry County 765-354-2281	D-10	1623	MS	D-10	1833	MS

Alexandra
These calls must be made when initiating and discontinuing diversion status
724-3222 Beth 1623 MS
Need to call Dispatch
911 or Madison Co. PD

Saint Johns Health System Ambulance Diversion Record

Type of Event: ED Overcrowding CT Scanner Physical Plant Disruption

Date of Diversion: 8/19/13 Time: 1240 Administrative Representative: Michael Turner

ED Manager notified: K. Lukas / K. Musilewski MD Physician Dr. Conroy, Dr. Bielcki

Reason(s) ED diversion was initiated: (detailed explanation to include number and types of patients in the ED) Penicillin

None

Steps taken to access additional staff and/or resources: CT Scanner across the street open / available

Diversion Notification Phone Numbers	ON DIVERSION			OFF DIVERSION		
	Person Contacted	Time	Initials	Person Contacted	Time	Initials
Community Hospital Anderson Administrative Representative 298-49242	Denise	1242	MS	Conroy		
City of Anderson Dispatch 644-6775	Mison	1242	MS	James	1435	MS
Madison County Dispatch 642-0221	Chris	1243	MS	Brad	1437	MS
EMAS of Anderson 644-1717	Kyra	1243	MS	Kyra	1437	MS
Rural Metro Anderson 644-2800	Karen	1244	MS	Becca	1438	MS
Delaware County / Salem Township 747-7878	Amy	1244	MS	Adam	1438	MS
Henry County 765-529-4900	Amy	1244	MS		1438	MS

These calls must be made when initiating and discontinuing diversion status

Saint Johns Health System Ambulance Diversion Record

Type of Event: ED Overcrowding CT Scanner Malfunction Physical Plant Disruption

Date of Diversion: 8/29/13 Time: 0659 Administrative Representative Jana Singer, RN

ED Manager notified Per Radiology - Brooks ED Physician Per Radiology

Reason(s) ED diversion was initiated: (detailed explanation to include number and types of patients in the ED) CT Malfunction
Expected to be down around 1000 AM - Micro bleed in

Steps taken to access additional staff and/or resources: CT open @ ER Skine -

Diversion Notification Phone Numbers	ON DIVERSION Person Contacted	Time	Initials	OFF DIVERSION Person Contacted	Time	Initials
Community Hospital Anderson Administrative Representative 298-4242	<u>Nonnie</u>	<u>0704</u>	<u>RL</u>	<u>1000 Cindy</u>		<u>NP</u>
City of Anderson Dispatch 648-6775	<u>Sue Lynn</u>	<u>0705</u>	<u>RL</u>	<u>0945</u>		<u>RL</u>
Madison County Dispatch 642-0221	<u>Sally</u>	<u>0704</u>	<u>RL</u>		<u>1000</u>	<u>NP</u>
EMAS of Anderson 644-1717	<u>Cathy</u>	<u>0707</u>	<u>RL</u>	<u>Kathy</u>	<u>1000</u>	<u>NP</u>
Rural Metro Anderson 644-2800	<u>Karen</u>	<u>0707</u>	<u>RL</u>	<u>Karen</u>	<u>1000</u>	<u>NP</u>
Delaware County / Salem Township 747-7878	<u>Randy</u>	<u>0708</u>	<u>RL</u>	<u>Rich</u>	<u>1000</u>	<u>NP</u>
Henry County 765-354-2281	<u>"forget name" ops</u>	<u>0708</u>	<u>RL</u>		<u>1000</u>	<u>NP</u>

These calls must be made when initiating and discontinuing diversion status

Current Status: Active

PolicyStat ID: 457418

Effective Date: 04/2004
Approved Date: 05/2013
Last Revised: 05/2013
Expires: 05/2016



St. Vincent
Anderson Regional Hospital

Author: Pitcock, Nancy: Vice President
of Nursing and Chief Nursing
Office

Policy Area: Administrative

References:

Applicability: St. Vincent Anderson Regional
Hospital :
St. Vincent Anderson Regional
Hospital (stvanderson)

Hospital Diversion - ADMIN-263

POLICY STATEMENT:

Diversion must only be initiated when safe patient care becomes a concern due to specific patient care areas at maximum capacity, depletion of available staff or unavailability of medical equipment necessary to provide specialized care or diagnostics. Patient care and safety will be the central consideration in all diversion decisions.

DEFINITION:

- A.
 1. Diversion is the rerouting of an ambulance(s) from St. Vincent Anderson Emergency Department to an alternative receiving facility due to a temporary lack of critical resources.
 2. Appropriate reasons to initiate hospital diversion include:
 - a. Critical/unstable patients occupy all suitable emergency department (ED) beds (overcrowding) and cannot be immediately transfer to inpatient beds.
 - b. Loss of key resource for care of specialty cases, i.e. loss of a CT scanner for head injuries or stroke patients; loss of Radiology Dept.
 - c. An in house disaster, e.g. fire, flood, loss of electrical power or other internal situations which compromise patient care/safety.
- B. Based on the above situations, the ED may initiate ambulance diversion for specialty cases or complete diversion of all patients. The decision to divert requires a rapid assessment of the entire hospital situation and should be made with input from the ED nurse manager/director, the ED physician and the Nursing Administrator.
- C. Patients will never be selectively diverted (i.e. accepting patients to the ED from one EMS agency, while diverting from another) or on the basis of ability to pay.
- D. St. Vincent Anderson and Community Anderson cannot simultaneously initiate ambulance diversion. If Community Anderson is unable to accept patients, St. Vincent Anderson must remain open to all ambulances and cannot divert. The appropriate aspects of the Emergency Management Plan will be implemented.
- E. When on diversion, St. Vincent Anderson will make every attempt to maximize bed space, screen elective admissions and use all available personnel and facility resources to minimize the length of time on diversion.

- F. Diversion status must be activated prior to being notified of an ambulance's impending arrival (i.e. there can be no "diversions in route").
- G. The following patients should not be diverted if St. Vincent Anderson is the closest hospital: cardiac arrest, respiratory arrest, traumatic arrest, post arrest patients who have been successfully resuscitated, patients in active labor, patients in profound shock or patients felt to be in "extremis", or patients exhibiting signs/symptoms of acute coronary syndrome.
- H. A record of the diversion will be maintained by the hospital after each episode which includes a record of appropriate approval, type of diversion, reason for diversion, time diversion initiated, and time diversion completed. All diversions must undergo review by the medical director and EMS coordinator. Records will be maintained for two years.
- I. It is the responsibility of the Nursing Administrator to notify city and county dispatch, EMAS, Rural Metro, St. Vincent Anderson EMS medical director or EMS/Paramedic Program coordinator and the Administrative Representative at Community Hospital, Anderson.
- J. There are situations in which EMS units may choose not to honor the diversion status of a hospital and are not obligated to do so. These might include a sudden Ambulatory Services change in the patient condition, weather conditions, patient request, and EMS system capabilities. If the ambulance staff transports the individual onto hospital property, the individual must have a medical screening exam and must be stabilized as defined by law, prior to affecting patient transfer. (EMTALA)
- K. Neuro-diversion is activated when the CT scanner is unavailable and a patient has an altered mental status due to possible ischemic or hemorrhagic stroke or head trauma.

ACTION STEPS:

- A. 1. CT SCANNER UNAVAILABLE (AMBULANCE NEURO-DIVERSION REQUIRED)

Radiology will:

- A. 1. Notify the Administrative Director that CT Scanner is unavailable and the anticipated time of return of service.
2. Maintain hourly communication with Administrative Director regarding the status of CT availability.
3. Arrange for CT at Ambulatory Services Center to stay open in the event that the CT Scanner at Community Hospital is also down.

Administrative Director will:

- A. 1. Notify the Emergency Department manager or charge nurse that CT scanner is not available.
2. Contact the Administrative Representative at Community Hospital Anderson to advise them of neuro diversion status and to confirm that they are able to accept patients.
3. Notify City of Anderson Dispatch, Madison County Dispatch, Alexandria Dispatch, EMAS, and Rural Metro of diversion status with the anticipated time of deactivation.
4. Reassess hourly to determine CT status.
5. Notify all above when diversion status is lifted.

Inpatient or Emergency Department patient needs an emergent diagnostic CT Scan between the hours of 0700-1530, the Administrative Director or ED RN will:

- A. 1. Notify the Radiologist in main Radiology Department of CT order.
2. Confirm Ambulatory Services Center CT Scan availability by calling 3290.
3. Ask Ambulatory Services Center Radiology if a nurse is available to monitor the patient.

4. Arrange for a RN to accompany the patient to Ambulatory Services Center if a nurse is not available at Ambulatory Services Center.
5. Notify EMAS or Rural Metro for ALS transport to Ambulatory Services Center.
6. Notify physician of any change in patient condition.

Inpatient or Emergency Department patient needs an emergent diagnostic CT Scan after 1530 and will require transfer to Community Hospital or other facility for these services:

- A.
 1. Inform the physician caring for the patient of the unavailability of CT services and as to whether to proceed with the transfer.
 2. If the patient has a high index of suspicion for an intra cerebral hemorrhage, the physician may decide to transport the patient to a tertiary facility with interventional capability for the initial CT scan.
 3. Call for ALS transport to Community Hospital Anderson.
 4. Complete Diagnostic Testing Unavailable Form.
 5. Send any available documentation pertinent to the patient's condition.

ULTRASOUND SERVICES UNAVAILABLE (AMBULANCE DIVERSION NOT REQUIRED)

Radiology will:

- A.
 1. Notify the Administrative Director that ultrasound is unavailable and with the anticipated time of return to service.
 2. Maintain hourly communication with the Administrative Director regarding the status of ultrasound availability.
 3. Arrange for ultrasound at Ambulatory Services Center to stay open in the event that ultrasound at Community Hospital is also down.

Inpatient or Emergency Department patient needs emergent diagnostic ultrasound between the hours of 0700-1530, the Administrative Director or ED RN will:

- A.
 1. Notify the Radiologist in main Radiology Department of ultrasound order.
 2. Confirm Ambulatory Services Center ultrasound availability by calling 8319 or 8202.
 3. Ask Ambulatory Services Center Radiology if a nurse is available to monitor patient.
 4. Arrange for a RN to accompany patient to Ambulatory Services Center if a nurse is not available at Ambulatory Services Center.
 5. Notify EMAS or Rural Metro for transport to Ambulatory Services Center. ED Physician will decide what level of transport is needed based on the condition of the patient. (BLS/ALS)
 6. Notify physician of any change in patient condition.

Inpatient or Emergency Department patient needs emergent diagnostic ultrasound after 1530 and will require transfer to Community Hospital or another facility for these services:

- A.
 1. Inform the physician caring for the patient of the unavailability of ultrasound services and as to whether to proceed with the transfer.
 2. Call for BLS or ALS transport to Community Hospital Anderson. ED physician will decide what level of transport is needed based on the condition of the patient.
 3. Complete Diagnostic Testing Unavailable Form.
 4. Send any available documentation pertinent to the patient's condition.

GE CT-16 DOWNTIME PROTOCOL

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This protocol will be followed when the GE CT-16 is unavailable for patient care between the hours of 5:00PM - 6:30 AM Monday through Friday, and 24 hours on Saturday, Sunday and Holidays.

When the GE CT-16 is unavailable for patient care:

Medical Imaging will:

- A. 1. Place CT technologist on call.
2. Open CT at Ambulatory Services Center.
3. Perform only non-IV contrast CT exams unless patient is accompanied by ED physician.
4. Send CT study to Virtual for interpretation.
5. Keep a list of ED patients and submit to the Director, Emergency Department.
6. Inform the Nursing Administrative Director and ED charge associate every 2 hours of CT status.

ED will:

- A. 1. Order CT non-IV contrast CT exams via Clinician's View.
2. Contact EMS to transport patient to Ambulatory Services Center.
3. Send with ALS Ambulance
4. Send ED physician with patient that requires IV contrast.
5. Use 20 gauge needle access for contrasted studies.
6. Consider sending all CT Contrast studies to SVMCNE.

II. COMPLETE DIVERSION

Emergency Department Physician will:

- A. 1. Notify ED manager or Nursing Administrator if conditions in the ED are in danger of compromising patient care/safety.
2. Continue to treat all patients enroute until diversion status is determined and activated.

Emergency Department Manager or Nursing Administrator will:

- A. 1. Evaluate conditions and possible solutions promptly and if the care issue has no immediate solution, the decision to divert may be made.
2. Call Community Hospital, Anderson Administrative Representative to advise them and to confirm that they are able to accept patients.
3. Notify City of Anderson dispatch, Madison County dispatch, EMAS, and Rural Metro of diversion status with the anticipated time of deactivation.
4. Make every effort to maximize bed space, screen elective admissions, and use all available personnel and facility resources to minimize the length of time on diversion.
5. Initiate diversion tracking record and send a copy to the EMS/paramedic program coordinator/educator.
6. Evaluate and document diversion status hourly.
7. Notify all EMS services and Community Hospital Anderson when diversion has been lifted.

Key Words: none

Related Forms: none

Related Policies: none

Policy Owner: Chief Nursing Officer

Policy Approvers: Cabinet

Attachments:

No Attachments

	Approver	Date
Cynthia L. Ruffer: Director of Quality, Risk and Regulatory Readiness		05/2013



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

St. Vincent Anderson Regional Hospital

Trauma Services

Table of Contents

- I. Description, Purpose
- II. Administration and Organization
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- VII. Personnel Management, Competencies, and Credentialing
- VIII. Nursing Responsibilities for Patient Care
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I. Description, Purpose, and Philosophy

A) Description: The Trauma Program at St. Vincent Anderson Regional Hospital is a clinical service that has oversight of and responsibility for the care of the trauma patient. The trauma service provides the comprehensive care that is recommended by the American College of Surgeons on a 24-hour basis. All care is under the close supervision of physicians with special training and expertise in the management of the patient with multiple injuries. This department supports the integration of services of the hospital into the continuum of care for the trauma patient. This integration includes injury prevention, pre-hospital, emergency department, critical care, perioperative services, rehabilitation, case management/care coordination, physical and occupational therapies as well as discharge planning. The trauma program serves as an educational and clinical resource for local and regional trauma service providers, including physicians, nurses, paramedics and other clinical personnel involved in the care of injured patients. The program ensures trauma care that is consistent with state and the American College of Surgeons standards through its stringent performance improvement program. The trauma service also maintains the trauma registry, which is an integral part of the PIPS program for the State and hospital, as well as a mechanism to study injury trends in the region, and assist in injury prevention.

B) Purpose: The purpose of the Trauma Program is to:

- Provide evidence based care to patients in the Emergency Department through a multidisciplinary approach to trauma care
- Provide evidence based care to patients meeting trauma criteria throughout their hospitalization
- Maintain state and national requirements for Level III designation.
- Serve as a resource to the community through referrals, outreach, education and injury prevention

II. Administration and Organization

A) Staff

1) Trauma Medical Director: The role of the Medical Director is to organize and manage the overall physician/surgeon component of the trauma service and to pursue the development of the trauma center in terms of quality of care, volume, scope of services and cost-effectiveness. The Medical Director:

- Assists in the process of evaluating the pre-hospital care of the trauma patient
- Is responsible for overseeing the care provided by the trauma team
- Chairs the Trauma Multidisciplinary Performance Improvement Committee. This Multidisciplinary Committee reviews the care provided to the trauma patient, recommends the trauma credentials to the Executive Medical Staff Committee and recommends trauma medical management protocols.

2) Trauma Program Manager: The Trauma Program Manager (TPM) is a registered nurse responsible for trauma care management across the continuum. This includes:

- Planning and implementation of clinical protocols/practice management guidelines
- Monitoring care of in-hospital patients, and serving as a resource for clinical practice
- Assures compliance with the State of Indiana regulations that governs trauma and the American College of Surgeon's Resources for Optimal Care of the Injured Patient
- Leads community-based initiatives designed to promote trauma education, injury prevention and safe city objectives.
- Leads the professional education efforts of the trauma program to provide trauma specific education to nurses, paramedics, physicians and others in trauma care in conjunction with community area health providers
- Manages the performance of other trauma program staff to improve patient care and outcomes
- Serves as a liaison to administration representing the trauma program to enhance and foster optimal trauma care management

3) Trauma Case Managers: The trauma case managers' role is to maximize the efficient utilization of available resources, formulate a discharge plan, anticipate discharge barriers and adjust the plan of care as needed to optimize outpatient outcomes. The Trauma Case Managers develop case monitoring processes to identify practice and outcome variances and track patterns where improvement is needed, while promoting the optimal allocation of healthcare dollars.

5) Trauma Performance Improvement: The role of the Trauma PI Program is:

- Identification of those areas where quality or efficiency of care may be improved
- Facilitation of review processes
- Collection and analysis of data
- Identification of trends and benchmarking opportunities
- Oversight of quality of registry data
- Coordinate the creation or revision of evidenced based practice management guidelines.

6) Trauma Registrar: The Trauma Registrar maintains the Trauma Registry Database, which provides for the collection, storage and reporting of information about trauma patients including the facts related to the patient's injury event, severity, care, and outcome. Obtaining, coding, and sorting this information for analysis and reporting individual and aggregate results are the expressed purposes of the trauma registry. The registrars are also responsible for interfacing with the state registry as well as the National Trauma Data Bank for trauma.

7) Injury Prevention Program: Utilizes registry and external data sources to develop and evaluate an injury prevention plan for Trauma Center service area community. Implements the injury prevention plan through community education and screening. Partners with local, regional and national organizations in injury

prevention development. Provides program operational support to all aspects of the trauma service. Coordinates and schedules courses and other educational venues.

B) Multidisciplinary Approach: The trauma team is a group of healthcare professionals organized to provide care to the trauma patient in a coordinated, systematic and timely manner. This multidisciplinary team approach to the care of trauma patients is critical to the success of the trauma program. Through collaboration, every member of the trauma team supports an important component of trauma care that contributes to successful patient outcomes. The Rehab service as well as PT, OT and speech are consulted early in the patient's hospitalization to assure early assessment of patient needs.

C) Committees/Meetings:

Trauma Peer Review Committee meets monthly. This physician peer review identifies variances in care and makes recommendations to the Trauma Performance Improvement Committee participants include staff physicians with liaison representatives from the Departments of Emergency Medicine, Orthopedic Surgery, Anesthesiology, Radiology. Other members include the core trauma surgeons and Pathology. Ad hoc members include ENT and Pediatrics.

Trauma Program Operational Process Performance Committee occurs immediately following Trauma Peer Review. This multidisciplinary meeting focuses on system issues and impacts of the trauma program. The committee is chaired by the Trauma Medical Director and includes representatives from the Departments of Emergency Medicine, Orthopedic, Surgery, Anesthesiology, Radiology, Administration, Laboratory Services including blood bank, Nursing and the Organ Procurement Organization. Advisory personnel may be invited to committee meetings on invitation by the committee Chair. Standing agenda items include:

- Diversion Reports
- Admission Statistics
- Policy presentation
- Education
- Research
- Prevention Activities
- Organ Procurement Conversion
- Audits, Trended Data and Benchmarking Data

III. Responsibilities for Continuous Operation and Supervision

The trauma service is an administrative office with primary hours of operation Monday through Friday, 0800-1630.

IV. Utilization of Patient Care Areas

A. Transfers: The decision to transfer patients to a Level I or Level II Trauma Center is based on national guidelines and follow trauma transfer policy.

B) Admissions: Patients who do not meet transfer guidelines and are admitted to St. Vincent Anderson Regional Hospital will be admitted to Critical Care or the surgical floor.

C) Mechanism of Admission: A trauma patient can enter the system through a variety of mechanisms including:

1) Trauma Activation: Trauma activation occurs when the emergency department physician, nurse, EMS, determines that a patient meets criteria to be in need of a focused multidisciplinary group of personnel who have been specially trained to collectively render care specifically for trauma patients. The trauma team consists of physicians, nurses, and allied health professionals.

Patient Classification for Trauma Team Activation:

• **Trauma Code 1 Activation**

- Traumatic Cardiac Arrest
- Glasgow Coma Scale 13 or lower or loss of consciousness greater than 5 minutes
- Respiratory rate less than 10 or greater than 29. Respiratory compromise/obstruction and/or intubation; needle chest decompression or cricothyroidotomy in the field.
- Penetrating injury to head, neck, chest, abdomen, back, buttocks or extremities proximal to the elbow or knee
- Flail chest
- Burns >15% or high voltage electrical injury
- 2 or more long bone fractures
- Crushed, degloved, mangled or pulseless extremity
- Traumatic amputation proximal to the wrist or ankle
- Known or suspected pelvic fracture
- Extremity paralysis suggestive of spinal cord injury
- Gunshot wounds to the abdomen, neck or chest
- ED physician, ER nurse, EMS discretion

• **Trauma Alert Activation**

Mechanism of Injury Criteria

- History or loss of consciousness following a traumatic event
- Fall >20 feet or 2 stories
- High risk auto crash
 - Intrusion: >12 in., occupant site; >18 in., any site
 - Ejection from vehicle
 - Death in the same vehicle
- Pedestrian or bicyclist struck, thrown or run over by a vehicle
- Motorcycle crash >20 mph
- Traumatic amputation distal to the wrist or ankle

- Open long bone fracture
- Rollover motor vehicle collision (MVC)
- Fall >20 Feet, or over 3 times the height of the child
- Explosion
- Pregnancy greater than 20 weeks with significant mechanism of injury

2) Direct Transfer Referrals: St. Vincent Anderson Regional Hospital may receive transfers from regional facilities if the patient is appropriate for a Level III Trauma Center.

V. Utilization of Staff, Staffing and Scheduling:

The trauma service is an administrative office with primary operation Monday through Friday, 0800-1630.

VI. Safety, Security and Emergency Procedures

The trauma service supports the hospital patient safety, infection control, and emergency procedure initiatives in addition to all unit specific visitor and security policies.

VII. Personnel Management, Competencies, and Credentialing

A) Orientation

Associates will follow General Orientation as well as a unit level orientation that is structured, formalized, and individualized to meet the needs of the new associate.

B) Staff Education/Development

All staff will attend ongoing educational events based on CEU requirements, routine and new responsibilities, and identified learning needs.

Mandatory education activities include:

- BLS for licensed and unlicensed staff
- Safety Training
- Annual competency fair requirements for RNs
- Unit based mandatory education reviews
- Corporate Compliance Training
- Suspected Abuse Training
- Workplace Violence Training
- RN's are required to have ACLS & TNCC

VIII Performance Improvement

A) The Trauma Services Performance Improvement Patient Safety plan is designed to provide an ongoing, comprehensive and systematic structure for monitoring the quality and appropriateness of multidisciplinary care for the injured patient. The monitoring and evaluation of patient care is based upon predetermined standards. The standards include the following:

- Evidenced-Based Practice Management Guidelines (EBPMGs) and Protocols/policies developed by the Trauma Performance Improvement (Trauma PIPS) Committee

- Resources for Optimal Care of the Injured Patient: 2006 developed by the American College of Surgeons, Committee on Trauma
- The State Rules and Regulations for Trauma Centers

B) The goals of the Trauma PIPS Plan include:

- Regular and systematic monitoring of the process of care and outcomes for the injured patient
- Monitor and intervene to assure the appropriate and timely provision of care
- Improve the knowledge and skills of the trauma care providers
- Assure compliance with accrediting and regulating agencies governing the designation of trauma centers
- Provide the institutional structure and organization to promote quality improvement
- Decrease death and disability by reducing inappropriate variation in care

C) Members: The members of the Trauma PIPS committee are responsible for peer review problem identification and recommendation for a plan of corrective action. The committee membership will be composed of a Chair, all core trauma surgeons and liaisons from the Departments of Emergency Medicine, Orthopedic surgery, Anesthesiology, and Radiology. Additional attendees include representatives from Administration, Laboratory Services including blood bank. The committee Chair may invite advisory personnel to committee meetings. A member of the Department of Trauma Services shall serve as support staff. Members are required to attend at a minimum of 50% of meetings. Minutes are housed in the Trauma Program office. Access to the minutes is restricted to maintain confidentiality.

The PIPS Committee functions as an adhoc committee of the Environment of Care Committee. A standing agenda item of each PIPS meeting is a report from the District 6 (Regional) Coordinator. The hospital's/ district disaster preparedness initiatives are discussed. Minutes from the Monthly Emergency Management Meeting are reviewed.

D) Scope of Care/Services

Monitoring and evaluation activities are performed on all Trauma patients that meet the parameters defined for inclusion and exclusion of the Trauma Registry at Trauma Center

E) Medical Staff Peer Review

Medical staff peer review is the process of monitoring and evaluating the competency of the physicians credentialed to practice at St. Vincent Anderson Regional Trauma Center.

1) Selected outcome audits may be referred for medical staff peer review:

- Mortality
- Patient with gunshot or stab wound which penetrates the abdominal wall that does not receive an exploratory laparotomy if patient is not transferred.
- Patient requiring a laparotomy, which is not performed within two hours of emergency department arrival. (if patient was not transferred)
- Negative exploratory laparotomy

- Unplanned abdominal, thoracic, vascular or intracranial complications that occur greater than 24 hours after arrival
 - Thoracotomy procedure performed in the emergency department if patient is not transferred.
 - Readmission: Patient previously an inpatient on the trauma service, discharged, and is readmitted as an inpatient within 7 days of initial discharge
 - Delay of diagnosis
 - Patients with an interval of greater than 8 hours between arrival and treatment of blunt, compound fracture or laceration into the joint (if patient was not transferred)
 - Missed activations with serious or potentially serious detriment to patient care
 - Sentinel events
 - Major complications, which significantly increase length of stay or impact positive patient outcomes
- 2) The reviewing physicians may:
- Determine that care was appropriate and close the case
 - Refer the case to Safety Operations Committee.
 - Determine need for intervention and action based on the case

F) Roles and Responsibilities of the Trauma Program Staff Related to Trauma PIPS

1) Trauma Services Medical Director

- Responsible for primary review of cases with Performance Improvement Coordinator and/or Trauma Program Manager
- Triage cases for closure or presentation and referral
- Assists with the development and review of Trauma Policies and Guidelines
- Assists with over-sight of the Performance Improvement Program
- Relays pertinent information to and from the Medical Staff Committee
- Oversees loop closure
- Leads education/counseling sessions regarding provider issues
- Reports trauma performance improvement data at hospital committees.

2) Trauma Program Manager

- Oversees validation of Trauma Registry data
- Assists with over-sight of the Trauma Performance Improvement Program
- Reports trauma performance improvement data at hospital committees.
- Responsible for follow-up on system issues
- Assists in the development of special studies

Trauma Performance Improvement

- Prepares trended data reports
- Responsible for issue identification and issue validation
- Maintains Trauma Performance Improvement database and files
- Coordinates cases for performance improvement forums
- Produces Provider Specific feedback

- Links educational programs to PIPS data
- Compiles Department Report Cards
- Captures Medical Examiner findings for entry into registry database
- Provides monthly reports for performance improvement forums

G) CREDENTIALING

Provider credentialing occurs through established channels within the hospital's medical staff and nursing structure. Mechanisms for monitoring compliance with Trauma Specific criteria will be coordinated within the Trauma Services PIPS structure:

- 1) **Physicians:** Compliance with the **Trauma Physician Credentialing** policy will be monitored and reported to each physician via quarterly Provider Profiles.
- 2) **Nursing staff:** specified under the **Trauma Nursing Education Requirements** policy will be monitored for compliance with the requirement of that policy. Unit managers will report compliance of employees upon their annual review.

H) DATA COLLECTION AND INFORMATION SOURCES

Issue identification will originate from both concurrent and retrospective review of data. The data sources include, but are not limited to the following:

- Trauma Registry Analysis
- Audit filters Complications
- Medical Examiner Report Review
- Sentinel Event Reporting
- Internal Special Studies
- Special Studies Conducted by Other Disciplines or Departments
- System Analysis Referrals
- Direct Observation and Reporting by Trauma Services Providers or other Care Providers
- Pre-hospital Reports
- Hospital Medical Records

I) INDICATORS

1) Policy/EBPMGs Review of established administrative/patient care policies will be scheduled for review will have the following completed prior to scheduled Trauma PIPS Committee review:

- a. Literature search: Benchmarks, ACS Committee on Trauma Resources for Optimal Care of the Injured Patient: 2006 and best practice performers.
- b. Consult appropriate departments for input (lab, blood bank, nursing, etc) and invite a representative to be present as a guest at the Trauma PIPS Committee in which the policy is being presented.

2) Approved changes will be documented in the minutes.

3) The staff will be educated on any policy/EBPMGs changes.

J) PIPS Plan:

1) Selected outcome audits will be referred for medical staff peer review (non-inclusive):

- Mortality (death)
- Patient with gunshot or stab wound which penetrates the abdominal wall who does not receive an exploratory laparotomy if not transferred to Level II Trauma Center.
- Patient requiring a laparotomy which is not performed within two hours of emergency department arrival, if patient is not transferred.
- ED to Transfer to a Level II Trauma Center of > 30 minutes in a hypotensive patient with intracranial or penetrating injury to chest/abdomen.
- Negative exploratory laparotomy.
- Unplanned abdominal, thoracic, vascular or intracranial complications occurring greater than 24 hours after arrival.
- Thoracotomy procedure performed in the emergency department
- Readmission: Patient previously an inpatient on the trauma service, discharged, and is readmitted as an inpatient within 7 days of initial discharge.
- Unplanned return to ICU
- Delay of diagnosis
- Patients with an interval of greater than 8 hours between arrival and treatment of blunt, compound fracture or laceration into the joint if patient is not transferred/
- Missed activations with serious or potentially serious detriment to patient care.
- Sentinel events.
- Major complications which significantly increase length of stay or impact positive patient outcomes.
- Unplanned return to OR within 48 hours of initial procedure
- Open tib-fib fracture went to the OR >8 hours after EDA

2) Outcomes for general, nursing or multidisciplinary review:

- Under or over-triage
- Major documentation issues (nursing)
- Fracture identified after 24 hours
- Comatose patient left ED without being intubated
- GCS <13 CT head greater than 2 hours after ED arrival
- Massive Transfusion Protocol initiated
- Problem intubation
- System issues (lost films, blood did not arrive, pager failure, activation not paged, etc)
- Delay of discharge to rehab/skilled facility >24 hours when patient ready for DC

- Patient seen in ED, discharged to home and re-presents to ED and is admitted within 72 hours of initial visit
- Pre-hospital inappropriate treatment (no IV access, esophageal intubation, no c-collar, no splint for obvious long bone fx, etc)
- No rectal exam in males prior to foley cath insertion
- NG tube inserted with mid-face fractures and /or basilar skull fracture.
- No nutritional support within 72 hours of admit
- No rehab consult prior to day of DC when needed

3) Audit filters:

- Time to C-Spine clearance >24 hours
- No documentation of spinal cord clearance
- DVT Prophylaxis not ordered and/or implemented
- Interfacility transfers
- Missing GCS and/or Temp
- Missing hourly VS for TTA
- No sequential GCS on pt. with skull fx
- Trauma Surgeon response time to trauma and documentation
- Complications
- Missing Pre-hospital run sheets/documentation or times
- Trauma patient admitted to medicine
- Reintubation within 48 hours of extubation
- TTA in ED greater than 2 hours
- Trauma consult not seen by Trauma Surgeon within 30 minutes of notification
- Activations discharged to home from ED
- Ambulance scene time >20 minutes
- Transfer out > 6 hours after arrival

4) Focused Audits:

- Nursing education compliance
- Physician credential compliance
- Multidisciplinary physician attendance
- Surgeon Response time
- Registry inter-rater reliability Audit Filters (ACS)
- Over and under triage

5) Issue defined Audits: Committee will identify topic on an as needed basis.

K) ACTION

The members of the Trauma PIPS committee will decide upon corrective action to be taken. Actions may include any of the following:

1) Education

- Multidisciplinary Trauma Lecture Series
- Focused Inservice
- Trauma Topics

K) ACTION

The members of the Trauma PIPS committee will decide upon corrective action to be taken. Actions may include any of the following:

1) Education

- Multidisciplinary Trauma Lecture Series
- Focused Inservice
- Trauma Topics
- 1:1 Focused education

2) Change in policies, evidenced-based practice management guidelines and procedures

- Each policy is scheduled for bi-annual review
- Changes are made on an as needed basis
- New Protocols are developed as needs are identified

3) Provider counseling (Individual Counseling) - Counseling is conducted by the Trauma Medical Director or designee. A written record of the counseling is kept in the PIPS records.

4) Referral to internal (including Risk Mangement) or external review

5) Focused audit

6) Change in privileges or credentialing

7) Enhanced resources or methods of communication

L) ASSESSMENT OF ACTION AND IMPROVEMENT (LOOP CLOSURE)

Corrective action is monitored for the desired outcome. Determination of the desired outcome may be measured by frequency tracking, benchmarking and variance analysis. The loop is closed after the desired outcome has been achieved by measurable data over a set time limit.

M) COMMUNICATION

Integrating quality improvement information contributes to the detection of trends, performance patterns and potential problems that effect more than one department. An annual summary report will be submitted to the Hospital Leadership and each department head is responsible to the dissemination of PIPS resolutions.

Signature:

Trauma Program Manager: Michelle Moore

Trauma Program Medical Director: J. Johnson

Approval Date:

Revision Date(s):



St. Vincent

Anderson Regional Hospital

Trauma Care Committee

Date: Thursday, February 21, 2013

Time: 10:30 a.m.

Location: Cafeteria Room 2

Attendees: Kathi Wasilewski, ED Director; Cortney Hofer, CCU Manager; Carrie Rowland, Bennett Rehab Manager; Sarah Asnicar, Laboratory Manager; Sam Walker, Radiology Manager; Julie Everitt, Radiology Tech; Michelle Moore TNCC RN, Trauma Program Manager; Emily Kovacic, ED Manager; Craig Mitchell, Director Imaging

Recorder: Michelle Moore

Kathi Wasilewski called meeting to order and opened with prayer	Opening
Kathi Wasilewski offered opportunity to discuss any safety concerns. No concerns @ this time.	Safety Concerns
Tiered Activation System discussed with committee, as this system is required for Level III Trauma Centers. The St Vincent Anderson Field Activation Criteria was introduced and lists the distinguishing criteria for Trauma Code 1 vs Trauma Alert activation. Also lists criteria for the trauma patient > 65 years old. The responding disciplines also discussed determining level of activation. EMS and staff education currently underway and activation of tiered system effective April 1, 2013. Pick list, discussed in January meeting, is a possibility and Dr Irick currently working on list. The pick list can be added as a protocol into the computer in the near future. Kathi Wasilewski asked radiology if there were any further delays or problems with getting orders in computer in timely manner. No delays or concerns @ this time. A copy of the Indiana Department of Homeland Security Level III Requirements handed out to committee and discussed our main obstacle being the TMD must be dedicated to one hospital.	Trauma Care Performance Improvement Priorities
Michelle Moore discussed trauma case which remained @ St Vincent Anderson Region in ICU.	Trauma Case Review
- Trauma Registry and ER Metrics: - Inpatient Metrics: Critical Care LOS, Complications, LOS - Rehab – was patient appropriate for Rehab, and did they get it?	Trauma Registry and ER Metrics

<ul style="list-style-type: none"> - Need to decide how we will collect data of patients that are kept in facility <ul style="list-style-type: none"> - Courtney is currently already collecting a lot of the data that we would want to collect on the Trauma patients that are kept at our facility -Michelle Moore will email Kristine Swank (pharmacy), Courtney Hofer (CCU) and Tracy Gross (case management) to have data forwarded to ED. <p>Michelle Moore discussed the trauma registry and the trauma indicators currently being collected.</p>	
<ul style="list-style-type: none"> - Meeting Adjourned at 11:15 - Next Meeting Date/Time – TBA <ul style="list-style-type: none"> - Will likely be made a series appointment 	



St. Vincent

Anderson Regional Hospital

Trauma Steering Committee

Date: Thursday, January 17, 2013

Time: 10:30 a.m.

Location: Executive Conference Room

Attendees: Kathi Wasilewski, ED Director; Bev Hilburt, ED Educator; Cortney Hofer, CCU Manager; Anna Clevenger, Respiratory Care Director; Carrie Rowland, Bennett Rehab Manager; Denise Bousman, StatFlight RN; Sarah Asnicar, Laboratory Manager; Tracie Davis, OR Practice Facilitator; Sam Walker, Radiology Manager; Julie Everitt, Radiology Tech; Kristin Quimby, TNCC ED RN; Sarah Contos, ED Manager; Michelle Moore ED RN, Trauma Program Manager; Emily Kovacik, ED Manager

Recorder: Sarah Contos

Kathi Wasilewski called meeting to order and opened with prayer	Opening
<p>Michelle Moore provided a Powerpoint overview and value of State Trauma System, purpose of organized trauma care and trauma centers and trauma levels, and current status of Trauma designation at St. Vincent Anderson Regional.</p> <ul style="list-style-type: none"> - Michelle has been reviewing Trauma Cases in the ED, and has been taking them to Dr. Irick, ED Chief, as needed for review. No cases have needed to be reviewed by Dr. Baer, Trauma Medical Director, at this time. 	Background/ State Trauma System
<ul style="list-style-type: none"> - SWOT analysis previously performed by Nancy Pitcock, CNO; Kathi Wasilewski, and Michelle Moore. SWOT presented by Michelle – many strengths are present – many requirements are already in place, main threat/weakness is financial cost. 	Gap Analysis
<ul style="list-style-type: none"> - Trauma Medical Director in place – Dr. Baer - Performance Improvement and Patient Safety Program to be put in place <ul style="list-style-type: none"> - 1. Trauma Program Operational Process Performance Committee will meet quarterly – Dr. Irick and Dr. Beeson <ul style="list-style-type: none"> - Consists of hospital and medical staff member. Addresses, assesses and corrects global trauma program and system issues. The committee handles process, includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to continue to optimize patient care - 2. Multi-Disciplinary Peer Review Committee (chaired by the Trauma Medical Director) <ul style="list-style-type: none"> - Purpose: Improve trauma care by reviewing selected cases (including deaths, sentinel events) 	Trauma Program Committees

<ul style="list-style-type: none"> - ---- Suggest that Multi-Disciplinary Peer Review follow the trauma program operational process performance committee quarterly. Both are essential committees for Level 3 and would require 2 separate sets of minutes - 3. Trauma Peer Review at ED Section 3rd Monday of each month - Multidisciplinary Trauma Care Committee <ul style="list-style-type: none"> - This group will begin the assessment of staff needs and performance; review data, identify process improvement, education needs, equipment needs and reefer concerns to appropriate consultation dept <ul style="list-style-type: none"> - Trauma Medical Director (consultation) Dr. Baer - Trauma Program Manager - Michelle Moore - Emergency Medicine Trauma Director (consultation) Dr. Irick/Beeson - EMS Coordinator: Bev Hilburt - Critical Care: Cortney Hofer - Respiratory Care: Anna Clevenger - Orthopedic Surgery-Trauma Liaison (consultation) Dr. Schick - Director/Managers: ED (Kathi Wasilewski, Emily Kovacik, Sarah Contos) - OR Practice Facilitator: Tracie Davis - Lab Manager/Blood Bank: Sarah Asnicar - Director Imaging: Craig Mitchell - Rehab Services: Carrie Rowland - TNCC RN Kristin Quimby 	
<ul style="list-style-type: none"> - Going forward, will need to differentiate Trauma levels between "Code 1" and "Trauma Alert" - Discussed RT role of assessing airway and respiratory status for each Trauma patient, and need by RT to have assessment documented <ul style="list-style-type: none"> - RT could inform Trauma Recorder of assessment and he/she could chart assessment, or RT could write assessment on paper Trauma chart if they preferred - RT could still document their assessment in the computer - Is there a way to make it known in the overhead call that there are multiple traumas? <ul style="list-style-type: none"> - Possibly, "Trauma Code 1 Multiple Patients" or "Trauma Code 1, 3 Patients" so RT knows how many of them need to respond to ED - Briefly mentioned need to assign roles in Trauma and make sure staff understand what their roles are - Discussion regarding radiology orders not being entered in timely manner on Trauma patients <ul style="list-style-type: none"> - Could have checklist of xrays and MD could check xrays needed and then someone needs to be identified who could enter orders (Trauma Recorder??) - Make "pick list" Protocol in computer, for ease and efficiency in ordering xrays 	<p>Trauma Care Performance Improvement Priorities</p>

<ul style="list-style-type: none"> - Order list would be limited so that unnecessary xrays could not be performed - May also need to make Trauma Protocol order set in computer 	
<ul style="list-style-type: none"> - Trauma Registry and ER Metrics: <ul style="list-style-type: none"> - GCS of 8 without mechanical airway secured - Door to transfer goal for CODE 1 will be < 1hour - ED LOS <2 hours for all trauma - Unplanned readmission - Backboard removal < 20 minutes - Inpatient Metrics: Critical Care LOS, Complications, LOS <ul style="list-style-type: none"> - Rehab – was patient appropriate for Rehab, and did they get it? - Need to decide how we will collect data of patients that are kept in facility <ul style="list-style-type: none"> - Cortney is currently already collecting a lot of the data that we would want to collect on the Trauma patients that are kept at our facility - Create Shared Excel Spreadsheet so that Data can be entered and shared between dept's – Ask Nick Theohares to help create spreadsheet - What constitutes a Trauma <ul style="list-style-type: none"> - Michelle has a list of trauma criteria <ul style="list-style-type: none"> - Basically – what we are currently using as our Trauma Alert Criteria - Mechanism of injury has to be taken into account, and is often overlooked at present <ul style="list-style-type: none"> - For example – Falls may at least initially be considered a trauma - St. Vincent Trauma Center currently has a list of criteria that differentiates between “Trauma Code 1” and “Trauma Alert” that we will likely follow - May need to bring a Pulmonologist into the Trauma Program since they are involved in caring for the Critical Care patients – possibly Dr. Mares? 	<p>Trauma Registry and ER Metrics</p>
<ul style="list-style-type: none"> - Meeting Adjourned at 11:45a.m. - Next Meeting Date/Time – TBA <ul style="list-style-type: none"> - Will likely be made a series appointment 	



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Trauma Designation Update

January 10, 2013

Present: Tom Vanosdol, Nancy Pitcock, Ed Irick, MD, James Beeson, MD, Michelle Moore, Cindy Ruffer, Dr. Schick, Gary Brazel, MD, Kathi Wasilewski

Kathi reported on the current status of Level III preparedness:

Current focus for the past 6 months has been performance improvement and peer review. This is currently being done by Michelle Moore, Trauma Program Manager and Dr. Ed Irick, Chief of the Emergency Department. Deficiencies identified and relayed back to the physicians involved but true loop closure not well documented. Examples of deficiencies identified: Delay in backboard removal, delays in transfer of the patient to Level I or Level II Trauma Center (Goal 30 minutes for Trauma Code 1) Critique form attached to minutes.

Discussed next steps for Level III application. Dr. Baer has agreed to serve as Trauma Medical Director and reviewed the proposed committee structure and definition for TMD (from the green book)

Trauma Medical Director: Dr. Baer

Works in cooperation with nursing administration to support the needs of trauma patients, develops treatment protocols along with the Trauma Care Committee and coordinates performance improvement and peer review process. The trauma director must have the authority to correct deficiencies in trauma care.

Trauma Service represents a structure of care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. (May vary based on specific needs of the medical facility, available personnel and the quantity of resources)

Performance Improvement and Patient Safety Program

1. **Trauma Program Operational Process Performance Committee (Essential) Quarterly**
*Dr. Beeson and Dr. Irick currently leading this but Dr. Baer will assume this role on date ____?
Format may be hospital specific; consists of hospital and medical staff members. It addresses, assesses and corrects global trauma program and system issues. The Committee handles process, includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to continue to optimize patient care.*
2. **Multi-Disciplinary Peer Review Committee (Chaired by the Trauma Medical Director)**

Purpose: Improve trauma care by reviewing selected cases (including deaths, sentinel events)

Suggest that Multi-Disciplinary Peer Review follow the Trauma Program Operational Process Performance Committee Quarterly. Both are essential committees for Level III.

3. Trauma Peer Review at ED Section 3rd Monday of Each Month

This is currently being done at the monthly ED Section to identify opportunities for improvement in the care of the trauma patient.

4. Multidisciplinary Trauma Care Committee

This group will begin the assessment of staff needs and performance; review data, identify process improvement, education needs, equipment needs and refer concerns to appropriate consultation department. First meeting January 2013.

- Trauma Medical Director Dr. Baer
- Trauma Program Manager – Michelle Moore
- Emergency Medicine Trauma Director (consultation) Dr. Irick/Beeson
- Chief Nursing Officer- Nancy Pitcock
- EMS Coordinator: Bev Hilburt
- Critical Care Manager: Courtney Hofer
- Respiratory Care Director: Anna Clevenger
- Orthopedic Surgery-Trauma Liaison (consultation) Dr. Schick
- Director /Managers: Emergency Department: Emily Kovacic, Sarah Contos, Kathi Wasilewski
- OR Practice Facilitator: Tracie Davis
- Lab Manager/Blood Bank: Sarah Asnicar
- Director Imaging: Craig Mitchell
- Rehab Services: Carrie Rowland
- Kristin Quimby ED Staff Nurse

Further group discussion: Kathi and Michelle will investigate further the State mandates for Level III application.

SWOT analysis reviewed and all agreed that an ACS consult visit should be planned for later in the year.

**Saint John's Emergency Department
Trauma Care Critique**

Instructions: Please complete this form in an effort to improve trauma care. Following completion, place the form in the mailbox of the Trauma Program Manager, Michelle Moore

Patient Name / Date / Encounter Number (Attach Sticker)		
Were all of the members of the Trauma Team present <i>prior</i> to the arrival of the patient?	RN Primary	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Secondary RN	Yes <input type="checkbox"/> No <input type="checkbox"/>
	AD/Scribe	Yes <input type="checkbox"/> No <input type="checkbox"/>
	ED Physician	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Surgeon	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Lab/Blood Bank	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Radiology Tech(s)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OR RN	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Chaplain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did <i>all</i> members of the Trauma Team prepare for arrival appropriately, e.g., all anticipated equipment and drugs are in the room prior to the arrival of the patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
Were there enough nurses present for the initial care?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments
Did staff need to leave the room for supplies or medications during the resuscitation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
Did <i>all</i> members of the Trauma Team at the immediate bedside wear personal protective equipment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
Was the team quiet for the paramedics report?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Comments:
Was the Trauma Team Leader identified?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
Was crowd control a problem? e.g., were uninvolved people present? Was corrective action initiated?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:
Were multiple physicians giving orders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:

Were the orders clear, concise and appropriate?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comments:
Was communication between all team members clear, professional, and timely?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comments:
Were medications immediately available for intubation?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Comments:
Were the principles of ATLS/TNCC followed?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comments:
Was the initial assessment and resuscitation well organized and expeditious?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comments:
Is there anything about the resuscitation that was well done or has improved?	Yes <input type="checkbox"/> No <input type="checkbox"/> Comments:
Overall grade of the resuscitation	1 – Poor <input type="checkbox"/> 2 - Needs improvement <input type="checkbox"/> 3 – Good <input type="checkbox"/> 4 - Very good <input type="checkbox"/> 5 – Excellent <input type="checkbox"/>
Additional Comments:	

**Emergency Dept.
RN Competencies Due Dates**

Name	Title	CPR	ACLS	PALS	TNCC	ENPC
Bennett, Julie	RN	Jul-14	Jul-14	Aug-15	May-15	
Browning, Pamela M	RN	Oct-14	Jun-15	May-14	May-15	Apr-15
Buck, Wendy	RN	Sep-13	May-15	Jan-14	May-13	
Clark, Denell	RN	Oct-13	Jul-14	May-14	Apr-17	
Contos, Sarah	RN	Apr-14	Feb-14	Mar-15	Instr.	Oct-14
Corder, Terri J	RN	May-14	Apr-15	Mar-15	May-12	Oct-14
Councillor, Kelly	RN	Aug-14	Apr-15	Sep-15	Aug-15	
Covey, Christopher L	RN	Jan-15	Jun-13	Jun-15		
Ellingwood, Shannon	RN	Jan-14	Sep-14	May-14		
Freeman, Stephanie	RN	May-14	Mar-14	Feb-14	Jan-14	Feb-11
Friend, Cara	RN	Nov-14	Sep-15			
Garrett, Pamela	RN	Jul-15	Jun-15	Jan-15	Oct-13	Nov-12
Green, Sara	RN	Sep-14	Sep-14	Mar-15	Oct-13	Feb-10
Grimes, Zac	RN	Aug-14	Sep-15			
Hamilton, Janet I	RN	Nov-14	Oct-14	Jul-14	Apr-16	Aug-17
Harlan, Terri	RN	Feb-14	Sep-14	May-14	Nov-12	Aug-13
Harper, Martha	RN	Apr-14	May-15	Mar-15	Nov-13	Aug-13
Harper, Olivia	RN	Oct-13	Jun-15	May-14		
Hart, Kristine	RN	Jun-15	Sep-14	Dec-14		
Hilburt, Bev	RN	May-15	Jun-15	Feb-14	Apr-17	Feb-13
Jarrett, Andrea	RN	Sep-15	Nov-13	May-14	Apr-17	Aug-17
Johnson, Julie L	RN	Jul-14	May-14	Sep-14	May-15	May-15
Kovacik, Emily	RN	May-14	Mar-14	Feb-14		
Lakas, Kathy L	RN	Aug-14	May-15	Jul-14	Jul-14	May-15
Lawson, Cynthia L	RN	Apr-14	Feb-15	Sep-14	Jul-14	May-15
Layton, Patricia A	RN	Sep-14	Mar-14	Sep-14	May-15	
Luckoski, Lisa	RN	Jan-14	Oct-13	Feb-15	Mar-17	Nov-16
Maddox, Kellie L	RN	May-14	Feb-15	Sep-14	Aug-15	
Mahurin, Kiely	RN	Oct-13	Apr-15	May-14	Apr-17	
McNicol, Rebecca	RN	Apr-14	May-15	Aug-15	Apr-17	
Miller, Sara	RN	Jan-14	Sep-14	Dec-14		
Montgomery, Sharon	RN	Jun-15	Nov-14	Jun-15		
Moore, Michelle D	RN	May-14	Jun-14	Jan-15	Instr.	Aug-13
Newland, Amy	RN	Sep-15	May-14	May-14		
Parsons, Lindsey	RN	Nov-13	Apr-15	Feb-14	Nov-12	
Patterson, Julie A	RN	Oct-13	Aug-15	Feb-14	Nov-13	
Pfiefer, Ann	RN	Jan-15	Feb-15	Jun-15	Aug-14	
Planalp, Tiana	RN	Dec-13	Jun-15	Apr-15		
Quimby, Kristin L	RN	Aug-14	Jun-14	Mar-15	Nov-12	

**Emergency Dept.
RN Competencies Due Dates**

Name	Title	CPR	ACLS	PALS	TNCC	ENPC
Rees, Cheryl	RN	Jul-14	Sep-14	May-14		
Scott, Kristina	RN	Feb-15	Apr-14	Sep-14	Oct-13	Aug-16
Shelton, Melissa	RN	Oct-13	Nov-14	Jan-15		
Sherman,Michelle	RN	Oct-13	Sep-15	Mar-15	Apr-17	
Stern,Jennifer A	RN	Oct-13	Sep-14	Sep-15		
Taylor,Donna L	RN	Jun-14	Mar-14	Sep-14	Jul-14	
Tester, Eric	RN	Jun-15	Jan-14	Apr-15	Apr-17	
Thomas,Jill	RN	Dec-13	Oct-13	Jun-15	Apr-17	
Thompson,Denna D	RN	Jan-14	Jan-14	Jan-15	Nov-13	
Tibbett,Lucinda J	RN	Apr-14	Jul-14	May-14	Apr-16	Aug-13
Todd, Sharine	RN	Jan-14	Sep-15	Apr-15	Apr-16	
Tucker Amanda	RN	Jul-15	Aug-15	Aug-15	Nov-13	
Vaughn, Donna	RN	Mar-14	May-15	Sep-15	Nov-12	Feb-13
Wallace, Apryll	RN	Apr-14	Sep-14	Oct-14	Feb-17	
Walterhouse, Sheila	RN	Sep-15	Oct-14	May-14	Mar-13	Apr-13
Warfel, Tiffany	RN	Nov-14	Sep-15	Jan-14	May-15	
Wasilewski, Kathi	RN	Feb-14	Feb-15	Feb-15	Jan-12	
Wensel, Rachel	RN	Aug-14	May-14	Jun-15	Aug-15	
Williams, Tyler	RN	Jul-15	Nov-13	May-14		

New Employee Orientation
St. Vincent Anderson Regional Hospital

Item Name	Item Type	Due Date	Status	Completed	Score	# of Units	Type of Unit	Provider
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/25/2013	80	1.4	Contact Hours	ENA
Abdominal and Genitourinary Trauma								
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/8/2013	80	2.6	Contact Hours	ENA
Behavioral Health Emergencies								
Emergency Nursing Orientation 2.0: Burns	Lesson	9/2/2013	Completed	7/29/2013	85	1.4	Contact Hours	ENA
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/5/2013	80	2.3	Contact Hours	ENA
Cardiovascular Emergencies Part I								
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/15/2013	80	2.1	Contact Hours	ENA
Cardiovascular Emergencies Part II								
Emergency Nursing Orientation 2.0: Child and Elder Maltreatment and Intimate Partner Violence	Lesson	9/2/2013	Completed	7/11/2013	80	1.7	Contact Hours	ENA
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/11/2013	80	2.3	Contact Hours	ENA
Communicable Diseases								
Emergency Nursing Orientation 2.0: Dental, Ear, Nose, Throat, and Facial Emergencies	Lesson	9/2/2013	Completed	7/17/2013	85	1.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Disaster Preparedness	Lesson	9/2/2013	Completed	7/9/2013	90	1.7	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Drug Calculations	Lesson	9/2/2013	Completed	7/15/2013	100	1.4	Contact Hours	ENA
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	8/5/2013	90	1.9	Contact Hours	ENA
Endocrine Emergencies								
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/11/2013	80	1.7	Contact Hours	ENA
Environmental Emergencies								
Emergency Nursing Orientation 2.0: Fluid and Electrolyte Imbalances and Vascular Access	Lesson	9/2/2013	Completed	7/3/2013	85	2.1	Contact Hours	ENA

New Employee Orientation
St. Vincent Anderson Regional Hospital

Emergency Nursing Orientation 2.0: Forensic Nursing in the Emergency Department	Lesson	9/2/2013	Completed	7/15/2013	86.67	0.88	Contact Hours	ENA
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/25/2013	80	1.8	Contact Hours	ENA
Gastrointestinal Emergencies	Lesson	9/2/2013	Completed	7/31/2013	95	1.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0:	Lesson	9/2/2013	Completed	7/23/2013	80	2	Contact Hours	ENA
Gynecologic Emergencies	Lesson	9/2/2013	Completed	7/23/2013	80	2	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Head Trauma	Lesson	9/2/2013	Completed	8/5/2013	90	1.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Hematologic and Oncologic Emergencies	Lesson	9/2/2013	Completed	7/11/2013	100	1.31	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Influenza“Seasonal, Avian, and Pandemic	Lesson	9/2/2013	Completed	7/29/2013	100			
Emergency Nursing Orientation 2.0: Introduction: How to Use Emergency Nursing Orientation 2.0	Lesson	9/2/2013	Completed	7/26/2013	85	2.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Management of the Critical Care Patient in the Emergency Department	Lesson	9/2/2013	Completed	7/23/2013	80	1.1	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Maxillofacial Trauma	Lesson	9/2/2013	Completed	8/5/2013	95	1.6	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Musculoskeletal and Neurovascular Trauma	Lesson	9/2/2013	Completed	7/29/2013	80	2.3	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Neurologic Emergencies	Lesson	9/2/2013	Completed	7/15/2013	90	2.4	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Nuclear, Biologic, and Chemical Agents of Mass Destruction	Lesson	9/2/2013	Completed	7/15/2013	90	2.4	Contact Hours	ENA

New Employee Orientation
St. Vincent Anderson Regional Hospital

Emergency Nursing Orientation 2.0: Obstetric Emergencies	Lesson	9/2/2013	Completed	7/31/2013	85	2.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Ocular Emergencies	Lesson	9/2/2013	Completed	7/25/2013	80	1.6	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Organ and Tissue Donation	Lesson	9/2/2013	Completed	7/8/2013	80	0.72	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Pain	Lesson	9/2/2013	Completed	7/8/2013	95	1.6	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Palliative and End-of-Life Care in the Emergency Department	Lesson	9/2/2013	Completed	7/29/2013	86.67	1.4	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Patient Assessment	Lesson	9/2/2013	Completed	7/8/2013	80	1.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Pediatric Emergencies Part I	Lesson	9/2/2013	Completed	8/8/2013	95	1.8	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Pediatric Emergencies Part II	Lesson	9/2/2013	Completed	8/8/2013	95	1.4	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Renal and Genitourinary Emergencies	Lesson	9/2/2013	Completed	7/25/2013	80	2.6	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Respiratory Emergencies	Lesson	9/2/2013	Completed	7/3/2013	85	1	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Sexual Assault	Lesson	9/2/2013	Completed	7/23/2013	85	0.9	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Shock Emergencies	Lesson	9/2/2013	Completed	7/29/2013	80	2.6	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Spinal Trauma	Lesson	9/2/2013	Completed	8/6/2013	90	2.8	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Substance Abuse	Lesson	9/2/2013	Completed	7/8/2013	90	1.5	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Thoracic Trauma	Lesson	9/2/2013	Completed	8/6/2013	90	1.3	Contact Hours	ENA

New Employee Orientation
St. Vincent Anderson Regional Hospital

Emergency Nursing Orientation 2.0: Toxicologic Emergencies, Part II“Overdoses	Lesson	9/2/2013	Completed	7/9/2013	100	1.1	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Toxicologic Emergencies, Part II“Poisoning.	Lesson	9/2/2013	Completed	7/9/2013	95	1.2	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Triage	Lesson	9/2/2013	Completed	7/23/2013	80	1.7	Contact Hours	ENA
Emergency Nursing Orientation 2.0: Wound Management	Lesson	9/2/2013	Completed	7/31/2013	85	1.03	Contact Hours	ENA



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Critical Care Nurse Credentialing Requirements

BLS

ACLS

TNCC (not required; will be sending 6 nurses in December 2013)

3 education days/year

1 skills day/year

Safe Patient Mobilization

ECCO (Essentials of Critical Care orientation)-10 modules

Critical Care orientation

EKG interpretation class

Introduction to equipment

IOPO

Phlebotomy class and check off

EKG interpretation class

RN CCU orientation list

BREATH SOUNDS [can identify]: clear breath sounds, coarse and fine crackles, wheezes inspiratory and expiratory, pleural rub, labor of breathing (SOB and retractions)
SKIN -temp, color, moisture
SPUTUM -color, amount, thickness COUGH -productive, nonproductive
OXYGEN DELIVERY: O2 cylinders and valves Nasal canula-basic, humidity, with reservoir Venti-mask- determines oxygen flow rate, states percent oxygen delivered Partial Rebreather and Non Rebreather mask – O2 flow rate Trach Collar- need for humidity Ambu bag- flow rate, peep valve
AIRWAY DEVICES: oral airway & nasopharyngeal airway (choose correct size, insertion, monitoring),
VENTILATORS BEDSIDE/TRANSPORT: FiO2, Tidal Volume, Mode (SIMV, Assist Control), Pressure Support, Peep, Alarms, Trouble shoot
Pressure Control Ventilation: voices understanding of
Sedation for Ventilation: barbiturates/propofol, ramsey scale, documentation
Paralysis for Ventilation: different types of medications, use of peripheral nerve stimulator, documentation
SUCTIONING: bag suctioning, in line suctioning, red robinson, suction catheter
TRACHEOSTOMY TUBES: shiley, bivona, others, trach changes
TRACHEOSTOMY CARE: verbalize policy, maintain sterile technique, monitors patient, changes trach ties
ENDOTRACHEAL TUBE: notes size, centimeter mark, recognizes cuff leak and takes appropriate measures to deal with cuff leak, assists with retaping ETT
CHEST TUBES: assists with insertion, procedure cart; assess breath sounds, subq emphysema, sets up thoro-seal (to underwater seal and/or suction), checks for respiratory variation, notes air leak, assess cause of air leak, chest tube dressing change
Respiratory Procedures: assists with intubation (elective and emergent), fibrolaryngoscope, reintubation, thoracentesis, bronchoscopy, tracheostomy
MISCELLANEOUS: obtains sputum specimen, interprets ABG results, review respiratory cart, assist with incentive spirometer
CARDIOVASCULAR ASSESSMENT: heart sounds (s1, s2, s3, s4, murmur, rub, gallop), heart rate (reg / irreg, apical / peripheral), palpate pulses (temporal, carotid, brachial, radial, femoral, popliteal, posterior tibial, dorsalis pedis), use of doppler
CIRCULATION - color, temp, sensation, edema
JUGULAR VEIN DISTENTION AUSCULTATION OF BRUITS HOMAN'S SIGN, CLAUDICATION VARICOSITIES
MONITORS: CENTRAL STATION – admits patient, runs strips, silences alarms, adjust arrhythmia alarms and alarm limits, discharges patient, changes recorder paper
PROGRESSIVE CARE – places patches, chooses lead, adjust gain, view multiple leads, checks wires, check/change batteries, storage, cleaning, remove for transport / shower, use of omni bedside monitor
TELEMETRY - places patches, chooses lead, adjust gain, view multiple leads, checks wires, check/change batteries, storage, cleaning, remove for transport / shower, use of omni bedside monitor

RN CCU orientation list

<p>CRITICAL CARE – places patches, states color codes, changes leads, adjusts gain, pacer view, silences and adjusts alarms, adjusts second lead, views multiple leads Non-Invasive BP – set frequency, set alarms, troubleshoots, verify manual when alarm / concern Respiratory monitor – adjust alarm, switch manual and auto Pulse Oximetry – correlation with HR for accuracy, adjust for high / low sats, adjusts alarms, verbalize understanding of perfusion.</p>
<p>ARTERIAL PRESSURE LINE: consent if able, procedure cart, set up continuous flush, date and label, maintain sterile field, assist MD as needed, support patient, note proper waveform, secure line and dressing, secure transducer, zero line Maintain – assess site, set alarms NEVER TURN OFF ALARMS Draws blood per policy Dressing change Change flush system / tubing Check for cuff correlation Voices possible complications and Troubleshoots system DC arterial line (radial / femoral)</p>
<p>INSERTION OF CENTRAL LINE: procedure cart, assist MD, maintain sterile field, secure and apply dressing, x-ray confirmation Policy – change caps and dressing, flush, filter, de-clotting, push pull blood draw, trouble shooting Line types – triple / quad lumen, groshong, hickman, picc, broviac, cook Draws blood from saline lock per policy</p>
<p>MEDICATIONS-PURPOSE, SIDE EFFECTS, DOSING: Aggrastat, Cardizem, Dobutamine, Dopamine (regitine injection for infiltration), Heparin (bleeding precautions, APTT protocol, saline lock for blood draws), Levophed (regitine injection for infiltration), Lidocaine (drug level 12 hours after initiation), Lovenox (protocol, dose calculation), Nitroglycerin, Natrecor, Nipride, Primacor, Procainamide, Propofol (tubing change and filter), TPN (tubing change, check prescription, filter), tNK-Ase, Definity</p>
<p>CODE BLUE PROTOCOL: phone 7000, role in code, code with exception, no code, sticker placement</p>
<p>BLOOD ADMINISTRATION: IV size, consent, education information, checking blood, transfusion reaction protocol, FFP, Platelets</p>
<p>PERMANENT PACEMAKER: educational video for patient, change monitor to pacer view, notes functioning properly, able to identify failures, states who to call if non-functioning, provides information to patient, pacemaker enrollment</p>
<p>LIFEPAK 20 Review with preceptor</p>
<p>ELECTIVE CARDIOVERSION: consent signed, prepare supplies, code cart, suction, ambu, hands free, documentation</p>
<p>TRANSESOPHAGEAL ECHOCARDIOGRAM: consent, prepare supplies, code cart, suction, ambu, documentation</p>
<p>CARDIAC CATHETERIZATION: order verified in computer, consent, education pamphlet and video, pre cath procedure, post cath procedure, notify MD of complications (chest pain, bleeding from site, hematoma procedure, change in vital signs)</p>
<p>CARDIAC STRESS TESTING: verify order in computer, radiology, cardiology, NPO, education</p>
<p>RECOVERY: Conscious Sedation, Anesthesia direct to CCU (Phase I), documentation</p>
<p>Cardiac Rhythm Interpretation: identifies – normal sinus, sinus arrhythmia, sinus tach, PAC, atrial fib, atrial flutter, heart block (1-3 degrees, all types), SVT, VT, PVC, Vfib, Torsades, Agonal / Idioventricular, pacing (different types), junctional, bundle branch blocks Able to recognize and treat.</p>
<p>PHLEBOTOMY: attends class, performs venipuncture correctly, line draw per policy (saline lock, central line, arterial line), uses correct tube for specimen, label correctly, send appropriate samples to lab via tube system (able to state what is not to be sent via the</p>

RN CCU orientation list

tube), uses appropriate safety devices
GASTROINTESTINAL: Identifies – normal sounds, hypo and hyperactive, absence of bowel sounds, guarding abdomen, rigid / acute abdomen, bloody stool (old and new blood), gastric contents (old and new blood), bile
NASOGASTRIC TUBE: set up, insertion, verify placement, suction (continuous and intermittent), securing, irrigation, measuring contents, emptying, troubleshooting, removal, change irrigation and canister Q 24 hours
FEEDING TUBE: insertion, verify placement, secure insertion wire, secure tube, removal, confirm with x-ray
PEG TUBE: Bolus feed, dressing change, removal
KANGAROO PUMP: set rate, clear pump, changing bag, troubleshooting
FLEXISEAL TUBE: order, insertion, removal
CALORIE COUNT – document food amounts, save menus, sign NPO – sticker, remove bedside fluid/food, patient instruction DYSPHAGIA – identify those at risk, thickened liquids, elevate HOB, chin tuck, adaptive equip.
COLOSTOMY – drain bag, stoma care, fitting wafer, contact enterostomal therapist STOOL SAMPLES – collection, label, send to lab
GU ASSESSMENT: identify- bloody urine, clots, concentrated and dilute urine, foul odor, retention FOLEY CATH – insertion, irrigation, securing, removal, change system as needed, output Q1-2 hours, documentation, measuring, 24 hour cumulative STRAIGHT CATH – sterile technique CBI – titrate flow, changing fluid FLUID RESTRICTION – removal of fluids, instruction, division of fluids 24 HOUR URINE COLLECTION – discard first void, icing specimen, proper container, sign for room MEASURING CONTAINERS- urine hat, urinal, graduated cylinder URINE SPECIMEN- voided, cath, clean catch, label, send to lab
NEUROLOGICAL ASSESSMENT: identify posturing (decorticate and decerebrate), seizures, changes in LOC, abnormal reflexes, changes in strength and pupils TPA for CVA protocol SEIZURE PRECAUTIONS- padding rails, patient safety Hypothermia protocol – reasons for, inclusion criteria, process
RESTRAINTS- documentation and proper maintenance SUICIDE PRECAUTIONS- no order needed, arms reach, documentation 72 HOUR HOLDS DRUGS- Mannitol (filter) and Dilantin (with NS only)
AQUA K THERMAL UNIT: set up, pad connection, temperature probe placement, setting controls, documentation, fluid level, never lift / pull patient with cooling pad
ZOLL Intravascular Temperature Management: set up, connection, operation, charging / ordering replacements
DIABETES: glucometer / diabetic flowsheet, hypoglycemia protocol, manage insulin gtt
PAIN MANAGEMENT: wasting dose, documentation (flowsheet, PGIE, MAK), pain scales, follow up EPIDURAL- pump lock out, no port tubing, documentation, neuroaxial orders only until they expire, hourly resp, disconnected cath care, removal / check for tip, sign CADD PUMP- change cassette, access information in settings, documentation PCA PUMP- setting up pump, reading pump information, changing syringe, documentation
HYGIENE: bathing (partial, complete bed bath, shower), provides for privacy, encourage patient participation, shampoo, shave (electric vs disposable), oral care (dentures, frequent oral care needs), linen changes
SKIN CARE: documentation, assessment tool, preventative skin care, pressure ulcer treatment, turning and positioning, nursing cream, moisture barrier, measures wounds, TLC program, dressing changes (tegaderm, gauze, duoderm, wet to dry, wound packing), special mattresses, contacts wound care RN

RN CCU orientation list

INCARCERATED PATIENT CARE: safety measures, restrictions, proper care
IOPO: referral triggers, donation after cardiac death process, IDA referral made by chaplains on all deaths, designated requesters are the only individuals to approach family for donation requests
POST MORTEM CARE: chaplain service, pronouncement of death, removal of tubes, coroner's cases, death dismissal form, paper gown
6pm-6am SHIFT DUTIES: new flowsheets, rhythm strips, lab cum sums, daily weights and documentation (computer, monitor, dose mode), diabetic hs snacks, baths, visitors after 2100 (ID sticker, entrance and exit), paging MD's (answering service, calls at home), housekeeping needs, special tests (radiology, stats, CT, ultrasound, ordering MD must call radiologist, cardiology, echo, stress tests, cath, lab, am labs at 0400)
MTT DUTIES FOR RN: recognize MTT duties, takes off admission orders, orders labs, stuff charts, checks daily labs, SPD charge cards

Essentials of Critical Care Orientation (ECCO) lessons in SEED to complete:



1. AACN - Introduction to Care of the Critically Ill
2. AACN - Care of the Patient with Cardiovascular Disorders
3. AACN - Basic Hemodynamic Monitoring
4. AACN - Care of the Patient with Endocrine Disorders
5. AACN - Care of the Patient with Gastrointestinal Disorders
6. AACN - Care of the Patient with Hematologic Disorders
7. AACN - Care of the Patient with Multisystem Disorders
8. AACN - Care of the Patient with Neurologic Disorders of the Brain
9. AACN - Care of the Patient with Pulmonary Disorders
10. AACN - Care of the Patient with Renal Disorders

Please text or email me if you have any questions or problems while I am at the meeting.

Stacy

765-617-2255

Stacy.Austin@stvincent.org



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Commitment of the Executive Leadership Team

The Executive Leadership Team of St. Vincent Anderson Regional Hospital is committed to becoming an established Level III Trauma Center and to pursue Indiana State "In the Process" status. The hospital shall pursue verification by the American College of Surgeons within one year and achieve this verification within two years of the granting of the "In the ACS verification process" status.

Thomas J. Vansdol, M.S., M.A., FACHE
President and CEO
St. Vincent Anderson Regional Hospital

9/30/13

Date

David Maxwell, RN, FACHE
Chief Operating Officer

9/25/13

Date

Gary Brazier, MD, CPE
Chief Medical Officer

9-25-13

Date

Nancy Pitcock, RN, BSW, MSN
Chief Nursing Officer

9/25/13

Date

Donald Apple
Chief Financial Officer

9-25-13

Date

Sister Kathleen Reilly, CSC
Vice President, Mission Integration

9/25/13

Date

LEADERSHIP TEAM

Marlene Frazier Carey
Regional Marketing Officer
St. Vincent Northeast Region

9-25-13

Date

Glenn C. Fields
Vice President, Human Resources
Facility Services

9/25/13

Date



St. Vincent
Anderson Regional Hospital

2015 Jackson Street
Anderson, IN 46016-4337
(765) 649-2511

stvincent.org/andersonregional

September 24, 2013

TO WHOM IT MAY CONCERN:

Please be advised that at the September 9, 2013 meeting of the Board of Directors of St. Vincent Anderson Regional Hospital, Inc. the Board, after considering the matter of applying for Level III trauma designation, passed the following motion:

It was moved, seconded and unanimously approved by the Board of Directors of St. Vincent Anderson Regional Hospital to support the pursuit of Level III trauma designation and to recommend support by the Medical Staff of this initiative.

By my signature below, I hereby attest that this motion was passed unanimously by the Board at a meeting at which a quorum of the Board was present and voting.

A member of



Core Values

We are called to:

Service of the Poor

Generosity of spirit,
especially for persons
most in need.

Reverence

Respect and compassion
for the dignity and diversity
of life.

Integrity

Inspiring trust through
personal leadership.

Wisdom

Integrating excellence
and stewardship.

Creativity

Courageous innovation.

Dedication

Affirming the hope and
joy of our ministry.

By: *Osborne J. Morgan*
(Signature)

Printed: OSBORNE J. MORGAN

Title: Chairman of the Board

Date: Sept. 25, 2013



St. Vincent Anderson Regional Hospital

2015 Jackson Street • Anderson, Indiana 46016

Commitment of the St. Vincent Anderson Regional Hospital Board

The Board of St. Vincent Anderson Regional Hospital is committed to becoming an established Level III Trauma Center and to pursue Indiana State "In the Process" status. The hospital shall pursue verification by the American College of Surgeons within one year of this application and achieve this verification within two years of the granting of the "In the ACS Verification Process" status. The Board recognizes that if the hospital does not pursue verification within one year and/or does not achieve ACS verification within two years of the granting of "In Process" status, the in process will be immediately revoked, become null and void and have no effect whatsoever.

9/23/13

Thomas J. VanOsdol, M.S., M.A., FACHE
President
St. Vincent Anderson Regional Hospital

9/24/2013
Date

Osborne J. Morgan
Board Chair
St. Vincent Anderson Regional Hospital



*St. Vincent
Anderson Regional Hospital*

2015 Jackson Street • Anderson, Indiana 46016

Commitment of the Medical Staff

The Medical Staff at St. Vincent Anderson Regional Hospital is committed becoming an established Level III Trauma Center and to pursue Indiana State "In the Process" status. The hospital shall pursue verification by the American College of Surgeons within one year of this application and achieve this verification within two years of the granting of the "In the ACS verification process" status. The Medical Staff recognizes that if the hospital does not pursue verification within one (1) year and/or does not achieve ACS verification within two (2) years of the granting of "in process" status the in process will be immediately revoked, become null and void and have no effect whatsoever.

E. D. Carrel MD

9-25-13

E. D. Carrel, MD
Medical Staff President
Chairman, Medical Executive Committee

Date