

APPENDIX A  
BLOOD AND BLOOD PRODUCT SERVICES  
Community Hospital South

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I. AGREEMENT

- A. Except as otherwise provided in this Agreement, the Blood Center shall provide to the Client one or more of the blood and blood product services as described on Exhibit A-1 and the Client shall pay the Blood Center the service fees set forth in Exhibit A-1.
  
- B. Transportation:
  - 1. Unless otherwise agreed, the Blood Center shall provide to the Client routine delivery service for blood and blood product services.
  - 2. The Blood Center shall provide to the Client emergency delivery service for the emergency delivery service fee set forth in Appendix X.
  - 3. The Blood Center shall provide and retain ownership of transportation containers and equipment for use in providing the routine delivery service for blood and blood product services.

II. RECALLS/MARKET WITHDRAWALS

- A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Consignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Indiana Blood Center  
EXHIBIT A-1  
BLOOD PRODUCTS/SERVICES  
Community Hospital South

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
LRBC/RBC	P9016	1100, 1105, 2205	275.00
LRBC/RBC - Autologous (Administrative fee is additional)		1100, 1105, 2205	275.00
LRBC/RBC - Irradiated	P9040	1103, 1108	350.00
LRBC/RBC - Deglycerolized	P9054	1400, 1405, 2405	350.00
LRBC/RBC - Frozen	P9057	1300, 1310, 2310	350.00
LRBC/RBC - Washed	P9054	1200, 1201, 2210	350.00
Whole Blood	P9010	1000	400.00
Cryoprecipitate	P9012	3000	75.00
Cryoprecipitate - Pooled	P9012 X 5	3010	450.00
Apheresis Platelets, Leuko Reduced, Bacterial Detected	P9035	2100	650.00
Apheresis Platelets-Irradiated, Leuko reduced, Bacterial Detected	P9037	2103	705.00
- HLA Typed Surcharge		9105	150.00
AFFP (400 ml)	P9017 X 2	2001	131.00
AFFP Pediatric pack (per individual pack)		2003	32.00
Frozen Plasma < 24 hours (250 ml)	P9017	2000, 3050, 3070	54.00
Frozen Plasma - Cryo Poor	P9044	3055	70.00
CMV Neg charge	86644	5061	18.00
Irradiation fee for one to five platelet concentrates	B9006	9106	55.00
Neonatal Pack Surcharge		9120	30.00
- Neo 3		9121	35.00
- Neo 4		N/A	40.00
- Neo 6		9123	50.00
- Neo 8			
<b>Imported Product Surcharge Fees:</b>			
- Import fee (one fee per imported unit, per patient)		9159, 9160, 9170	150.00
- Excess fees above the Blood Center charges will be passed onto the hospital			*

Legend: LRBC -- Leukoreduced Red Blood Cell  
RBC -- Red Blood Cell

AFFP -- Apheresis Fresh Frozen Plasma  
FFP -- Fresh Frozen Plasma

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
Source Leukocyte	85009	3106	40.00
Segments for Crossmatching (each group of 20)		9442	20.00
Packing Whole Blood (up to 4 units)		9168	30.00
Washing Platelet (per unit) (additional fee for one FFB used in processing)	B9064	9165	75.00
One Liter Wash (per unit)	B9064	N/A	75.00
Glycerolizing & Freezing	B4001	9158	75.00
Deglycerolizing	B4001	9163	85.00
Apheresis Special Draws		N/A	*
<b>Donor / Patient Services</b>			
Autologous Donation Fee (per unit)	86890	9102	300.00
Autologous Apheresis Donation Fee (per donation)	86890	9102	300.00
Directed Donation Fee (per unit)		9103	300.00
Additional Handling Fees - after hours, without appointment (per unit)		N/A	200.00
Annual Storage Fee for Autologous Frozen Cells		N/A	150.00
Off-site Draw Fee (per unit)		N/A	*
After Hours Charge - Apheresis		9150	350.00
<b>Blood Derivatives</b>			
Rho Gam (per package)	J27790		**
V-Zig Immune Globulin ( <i>comes in volume 125 &amp; 625</i> )			**
Factor 8	J7190, J7191, J7192		**
<b>Non-Blood Products</b>			
Platelet Leukocyte Removal Filters			
- PLX8C	PLX8C		***
- PLX12C	PLX12C		***
Red Cell Leukocyte Removal Filters			
- RCXL1C	RCXL1C		***

Regular hours are Monday - Friday, 5:30a.m.-6:30p.m; Saturday, 6:30a.m -12:00noon (excluding holidays)  
Services outside of these hours may incur additional charges

\* Price based on order

\*\* Fees are subject to change

\*\*\* Price based on the manufacturer's charge

TESTING – Outpatient

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
Complete Donor Profile and NAT HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH, HIV 1/ HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5502	89.00
Complete Donor Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5503	68.50
BMR Panel HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592	5151	67.50
Infectious Disease Profile Only HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, HIV 1/HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592	5120	74.25
Tissue Bank Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86644	5091	64.00
Fertility Donor Profile HBSAG, HCV, HIV 1/2, HBC, (STS) Syphilis	87340, 86704, 86703, 86803, 86592	5552	58.25
ABO Group & Rh Type (donor)	86900, 86901	5030	10.50
ABO Group & Rh Type (cord)	86900, 86901	5031	12.50
Antibody Screen	86850	5200	10.50
Antibody to CMV	N/A	5060	5.50
Antibody to HB Core (EIA)	86704	5040	17.00
Antibody to HCV (EIA)	86803	5105	18.00
Antibody to HIV 1/2 (EIA)	86703	5110	17.00
Antibody to HTLV-I/II (EIA)	86687, 86688	5082	17.00
Cholesterol	82465	5220	5.50
HCV/HIV1 NAT (pool)	donor only	5007	19.25
HCV/HIV1 NAT (individual)	donor only	5011	31.00
WNV NAT (pool)	donor only	5008	11.00
WNV NAT (individual)	donor only	5012	19.25
Hepatitis B Surface Antigen (EIA)	87340	5010	17.00
Syphilis (STS)	86592	5086	5.25
Antibody to HBs (EIA)	86706	5020	15.75

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
Syphilis Confirmatory	86781	5090	48.75
RPR Titer		5088	11.00
RPR Titer w/FTA if ind		5089	44.00
HBsAg Confirmatory Neutralization	86382	5005	157.50
HCV Immunoblot Assay	86804	5095	152.25
HIV1 Western Blot and HIV2 Antibody Confirmation	86689	5125/5127	126.00
HIV2 Western Blot	86689	5124	156.50
HTLV Antibody by WB	86689	5096	111.50
HTLV I/II Antibody w/WB if ind	86687	5129	21.25
HIV-1 Whole Viral Lysate	Donor only	5126	124.50
CMV IgG/IgM	86644/86645	5161	54.50
GC/Chlamydia	87490, 87491, 87590, 87591	5128	64.50
Chagas	87449	5021	20.00
Chagas RIPA	86753	5121	500.00
Leishmania IFA	86717	5101	131.25
Complete Blood Count			7.50

The laboratory can be reached at Monday-Saturday. If no answer, call  
 \* Panel prices are for pooled pricing. Individual WNV NAT is an additional \$7.60

to have the staff paged.

TESTING -- Reference Lab

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
ABO & Rh	86900, 86901	4000 RC	35.70
Allogeneic Adsorption	86971, 86978	4210	204.00
Antibody Identification	86870	4020 RC	97.00
Autoadsorption	86971, 86978	4220	153.00
Chloroquine/EGA Treatment of RBC's	86860	4270	142.75
Compatability Screening	86922	4070	40.75
Direct Antiglobulin Test	86880	4060	46.00
<b>Donor Antigen Test, confirmed per antigen</b>			
- CEceK	86903	4041 UPH	49.00
- AHG	86903	4042 UPH	72.50
- Direct	86903	4043 UPH	79.50
- Rare Low Frequency	86903	4044 UPH	79.50
- Rare High Frequency	86903	4045 UPH	118.25
Saline Replacement	86977	4320	20.50
DTT Treatment of RBC's	86970	4271	71.50
Eluate	86860	4290	132.50
Enzyme Treatment of Panel	86971	4250	66.25
Hemoglobin Screening	85660	4082 UPH	46.00
Microhematocrit/Hypotonic Cell Separation	86972	4280	86.75
Neutralization (HPC/Plasma/ Lewis/ P)	86977	4260	102.00
<b>Patient Antigen Test</b>			
- Rh Phenotype	86906	4031 RC	128.50
- CEceK. (individual antigen)	86905	4032 RC	49.00
- AHG	86905	4033 RC	72.50
- Direct	86905	4034 RC	79.50
- Rare Low Frequency	86905	4035 RC	79.50
- Rare High Frequency	86905	4036 RC	118.25
Pre-warm	86940	4230	51.00
Titration	86886	4240	66.25
Triple Adsorbing Cells	86971	4084	61.25
RBC Molecular typing (patient)	83891, 83900, 83901x22, 83892x2, 83912, 83914x22	4115 P	510.00
RBC Molecular typing (donor)		4115 U	153.00
ARDP Fee (per unit)	86999	4105	204.00
Export Fee for Rare units (per unit)	86999	9171	127.50
Import Fee for Rare units (per unit)	86999	9170	127.50
Coordination/Consultation Fee	86999	4120	81.50
STAT Fee, For immediate provision of services Mon -Thur evenings and overnight and Fri evening	86999	4130	255.00
STAT Fee, For immediate provision of services during holidays, Fri overnight, Sat and Sun	86999	4130 N	510.00

The Blood Center Reference Laboratory is available on-site or on-call 24/7 by calling

DESCRIPTION	SUGGESTED CPT CODES	PRICE (\$)
<b>ROUTINE ITEMIZED TESTING</b>		
1. HLA Typing (ABC)	83891, 83896x224, 83898x3, 83912	400.00
2. HLA Typing (ABCDRDQ)	83891, 83896x224, 83898x3, 83912	500.00
3. ABO	86900	15.00
4. Autocrossmatch T-Cell Flow	86805 X 6	212.50
5. Autocrossmatch B-Cell Flow	86805 X 6	212.50
6. Crossmatch (Donor T-Cell) Flow	86805X6	212.50
7. Crossmatch (Donor B-Cell) Flow	86805 X 6	212.50
8. Flow Antibody Screen Class I PRA	88184, 88185, 88187	158.00
9. Flow Antibody Screen Class II PRA	88184, 88185, 88187	158.00
10. Antibody Identification Class I	88184, 88185, 88187	350.00
11. Antibody Identification Class II	88184, 88185, 88187	325.00
12. Donor Specific Antibody DSA Class I	88184, 88185, 88187	350.00
13. Donor Specific Antibody DSA Class II	88184, 88185, 88187	325.00
14. SPRCA Crossmatch (HLA or Single Donor) Platelet	86806	165.00
15. Platelet Antibody Screen	86022	200.00
<b>ROUTINE PANELS for Ease of Ordering</b> (See itemized listing for tests included in panel)	<b>TEST NUMBER</b> (Routine itemized Testing List)	
<b>Platelet Support Services</b>		
Hematology Profile		1, 3, 10, 15
HLA Class I PRA and Antibody Identification Class I (Flow)		8, 15
SPRCA Crossmatch (HLA or Single donor) Platelet		14
<b>Cardiac/Renal Services</b>		
Transplant Candidate Profile		2, 3, 4, 5, 8, 9, 10, 11
Cadaveric Transplant Donor		3
Living (renal) Transplant Donor Profile		2, 3
Cardiac/Renal Transplant Recipient (day of transplant)		6, 7, 8, 9, 10, 11
<b>Bone Marrow Transplant</b>		
Bone Marrow Transplant Profile		2, 3, 8, 9
Bone Marrow Donor		2
Neonatal Alloimmune Thrombocytopenia (NATP) Panel		10, 14, 15
TRALI Investigation	No Charge for the Blood Center Units	

DESCRIPTION	SUGGESTED CPT CODES	PRICE (\$)
<b>Other Services</b>		
<b>Platelet Antigen Typing</b>		
Full Platelet Antigen Typing (HPA-1,2,3,4,5,6,15)	83896 x 2,83912	360.00
PLA1	83896 x 2,83912	175.00
<b>Disease Association Profile</b>		
HLA Typing (AB/DR/DQ) per antigen	83891,83896x224,8 3898x3,83912	200.00
Parathyroid Tissue Cryopreservation	60500	850.00
Parathyroid Freezing Solution Sterility Check	87070, 87102	150.00
Parathyroid Tissue Release/Transportation Charges		varies with shipping
<b>Parentage Testing</b>		
Trio (Domestic)		490.00
Trio (International)		550.00
Single Parent Testing (Domestic)		550.00
Single Parent Testing (International)		585.00
Siblingship Testing (each person tested)		300.00
Each additional client		200.00
Specimen Collection Fee (out of state)		37.00

Regular hours are Monday – Friday, 8:00a.m.–4:30p.m. (excluding holidays)  
 Services outside of these hours will incur an additional STAT charge of \$250.00 per order

**RECALLS/MARKET WITHDRAWALS**

A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Cosignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial ABL Date 7-8-13

**EXHIBIT A-2**  
**CONSIGNEE/RECIPIENT NOTIFICATION**  
**OF RECALLS/MARKET WITHDRAWALS**

The Blood Center shall notify the Client of recalls and market withdrawals of blood products as soon as possible after discovery of a reactive screening test or other reason for product unsuitability.

- I. The Blood Center shall notify the Client as soon as possible, and no later than 72 hours of test completion of any potentially infectious disease marker or other reason for product unsuitability for blood products the Client has received from the Blood Center. For products intended for transfusion, the scope of review will include all of the donor's units collected within the past five (5) years. For products intended for further manufacture into injectable products, the scope of review will include all of the donor's units collected within the past six (6) months.
- A. Current positive tests for HIV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
    - HIV ABY repeat reactive lookback extends back 5 years or 1 year prior to the last negative test of record, whichever time is shorter.
    - HIV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
  - Available components are to be returned to IBC for credit.
  - Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
    - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).
- B. Current positive tests for HCV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
    - HCV ABY repeat reactive lookback extends back 10 years or 1 year prior to the last negative test of record, whichever time is shorter.
    - HCV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
  - Available components are to be returned to IBC for credit.
  - Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
    - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

C. Other lookbacks, recalls, or reasons for Post Donation Information:

- Notifications and recalls will be made similarly as above and in accordance with applicable guidance; however, for recalled products that are no longer potentially available (post-expiration date), written notification using IBC forms (e.g. Post Donation Information Consignee Notification form, Recipient Data Sheet, etc.) will be sent to the transfusion service. If requested, such forms should be returned as soon as possible, and within 15 days to allow for meeting FDA BPDR reporting timeframes.

II. The Client shall have a clearly defined and written policy that ensures recall notifications from IBC are appropriately received and managed per applicable guidance, and that recalled products are not inadvertently distributed for transfusion. The policy shall include identification of the person responsible for performing this activity, how the units are identified as "in quarantine", and how the units are physically separated from the regular blood inventory. The Client shall, upon request, provide the Blood Center with a copy of the written policy.

References:

- 21 CFR §§ 610.46-610.48
- *Guidance for Industry: Nucleic Acid Testing (NAT) for Human Immunodeficiency Virus Type 1 (HIV-1) and Hepatitis C Virus (HCV): Testing Product Disposition, and Donor Deferral and Reentry.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, May 2010.
- *Guidance for Industry: "Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, December 2010.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial GBC Date 7-8-13

260

**APPENDIX B  
TESTING SERVICES**

**I. AGREEMENT**

- A. The Blood Center shall provide to the Client one or more of the Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services set forth in Exhibit A, attached hereto and incorporated herein, upon submission of the appropriate testing request form by the Client and the Client shall pay the Blood Center the service fees set forth in Exhibit A,

**II. TESTING PROTOCOL**

A. Testing Request Process

1. The Client shall comply with the applicable testing request processes described in the Customer Resource Manual when the Client requests Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services.

B. Sample Requirements

1. The Client shall collect, label, store, pack, transport and ship all blood samples in accordance with applicable federal, state and local laws and in accordance with the Customer Resource Manual.
2. The Blood Center shall provide packing materials to the Client upon request.

C. Sample Transport

1. The Client shall transport all blood samples in accordance with the Customer Resource Manual.
2. The Client shall pack samples in accordance with federal, state or local regulations and shipping container manufacturers' specifications and requirements for clinical/diagnostic specimens.
3. The Client shall transport samples at refrigerated temperature to the testing laboratory located at Central Indiana Regional Blood Center, Inc., d/b/a Indiana Blood Center,
4. The Client shall pay for all costs for transporting and shipping to the Blood Center or Third Party Laboratories and reimburse the Blood Center for any freight costs incurred by the Blood Center.

D. Sample Integrity

1. The parties agree that that the integrity of the specimen received by the Blood Center dictates the integrity of the results obtained. The parties agree that the Client must properly collect, store, identify, pack, and ship samples to ensure accurate and efficient processing of the samples.

201

2. The parties agree that the Blood Center shall not be responsible for any delay in processing under the following circumstances:
  - a) The sample and supporting documentation accompanying the shipment is incomplete or in a condition not reasonably satisfactory to the Blood Center (or its Third Party Laboratory) in accordance with the guidelines specified in the Customer Resource Manual;
  - b) The sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
  - c) The specimen contains incorrect information for sample shipment reconciliation;
  - d) Any aspect of sample identification is incorrect or illegible;
  - e) The specimen is not the appropriate quantity, type, or age; or
  - f) The Blood Center determines, in its sole judgment, that the specimen has not been properly stored.

#### E. Sample Receipt and Turn-Around Time

1. Upon receipt of a sample from the Client, the Blood Center shall:
  - a) Notify the Client of any damaged samples or any inadequate documentation relating thereto promptly after the arrival of a shipment at the Blood Center or its Third Party Laboratory; and
  - b) Handle the samples with all due care for as long as the samples are within the Blood Center's control.
2. Upon receipt of a sample from the Client, the Blood Center may, in its sole discretion:
  - a) Refuse to perform services hereunder in any instance in which the Blood Center deems that the samples or related documentation are not in reasonably satisfactory condition; or
  - b) Refuse to perform services hereunder in any instance in which the Blood Center deems that the sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
3. The Blood Center shall complete testing, review and reconciliation of records and transmit test results to the Client in accordance with the testing schedules set forth in the Customer Resource Manual for Testing Laboratory Services, Immunohematology Reference Laboratory Services, and Histocompatibility Laboratory Services.
4. The Blood Center shall immediately convey results from any specimen that registers a critical value to the appropriate Client personnel by telephone, facsimile or other electronic means.
5. The Blood Center shall provide the Client with the following technical information for all tests:
  - a) Normal values;
  - b) Technical method of analysis; and
  - c) Specimen requirements, including special handling instructions.
6. The Blood Center shall notify the Client a minimum of 30 days in advance of significant changes in the test protocols, reagents sample volumes or sample types set forth in the Customer Resource Manual.
7. The Blood Center shall not provide STAT testing unless the parties agree in writing upon the terms, conditions, and fees for STAT testing.

F. Test Performance and Procedures:

1. The Blood Center shall perform and cause its Third Party Laboratories to perform the blood testing services and interpret blood test results in accordance with applicable laws, regulations, manufacturer's package insert instructions (except where otherwise approved by the United States Food and Drug Administration (FDA), and use testing procedures at least as stringent as those recommended by the American Association of Blood Banks (collectively the Regulations).
2. The Blood Center shall perform blood testing services with licensed screening and confirmatory tests or, in the absence of licensed confirmatory tests, by a confirmatory test recognized as appropriate by standard of care and standard industry practices.
3. The Blood Center shall use FDA licensed reagents whenever available.
4. The Blood Center shall provide to the Client copies of the package inserts of each of the assays that the Blood Center and any Third Party Laboratories will perform.
5. The Blood Center shall implement any new immunohematology and viral marker tests approved for use in blood banking/screening by the FDA or applicable standards upon written agreement by the parties of the service fees for such new immunohematology and viral marker tests.
6. The Blood Center and the Client shall comply with applicable state reporting requirements with regard to infectious disease markers.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial ABC Date 7-8-13

APPENDIX X  
 SERVICES AGREEMENT – COMMITTED VOLUMES  
 COMMUNITY HOSPITAL SOUTH

I. PURCHASE COMMITMENT

A. Client and the Blood Center shall agree upon Annual Unit Quantity or percent of amount to be purchased under this agreement, which shall be as follows:

<u>Product Unit</u>	<u>Price per Unit (\$)</u>	<u>Annual Unit Quantity or % of Annual Purchased Amount</u>
LRC	215.00	2,195
APLT	500.00	160
FP24	50.00	300
CRYO	43.00	0
POOLED CRYO	300.00	16

B. Pricing for the Committed Volume shall be determined on an annual basis, provided, however, the Blood Center may adjust the price if, in any 3-month calendar quarter (i.e., January-March, April-June, etc.), the quarterly purchases by Client are not within five percent (5%) of the quarterly volume as set forth below for the quarter just completed, in which case, pricing shall default to Blood Center list pricing set forth on Exhibit A-1.

	<u>Jul-Sep</u>	<u>Oct-Dec</u>	<u>Jan-Mar</u>	<u>Apr-Jun</u>	<u>Total</u>
LRC	557	550	538	550	2,195
APLT	41	40	39	40	160
FP24	76	75	74	75	300
CRYO	0	0	0	0	0
POOLED CRYO	4	4	4	4	16

II. DELIVERY AND TRANSPORTATION

A. Routine delivery. The Blood Center shall provide scheduled delivery one (1) time per weekday (Mon-Fri) at no charge.

B. Additional delivery. Deliveries requested by the Client beyond the routine delivery will be made the most cost-effective way, one way or round trip, depending on the customer need and ability to schedule the delivery for an additional fee of:

One-way fee	\$25.00
Round-trip fee	\$50.00

C. Emergency Delivery. Emergency delivery fee will be added to the delivery for those orders which require immediate delivery at the then-current emergency rates charged by third-party delivery services plus a reasonable administrative fee.

264

D. Transfers. Products transferred from the Client will be credited to Client's account at the service fee in effect at the time the product was shipped to the Client. Products transferred to the Client will be invoiced at the Client's current service fee in effect.

### III. RETURNS

Red Cells received with 10 days or more remaining before expiration will be given full credit for the Leukoreduced Red Cell product, excluding any additional special services provided for that unit, in the amount of the service fee in effect at the time the product was shipped to the Client. Apheresis Platelets received with 24 hours or more remaining before expiration and resold, will be given full credit in the amount of the service fee paid in effect at the time the products were shipped to the Client in the month following the calendar quarter end. Special order Apheresis Platelets including Irradiated, HLA matched and cross-matched are not eligible for credit.

### IV. STANDING ORDERS

Client may establish a written standing order for blood and blood product services. Standing orders submitted to the Blood Center by any client will be filled ahead of additional orders submitted by the Client. Changes in Client's standing order require seven (7) days written notification, provided, however, such changes may only be made one time per calendar month. Client is to submit a standing order to Blood Center within seven (7) days of contract execution.

To assist both client and Blood Center with utilization review, installation of the AIM software is to be included as part of this process.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial u66 Date 7-8-13



**CORPORATE NURSING POLICY AND PROCEDURE**

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 5/21/13emergent

NPP#: I-14B1

Page 1 of 12

EFFECTIVE: 8/8/13

**TITLE: Blood Component Administration**

Performed by:

1. Obtain blood components from Blood Bank: RN, LPN, MHC, PSP, PST, AP, SE, EMT-P (competency verified). Nursing may request Security to obtain blood component from Blood Bank.
2. Start Infusion and administer blood products: RN, LPN, NP, CNS

Purpose: To provide guidelines for administering blood components.

**Policy Statements:**

1. A patient must be identified prior to the administration of any blood product according to CLN 3017, Identification of Patient, Use of Two Patient Identifiers. If the patient is able to communicate, ask the patient to state their name and birthdate. Additionally, verification of patient identification will occur by comparison of patient name, birthdate and medical record number on the blood product slip and the EMR to the patient name, birthdate, and medical record number on the patient's armband. If the patient is unable to communicate, nursing will compare the EMR, patient's armband, and blood product information and verify that all are accurate. All information will be an identical match to patient EMR, armband and blood product. If any information is not correct the blood product must be returned immediately to the blood bank.
2. A physician order is required to administer blood components. Blood Consent/Refusal form must be completed for all blood component transfusions, which includes: Red Blood Cells, Plasma, Cryoprecipitate and Platelets. The form should be signed before obtaining the Type and Crossmatch (T&C) or Type and Screen (T&S) blood sample, but must be signed before the blood component is administered. (Exception: Physician order to administer blood without the patient's consent in an emergency situation. If blood is administered in an emergency without consent, the reason must be documented in the patient's medical record.) The consent remains in effect during the hospitalization and a new consent is required for each new inpatient admission. A new consent is required when a patient is admitted to or from Behavioral Health or Rehabilitation Hospital or from an outpatient to an inpatient status.
3. IgG or Rh Immune Globulin are not blood components and do not require signed consents before administration.
4. A red Blood Bank Armband (Blood Recipient ID Band) will be placed on all patients who have a T&S/T&C drawn in an outpatient area/Emergency Department, or on all patients who do not have a Medical Record number. The armband must remain on the patient until midnight of the third day after the T&C/T&S specimen was drawn. If present, this armband must be used as a method of identification. If removed during this period, a new T&S/T&C must be ordered and a specimen drawn.
5. Do not obtain blood products from the Blood Bank until a working patient IV is established. (Exception: Emergency Situations.) The physician's order or the RN's judgment regarding the condition of the patient will be used to determine whether or not to interrupt an already existing IV infusion or to start a second IV site to administer the transfusion. If infusing parenteral nutrition, (D<sub>10</sub>W concentration or greater and/or lipids), or a continuous PCA narcotic, a second IV site must be started. If unable to obtain a second IV site receive orders from physician for possible interruption of other therapies that cannot be given during blood component infusion.
6. If the patient has an arteriovenous (AV) graft or fistula, blood may not be infused through the graft or fistula unless it is during dialysis.
7. A computer generated requisition to obtain blood label with the patient name (first and last), medical record number, and DOB must be presented when picking blood components up from the Blood Bank. Exception: A handwritten label with the patient's first and last name, Medical Record

2660



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH  
CANCELS: 5/21/13 emergent

NPP#: I-14B1

Page 2 of 12

EFFECTIVE: 8/8/13

- Number, and DOB may be used if the patient's condition warrants emergency blood administration and a computer label is not readily available. The person picking up the blood component from the Blood Bank (known as the transporter) must be aware which blood component is to be obtained if the patient has multiple blood components ordered. Blood bank personnel are to be informed by transporter which product component is needed. NOTE: If patient has a red armband, the sticker from the red armband must accompany the label with patient's name, DOB and medical record number in order to pick up the blood.
8. Uncrossmatched red blood cells will be given in an emergency situation when a T&C/T&S specimen has not yet been obtained, but T&C must be obtained as soon as possible and sent to Blood Bank. See NPP#I-14,B-2, Blood, Uncrossmatched for additional information.
  9. Blood tubing must not hang for greater than four hours. If more than one blood component is infused, the blood tubing must be changed if the infusions are not completed within the four hour time period. No more than four red cell products can be infused through the same blood tubing.
  10. All blood components must be started and be completely infused within four hours from the time the units leave the blood bank.
  11. If it is necessary to infuse longer than this, prior arrangements must be made with Blood Bank. Blood Bank will arrange smaller volumes ("aliquets") to infuse if necessary; for example, Pediatric patient or patients with CHF.
  12. If the blood component cannot be started upon arrival to the unit it must be returned to Blood Bank as soon as possible to avoid wasting it.
  13. Multiple blood components on a single patient can be released to a nursing unit if the patient's condition warrants. Under no circumstances is blood to be stored in a refrigerator on the nursing units. Coolers will be provided to nursing by the Blood Bank for the storage of multiple units in surgery, critical care areas, ED or transfusions taking place at areas remote to the blood bank. These coolers are for the use of red cells and plasma products. Platelets and cryoprecipitate are stored at room temperature. The coolers are labeled with information stating when the ice in the cooler must be replaced or returned to the blood bank.
  14. For the pediatric patients less than 100 pounds, the physician must order the amount and rate of blood administration. If this is not specifically ordered, the physician must be contacted.
  15. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion:
    - a. By checking the specific physician order for accuracy of blood component to be administered before hanging the component.
    - b. By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the start time of the transfusion and the second set of vital signs between the first 10 and 20 minutes of the infusion.
    - c. By obtaining patient temperature a minimum of every 30 minutes during the transfusion when clinically indicated for signs and symptoms of a possible reaction.
    - d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion.  
NOTE: If a transfusion takes less than 15 minutes to complete, the 15 minute assessment and the completion assessment may be completed and documented at the same time, the vital signs would be completed in the post transfusion section and the pre transfusion section for the next unit.
  16. During the transfusion of all blood components products or upon its completion, if the patient experiences a 2°F increase or more (one degree Celsius) in temperature, or any other sign/symptom of a transfusion reaction, the transfusion is to be stopped. Call the Blood Bank immediately, receive instructions for transfusion reaction work-up and notify physician. The Blood Bank will inform the nurse of the necessary items for a Transfusion Reaction Work-Up. (These include: post transfusion blood bank specimen correctly labeled, yellow copy of the transfusion record form with reaction information completely filled out, all tubing, filters, fluids and blood components used in the transfusion, and the Transfusion Reaction work up order

267



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 5/21/13emergent

NPP#: I-14B1

Page 3 of 12

EFFECTIVE: 8/8/13

- requisition.) Orders received from the physician and rationale for interventions must be documented.
17. In the event that the patient dies while receiving a transfusion, perform the following: document on the transfusion record form that patient died, contact blood bank, send all paper work and tubing to the blood bank, and if possible obtain a post transfusion specimen.
  18. No medication is to be added to or administered with blood components. Use only normal saline (0.9% saline) with blood components.
  19. All crossmatched blood and T&C/T&S orders will be automatically released at midnight of the 3<sup>rd</sup> day from when the specimen is collected. Should the patient require blood after this time period, a new order and crossmatched specimen must be obtained. EXCEPTIONS include pre-op T&C and Pre-op T&S which may be extended for 30 days with pre-op questionnaire.
  20. A patient refusing to receive blood for religious or other reasons must sign the Blood Consent/Refusal form section. See Corporate Policy CLN:2062, "Blood Transfusions, Refusal Considerations".
  21. Patients requiring transportation while receiving a transfusion must have an RN, Perfusionist or physician in attendance. Hand off to the unit of destination must be to an RN, Perfusionist or physician.

### General Information:

1. Potential signs and symptoms of a transfusion reaction include: chest pain, back pain, itching, rash, hives, shortness of breath, feeling anxious, increase in temperature greater than or equal to 2 degrees Fahrenheit or 1 degree Celsius from pre-transfusion baseline vital signs or anything out of the ordinary.
2. Patient identification consists of inspection of the identification armband to verify that the name, date of birth and medical record number are the same as on the Transfusion Record Form and the blood component unit label. If a red Blood Bank Armband (Blood Recipient ID Band) present, this armband must be used as a method of identification.
3. Unit(s) identification consists of verification from the blood component unit label, including:
  - a. Patient's Name
  - b. Medical Record Number or identification number on red blood bank armband(Blood Recipient Identification Band)
  - c. Date of Birth (DOB)
  - d. Donor number
  - e. Blood Type of unit
  - f. Blood type of patient
  - g. Unit Expiration
  - h. Other specifics, for example, irradiated, CMV.
4. T&C/T&S at CHVH, CHN, CHE, or CHS and processed by Mid America Clinical Laboratories is valid for use at all sites listed above. Any patient transferring from any other location needs need a new T&C and T&S drawn.
5. A physician, NP, CNS or Perfusionist may start infusion and administer blood products.
6. It is recommended that intravenous catheter sizes for use in transfusing cellular products, (Red cells and platelets), range from 14 to 22 gauges.
7. All Red Blood Cells received from Indiana Blood Center are Leukoreduced.

### Equipment:

1. IV Pole
2. Blood Administration set
  - a. Double Y- type blood tubing (Whole Blood, Packed Cells, and FFP, Platelets, Leukocytes, and Cryoprecipitate)

268



**CORPORATE NURSING POLICY AND PROCEDURE**

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 4 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

- b. 30ml syringe with filter needle (Factor VIII/Factor IX)
3. Blood warmer (optional) is ordered by physician. (Instruction sheet on machine.)
4. Infusion pump if blood component is to be infused through a central line. An infusion pump is optional if a blood component is infused peripherally.
5. 250 ml Normal Saline (0.9% saline)
- A. **Obtaining T&C or T&S (Type and Cross/ Type and Screen):**
  1. If T&C or T&S is needed, identify the patient using the two patient identifiers as described in CLN 3017, Identification of Patient, Using two patient identifiers.
  2. Obtain specimen by drawing blood in Blood Bank designated vacutainer tube.
  3. On the vacutainer pre-affixed label and print in indelible ink the following information:
    - a. Patient's full name
    - b. Patient Date of Birth
    - c. Medical Record number
    - d. Date, time and phlebotomist's initials
  4. Complete collection information on the lab requisition to include:
    - a. Date/time of collection
    - b. Phlebotomist's initials
    - c. Notation that hospital or red blood bank arm band is present when specimen was drawn.
    - d. One additional patient identification item listed below
      - 1.) Patient said name was: \_\_\_\_\_
      - 2.) DOB
      - 3.) Staff identification of patient
  5. Place a red blood bank armband (Blood recipient Identification Band) on patients who have had T&C/T&S drawn in outpatient areas or before a Medical Record number is available. Affix the patient ID portion of this armband on to the tube of blood in the presence of the patient.
  6. Place specimen, strip of armband numbers if using Identification Band and requisition in plastic bag and deliver to Blood Bank. Blood Bank refuses specimen if:
    - a. There is incomplete labeling of specimen including misspelling of any portion of the name, missing medical record numbers including zeros and omission of date/time of collection and phlebotomist's initials.
    - b. There is inaccurate labeling of specimen which includes using printed labels for T&C and T&S.
    - c. Specimen labeling is not in agreement with requisition.

**B. Obtaining Blood Component(s) from the Blood Bank**

1. The transporter hands the pick-up slip to the Blood Bank associate at Blood Bank If the patient has a red armband, the sticker from the red armband accompanies the label with patient's name, DOB, and medical record number in order to pick up the blood.
2. The Blood Bank associate retrieves the blood component(s) and dispenses in the laboratory computer.
3. The transporter then reads to the Blood Bank associate the following from the Transfusion Record Form:
  - a. Patient Name
  - b. Medical Record Number
  - c. Date of Birth
  - d. Patient ABO/Rh
  - e. Unit ABO/Rh
  - f. Unit number and correlating red armband number if appropriate
  - g. Component
  - h. Crossmatch results



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH  
 CANCELS: 5/21/13 emergent

NPP#: I-14B1

Page 5 of 12

EFFECTIVE: 8/8/13

- i. Unit expiration date and time
  - j. Comment
  - 4. The transporter then signs the Transfusion Record Form (s) in the area **TRANSPORTED BY** along with the date and time, and the department where the transfusion will take place.
  - 5. The transporter hands the Transfusion Record Form (s) back to the Blood Bank associate to sign in the area marked Technician Issuer
  - 6. The Blood Bank associate removes the pink copy from the Transfusion Record Form (s) and places the Transfusion Record Form, Blood Bag label and blood component in a bag (either paper or plastic) or cooler for transportation to the nursing unit.
  - 7. The Blood Bank associate dates and writes the 4 hour blood product outdate time on the Blood Bag Label sheet and includes this in the bag or cooler for transportation to the nursing unit.
  - 8. Pneumatic Tubing of Blood and Blood Products for NICU and CHVH (weekends only for CHVH): Complete the Blood Pneumatic Tube Transport form (see addendum # 3).
    - a. Perform 2 patient Identifiers with physician order before sending form to Blood Bank
    - b. If patient has a blood bank band include the number in the space provided on form
    - c. Handwrite the patient's full name and birthdate, Medical Number, and Room number
    - d. Fill in number of Product Requested : \_\_\_\_\_
    - e. Quantity: \_\_\_\_\_ Tube Station: \_\_\_\_\_
    - f. Phone: \_\_\_\_\_ Initials: \_\_\_\_\_
    - g. Follow the instructions to "Send request form via pneumatic tube"
  - 2. Blood Bank :
    - a. Completes the "Date/Time Product Sent" section of the Blood Pneumatic Tube Transport form and they will retain the bottom (yellow) copy
    - b. Notifies the Clinical area that the blood product is being sent.
    - c. Places product, Blood bag label dated with the 4 hour blood product outdate time and top copy of transport form in sealed Ziploc bag(s). Place
    - d. Ziploc bag into a pneumatic tube.
    - e. Blood bank tech calls receiving area if "Blood Pneumatic Tube Transport" form is not returned to the Blood Bank within 15 minutes.
  - 3. Clinical area removes unit from the pneumatic tube system and
    - a. compares the information on Unit Compatibility label, Transfusion Record Form and Blood Product Request Form.
    - b. Complete the "Receipt" section of the Blood Pneumatic Tube Transport form
    - c. Returns the form and the refrigerated gel pack (if applicable), via the tube system to the blood bank.
    - d. Two members of the transfusing staff verifies donor unit information per Blood Administration policy, with the transfusion tag and patient wristband information at the patient's bedside.
    - e. If there are any discrepancies, the Neonatal Intensive Care Unit (NICU) personnel will **WALK** the unit back to the Blood Bank for resolution. For discrepancies at The Indiana Heart Hospital (CHVH) the staff call the Blood Bank for further instructions.
- C. Transfusion**
- 1. Complete bedside verification process using the Transfusion Record Form. Utilizing two 2 staff members, one of which is a licensed professional (RN, LPN, Physician/NP, Perfusionist). Compare -the specific physician order for accuracy of blood component to be administered before hanging the component. Scans the blood bag for the unit number and the product code number.
  - 2. Compare the patient's name, DOB, and medical record number on the identification armband with the patient's name, DOB and medical record number, and if applicable the red armband number on the Transfusion Record Form and the blood component unit label.

270



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 6 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

3. Compare the unit number, ABO group, and Rh on the blood component unit label with the unit number ABO group, and Rh on the Transfusion Record Form. Contact Blood Bank immediately for any discrepancies.
4. Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion. If patient's temperature is 101<sup>0</sup>F or above, notify the physician prior to starting the blood component and receive orders.
5. Attach blood component to prepared IV tubing.

Infuse at:

Component	1 <sup>st</sup> 15 minutes	After 15 minutes	Pediatric
Red Blood Cells	75 ml/hour	150 ml/hr	2-5mL/kg/hr
Plasma	NA	200-300ml/hr	60-120 mL/hr
Platelets	30ml/hr	200-300mL/hr	60-120mL/hr
Cryoprecipitated AHF	As Rapidly as Tolerated		As Rapidly as tolerated

6. The RN observes the patient closely, assessing and monitoring the patient for the first 15 minutes after the transfusion is started to observe for potential signs and symptoms of a transfusion reaction.
7. Between the first 10 and 20 minutes of the infusion, obtain vital signs including temperature, pulse, respiratory rate, and blood pressure and document the complete vital signs on the Transfusion Record Form. Observe the patient for shaking, chills, pain, nausea, itching or other symptoms and document. If the patient's condition is satisfactory, the rate can be increased to that listed in the table above.
8. Continue to monitor and assess the patient intermittently throughout the transfusion.
9. If a unit of blood has been infusing for more than 4 hours, discard remaining blood in red biohazard containers in dirty utility area and completely change all IV tubing that was used for transfusion.

### D. Post Transfusion:

1. After transfusion is complete, flush blood tubing with normal saline, then discard all blood tubing, bag and supplies from transfusion in red biohazard container in dirty utility area.
2. Resume previous IV fluids. If IV site may be needed for additional transfusions, then maintain as a PIV lock.
3. Take post-transfusion vital signs (T-P-R & BP) within 15 minutes of completion of the transfusion and record on the Transfusion Record Form.
4. Review and verify Transfusion Record Form is complete with all appropriate signatures, dates and times. Unlicensed personnel may collect vital sign data; however, all vital signs must be reviewed and initialed by the RN. Place original in chart and send yellow copy to Blood Bank via pneumatic tube. If no access to pneumatic tube send via interdepartmental mail.

### E. Transfusion Reaction

1. Stop the transfusion immediately if any symptoms of a reaction occur. Immediately switch from blood infusion to saline and get specific treatment orders for reaction from physician. Mild urticaria, hives, or an increased of temperature less than 2<sup>0</sup>F (or 1<sup>0</sup>C) alone may not be deemed a sufficient indication by the physician to discontinue the transfusion. All other symptoms require the stopping of the transfusion and proceeding with steps 2, 3, 4 and 5.
2. Immediately, visually check the patient armband, blood product unit label and transfusion record form, to verify that this is right patient, right blood product, right patient medical record number, and that all information matches the patient arm band, blood component unit label and the Transfusion Record Form.
3. Call the Blood Bank for instructions on proceeding with a transfusion reaction work-up.

271



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 7 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

4. Order a transfusion reaction work up. Complete and sign the Transfusion Record Form and return yellow copy of the Transfusion Record Form and the blood component bag with all blood tubing, tags and fluids to the blood bank (place in biohazard bag for transport from patient unit to the blood bank.) Transfusion Reaction Record is completed by the Blood Bank. Nursing to document in the EMR.
5. For general information regarding specific transfusion reaction, see addendum. There is the possibility of delayed hemolytic reaction. This type of reaction most frequently occurs between 3-14 days post-transfusion.

a. **Transfusion Associated Circulatory Overload (TACO)**

Definition: Infusion volume that cannot be effectively processed by the patient either due to the high infusion rate and/or volume or an underlying cardiac or pulmonary pathology

Signs and Symptoms: New onset of exacerbation of  $\geq 3$  of the following within 6 hours of transfusion:

- Acute respiratory distress (dyspnea, orthopnea, cough)
- Evidence of positive fluid balance
- Elevated brain natriuretic peptide (BNP)
- Radiographic evidence of pulmonary edema
- Evidence of left heart failure
- Elevated central venous pressure (CVP)

b. **Transfusion Related Acute Lung Injury (TRALI)**

Definition: Acute hypoxemia with  $\text{PAO}_2/\text{fraction of inspired oxygen [FIO}_2\text{]}$  ratio of 300mm HG or less combined and chest e-ray showing bilateral infiltrates in the absence of left atrial hypertension (ie, circulatory overload)

Onset of TRALI is abrupt in association with transfusion

Signs and Symptoms:

- No evidence of Acute Lung Injury (ALI) prior to transfusion
- Acute Lung Injury onset during or within 6 hours of transfusion
- Hypoxemia defined by any of these methods:
  - $\text{PaO}_2/\text{FIO}_2 \leq 300\text{mm Hg}$
  - Oxygen saturation is  $< 90\%$  on room air
- Other clinical evidence:
  - No evidence of left atrial hypertension (i.e. circulatory overload)
  - No temporal relationship to an alternative risk factor for Acute Lung Injury during or within 6 hours of completion of transfusion

c. **Transfusion Associated Dyspnea (TAD)**

Definition: Respiratory distress within 24 hours of transfusion that does not meet the criteria of TRALI, TACO or allergic reaction. Respiratory distress should not otherwise be explained by a patient's underlying or pre-existing medical condition.

Signs and Symptoms:

- Acute respiratory distress and occurs within 24 hours of transfusion and TRALI, TACO and allergic reaction and other underlying medical conditions ruled out.

### Documentation -- Complete the following:

1. Transfusion Record Form
  - a. Signatures of personnel starting and stopping transfusion
  - b. Signature of personnel verifying patients identity
  - c. Date/Time started
  - d. Date/Time stopped
  - e. Vital signs before the transfusion starts, between the first 10 and 20 minutes of the transfusion and within 15 minutes after the transfusion is complete.

272



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 8 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

- f. Consent signed Yes/No
  - g. If the patient is an infant has the infant blood screen been drawn? Yes/No
  - h. If blood or blood product is given under anesthesia check the box " Given Under Anesthesia see Anesthesia Record". This will direct healthcare providers to vital signs recorded by anesthesia to avoid duplication.
2. EMR on Blood Flow sheet
    - a. Document time when unit was hung.
    - b. Document normal saline use.
    - c. Vital signs recorded at appropriate times as described above
  3. Document any patient responses, treatments or further care that is not within normal limits.

Reference:

CDC. (n.d.). Biovigilance Component. *National Healthcare Safety Network (NHSN) Manual*. Retrieved from Center for Disease Control and Prevention: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn) June 2011 pages 18, 19, & 21

Circular of Information for the Use of Human Blood and Blood Components, AABB, American Blood Centers, American Red Cross, Armed Services Blood Program, August 2009.

Community Health Network Transfusion Committee 2011

Practice Guidelines for Blood Transfusion Developed by America Red Cross Biomedical Headquarters, April 2007

Recommendations from Indiana State Department of Health, October 2011

Standards for Blood Banks and Transfusion Services, AABB, 27<sup>th</sup> Edition, 2011  
AABB Technical Manual, 17<sup>th</sup> Edition, 2011

<u>Approved by:</u>	IV NPP Committee	<u>Date:</u> 3/2013
	Infection Control	<u>Date:</u> 5/2013
	Risk Management	<u>Date:</u> 5/2013
	Network Blood Management Officer	<u>Date:</u> 2/2013

<u>Approved:</u>	NPP Steering Committee	<u>Date:</u> 6/12/13
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APPENDIX A  
BLOOD AND BLOOD PRODUCT SERVICES  
Community Hospital South

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I. AGREEMENT

- A. Except as otherwise provided in this Agreement, the Blood Center shall provide to the Client one or more of the blood and blood product services as described on Exhibit A-1 and the Client shall pay the Blood Center the service fees set forth in Exhibit A-1.
- B. Transportation:
1. Unless otherwise agreed, the Blood Center shall provide to the Client routine delivery service for blood and blood product services.
  2. The Blood Center shall provide to the Client emergency delivery service for the emergency delivery service fee set forth in Appendix X.
  3. The Blood Center shall provide and retain ownership of transportation containers and equipment for use in providing the routine delivery service for blood and blood product services.

II. RECALLS/MARKET WITHDRAWALS

- A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Consignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Indiana Blood Center  
**EXHIBIT A-1**  
**BLOOD PRODUCTS/SERVICES**  
 Community Hospital South

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
LRBC/RBC	P9016	1100, 1105, 2205	275.00
LRBC/RBC - Autologous (Administrative fee is additional)		1100, 1105, 2205	275.00
LRBC/RBC - Irradiated	P9040	1103, 1108	350.00
LRBC/RBC - Deglycerolized	P9054	1400, 1405, 2405	350.00
LRBC/RBC - Frozen	P9057	1300, 1310, 2310	350.00
LRBC/RBC - Washed	P9054	1200, 1201, 2210	350.00
Whole Blood	P9010	1000	400.00
Cryoprecipitate	P9012	3000	75.00
Cryoprecipitate - Pooled	P9012 X 5	3010	450.00
Apheresis Platelets, Leuko Reduced, Bacterial Detected	P9035	2100	650.00
Apheresis Platelets-Irradiated, Leuko reduced, Bacterial Detected	P9037	2103	705.00
- HLA Typed Surcharge		9105	150.00
AFFP (400 ml)	P9017 X 2	2001	131.00
AFFP Pediatric pack (per individual pack)		2003	32.00
Frozen Plasma < 24 hours (250 ml)	P9017	2000, 3050, 3070	54.00
Frozen Plasma - Cryo Poor	P9044	3055	70.00
CMV Neg charge	86644	5061	18.00
Irradiation fee for one to five platelet concentrates	B9006	9106	55.00
<b>Neonatal Pack Surcharge</b>			
- Neo 3		9120	30.00
- Neo 4		9121	35.00
- Neo 6		N/A	40.00
- Neo 8		9123	50.00
<b>Imported Product Surcharge Fees:</b>			
- Import fee (one fee per imported unit, per patient)		9159, 9160, 9170	150.00
- Excess fees above the Blood Center charges will be passed onto the hospital			*

Legend: LRBC - Leukoreduced Red Blood Cell  
 RBC - Red Blood Cell

AFFP - Apheresis Fresh Frozen Plasma  
 FFP - Fresh Frozen Plasma

<u>DESCRIPTION</u>	<u>SUGGESTED P-CODES</u>	<u>ITEM CODE</u>	<u>PRICE (\$)</u>
Source Leukocyte	85009	3106	40.00
Segments for Crossmatching (each group of 20)		9442	20.00
Packing Whole Blood (up to 4 units)		9168	30.00
Washing Platelet (per unit) (additional fee for one FFB used in processing)	B9064	9165	75.00
One Liter Wash (per unit)	B9064	N/A	75.00
Glycerolizing & Freezing	B4001	9158	75.00
Deglycerolizing	B4001	9163	85.00
Apheresis Special Draws		N/A	*
<b>Donor / Patient Services</b>			
Autologous Donation Fee (per unit)	86890	9102	300.00
Autologous Apheresis Donation Fee (per donation)	86890	9102	300.00
Directed Donation Fee (per unit)		9103	300.00
Additional Handling Fees - after hours, without appointment (per unit)		N/A	200.00
Annual Storage Fee for Autologous Frozen Cells		N/A	150.00
Off-site Draw Fee (per unit)		N/A	*
After Hours Charge - Apheresis		9150	350.00
<b>Blood Derivatives</b>			
Rho Gam (per package)	J27790		**
V-Zig Immune Globulin (comes in volume 125 & 625)			**
Factor 8	J7190, J7191, J7192		**
<b>Non-Blood Products</b>			
Platelet Leukocyte Removal Filters			
- PLX8C	PLX8C		***
- PLX12C	PLX12C		***
Red Cell Leukocyte Removal Filters			
- RCXL1C	RCXL1C		***

Regular hours are Monday – Friday, 5:30a.m.–6:30p.m; Saturday, 6:30a.m –12:00noon (excluding holidays)  
Services outside of these hours may incur additional charges

\* Price based on order

\*\* Fees are subject to change

\*\*\* Price based on the manufacturer's charge

TESTING – Outpatient

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
Complete Donor Profile and NAT HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH, HIV 1/ HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5502	89.00
Complete Donor Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5503	68.50
BMR Panel HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592	5151	67.50
Infectious Disease Profile Only HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, HIV 1/HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592	5120	74.25
Tissue Bank Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86644	5091	64.00
Fertility Donor Profile HBSAG, HCV, HIV 1/2, HBC, (STS) Syphilis	87340, 86704, 86703, 86803, 86592	5552	58.25
ABO Group & Rh Type (donor)	86900, 86901	5030	10.50
ABO Group & Rh Type (cord)	86900, 86901	5031	12.50
Antibody Screen	86850	5200	10.50
Antibody to CMV	N/A	5060	5.50
Antibody to HB Core (EIA)	86704	5040	17.00
Antibody to HCV (EIA)	86803	5105	18.00
Antibody to HIV 1/2 (EIA)	86703	5110	17.00
Antibody to HTLV-I/II (EIA)	86687, 86688	5082	17.00
Cholesterol	82465	5220	5.50
HCV/HIV1 NAT (pool)	donor only	5007	19.25
HCV/HIV1 NAT (individual)	donor only	5011	31.00
WNV NAT (pool)	donor only	5008	11.00
WNV NAT (individual)	donor only	5012	19.25
Hepatitis B Surface Antigen (EIA)	87340	5010	17.00
Syphilis (STS)	86592	5086	5.25
Antibody to HBs (EIA)	86706	5020	15.75

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
Syphilis Confirmatory	86781	5090	48.75
RPR Titer		5088	11.00
RPR Titer w/FTA if ind		5089	44.00
HBsAg Confirmatory Neutralization	86382	5005	157.50
HCV Immunoblot Assay	86804	5095	152.25
HIV1 Western Blot and HIV2 Antibody Confirmation	86689	5125/5127	126.00
HIV2 Western Blot	86689	5124	156.50
HTLV Antibody by WB	86689	5096	111.50
HTLV I/II Antibody w/WB if ind	86687	5129	21.25
HIV-1 Whole Viral Lysate	Donor only	5126	124.50
CMV IgG/IgM	86644/86645	5161	54.50
GC/Chlamydia	87490, 87491, 87590, 87591	5128	64.50
Chagas	87449	5021	20.00
Chagas RIPA	86753	5121	500.00
Leishmania IFA	86717	5101	131.25
Complete Blood Count			7.50

The laboratory can be reached at Monday-Saturday. If no answer, call to have the staff paged.  
 \* Panel prices are for pooled pricing. Individual WNV NAT is an additional \$7.60

TESTING – Reference Lab

Confidential

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE (\$)
ABO & Rh	86900, 86901	4000 RC	35.70
Allogeneic Adsorption	86971, 86978	4210	204.00
Antibody Identification	86870	4020 RC	97.00
Autoadsorption	86971, 86978	4220	153.00
Chloroquine/EGA Treatment of RBC's	86860	4270	142.75
Compatability Screening	86922	4070	40.75
Direct Antiglobulin Test	86880	4060	46.00
<b>Donor Antigen Test, confirmed per antigen</b>			
- CEceK	86903	4041 UPH	49.00
- AHG	86903	4042 UPH	72.50
- Direct	86903	4043 UPH	79.50
- Rare Low Frequency	86903	4044 UPH	79.50
- Rare High Frequency	86903	4045 UPH	118.25
Saline Replacement	86977	4320	20.50
DTT Treatment of RBC's	86970	4271	71.50
Eluate	86860	4290	132.50
Enzyme Treatment of Panel	86971	4250	66.25
Hemoglobin Screening	85660	4082 UPH	46.00
Microhematocrit/Hypotonic Cell Separation	86972	4280	86.75
Neutralization (HPC/Plasma/ Lewis/ P)	86977	4260	102.00
<b>Patient Antigen Test</b>			
- Rh Phenotype	86906	4031 RC	128.50
- CEceK (individual antigen)	86905	4032 RC	49.00
- AHG	86905	4033 RC	72.50
- Direct	86905	4034 RC	79.50
- Rare Low Frequency	86905	4035 RC	79.50
- Rare High Frequency	86905	4036 RC	118.25
Pre-warm	86940	4230	51.00
Titration	86886	4240	66.25
Triple Adsorbing Cells	86971	4084	61.25
RBC Molecular typing (patient)	83891, 83900, 83901x22, 83892x2, 83912, 83914x22	4115 P	510.00
RBC Molecular typing (donor)		4115 U	153.00
ARDP Fee (per unit)	86999	4105	204.00
Export Fee for Rare units (per unit)	86999	9171	127.50
Import Fee for Rare units (per unit)	86999	9170	127.50
Coordination/Consultation Fee	86999	4120	81.50
STAT Fee, For immediate provision of services Mon -Thur evenings and overnight and Fri evening	86999	4130	255.00
STAT Fee, For immediate provision of services during holidays, Fri overnight, Sat and Sun	86999	4130 N	510.00

The Blood Center Reference Laboratory is available on-site or on-call 24/7 by calling

TESTING – HLA-DNA Lab

Confidential

DESCRIPTION	SUGGESTED CPT CODES	PRICE (\$)
<b>ROUTINE ITEMIZED TESTING</b>		
1. HLA Typing (ABC)	83891, 83896x224, 83898x3, 83912	400.00
2. HLA Typing (ABCD RDQ)	83891, 83896x224, 83898x3, 83912	500.00
3. ABO	86900	15.00
4. Autocrossmatch T-Cell Flow	86805 X 6	212.50
5. Autocrossmatch B-Cell Flow	86805 X 6	212.50
6. Crossmatch (Donor T-Cell) Flow	86805X6	212.50
7. Crossmatch (Donor B-Cell) Flow	86805 X 6	212.50
8. Flow Antibody Screen Class I PRA	88184, 88185, 88187	158.00
9. Flow Antibody Screen Class II PRA	88184, 88185, 88187	158.00
10. Antibody Identification Class I	88184, 88185, 88187	350.00
11. Antibody Identification Class II	88184, 88185, 88187	325.00
12. Donor Specific Antibody DSA Class I	88184, 88185, 88187	350.00
13. Donor Specific Antibody DSA Class II	88184, 88185, 88187	325.00
14. SPRCA Crossmatch (HLA or Single Donor) Platelet	86806	165.00
15. Platelet Antibody Screen	86022	200.00
<b>ROUTINE PANELS for Ease of Ordering</b> (See itemized listing for tests included in panel)	<b>TEST NUMBER</b> (Routine itemized Testing List)	
<b>Platelet Support Services</b>		
Hematology Profile		1, 3, 10, 15
HLA Class I PRA and Antibody Identification Class I (Flow)		8, 15
SPRCA Crossmatch (HLA or Single donor) Platelet		14
<b>Cardiac/Renal Services</b>		
Transplant Candidate Profile		2, 3, 4, 5, 8, 9, 10, 11
Cadaveric Transplant Donor		3
Living (renal) Transplant Donor Profile		2, 3
Cardiac/Renal Transplant Recipient (day of transplant)		6, 7, 8, 9, 10, 11
<b>Bone Marrow Transplant</b>		
Bone Marrow Transplant Profile		2, 3, 8, 9
Bone Marrow Donor		2
Neonatal Alloimmune Thrombocytopenia (NATP) Panel		10, 14, 15
TRALI Investigation	No Charge for the Blood Center Units	

DESCRIPTION	SUGGESTED CPT CODES	PRICE (\$)
<b>Other Services</b>		
<b>Platelet Antigen Typing</b>		
Full Platelet Antigen Typing (HPA-1,2,3,4,5,6,15)	83896 x 2,83912	360.00
PLA1	83896 x 2,83912	175.00
<b>Disease Association Profile</b>		
HLATyping (AB/DR/DQ) per antigen	83891,83896x224,8 3898x3,83912	200.00
Parathyroid Tissue Cryopreservation	60500	850.00
Parathyroid Freezing Solution Sterility Check	87070, 87102	150.00
Parathyroid Tissue Release/Transportation Charges		varies with shipping
<b>Parentage Testing</b>		
Trio (Domestic)		490.00
Trio (International)		550.00
Single Parent Testing (Domestic)		550.00
Single Parent Testing (International)		585.00
Siblingship Testing (each person tested)		300.00
Each additional client		200.00
Specimen Collection Fee (out of state)		37.00

Regular hours are Monday – Friday, 8:00a.m.–4:30p.m. (excluding holidays)  
 Services outside of these hours will incur an additional STAT charge of \$250.00 per order

#### RECALLS/MARKET WITHDRAWALS

- A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Cosignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial AGL Date 7-8-13

EXHIBIT A-2  
CONSIGNEE/RECIPIENT NOTIFICATION  
OF RECALLS/MARKET WITHDRAWALS

The Blood Center shall notify the Client of recalls and market withdrawals of blood products as soon as possible after discovery of a reactive screening test or other reason for product unsuitability.

I. The Blood Center shall notify the Client as soon as possible, and no later than 72 hours of test completion of any potentially infectious disease marker or other reason for product unsuitability for blood products the Client has received from the Blood Center. For products intended for transfusion, the scope of review will include all of the donor's units collected within the past five (5) years. For products intended for further manufacture into injectable products, the scope of review will include all of the donor's units collected within the past six (6) months.

A. Current positive tests for HIV for donors with prior donations:

- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HIV ABY repeat reactive lookback extends back 5 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HIV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

B. Current positive tests for HCV for donors with prior donations:

- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HCV ABY repeat reactive lookback extends back 10 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HCV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

C. Other lookbacks, recalls, or reasons for Post Donation Information:

- Notifications and recalls will be made similarly as above and in accordance with applicable guidance; however, for recalled products that are no longer potentially available (post-expiration date), written notification using IBC forms (e.g. Post Donation Information Consignee Notification form, Recipient Data Sheet, etc.) will be sent to the transfusion service. If requested, such forms should be returned as soon as possible, and within 15 days to allow for meeting FDA BPDR reporting timeframes.

II. The Client shall have a clearly defined and written policy that ensures recall notifications from IBC are appropriately received and managed per applicable guidance, and that recalled products are not inadvertently distributed for transfusion. The policy shall include identification of the person responsible for performing this activity, how the units are identified as "in quarantine", and how the units are physically separated from the regular blood inventory. The Client shall, upon request, provide the Blood Center with a copy of the written policy.

References:

- 21 CFR §§ 610.46-610.48
- *Guidance for Industry: Nucleic Acid Testing (NAT) for Human Immunodeficiency Virus Type 1 (HIV-1) and Hepatitis C Virus (HCV): Testing Product Disposition, and Donor Deferral and Reentry.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, May 2010.
- *Guidance for Industry: "Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, December 2010.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial GBC Date 7-8-13

260

**APPENDIX B  
TESTING SERVICES**

**I. AGREEMENT**

- A. The Blood Center shall provide to the Client one or more of the Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services set forth in Exhibit A, attached hereto and incorporated herein, upon submission of the appropriate testing request form by the Client and the Client shall pay the Blood Center the service fees set forth in Exhibit A,

**II. TESTING PROTOCOL**

A. Testing Request Process

1. The Client shall comply with the applicable testing request processes described in the Customer Resource Manual when the Client requests Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services.

B. Sample Requirements

1. The Client shall collect, label, store, pack, transport and ship all blood samples in accordance with applicable federal, state and local laws and in accordance with the Customer Resource Manual.
2. The Blood Center shall provide packing materials to the Client upon request.

C. Sample Transport

1. The Client shall transport all blood samples in accordance with the Customer Resource Manual.
2. The Client shall pack samples in accordance with federal, state or local regulations and shipping container manufacturers' specifications and requirements for clinical/diagnostic specimens.
3. The Client shall transport samples at refrigerated temperature to the testing laboratory located at Central Indiana Regional Blood Center, Inc., d/b/a Indiana Blood Center,
4. The Client shall pay for all costs for transporting and shipping to the Blood Center or Third Party Laboratories and reimburse the Blood Center for any freight costs incurred by the Blood Center.

D. Sample Integrity

1. The parties agree that that the integrity of the specimen received by the Blood Center dictates the integrity of the results obtained. The parties agree that the Client must properly collect, store, identify, pack, and ship samples to ensure accurate and efficient processing of the samples.

2. The parties agree that the Blood Center shall not be responsible for any delay in processing under the following circumstances:
  - a) The sample and supporting documentation accompanying the shipment is incomplete or in a condition not reasonably satisfactory to the Blood Center (or its Third Party Laboratory) in accordance with the guidelines specified in the Customer Resource Manual;
  - b) The sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
  - c) The specimen contains incorrect information for sample shipment reconciliation;
  - d) Any aspect of sample identification is incorrect or illegible;
  - e) The specimen is not the appropriate quantity, type, or age; or
  - f) The Blood Center determines, in its sole judgment, that the specimen has not been properly stored.

#### E. Sample Receipt and Turn-Around Time

1. Upon receipt of a sample from the Client, the Blood Center shall:
  - a) Notify the Client of any damaged samples or any inadequate documentation relating thereto promptly after the arrival of a shipment at the Blood Center or its Third Party Laboratory; and
  - b) Handle the samples with all due care for as long as the samples are within the Blood Center's control.
2. Upon receipt of a sample from the Client, the Blood Center may, in its sole discretion:
  - a) Refuse to perform services hereunder in any instance in which the Blood Center deems that the samples or related documentation are not in reasonably satisfactory condition; or
  - b) Refuse to perform services hereunder in any instance in which the Blood Center deems that the sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
3. The Blood Center shall complete testing, review and reconciliation of records and transmit test results to the Client in accordance with the testing schedules set forth in the Customer Resource Manual for Testing Laboratory Services, Immunohematology Reference Laboratory Services, and Histocompatibility Laboratory Services.
4. The Blood Center shall immediately convey results from any specimen that registers a critical value to the appropriate Client personnel by telephone, facsimile or other electronic means.
5. The Blood Center shall provide the Client with the following technical information for all tests:
  - a) Normal values;
  - b) Technical method of analysis; and
  - c) Specimen requirements, including special handling instructions.
6. The Blood Center shall notify the Client a minimum of 30 days in advance of significant changes in the test protocols, reagents sample volumes or sample types set forth in the Customer Resource Manual.
7. The Blood Center shall not provide STAT testing unless the parties agree in writing upon the terms, conditions, and fees for STAT testing.

F. Test Performance and Procedures:

1. The Blood Center shall perform and cause its Third Party Laboratories to perform the blood testing services and interpret blood test results in accordance with applicable laws, regulations, manufacturer's package insert instructions (except where otherwise approved by the United States Food and Drug Administration (FDA), and use testing procedures at least as stringent as those recommended by the American Association of Blood Banks (collectively the Regulations).
2. The Blood Center shall perform blood testing services with licensed screening and confirmatory tests or, in the absence of licensed confirmatory tests, by a confirmatory test recognized as appropriate by standard of care and standard industry practices.
3. The Blood Center shall use FDA licensed reagents whenever available.
4. The Blood Center shall provide to the Client copies of the package inserts of each of the assays that the Blood Center and any Third Party Laboratories will perform.
5. The Blood Center shall implement any new immunohematology and viral marker tests approved for use in blood banking/screening by the FDA or applicable standards upon written agreement by the parties of the service fees for such new immunohematology and viral marker tests.
6. The Blood Center and the Client shall comply with applicable state reporting requirements with regard to infectious disease markers.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial ABC Date 7-8-13

**APPENDIX X  
SERVICES AGREEMENT – COMMITTED VOLUMES  
COMMUNITY HOSPITAL SOUTH**

**I. PURCHASE COMMITMENT**

A. Client and the Blood Center shall agree upon Annual Unit Quantity or percent of amount to be purchased under this agreement, which shall be as follows:

<u>Product Unit</u>	<u>Price per Unit (\$)</u>	<u>Annual Unit Quantity or % of Annual Purchased Amount</u>
LRC	215.00	2,195
APLT	500.00	160
FP24	50.00	300
CRYO	43.00	0
POOLED CRYO	300.00	16

B. Pricing for the Committed Volume shall be determined on an annual basis, provided, however, the Blood Center may adjust the price if, in any 3-month calendar quarter (i.e., January-March, April-June, etc.), the quarterly purchases by Client are not within five percent (5%) of the quarterly volume as set forth below for the quarter just completed, in which case, pricing shall default to Blood Center list pricing set forth on Exhibit A-1.

	<u>Jul-Sep</u>	<u>Oct-Dec</u>	<u>Jan-Mar</u>	<u>Apr-Jun</u>	<u>Total</u>
LRC	557	550	538	550	2,195
APLT	41	40	39	40	160
FP24	76	75	74	75	300
CRYO	0	0	0	0	0
POOLED CRYO	4	4	4	4	16

**II. DELIVERY AND TRANSPORTATION**

A. Routine delivery. The Blood Center shall provide scheduled delivery one (1) time per weekday (Mon-Fri) at no charge.

B. Additional delivery. Deliveries requested by the Client beyond the routine delivery will be made the most cost-effective way, one way or round trip, depending on the customer need and ability to schedule the delivery for an additional fee of:

One-way fee	\$25.00
Round-trip fee	\$50.00

C. Emergency Delivery. Emergency delivery fee will be added to the delivery for those orders which require immediate delivery at the then-current emergency rates charged by third-party delivery services plus a reasonable administrative fee.

D. Transfers. Products transferred from the Client will be credited to Client's account at the service fee in effect at the time the product was shipped to the Client. Products transferred to the Client will be invoiced at the Client's current service fee in effect.

### III. RETURNS

Red Cells received with 10 days or more remaining before expiration will be given full credit for the Leukoreduced Red Cell product, excluding any additional special services provided for that unit, in the amount of the service fee in effect at the time the product was shipped to the Client. Apheresis Platelets received with 24 hours or more remaining before expiration and resold, will be given full credit in the amount of the service fee paid in effect at the time the products were shipped to the Client in the month following the calendar quarter end. Special order Apheresis Platelets including Irradiated, HLA matched and cross-matched are not eligible for credit.

### IV. STANDING ORDERS

Client may establish a written standing order for blood and blood product services. Standing orders submitted to the Blood Center by any client will be filled ahead of additional orders submitted by the Client. Changes in Client's standing order require seven (7) days written notification, provided, however, such changes may only be made one time per calendar month. Client is to submit a standing order to Blood Center within seven (7) days of contract execution.

To assist both client and Blood Center with utilization review, installation of the AIM software is to be included as part of this process.

Blood Center:

Initial BBB Date 6-27-13

Client:

Initial u66 Date 7-8-13

265



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 1 of 12

CANCELS: 5/21/13emergent

EFFECTIVE: 8/8/13

### TITLE: Blood Component Administration

Performed by:

1. Obtain blood components from Blood Bank: RN, LPN, MHC, PSP, PST, AP, SE, EMT-P (competency verified). Nursing may request Security to obtain blood component from Blood Bank.
2. Start Infusion and administer blood products: RN, LPN, NP, CNS

Purpose: To provide guidelines for administering blood components.

### Policy Statements:

1. A patient must be identified prior to the administration of any blood product according to CLN 3017, Identification of Patient, Use of Two Patient Identifiers. If the patient is able to communicate, ask the patient to state their name and birthdate. Additionally, verification of patient identification will occur by comparison of patient name, birthdate and medical record number on the blood product slip and the EMR to the patient name, birthdate, and medical record number on the patient's armband. If the patient is unable to communicate, nursing will compare the EMR, patient's armband, and blood product information and verify that all are accurate. All information will be an identical match to patient EMR, armband and blood product. If any information is not correct the blood product must be returned immediately to the blood bank.
2. A physician order is required to administer blood components. Blood Consent/Refusal form must be completed for all blood component transfusions, which includes: Red Blood Cells, Plasma, Cryoprecipitate and Platelets. The form should be signed before obtaining the Type and Crossmatch (T&C) or Type and Screen (T&S) blood sample, but must be signed before the blood component is administered. (Exception: Physician order to administer blood without the patient's consent in an emergency situation. If blood is administered in an emergency without consent, the reason must be documented in the patient's medical record.) The consent remains in effect during the hospitalization and a new consent is required for each new inpatient admission. A new consent is required when a patient is admitted to or from Behavioral Health or Rehabilitation Hospital or from an outpatient to an inpatient status.
3. IgG or Rh Immune Globulin are not blood components and do not require signed consents before administration.
4. A red Blood Bank Armband (Blood Recipient ID Band) will be placed on all patients who have a T&S/T&C drawn in an outpatient area/Emergency Department, or on all patients who do not have a Medical Record number. The armband must remain on the patient until midnight of the third day after the T&C/T&S specimen was drawn. If present, this armband must be used as a method of identification. If removed during this period, a new T&S/T&C must be ordered and a specimen drawn.
5. Do not obtain blood products from the Blood Bank until a working patient IV is established. (Exception: Emergency Situations.) The physician's order or the RN's judgment regarding the condition of the patient will be used to determine whether or not to interrupt an already existing IV infusion or to start a second IV site to administer the transfusion. If infusing parenteral nutrition, (D<sub>10</sub>W concentration or greater and/or lipids), or a continuous PCA narcotic, a second IV site must be started. If unable to obtain a second IV site receive orders from physician for possible interruption of other therapies that cannot be given during blood component infusion.
6. If the patient has an arteriovenous (AV) graft or fistula, blood may not be infused through the graft or fistula unless it is during dialysis.
7. A computer generated requisition to obtain blood label with the patient name (first and last), medical record number, and DOB must be presented when picking blood components up from the Blood Bank. Exception: A handwritten label with the patient's first and last name, Medical Record

2660



CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 5/21/13 emergent

NPP#: I-14BI

Page 2 of 12

EFFECTIVE: 8/8/13

- Number, and DOB may be used if the patient's condition warrants emergency blood administration and a computer label is not readily available. The person picking up the blood component from the Blood Bank (known as the transporter) must be aware which blood component is to be obtained if the patient has multiple blood components ordered. Blood bank personnel are to be informed by transporter which product component is needed. NOTE: If patient has a red armband, the sticker from the red armband must accompany the label with patient's name, DOB and medical record number in order to pick up the blood.
8. Uncrossmatched red blood cells will be given in an emergency situation when a T&C/T&S specimen has not yet been obtained, but T&C must be obtained as soon as possible and sent to Blood Bank. See NPP#I-14,B-2, Blood, Uncrossmatched for additional information.
  9. Blood tubing must not hang for greater than four hours. If more than one blood component is infused, the blood tubing must be changed if the infusions are not completed within the four hour time period. No more than four red cell products can be infused through the same blood tubing.
  10. All blood components must be started and be completely infused within four hours from the time the units leave the blood bank.
  11. If it is necessary to infuse longer than this, prior arrangements must be made with Blood Bank. Blood Bank will arrange smaller volumes ("aliquets") to infuse if necessary; for example, Pediatric patient or patients with CHF.
  12. If the blood component cannot be started upon arrival to the unit it must be returned to Blood Bank as soon as possible to avoid wasting it.
  13. Multiple blood components on a single patient can be released to a nursing unit if the patient's condition warrants. Under no circumstances is blood to be stored in a refrigerator on the nursing units. Coolers will be provided to nursing by the Blood Bank for the storage of multiple units in surgery, critical care areas, ED or transfusions taking place at areas remote to the blood bank. These coolers are for the use of red cells and plasma products. Platelets and cryoprecipitate are stored at room temperature. The coolers are labeled with information stating when the ice in the cooler must be replaced or returned to the blood bank.
  14. For the pediatric patients less than 100 pounds, the physician must order the amount and rate of blood administration. If this is not specifically ordered, the physician must be contacted.
  15. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion:
    - a. By checking the specific physician order for accuracy of blood component to be administered before hanging the component.
    - b. By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the start time of the transfusion and the second set of vital signs between the first 10 and 20 minutes of the infusion.
    - c. By obtaining patient temperature a minimum of every 30 minutes during the transfusion when clinically indicated for signs and symptoms of a possible reaction.
    - d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion.  
NOTE: If a transfusion takes less than 15 minutes to complete, the 15 minute assessment and the completion assessment may be completed and documented at the same time, the vital signs would be completed in the post transfusion section and the pre transfusion section for the next unit.
  16. During the transfusion of all blood components products or upon its completion, if the patient experiences a 2<sup>o</sup>F increase or more (one degree Celsius) in temperature, or any other sign/symptom of a transfusion reaction, the transfusion is to be stopped. Call the Blood Bank immediately, receive instructions for transfusion reaction work-up and notify physician. The Blood Bank will inform the nurse of the necessary items for a Transfusion Reaction Work-Up. (These include: post transfusion blood bank specimen correctly labeled, yellow copy of the transfusion record form with reaction information completely filled out, all tubing, filters, fluids and blood components used in the transfusion, and the Transfusion Reaction work up order

267



**CORPORATE NURSING POLICY AND PROCEDURE**

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 3 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

requisition.) Orders received from the physician and rationale for interventions must be documented.

17. In the event that the patient dies while receiving a transfusion, perform the following: document on the transfusion record form that patient died, contact blood bank, send all paper work and tubing to the blood bank, and if possible obtain a post transfusion specimen.
18. No medication is to be added to or administered with blood components. Use only normal saline (0.9% saline) with blood components.
19. All crossmatched blood and T&C/T&S orders will be automatically released at midnight of the 3<sup>rd</sup> day from when the specimen is collected. Should the patient require blood after this time period, a new order and crossmatched specimen must be obtained. EXCEPTIONS include pre-op T&C and Pre-op T&S which may be extended for 30 days with pre-op questionnaire.
20. A patient refusing to receive blood for religious or other reasons must sign the Blood Consent/Refusal form section. See Corporate Policy CLN:2062, "Blood Transfusions, Refusal Considerations".
21. Patients requiring transportation while receiving a transfusion must have an RN, Perfusionist or physician in attendance. Hand off to the unit of destination must be to an RN, Perfusionist or physician.

General Information:

1. Potential signs and symptoms of a transfusion reaction include: chest pain, back pain, itching, rash, hives, shortness of breath, feeling anxious, increase in temperature greater than or equal to 2 degrees Fahrenheit or 1 degree Celsius from pre-transfusion baseline vital signs or anything out of the ordinary.
2. Patient identification consists of inspection of the identification armband to verify that the name, date of birth and medical record number are the same as on the Transfusion Record Form and the blood component unit label. If a red Blood Bank Armband (Blood Recipient ID Band) present, this armband must be used as a method of identification.
3. Unit(s) identification consists of verification from the blood component unit label, including:
  - a. Patient's Name
  - b. Medical Record Number or identification number on red blood bank armband (Blood Recipient Identification Band)
  - c. Date of Birth (DOB)
  - d. Donor number
  - e. Blood Type of unit
  - f. Blood type of patient
  - g. Unit Expiration
  - h. Other specifics, for example, irradiated, CMV.
4. T&C/T&S at CHVH, CHN, CHE, or CHS and processed by Mid America Clinical Laboratories is valid for use at all sites listed above. Any patient transferring from any other location needs need a new T&C and T&S drawn.
5. A physician, NP, CNS or Perfusionist may start infusion and administer blood products.
6. It is recommended that intravenous catheter sizes for use in transfusing cellular products, (Red cells and platelets), range from 14 to 22 gauges.
7. All Red Blood Cells received from Indiana Blood Center are Leukoreduced.

Equipment:

1. IV Pole
2. Blood Administration set
  - a. Double Y- type blood tubing (Whole Blood, Packed Cells, and FFP, Platelets, Leukocytes, and Cryoprecipitate)

2608



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 5/21/13 emergent

NPP#: I-14B1

Page 4 of 12

EFFECTIVE: 8/8/13

- b. 30ml syringe with filter needle (Factor VIII/Factor IX)
  3. Blood warmer (optional) is ordered by physician. (Instruction sheet on machine.)
  4. Infusion pump if blood component is to be infused through a central line. An infusion pump is optional if a blood component is infused peripherally.
  5. 250 ml Normal Saline (0.9% saline)
- A. Obtaining T&C or T&S ( Type and Cross/ Type and Screen):**
1. If T&C or T&S is needed, identify the patient using the two patient identifiers as described in CLN 3017, Identification of Patient, Using two patient identifiers.
  2. Obtain specimen by drawing blood in Blood Bank designated vacutainer tube.
  3. On the vacutainer pre-affixed label and print in indelible ink the following information:
    - a. Patient's full name
    - b. Patient Date of Birth
    - c. Medical Record number
    - d. Date, time and phlebotomist's initials
  4. Complete collection information on the lab requisition to include:
    - a. Date/time of collection
    - b. Phlebotomist's initials
    - c. Notation that hospital or red blood bank arm band is present when specimen was drawn.
    - d. One additional patient identification item listed below
      - 1.) Patient said name was: \_\_\_\_\_
      - 2.) DOB
      - 3.) Staff identification of patient
  5. Place a red blood bank armband (Blood recipient Identification Band) on patients who have had T&C/T&S drawn in outpatient areas or before a Medical Record number is available. Affix the patient ID portion of this armband on to the tube of blood in the presence of the patient.
  6. Place specimen, strip of armband numbers if using Identification Band and requisition in plastic bag and deliver to Blood Bank. Blood Bank refuses specimen if:
    - a. There is incomplete labeling of specimen including misspelling of any portion of the name, missing medical record numbers including zeros and omission of date/time of collection and phlebotomist's initials.
    - b. There is inaccurate labeling of specimen which includes using printed labels for T&C and T&S.
    - c. Specimen labeling is not in agreement with requisition.

### B. Obtaining Blood Component(s) from the Blood Bank

1. The transporter hands the pick-up slip to the Blood Bank associate at Blood Bank If the patient has a red armband, the sticker from the red armband accompanies the label with patient's name, DOB, and medical record number in order to pick up the blood.
2. The Blood Bank associate retrieves the blood component(s) and dispenses in the laboratory computer.
3. The transporter then reads to the Blood Bank associate the following from the Transfusion Record Form:
  - a. Patient Name
  - b. Medical Record Number
  - c. Date of Birth
  - d. Patient ABO/Rh
  - e. Unit ABO/Rh
  - f. Unit number and correlating red armband number if appropriate
  - g. Component
  - h. Crossmatch results



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 5 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

- i. Unit expiration date and time
- j. Comment
4. The transporter then signs the Transfusion Record Form (s) in the area **TRANSPORTED BY** along with the date and time, and the department where the transfusion will take place.
5. The transporter hands the Transfusion Record Form (s) back to the Blood Bank associate to sign in the area marked Technician Issuer
6. The Blood Bank associate removes the pink copy from the Transfusion Record Form (s) and places the Transfusion Record Form, Blood Bag label and blood component in a bag (either paper or plastic) or cooler for transportation to the nursing unit.
7. The Blood Bank associate dates and writes the 4 hour blood product outdate time on the Blood Bag Label sheet and includes this in the bag or cooler for transportation to the nursing unit.
8. Pneumatic Tubing of Blood and Blood Products for NICU and CHVH (weekends only for CHVH): Complete the Blood Pneumatic Tube Transport form (see addendum # 3).
  - a. Perform 2 patient Identifiers with physician order before sending form to Blood Bank
  - b. If patient has a blood bank band include the number in the space provided on form
  - c. Handwrite the patient's full name and birthdate, Medical Number, and Room number
  - d. Fill in number of Product Requested : \_\_\_\_\_
  - e. Quantity: \_\_\_\_\_ Tube Station: \_\_\_\_\_
  - f. Phone: \_\_\_\_\_ Initials: \_\_\_\_\_
  - g. Follow the instructions to "Send request form via pneumatic tube"
2. Blood Bank :
  - a. Completes the "Date/Time Product Sent" section of the Blood Pneumatic Tube Transport form and they will retain the bottom (yellow) copy
  - b. Notifies the Clinical area that the blood product is being sent.
  - c. Places product, Blood bag label dated with the 4 hour blood product outdate time and top copy of transport form in sealed Ziploc bag(s). Place
  - d. Ziploc bag into a pneumatic tube.
  - e. Blood bank tech calls receiving area if "Blood Pneumatic Tube Transport" form is not returned to the Blood Bank within 15 minutes.
3. Clinical area removes unit from the pneumatic tube system and
  - a. compares the information on Unit Compatibility label, Transfusion Record Form and Blood Product Request Form.
  - b. Complete the "Receipt" section of the Blood Pneumatic Tube Transport form
  - c. Returns the form and the refrigerated gel pack (if applicable), via the tube system to the blood bank.
  - d. Two members of the transfusing staff verifies donor unit information per Blood Administration policy, with the transfusion tag and patient wristband information at the patient's bedside.
  - e. If there are any discrepancies, the Neonatal Intensive Care Unit (NICU) personnel will **WALK** the unit back to the Blood Bank for resolution. For discrepancies at The Indiana Heart Hospital (CHVH) the staff call the Blood Bank for further instructions.

### C. Transfusion

1. Complete bedside verification process using the Transfusion Record Form. Utilizing two 2 staff members, one of which is a licensed professional (RN, LPN, Physician/NP, Perfusionist). Compare -the specific physician order for accuracy of blood component to be administered before hanging the component. Scans the blood bag for the unit number and the product code number.
2. Compare the patient's name, DOB, and medical record number on the identification armband with the patient's name, DOB and medical record number, and if applicable the red armband number on the Transfusion Record Form and the blood component unit label.

270



**CORPORATE NURSING POLICY AND PROCEDURE**

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 6 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

3. Compare the unit number, ABO group, and Rh on the blood component unit label with the unit number ABO group, and Rh on the Transfusion Record Form. Contact Blood Bank immediately for any discrepancies.
4. Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion. If patient's temperature is 101<sup>0</sup>F or above, notify the physician prior to starting the blood component and receive orders.
5. Attach blood component to prepared IV tubing.

Infuse at:

Component	1 <sup>st</sup> 15 minutes	After 15 minutes	Pediatric
Red Blood Cells	75 ml/hour	150 ml/hr	2-5mL/kg/hr
Plasma	NA	200-300ml/hr	60-120 mL/hr
Platelets	30ml/hr	200-300mL/hr	60-120mL/hr
Cryoprecipitated AHF	As Rapidly as Tolerated		As Rapidly as tolerated

6. The RN observes the patient closely, assessing and monitoring the patient for the first 15 minutes after the transfusion is started to observe for potential signs and symptoms of a transfusion reaction.
7. Between the first 10 and 20 minutes of the infusion, obtain vital signs including temperature, pulse, respiratory rate, and blood pressure and document the complete vital signs on the Transfusion Record Form. Observe the patient for shaking, chills, pain, nausea, itching or other symptoms and document. If the patient's condition is satisfactory, the rate can be increased to that listed in the table above.
8. Continue to monitor and assess the patient intermittently throughout the transfusion.
9. If a unit of blood has been infusing for more than 4 hours, discard remaining blood in red biohazard containers in dirty utility area and completely change all IV tubing that was used for transfusion.

**D. Post Transfusion:**

1. After transfusion is complete, flush blood tubing with normal saline, then discard all blood tubing, bag and supplies from transfusion in red biohazard container in dirty utility area.
2. Resume previous IV fluids. If IV site may be needed for additional transfusions, then maintain as a PIV lock.
3. Take post-transfusion vital signs (T-P-R & BP) within 15 minutes of completion of the transfusion and record on the Transfusion Record Form.
4. Review and verify Transfusion Record Form is complete with all appropriate signatures, dates and times. Unlicensed personnel may collect vital sign data; however, all vital signs must be reviewed and initialed by the RN. Place original in chart and send yellow copy to Blood Bank via pneumatic tube . If no access to pneumatic tube send via interdepartmental mail .

**E. Transfusion Reaction**

1. Stop the transfusion immediately if any symptoms of a reaction occur. Immediately switch from blood infusion to saline and get specific treatment orders for reaction from physician. Mild urticaria, hives, or an increased of temperature less than 2<sup>0</sup>F (or 1<sup>0</sup>C) alone may not be deemed a sufficient indication by the physician to discontinue the transfusion. All other symptoms require the stopping of the transfusion and proceeding with steps 2, 3 ,4 and 5.
2. Immediately, visually check the patient armband, blood product unit label and transfusion record form, to verify that this is right patient, right blood product, right patient medical record number, and that all information matches the patient arm band, blood component unit label and the Transfusion Record Form.
3. Call the Blood Bank for instructions on proceeding with a transfusion reaction work-up.

271



CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 7 of 12

CANCELS: 5/21/13emergent

EFFECTIVE: 8/8/13

4. Order a transfusion reaction work up. Complete and sign the Transfusion Record Form and return yellow copy of the Transfusion Record Form and the blood component bag with all blood tubing, tags and fluids to the blood bank (place in biohazard bag for transport from patient unit to the blood bank.) Transfusion Reaction Record is completed by the Blood Bank. Nursing to document in the EMR.
5. For general information regarding specific transfusion reaction, see addendum. There is the possibility of delayed hemolytic reaction. This type of reaction most frequently occurs between 3-14 days post-transfusion.

a. **Transfusion Associated Circulatory Overload (TACO)**

Definition: Infusion volume that cannot be effectively processed by the patient either due to the high infusion rate and /or volume or an underlying cardiac or pulmonary pathology  
Signs and Symptoms: New onset of exacerbation of  $\geq 3$  of the following within 6 hours of transfusion:

- Acute respiratory distress (dyspnea, orthopnea, cough)
- Evidence of positive fluid balance
- Elevated brain natriuretic peptide (BNP)
- Radiographic evidence of pulmonary edema
- Evidence of left heart failure
- Elevated central venous pressure (CVP)

b. **Transfusion Related Acute Lung Injury (TRALI)**

Definition: Acute hypoxemia with  $\text{PAO}_2/\text{fraction of inspired oxygen [FIO}_2\text{]}$  ratio of 300mm HG or less combined and chest e-ray showing bilateral infiltrates in the absence of left atrial hypertension (ie, circulatory overload)

Onset of TRALI is abrupt in association with transfusion

Signs and Symptoms:

- No evidence of Acute Lung Injury (ALI) prior to transfusion
- Acute Lung Injury onset during or within 6 hours of transfusion
- Hypoxemia defined by any of these methods:
  - $\text{PaO}_2/\text{FIO}_2 \leq 300\text{mm Hg}$
  - Oxygen saturation is  $< 90\%$  on room air
  - Other clinical evidence:
    - No evidence of left atrial hypertension (i.e. circulatory overload)
    - No temporal relationship to an alternative risk factor for Acute Lung Injury during or within 6 hours of completion of transfusion

c. **Transfusion Associated Dyspnea (TAD)**

Definition: Respiratory distress within 24 hours of transfusion that does not meet the criteria of TRALI, TACO or allergic reaction. Respiratory distress should not otherwise be explained by a patient's underlying or pre-existing medical condition.

Signs and Symptoms:

- Acute respiratory distress and occurs within 24 hours of transfusion and TRALI, TACO and allergic reaction and other underlying medical conditions ruled out.

Documentation – Complete the following:

1. Transfusion Record Form
  - a. Signatures of personnel starting and stopping transfusion
  - b. Signature of personnel verifying patients identity
  - c. Date/Time started
  - d. Date/Time stopped
  - e. Vital signs before the transfusion starts, between the first 10 and 20 minutes of the transfusion and within 15 minutes after the transfusion is complete.

272

 **Community  
Health Network**

**CORPORATE NURSING POLICY AND PROCEDURE**

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 8 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

- f. Consent signed Yes/No
  - g. If the patient is an infant has the infant blood screen been drawn? Yes/No
  - h. If blood or blood product is given under anesthesia check the box " Given Under Anesthesia see Anesthesia Record". This will direct healthcare providers to vital signs recorded by anesthesia to avoid duplication.
2. EMR on Blood Flow sheet
    - a. Document time when unit was hung.
    - b. Document normal saline use.
    - c. Vital signs recorded at appropriate times as described above
  3. Document any patient responses, treatments or further care that is not within normal limits.

Reference: .

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Community Health Network Transfusion Committee 2011

Practice Guidelines for Blood Transfusion Developed by America Red Cross Biomedical Headquarters, April 2007

Recommendations from Indiana State Department of Health, October 2011

Standards for Blood Banks and Transfusion Services, AABB, 27<sup>th</sup> Edition, 2011  
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<u>Approved by:</u>	IV NPP Committee	<u>Date:</u>	3/2013
	Infection Control	<u>Date:</u>	5/2013
	Risk Management	<u>Date:</u>	5/2013
	Network Blood Management Officer	<u>Date:</u>	2/2013

<u>Approved:</u>	NPP Steering Committee	<u>Date:</u>	6/12/13
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# Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 9 of 12

CANCELS: 5/21/13 emergent

EFFECTIVE: 8/8/13

## ADDENDUM 1

### Complications From The Transfusion of Blood/Blood Products

1. **Hemolytic Reaction: Immediate**
  - a. **Causes:** The patient receives red cells that are ABO incompatible, this results in the hemolysis of red blood cells. It happens most often due to a mismatch of blood rather than a crossmatching problem. The severity of reaction correlates with the amount of blood transfused.
  - b. **Symptoms:** Fever, chills, pain the lower back/legs, chest tightness, dyspnea, nausea, vomiting, flushing, tachycardia, bleeding from a wound/IV site, feeling of impending doom.
  - c. **Blood Products:** Whole Blood, Packed Cells, leukocyte reduced RBC's, washed RBC's, and deglycerolized RBC's.
2. **Hemolytic Reaction: Delayed**
  - a. **Causes:** Patient develops RBC's antibody due to transfusion, the antibody hemolyzes RBC's that are incompatible.
  - b. **Symptoms:** In the hospital, this will be detected as a decrease in Hgb/Hct or an increase in bilirubin due to hemolysis of the incompatible red cells. You will usually not see the immediate, acute signs and symptoms.
  - c. **Blood Products:** Whole Blood, Packed Cells, and all RBC products.
3. **Nonhemolytic Febrile Reactions**
  - a. **Causes:** Leukoagglutinins react with WBC's. cytokines in donor plasma or bacterial contamination.
  - b. **Symptoms:** Fever, chills, nausea, vomiting, headache, dyspnea.
  - c. **Blood components:** RBC products, Platelets, FFP.

Nonhemolytic allergic reaction:

  - a. **Causes:** IgE antibodies
  - b. **Symptoms:** Urticaria, pruritis, erythema, asthmatic symptoms, anaphylaxis, dyspnea and/or laryngeal edema.
  - c. **Blood Components:** All products containing plasma including RBC products, platelet products, fresh frozen plasma, and Cryoprecipitate.
4. **Bacterial Contamination**
  - a. **Causes:** This is a rare complication caused by bacteria in the donor blood, usually gram - negative organisms. Immunocompromised patients are at a high risk.
  - b. **Symptoms:** Chills, fever, vomiting, abdominal pain, hypotension, shock.
  - c. **Blood Products:** Whole Blood, Packed Cells, Platelets, Plasma, and Cryoprecipitate.
5. **Transmitted Diseases**
  - a. **Causes:** HIV, Viral hepatitis, human te cell lymphocyte te virus I/II, syphilis, malaria, babesiosis, etc.
  - b. **Symptoms:** Onset delayed, disease dependent.
  - c. **Blood Products:** RBC products, Platelets, Plasma, and Cryoprecipitate.



# Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 10 of 12

CANCELS: 5/21/13emergent

EFFECTIVE: 8/8/13

## ADDENDUM 1 PAGE 2

### Complications From The Transfusion of Blood/Blood Products (continued)

6. **Circulatory Overload**
  - a. **Causes:** The volume or rate of infusion exceeds the circulatory system's capacity. Usually seen in patients with underlying cardiac, renal or pulmonary disease; elderly or very young; or massive transfusion (defined as 10 or more units of blood in a 24-hour period.) The possibility of overload can be decreased by the use of packed cells rather than whole blood, an infusion pump and slow rate of infusion, and administration of diuretics as ordered, and transfusion of patients in an upright position.
  - b. **Symptoms:** Usually have gradual onset and correlate with the amount of fluid infused; dyspnea, cough, pulmonary congestion/edema, neck vein distention, tachycardia, peripheral edema.
  - c. **Blood Products:** RBC Products, platelets, Plasma.
7. **Pulmonary Embolism**
  - a. **Causes:** Air, clot or foreign material entering the bloodstream via the tubing. Blood filters aid in prevention of emboli.
  - b. **Symptoms:** Sudden chest pain, dyspnea, cough, hemoptysis, anxiety, and hypotension.
  - c. **Blood Products:** RBC Products, Platelets, Plasma, and Cryoprecipitate.
8. **Hypothermia**

Blood is stored between 1-6° C (33-43° F) compared to a person's blood with a normal temperature of 37° C. The rapid infusion of large quantities of cold blood especially through a central catheter directly into the right atrium can cause a patient to become hypothermic and result in decreased heart rate, blood pressure, cardiac output, coronary blood flow and ultimately cardiac arrhythmia's and arrest. The use of a blood warmer should be strongly considered with these patients.
9. **Acidosis**

An anticoagulant solution, usually Citrate-Phosphate-Dextrose (CPD), is added to the blood as it is collected. The pH of CPD solution is 5.6, but the buffering action of Whole Blood (7.4) produces a final pH of 7.1 in freshly donated blood. As blood is kept in storage, despite the hypothermic conditions, anaerobic metabolism occurs with the end products being lactic and pyruvic acids. Thus, blood stored for two days has a pH of 6.9 and continues to decrease to 6.5 after 14 days of storage. The low pH of stored blood usually causes no difficulty because it is diluted with the patient's own blood.
10. **Citrate Toxicity and Hypocalcemia**

The citrate added to stored blood is a calcium-binding agent to prevent coagulation during storage. Normally the excess citrate is metabolized in the liver and excreted in the urine. Toxic levels of citrate accumulate when this process is ineffective because of impaired hepatic and/or renal function, or in massive transfusion. The additional citrate binds ionized calcium in the recipient's blood, which can lower the serum ionized calcium level to the point of depressed cardiac contractility.
11. **Hyperkalemia**

Potassium levels in stored blood rise gradually as potassium is released into the plasma by red cells lysis. The American Association of Blood Banks reports that the average amount of Potassium in one unit of 21-day old Whole Blood is 4mEq. This does not normally cause problems, except rarely in patients with impaired renal function.



CORPORATE NURSING POLICY AND PROCEDURE

NPP#: I-14B1

Approved For:  CHE  CHN  CHS  CHVH

Page 11 of 12

CANCELS: 5/21/13emergent

EFFECTIVE: 8/8/13

ADDENDUM 3

**BLOOD PNEUMATIC TUBE TRANSPORT**

Mid America Clinical Laboratories  
Indianapolis, IN 46219

REQUEST	RECEIPT
Patient Information: Full Name, MR#, Room #, or Addressograph  BB ID #, if applicable _____	I have received the ordered products and have verified acceptable condition.  Initials _____  Date/Time _____
Product Requested: _____  Quantity: _____ Tube Station: _____  Phone #: _____ Initials: _____ Send request form via pneumatic tube.	IMMEDIATELY UPON RECEIPT OF PRODUCT, RETURN THIS COMPLETED FORM TO BLOOD BANK VIA PNEUMATIC TUBE.
Date/Time Product Sent: _____ To be completed by Blood Bank If requested product is not received within 30 minutes, call the Blood Bank.	

276



CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH  
CANCELS: 5/21/13emergent

NPP#: I-14B1  
Page 12 of 12  
EFFECTIVE: 8/8/13

COMMUNITY HOSPITALS OF INDIANA, INC.

1500 N. RITTER AVENUE  
INDIANAPOLIS, IN 46219

INSTRUCTIONS TO PATIENTS RECEIVING BLOOD OR  
BLOOD COMPONENT TRANSFUSIONS

Your physician has requested that you be transfused with a blood product. While the great majority of blood transfusions are accomplished without complications, a small number of persons who receive blood may experience one or more of the following symptoms within a few hours of receiving the blood product:

1. Hives
2. Itching of skin
3. Redness or flushing of skin
4. Fever or chilling sensation
5. Shortness of breath
6. Very dark or black urine

These symptoms will usually disappear in a matter of hours but report them to your physician as soon as possible.

During the next 2-3 months, if you develop any onset of fever/chills, fatigue, aching pains, or yellow skin color please contact your physician. Any other change in your condition should also be reported right away.

The symptoms above may not be a complete list of possible adverse effects of blood transfusions. You should call your physician regarding any other problem or symptom.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

277



CORPORATE CLINICAL POLICY AND PROCEDURE  
Approved For:  CHE  CHN  CHS  TIHH  
CANCELS: 8/30/09

NPP#: I-14, B-02  
Page 1 of 2  
EFFECTIVE: 5/23/12

Approved For:  
 CHE  CHN  CHS  TIHH  
TITLE: BLOOD, UNCROSSMATCHED

Performed by: RN, LPN, Administrative Partner, EMT-P, EDCT, PSP  
And PST

Purpose: To outline the process for obtaining blood and blood products before completion of crossmatch testing.

Policy Statements:

1. The record will contain a signed statement from the ordering physician indicating that the clinical situation was sufficiently urgent to require release of blood.

General Information:

1. Blood Bank never releases red blood cells solely on a blood type based on a historical record.
2. The Blood Bank stock O-Rh-negative red blood cells for emergency release.
3. The blood bank stocks AB or A plasma for the emergency release of plasma.
4. If O Rh-negative red blood cells are unavailable, then O Rh-positive red blood cells may be used after consultation with the Blood Bank Medical Director and/or attending physician.
5. If the ABO of the patient is determined before compatibility testing is completed, the Blood Bank will switch to ABO compatible components.
6. The Blood Bank Medical Director and the attending physician are notified by Blood Bank immediately of any abnormal testing results that may affect patient safety.

Equipment: None

Procedure:

1. Request Emergency Release of Blood when the physician deems that the need for blood and blood components is necessary prior to the completion of compatibility testing
2. Place order in the computer for blood products requested.
3. Obtain specimen for crossmatch as soon as possible.
4. Call the Blood Bank and inform them for the need for Uncrossmatched blood and give the following information (if available)
  - A. Patient name
  - B. Patient date of birth
  - C. Medical Record Number
  - D. Physician's Name

278



CORPORATE CLINICAL POLICY AND PROCEDURE  
Approved For:  CHE  CHN  CHS  TIHH  
CANCELS: 8/30/09

NPP#: I-14, B-02  
Page 2 of 2  
EFFECTIVE: 5/23/12

- E. Number of units requested.
3. Obtain the number of requested units from the Blood Bank along with the transfusion record form. NOTE: Each has a bright orange Uncrossmatched label on each unit of blood.
  4. Obtain physician signature for the transfusion of Emergency Release.
  5. Administer blood per Blood Administration Policy I-014 B-01, "Blood Component Administration".
  6. Place original copy of the Transfusion Record Form on the patient's Medical Record Chart and return the 2<sup>nd</sup> copy to Blood Bank.

Documentation Guidelines:

Document blood administration in electronic medical record and complete Emergency Release Transfusion Record Form

References: Standards for Blood Banks and Transfusion Services, AABB, 27<sup>th</sup> Edition, 2011  
AABB Technical Manual, 17<sup>th</sup> Edition, 2011

<u>Approved by:</u>	IV Advanced Practice	<u>Date:</u> 4/30/12
	Risk Management	<u>Date:</u> 3/21/12
	Infection Control	<u>Date:</u> 2/29/12

<u>Approved:</u>	NPP Steering Committee	<u>Date:</u> 5/9/12
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279



## Emergency Release of Blood Components

### BB.Issue.1.0            Emergency Release of Blood Components

#### STATEMENT OF PURPOSE

To outline steps to be taken for release of:

- a) Uncrossmatched red cells in an emergency situation;
- b) Release of plasma and platelet products when an ABO/Rh type is not available.
- c) Product selection for Neonatal Emergency Release.

#### SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

#### RELATED DOCUMENTS

BB.ABO/Rh.1.0	ABO Blood Grouping
BB.ABO/Rh2.0	Rh testing – D and Weak D
BB.IAT/DAT.1.0	IAT – Indirect Antiglobulin Testing
BB.TYSC/TRBC.1.0	Compatibility Testing – Required Testing
BB.Issue.2.0	Dispensing of Blood Components
BB.TYSC/TRBC.6.0	Selection of and Indications for Products for Transfusion
BB.Issue.8.0	Preparation of Emergency Release Container

#### SPECIMEN

EDTA or Clot tube as described in BB.Spec.1.0

#### MATERIALS

Emergency Release Container in BB refrigerator:

- 2 to 4 units of O negative red cells
- TRF with completed Emergency Release Block
- Orange Uncrossmatched Blood stickers
- Labeled segments from each issued unit
- Optional: Make a Xerox copy of each unit label in the container to scan when the emergency release units are allocated and issued after crossmatch is complete.

7.800



**MACL Emergency Release of Blood Components  
PROCESS**

**I. Neonatal Emergency Release**

In the event that blood is need emergently for a neonate, the following product will be released:

- O negative
- Irradiated
- CMV negative
- Freshest unit available, preferable less than 5 days.
- If irradiated and or CMV negative blood is not available, contact the transfusion physician on possible product substitution, as in CVM not required due to red cells being leukoreduced.

**II. MACL Staff Available**

**A. Blood Product Selection**

1. Based upon available history, if the patient has special needs, then immediately consult Medical Director/pathologist on call. If history indicates patient has antibodies, notify ordering physician immediately of unavailability of compatible product. However, **DO NOT REFUSE** to give potentially incompatible product if warranted.
2. Each Blood Bank will routinely stock at least 2 units of O negative red cells for Emergency release.
3. If O negative blood is unavailable, do not delay releasing blood, but issue O positive red cells
4. O positive blood should not be given to women less than 55 years of age or pediatric patients unless Medical Director and/or patient's physician have been consulted
5. **NEVER** give Red Cells Products based on historical type.
6. If the contents of the Emergency Release Container are transfused, the container needs to be restocked at the earliest time possible. See BB.Issue.8.0 Preparation of Emergency Release container.

**B. Emergency Release No Specimen Available**

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	State need for blood bank specimen as soon as possible.	



Emergency Release of Blood Components

4	Remove either of the following: <ul style="list-style-type: none"> <li>• Emergency Release Container</li> <li>• 2 units of either O neg or O positive blood (dependent on the age and sex of the patient)</li> </ul>	See BB.ISSUE.8.0 Preparation of Emergency Container.
5	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
6	Complete Emergency Release Block of the Transfusion Record Form.	
7	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
8	Issuing tech signs "Issued By" line of Emergency Release Block.	
9	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
10	Perform read back procedure for the issue of blood between transporter and blood bank associate. <ul style="list-style-type: none"> <li>• Any patient information that is available</li> <li>• Unit number</li> <li>• Unit type</li> <li>• Exp. date</li> </ul>	
9	Emergency release to a transporter: <ol style="list-style-type: none"> <li>Transporter signs "Transported By/Received By" line of Unit Transportation Block.</li> <li>Retain bottom copy of Transfusion Record Form.</li> <li>Send top 2 copies of Transfusion Record Form with unit(s).</li> </ol>	Transporter is defined as an appropriately trained MACL or hospital employee.  Use copy to help track units and documentation of physician signature.

C. Emergency Release – Specimen Available

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request the following information: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.

787



Emergency Release of Blood Components

4	Select type specific red cells if there is current TRBC or TYSC order.	<ul style="list-style-type: none"> <li>A current specimen is one drawn within the last 3 days. Order as additional red cells.</li> <li>Perform an eXM if IAT is negative.</li> <li>If patients requires AHG crossmatch, contact pathologist and/or attending physician with patient's history.</li> </ul>
6	If antibody screen was positive, or patient has a history of positive antibody screen, retain one segment from each unit. Label segment with unit number.	
7	Complete "Emergency Release Block" of Transfusion Record Form.	Up to 4 units may be initially released. (Exception: Surgery may be given more depending on circumstances.)
8	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
9	Place orange "Uncrossmatched Blood For" label on each unit.	
10	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
11	Issuing tech signs "Issued By" line of Emergency Release Block.	
12	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
13	Perform read back procedure for the issue of blood between transporter and blood bank associate. <ul style="list-style-type: none"> <li>Any patient information that is available</li> <li>Unit number</li> <li>Unit type</li> <li>Exp. date</li> </ul>	
14	Emergency release to a transporter: <ol style="list-style-type: none"> <li>Transporter signs "Transported By/Received By" line of Unit Transportation Block.</li> <li>Retain bottom copy of Transfusion Record Form.</li> <li>Send top 2 copies of Transfusion Record Form with unit(s).</li> </ol>	Transporter is defined as an appropriately trained MACL or hospital employee.  Use copy to help track units and documentation of physician signature.
15	Upon completion of testing: <ul style="list-style-type: none"> <li>Enter testing results in computer</li> <li>Dispense units in the computer</li> <li>Unit comment: ";ISUN"</li> </ul>	ISUN = Units issued Uncrossmatched.

702



Emergency Release of Blood Components

D. Emergency Release – Testing and Paper Work Completion

Step	Action	Notes
1	Perform ABO/Rh immediately upon receipt of a properly labeled specimen.	If unable to obtain specimen due to patient demise, enter comment in patient history (e.g., "Patient specimen never received for crossmatch.") See computer steps.
2	Perform antibody screen. If negative, allocate units and electronically crossmatch emergency released units. Notify floor of completed antibody screen results.	If additional units are ordered, select ABO compatible units and continue with electronic crossmatch.
3	--If positive antibody screen results are obtained, notify requesting physician immediately. --If physician wishes to continue with the transfusion, ensure yellow copy of transfusion record form has been signed by that physician.  --If physician decides to continue transfusing, perform gel crossmatch using segments from units that were emergency released. --If crossmatch incompatible, notify physician IMMEDIATELY.  --Proceed with antibody identification.	"Contact Supervisor/Designee and Medical Director."  Enter a BBCMT comment to indicate name of physician called, date, time, and initials of tech entering comment.  Write same comment on the requisition: name of physician notified, date, time and initials of tech doing the notifying.
4	Verify that a type and crossmatch has been ordered.	
5	Receive orders.	
6	Record patient results in the computer.	
7	Discard printed Transfusion Record Forms after allocation of units and crossmatch results are entered.	Hand written Transfusion Record Form is the permanent record.
8	Issue units in the computer in Blood Product Issue Function: At the "Issue Comments" field (within Issue Information Area): Type ISUN TAB (ISUN populates with Issued Uncrossmatched).	See BB.Issue.2.0 Dispensing of Blood Components.
9	Paper work follow up: <ul style="list-style-type: none"> <li>Keep pink copy in view for reminder of follow up till yellow copy received from nursing unit.</li> <li>Obtain yellow copy of Transfusion Record Form with physician's signature.</li> <li>File yellow copy in blood file labeled "Emergency Release.</li> </ul>	When finalized, one copy should be retained on patient's chart (white copy).  Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)



**Emergency Release of Blood Components**  
**II. MACL Staff Unavailable – Sites without staffing 24/7**

**NOTE: Red cell products shall be made accessible for emergency transfusion at all MACL hospital based lab sites that are not staffed continuously. These blood products must be easily identifiable by non MACL staff and must be labeled appropriately. The necessary accompanying paperwork should be stored with the red cells.**

**A. Blood Product Selection and Release – Utilizing Emergency Release Container**

Step	Action	Notes
1	Patient requires emergency transfusion at a time when the laboratory is not staffed.	
2	An appropriately labeled blood bank specimen should be obtained on the patient prior to transfusion.	
3	An order for crossmatch must be placed in the hospital computer system.	
4	Nurse or physician enters blood bank area and removes the "Red Cells for Emergency Transfusion" container from the blood bank refrigerator.	
5	Following the "Nursing Instructions for Emergency Transfusion", the blood transporter (nurse or physician) completes the indicated portion of the Transfusion Record Form.	
6	Transporter (nurse or physician) fills out patient information on the orange "Uncrossmatched Blood For" label.	
7	Transporter (nurse or physician) takes top two copies of the Transfusion Record Form with the units and leaves the bottom copy for the laboratory staff.	
8	Transporter (nurse or physician) will obtain the ordering physicians signature in the appropriate area of the Transfusion Record Form. The signed copy MUST be returned to the blood bank.	
9	Units that are not transfused must be returned to the blood bank refrigerator within 30 minutes. Accompanying paper work must also be returned.	

**B. Emergency Release Specimen Work Up by MACL Staff**

Step	Action	Notes
1	Perform blood type, antibody screen and crossmatch testing on the pretransfusion specimen.	Send the specimen to CTS if staff is not present to perform testing.
2	Notify patient care area of the results when testing is completed.	

705



Emergency Release of Blood Components

3	Discard the Transfusion Record Forms that are generated during result entry if the units have been transfused. <b>The handwritten Transfusion Record Form is the permanent record.</b>	If the units have been returned to the blood bank, they may be relabeled with the computer generated Transfusion Record Forms.
4	Issue any transfused units in the computer in Blood Product Issue Function: At the "Issue Comments" field (within Issue Information Area): <b>Type ISUN TAB (ISUN populates with Issued Uncrossmatched).</b>	
5	Obtain the yellow copy of the Transfusion Record Form that is completed with the physician's signature documenting the emergency release. File appropriately.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

III. Plasma or Platelet Products

- If MACL staff is unavailable, patient care staff follows "Nursing Instructions for Emergency Transfusion".

Step	Action	Notes
1	Receive call requesting plasma products.	FFP, Cryo or Platelets
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	Perform history check, if no historical type is available, issue the following: FFP- type AB Platelets – any type available Cyroprecipitate- A or O	<b>NOTE: Up to 500 mls of incompatible plasma may be given in 24 hours without notification of Medical Director.</b>
4	State need for blood bank specimen as soon as possible.	
5	Upon receipt of properly labeled specimen, perform blood type and proceed with giving type compatible products.	



Emergency Release of Blood Components

**COMPUTER STEPS**

1. Completing Sample Testing Results in Function Blood Order Processing after Emergency Issue

Step	Menu Selection	Action	Notes
1.	Blood Order Processing	Enter patient's MR# in the "Value" field and select appropriate patient.	M# must be entered from patient's specimen tube.
2.		Select Order Selection tab.	
3.		Select accession number.	
4.	Patient Specimen	Perform and enter patient test results.	See computer steps in BB.ABO/Rh.1.0 ABO Blood Group Testing BB.ABO/Rh.2.0 Rh Testing- D and Weak D BB.IAT/DAT.1.0 IAT-Indirect Antiglobulin Testing.  If unable to obtain specimen due to patient demise, order BBCMT in "add spec. test" field. Free text ; Patient specimen never received for crossmatch. Add date and initials of tech commenting.
5.	Allocation	Press Allocation tab. Place cursor in Unit # field. Enter unit number of each unit issued. Sites that make a copy of emergency kit unit labels will be able to scan the unit number from the Xerox copy. Press Select.	Perform crossmatch methodology required for patient. BB.TYSC/TRBC.1.0 Compatibility Testing – Required Testing BB.TYSC/TRBC.2.0 Electronic Crossmatch BB.TYSC/TRBC.3.0 Crossmatch - IS BB.TYSC/TRBC.4.0 Crossmatch- AHG
6.		Click on Save button.	

**REFERENCES**

Standards for Blood Banks and Transfusion Services, AABB, Current Edition.  
AABB Technical Manual, Current Edition.

WRITTEN BY: Pat Smith, MT (ASCP)

IMPLEMENTATION DATE: January, 2000

707



**BB.TYSC/TRBC.6.1 NURSING GUIDE FOR RED CELL SUBSTITUTIONS**

The following explanation may be sent with red cell units that are non ABO/RH identical.

Whenever there is a blood shortage from our blood suppliers (Indiana Blood Center or American Red Cross), the possibility exists that patients may receive a unit different from their own blood type. The following chart lists the acceptable blood type substitutions.

Red Cell Product Transfusion		
A. Substitution Table - ABO		
	Patient Type	Acceptable ABO TYPE
	O	O
	A	A, O
	B	B, O
	AB	AB, A, B, O
B. Substitution Table - RH		
	Patient Type	Acceptable Rh TYPE
	Rh positive	Rh positive or Rh negative
	Rh Negative	Negative OR positive if inventory warrants with the following guidelines:
		<ol style="list-style-type: none"> <li>1. Patient is a male</li> <li>2. Female older than 55 years of age or consent has been obtained from the Medical Director.</li> <li>3. Patient does not have the Anti-D antibody.</li> </ol>

208



**OBTAINING BLOOD COMPONENTS**

**BB.Recv.4.0**

**OBTAINING BLOOD COMPONENTS**

**STATEMENT OF PURPOSE**

The purpose of this document is to outline the process for ordering blood components from suppliers.

**SCOPE**

This process applies to all Mid America Clinical Laboratory Blood Banks.

**RELATED DOCUMENTS**

- BB.Gen.2.0 Minimum Inventory (Site Specific)
- BB.Recv.1.0 Receipt, Inspection, Storage and Disposal of Blood Components and Reagents
- BB.Misc.5.0 Indiana Blood Center Critical Policy

**PROCESS**

Standing Orders are established for all hospital sites with our blood suppliers. These standing orders apply to red cell and platelet products. Standing order blood components for sites in the Indianapolis area will be delivered to the CTS (Centralized Transfusion Service) for processing and distribution to hospital sites. Standing orders may be altered by either CTS or the respective hospital site when inventory needs change.

If a site hospital changes a standing order scheduled to be delivered to CTS, CTS is to be notified of the change. If CTS does not receive a scheduled standing order, they notify the site hospital.

When red cell products or platelets are needed immediately, the hospital site should contact the blood supplier directly and have the blood product delivered directly to the hospital site. Plasma products and cryoprecipitate should be ordered by and delivered directly to the hospital site.

**I. Placing Orders with IBC (Indiana Blood Center)**

Step	Action	Notes
1	Phone distribution department,	

289



**OBTAINING BLOOD COMPONENTS**

2	<p>When placing the order, the following information will be given:</p> <ul style="list-style-type: none"> <li>• Callers name</li> <li>• Facility's name</li> <li>• Product needed</li> <li>• ABO/Rh type needed</li> <li>• Number of units for each product/type needed.</li> <li>• Type of special run               <ul style="list-style-type: none"> <li>○ Express: Orders are filled and picked up from IBC within 1 – 1 ½ hours from time order is placed</li> <li>○ Stat: Stat orders will be filled and picked up from IBC within thirty (30) minutes form the time the order is packed or delivered immediately following packing into IBC STAT car.</li> <li>○ Standard: Standard orders have a three hour window form pickup to delivery.</li> </ul> </li> </ul>	
3	Document order on Blood Supply Order Log, (BB.Recvng.4.1) or any other documentation method.	
4	In the event of a disaster, IBC will make every effort to maintain the blood supply to its customers.	

**Placing Orders with ARC (American Red Cross- Fort Wayne)**

Step	Action	Notes
1	Phone distribution departmen	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

**Placing Orders with ARC (American Red Cross- Louisville)**

Step	Action	Notes
1	Phone distribution departmen	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

290



## MACL OBTAINING BLOOD COMPONENTS

### REFERENCES

IBC Disaster Plan for Blood Product Supply.  
IBC Blood Services Guide.  
ARC Disaster Plan for Blood Product Supply.

WRITTEN BY: Kim Coors, MT (ASCP) BB

IMPLEMENTATION DATE: April 2000

291



## BB.GEN.8.0

## Verbal Orders for the Provision of Blood Components

### STATEMENT OF PURPOSE

During emergent situations, there may be times when the entry of orders into the hospital order system may not be able to be completed in a timely manner. During these rare times, the blood bank may take verbal orders over the phone. After the crisis situation has been resolved, the nursing unit along with the ordering physician will ensure that written/electronic orders are sent to the blood bank per CLIA regulations. (42CFR 493.1241(c))

The purpose of this document is to outline the steps necessary to take when receiving verbal orders for the provision of blood components.

### SCOPE

This protocol pertains only to Mid America Clinical Laboratories Blood Banks.

### RELATED DOCUMENTS

BB.GEN.8.1 Verbal order form

### PROCEDURE

The procedure for receipt and processing of verbal orders from surgical areas will be as follows:

- I. Receipt of the verbal order:
  - A. Associates answering the phone in the blood bank will take the following information and document on the Verbal order form BB.GEN.8.1:
    1. Patient's full name
    2. Medical Record number
    3. Blood Bank ID number if applicable
    4. Patient's date of birth
    5. Ordering physician's first and last name
    6. Name of person giving the verbal order
    7. Location
    8. Component(s) being requested
    9. Number of units requested for each component type.

792



## Verbal Orders for the Provision of Blood Components

- B. Placing orders into Sunquest:
1. In function REH, place the order for each component ordered and the amount requested
  2. Place the Sunquest order labels on the Verbal Order form BB.GEN.8.1
- C. Processing the orders:  
Orders will be processed in Misys in the standard manner.
- D. Follow up:
1. Upon the completion of the case, the OR team will place the orders in the hospital order system.
  2. The blood bank associate will take the printed order requisition(s) from the printer and attach to the Verbal Order Form BB.GEN.8.1.
  3. The printed orders will be retained in the blood bank for a period of at least 3 months.

### REFERENCES

42 CFR 493.1241(c):  
AABB Standard 5.11.1, 27<sup>th</sup> Edition,  
The Interpretive Guidelines §482.23(c)2(i) and §482.23(c)3

793



Verbal Order Form BB.GEN.8.1

Patient Name:		
Medical Record Number		
Patient's DOB		
BBID(if Applicable):		
Surgical location/Rm #		
Ordering Physician: (First and Last Name)		
Name of person giving order		
Component ( ✓ if ordered)	Number of units	
Red Cells		
Platelets		
Plasma		
Cyro		
Attributes: ( ) Irr ( ) CMV negative ( ) HgbS negative ( ) Other: _____		

History Checked by: \_\_\_\_\_

ABO/RH: \_\_\_\_\_ AG/AB: \_\_\_\_\_

Auto/DD units: \_\_\_\_\_ Comments: \_\_\_\_\_

Retype ABO/RH: \_\_\_\_\_

Place Sunquest Order labels Here:

Upon receipt of written orders attach to back of this form.

794



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.)

• Community Hospital South

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	10	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								
Platelets	1 apheresis available								

- 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.
- 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.



**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"> <li>• 4 Platelet pheresis, any type for general population.</li> <li>• 2 A+/= platelet pheresis, for trauma</li> <li>• 1 AB +/- or A+/, CMV negative, for neonatal use.</li> </ul>								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								

2910



MACL 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								

797



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									

798



**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								

• **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	10	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								
Platelets	1 apheresis available								

799



#### MACL Minimum Inventory

- **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.
- 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

300



## Critical Blood Supply Policy

### BB.Misc.4.0 Critical Blood Supply Policy

#### STATEMENT OF PURPOSE

To outline the steps to be taken Mid America Clinical Laboratories when there is a notification from the blood supplier of a "Critical Blood Shortage".

#### SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

#### POLICY

- A. The site blood supplier notifies the Transfusion Service(s) (Medical Director, Blood Bank Supervisor or designee) that the blood supply is at a critically low level.
- B. The supervisor/designee of each blood bank performs an immediate inventory of products on hand and communicates this to the Medical Director.
- C. The Laboratory Medical Director contacts Transfusion Committee Chair(s) and together with the Blood Bank Supervisor(s) reviews immediate needs for blood products (crossmatch requests) needed for upcoming surgery. If a decision is made that current blood inventory may not meet anticipated need, elective surgical cases may need to be postponed or rescheduled. In this case the following people/departments are contacted:
  1. Surgeons involved
  2. Surgery Managers
  3. Surgery Scheduling
  4. Corporate communications officer
  5. Chief of Medical Staff

Depending on the urgency and projected length of the blood shortage, consideration may be given to an urgent email notification of the entire Medical Staff.

- D. Emergency requests for blood (intraoperative, ED, Labor and Delivery) should be immediately crossmatched and issued. If crossmatching is not possible due to the urgency of the request, follow policy for emergency release of blood.
- E. With the resolution or easing of the blood shortage, the contacted individuals in section C shall be informed/updated.



## Critical Blood Supply Policy

### 4. REFERENCES

- CHI Critical Blood Supply Policy
- St. Vincent Hospitals and Health Services, Carmel and Indianapolis, Blood Shortage Notification Flow Sheet
- St. Vincent Hospitals and Health Services Blood Shortage Memorandum

WRITTEN BY: Dr. Terry Cudahy and Dr. David Powers

IMPLEMENTATION DATE: April 2000

307



## BB.GEN.7.0 RESOURCES - STAFFING

### STATEMENT OF PURPOSE

This policy defines the determination of staffing levels within the blood banks and also defines the location and determination of job descriptions and qualifications.

### SCOPE

This policy applies to all Mid America Clinical Laboratories blood banks

### RELATED DOCUMENTS

### MACL QUALITY PLAN

### POLICY

- A. Staffing requirements will be determined by the following criteria:
  - 1. Workload as determined by the IEB and workload recording programs in Sunquest.
  - 2. Overtime paid as determined by the payroll department.
  - 3. Staffing requirements for all shifts including weekends, holidays and vacations.
  - 4. The above criteria will be reviewed by the VP for Hospital Operations, HR and the site supervisor when staffing issues arise.
  
- B. Role summaries are written and maintained in the Human Resources Department of Mid America Clinical Laboratories.
  - 1. Role Summaries are written by the Human Resources Department along with input from Directors and Supervisors.
  - 2. Job descriptions are maintained in the Human Resources Department residing at the Regional Facility on Shadeland Avenue.
  
- C. Contingency Plans for staffing may include the following:
  - 1. Staff from other sites may be deployed to the area in need.
  - 2. Workload may be shifted to other sites (i.e. routine work may be sent to another location).
  - 3. Antibody identification and problem patients may be sent to the Reference Lab at Indiana Blood Center.

303



MACL. RESOURCES - STAFFING

WRITTEN BY: Kim Coors, MT(ASCP)BB

IMPLEMENTATION DATE: Feb 2003

304



## MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

### QA.GEN.1.5 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).

3010



## 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).

3/17



## 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)	Protine (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 <sub>2</sub> )	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)

308



## 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](http://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.

309



June 9, 2014

William C VanNess II, MD – Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

Subject: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

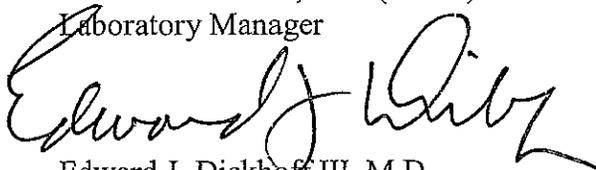
Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that the Laboratory supports Community South Hospital's effort to complete the "in the process" Level III Trauma Center Requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

We further understand that our role is to ensure that laboratory services are available twenty-four hours per day at Community South Hospital. This includes the standard analyses for blood, urine, and other body fluids, including micro sampling when appropriate. Our lab services also include coagulation studies, blood gasses, and microbiology.

Respectfully,

  
Gabrielle Houston, MLS(ASCP)  
Laboratory Manager

  
Edward J. Diekhoff III, M.D.  
Trauma Medical Director

  
Michael Sever, M.D.  
Laboratory Medical Director



# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

### SECTION 17

## Post-Anesthesia Care Unit (PACU)

17. "Post-Anesthesia Care Unit. The post-anesthesia care unit (PACU) must qualified nurse and necessary equipment 24 hours per day. Documentation for this requirement must include a list of available equipment in the PACU."

### Narrative Response and Discussion

The requirements of section 17 are met with a signed letter from the Director of Surgical Services and Anesthesia Section Chairman affirming the PACU has met the requirements for Level III Trauma Center requirements. Also included are policies and equipment list for the PACU.

# Community Health Network

Community Hospital South  
Emergency Department  
1402 E. County Line Road  
Indianapolis, Indiana 46227-0963  
317-887-7200 (tel)  
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

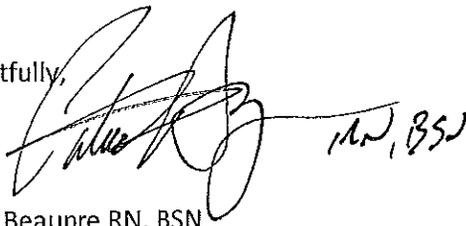
SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I am the Director of Surgical Services. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that qualified nurses and all necessary equipment are available twenty – four hours per day in the Community Hospital South Post Anesthesia Care Unit.

Respectfully,



Patrick Beaupre RN, BSN  
Director Surgical Services



Edward Diekhoff, M.D., F.A.C.S.  
Trauma Medical Director

Community  
Health Network

Community Hospital South  
Emergency Department  
1402 E. County Line Road  
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June 17, 2014

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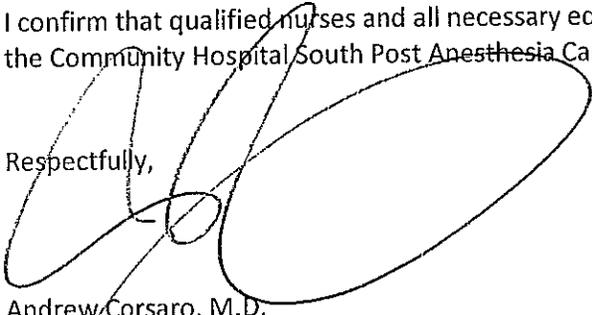
SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I serve as Anesthesiologist Chairman. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I confirm that qualified nurses and all necessary equipment are available twenty – four hours per day in the Community Hospital South Post Anesthesia Care Unit.

Respectfully,

  
Andrew Corsaro, M.D.  
Anesthesia Chairman

  
Edward Diekhoff, M.D., F.A.C.S.  
Trauma Medical Director



# Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE  
Approved For:  CHE  CHN  CHS  CHVH  
CANCELS: 3/21/053/25/08

NPP#: PACU: E-001  
Page 1 of 2  
EFFECTIVE: 8/12/13

## TITLE: RESPONSIBILITIES OF (PACU) PERI-ANESTHESIA CARE UNIT REGISTERED NURSES IN EMERGENCIES

Performed by: RN

Purpose: To outline the nursing guidelines for the emergency treatment of patients in the PACU when no anesthesiologist is available.

### Policy Statement:

In the event of an emergency, when no anesthesiologist is in attendance, PACU RNs can initiate these protocols/interventions. The orders listed within this policy may be initiated by RN prior to physician notification.

### General Information:

PACU RNs are verified as an ACLS provider and re-verified every two years. Emergency situations include acute chest pain, hypotension, questionable or life threatening cardiac rhythms, an acute change in respiratory status, cyanosis, symptoms of hypoglycemia, increased bleeding.

### Equipment:

1. Monitoring equipment (ECG, Blood Pressure, Pulse Oximetry)
2. Crash Cart
3. Defibrillator
4. POC testing (iSTAT) if available.

### Procedure:

1. The RN initiates the following measures as the patient condition warrants:
  - a. Obtain a stat 12 lead ECG for acute chest pain or questionable cardiac rhythms.
  - b. Start 2-4L of O<sub>2</sub> per nasal cannula for acute chest pain, questionable cardiac rhythms, or acute change in respiratory status or cyanosis.
  - c. Obtain a stat chest x-ray for acute changes in respiratory status, cyanosis, or to check central line placement.
  - d. Obtain a stat arterial blood gas for acute changes in respiratory status or cyanosis.
  - e. Check the patient's blood sugar by using the bedside glucometer.
  - f. Obtain a stat hemoglobin and hematocrit for an acute episode of bleeding or hypotension.
  - g. Check the patient's electrolytes by using the iSTAT (if available) or obtain a STAT electrolyte or serum potassium for cardiac arrhythmia.
  - h. Start an IV infusion of Lactated Ringers/Normal Saline at a continuous rate, or start a Saline lock for IV access for patients with chest pain, cardiac arrhythmia, hypotension, or changes in respiratory status or cyanosis



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 3/21/053/25/08

NPP#: PACU: E-001

Page 2 of 2

EFFECTIVE: 8/12/13

2. Per ACLS protocol, the nurse initiates the American Heart Association treatment protocols for asystole, ventricular fibrillation, ventricular tachycardia or symptomatic bradycardia.
3. Notify attending anesthesiologist immediately.
4. At CHE and CHN if the anesthesiologist is unavailable, notify the house staff doctor. At CHS, notify the Emergency Department.

### Documentation Guidelines:

Document patient assessment, intervention, responses, and communication/attempts at communication with physicians, and patient responses on the multidisciplinary notes, Post Anesthesia Care Unit record. Write orders for initiated treatments, medications, and intravenous fluids on the physician's order sheet.

### References:

American Heart Association Advanced Cardiovascular Life Support Provider Manual, 2010.

Formulated by: PACU Staff

Approved by: Perioperative NPP Subcommittee  
Infection Prevention  
Risk Management

Date: 7/13

Date: 7/13

Approved: NPP Steering Committee

Date: 7/10/13



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 4/2/10

NPP#: PACU-E03

Page 1 of 2

EFFECTIVE: 5/1/14

### TITLE: EXTUBATION IN THE POST ANESTHESIA CARE UNIT

Performed by: Competency Verified Post Anesthesia Care Unit RNs

Purpose: To provide guidelines for the extubation of patients in the Post Anesthesia Care Unit

#### Policy Statements:

1. Extubation is done only if an anesthesiologist is available for re-intubation if necessary.
2. Re-Intubation equipment must be immediately available on the unit prior to extubation.
3. RNs will not suction through a laryngeal mask airway unless an anesthesiologist is in attendance.
4. Prior to extubation, the patient's respiratory status must meet the following criteria:
  - a. Respiratory effort spontaneous.
  - b. Respiratory rate, depth and pattern sufficient to maintain an O<sub>2</sub> saturation above 90% (with or without supplemental oxygen). If the preoperative level was less than 90%, the saturation must be equal to, or better than, the preoperative level.
  - c. Skin color or mucous membranes pink
  - d. Bilateral breath sounds audible to auscultation.
5. Prior to removal of an endotracheal tube, the patient must meet at least 2 of the following criteria:
  - a. Be able to open their eyes
  - b. Stick out their tongue
  - c. Move their extremities
  - d. Sustain a five second head lift
  - e. Demonstrate airway protective reflexes (eg swallow, gagging)
6. Prior to removal of a laryngeal mask airway, the patient must be able to open their mouth and/or stick out their tongue.

#### General Information:

1. Extubation in the Post Anesthesia Care Unit includes the removal of an endotracheal tube or a laryngeal mask airway.
2. Potential airway complications, such as partial or complete obstruction, or laryngospasm, may occur post extubation.
3. The suctioning of pooled pharyngeal secretions before deflating the cuff on the endotracheal tube decreases the chance of aspiration and laryngeal irritation.
4. Stimulation of a patient with a laryngeal mask airway may cause premature rejection of the airway-this includes suctioning the patient.
5. There is a danger of laryngospasm when suctioning through a laryngeal mask airway.
6. If the anesthesiologist is in agreement, the laryngeal mask airway can be removed without deflating the cuff.

#### Equipment:

1. Suctioning equipment (oral/endotracheal)
2. Bag/valve mask unit
3. Oxygen supply source and delivery system (eg nasal cannula, face tent, trach mask)
4. Syringe for cuff deflation (10 ml for endotracheal tube, 20 ml for adult Laryngeal mask airway)
5. Gloves
6. Protective eye coverings

#### Procedure:

1. Apply personal protective equipment including protective eye wear.
2. Perform respiratory assessment.



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 4/2/10

NPP#: PACU-E03

Page 2 of 2

EFFECTIVE: 5/1/14

3. Perform level of consciousness assessment.
4. Prepare suction equipment for usage.
  - a. Use sterile procedure for the set up of suction of endotracheal tubes.
  - b. Use clean procedure for the set up of the oral or nasopharynx.
5. Loosen tape.
6. If necessary, suction endotracheal tube and/or oral nasopharynx.
7. Deflate the cuff using a syringe (10 ml for endotracheal tube, 20ml for laryngeal mask airway).
8. Instruct the patient to take a deep breath.
9. Remove the endotracheal tube or the laryngeal mask airway during end inspiration using a smooth outward motion. If a bite block is in place, remove the artificial airway first, then the bite block. This prevents the patient from biting the airway and causing an obstruction.
10. Apply oxygen, if needed, to maintain the patient's oxygen saturation greater than 90% (or equal to preoperative level if preoperative level was less than 90%), unless otherwise ordered by the physician.
11. Re-assess respiratory status and document in the electronic medical record.
12. Instruct the patient to take deep breaths to maintain oxygen saturation levels at greater than 90%, or equal to preoperative levels.
13. Instruct the patient to cough as necessary to clear the airway.

### Documentation Guidelines:

Document on the Post Anesthesia Care Unit Record in the electronic medical record.  
Respiratory assessment

References: Core Curriculum for Peri-Anesthesia Nursing Practice 2nd edition; Schick/Windle 2010.  
Peri-Anesthesia Nursing, A Critical Care Approach; Cecil B. Drain 6<sup>th</sup> edition; 2012

ASPAN Standards of Peri-Anesthesia Nursing Practice 2012 - 2014

Approved: Peri-Operative NPP Committee  
Infection Prevention  
Risk Management

Date: 4/2014  
Date: 4/2014  
Date: 4/2014

Approved: NPP Steering Committee

Date: 4/9/2014



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH  
CANCELS: 4/2/10

NPP#: T-034

Page 1 of 2

EFFECTIVE: 6/13/14

### TITLE: TRANSPORTATION TO AND FROM SURGERY AND/OR PACU

Performed by: RN, SE, CST, SST, Clinical Technicians

#### Purpose:

To provide guidelines for transporting from surgery or PACU.

#### Policy Statements:

1. An RN must accompany a monitored patient during transport.
2. If the PACU personnel are unable to leave the PACU to transport the patient, the nursing unit will be notified and arrangements made for transfer of the patient by unit personnel.

#### General Information:

1. Patient care needs are identified by communication between departments (ie oxygen, monitors).
2. Patients may be transported via a cart, wheelchair, or patient bed.

#### Equipment:

Vehicle for transportation-cart, wheelchair or bed, Surgery call slip.

#### Procedure:

1. Transportation to Surgery
  - a. For non scheduled procedures, surgery personnel notify the nursing unit of their anticipated arrival time.
  - b. Surgery personnel inform the staff on the nursing unit that he/she has arrived to transport the patient to surgery.
  - c. Surgery personnel verify the identity of the patient, check the chart for completeness, and review the pre-op checklist.
  - d. Surgery personnel assist in transferring the patient to the cart or wheelchair, if necessary, and transport the patient to the Surgical Services Department and instruct the patient's visitors on where to wait.
  - e. For weekend cases the patient may be transported by house supervisor or nurse taking care of patient directly to surgery.
  - f. Surgery personnel transport any physiologically monitored patient with at least two (2) people one of which has to be an RN.
2. Transportation to the Nursing Unit from Surgery or PACU
  - a. Give report to the receiving RN either by phone, or in person upon transfer to the patient's room. Report include, but is not limited to:
    1. Surgical procedure
    2. Physical status and vital signs
    3. IV site, condition, and fluids
    4. Drains
    5. Intake and Output
    6. Stat or special orders for the nursing unit
    7. Orders transcribed in PACU
    8. Level of consciousness
    9. Patient concerns
    10. Meds given if any
    11. Equipment as necessary



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 4/2/10

NPP#: T-034

Page 2 of 2

EFFECTIVE: 6/13/14

- c. PACU: Verify and document that discharge criteria are met. Complete all sections of the Post Anesthesia Care Record and complete all orders specific to PACU.
- d. PACU: Empty all drains, foley catheters etc., unless otherwise ordered by the physician.
- e. Upon arrival to the nursing unit, the surgical services personnel and the receiving nurse assist the patient to transfer to their bed (if necessary). Leave the bed in the low position, side rails up, and wheel locks secured unless the receiving nurse requests otherwise. After report is given vital signs are taken by receiving personnel and documented by both RNs. Vital Signs include but are not limited to, blood pressure, temperature, pulse, O<sub>2</sub> Saturation and respirations. Leave the chart with the receiving nurse unless otherwise directed.
- f. Surgical Services personnel notify the surgery waiting room of the patient's return to the room. If unable to locate the patient's family/significant other, surgical services personnel informs the nursing unit.
- g. CHVH patients: Surgical services personnel notify the front desk to put the patient's family in a consult room for the surgeon to discuss the surgery. Surgery notifies surgeon of consult room.

### Documentation Guidelines:

Document in the electronic medical record

References: NPP - PACU: A-2

Approved by: Perioperative NPP Subcommittee  
Infection Prevention  
Risk Management

Date: 6/2014

Date: 6/2014

Date: 6/2014

Approved: NPP Steering Committee

Date: 6/11/2014



# Community Health Network

## CORPORATE NURSING POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 4/2/10

NPP#: PACU-D02

Page 1 of 2

EFFECTIVE: 8/9/13

### TITLE: DISCHARGE CRITERIA, PACU

Performed by: RN

Purpose: To provide guidelines for the discharge of patients from the Post Anesthesia Care Unit.

#### Policy Statements:

1. The order to discharge a patient from the Post Anesthesia Care Unit is written by the anesthesiologist. If no anesthesiologist was present for the procedure (e.g., IV Sedation by the nursing staff or physician), the surgeon writes the order to discharge the patient from the Post Anesthesia Care Unit.
2. A specific order from the anesthesiologist is required to discharge a patient who does not have an Aldretti score of at least 9.
3. An adult patient's oxygen saturation must be greater than 90% prior to discharge from the Post Anesthesia Care Unit (unless their preoperative oxygen saturation was less than 90%).
4. If the patient's preoperative oxygen saturation was less than 90%, their oxygen saturation must be within 2 % points of that preoperative level prior to discharge from the Post Anesthesia Care Unit.
5. A patient's temperature is defined as documentation of active warming used intraoperatively or a least one body temp >96.8 F/36C within 30 minutes immediately prior to or the 15 minutes immediately after anesthesia end time. (Surgical Care Improvement (SCIP) 10 with Perioperative Temperature Management) or within two degrees (Fahrenheit) of their preoperative temperature prior to discharge from the post Anesthesia Care Unit.
6. Adult patients must have three consecutive blood pressure readings within 20% of their pre-anesthesia readings prior to discharge from the Post Anesthesia Care unit.
7. Pediatric patients must have apical heart and respiratory rates within 20% of their pre-anesthesia readings with an Aldretti score of 2 on "level of consciousness." (Is this a national guideline? Feel like this is not always followed)
8. The patient's pain level must be assessed prior to discharge. The patient may be discharged if their pain level is 4 or less, acceptable to the patient, or if ongoing pain management orders are on the chart.

#### General Information:

1. Inpatients undergoing operative procedure with only local anesthetic may go directly back to their inpatient unit without being admitted to the Post Anesthesia Care Unit.
2. Inpatients receiving IV sedation may be transported directly back to their inpatient unit ONLY if they have not received sedation within the last 30 minutes and they meet the discharge criteria outlined in CORP#: CLN 2052, "Conscious Sedation."
3. May refer to NPP M2.35 "Epidural Analgesia: Monitoring and Care of Patients Receiving."

#### Equipment:

Blood pressure cuff with sphygmomanometer and stethoscope, or noninvasive blood pressure unit with appropriate size cuff, or arterial line with appropriate monitoring device.

Cardiac Monitor

Pulse Oximeter

Thermometer

Stethoscope

#### Procedure:

1. Complete the patient assessments.
2. Complete documentation as outlined in NPP PACU I A-1 "Post Anesthesia Care Unit Record."



**CORPORATE NURSING POLICY AND PROCEDURE**

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 4/2/10

NPP#: PACU-D02

Page 2 of 2

EFFECTIVE: 8/9/13

3. If patient does not meet the above criteria for discharge, notify the anesthesiologist. If anesthesia determines that the patient is to be discharged without meeting the criteria, document the order as given.
4. Report to the next caregiver receiving the patient. After report is given, vital signs will be taken by admitting personnel and documented by both RNs. Vital signs include but are not limited to blood pressure, temperature, pulse, O<sub>2</sub> saturation and respirations.

Documentation Guidelines:

Document on the PACU Patient Care Flowsheet, the multidisciplinary notes, the neurovascular checklist, Symptom Management Tool

References:

CORP#: CLN 2052 "Conscious Sedation"

NPP PACU A-1 "Post Anesthesia Care Unit Record"

NPP M 2.35 "Epidural Analgesia: Monitoring and Care of Patients Receiving"

*Perianesthesia Nursing Standards, Practice Recommendations and Interpretive*

*Statements: 2012-2014 ASPAN*

Approved by: Perioperative NPP Committee  
Infection Prevention  
Risk Management

Approved: NPP Steering Committee

0  
Date: 7/13  
Date: 7/13  
Date: 7/10/13

QUALITY/SAFETY MANAGEMENT PLAN  
ENDOSCOPY SERVICES

Community Hospital North  
Community Hospital South  
Community Hospital East  
Community Hospital Anderson  
Indiana Heart Hospital

July 2011

Community Hospitals of Indiana, Inc.  
 Quality Safety Management/Scope of Service Plan  
 Endoscopy Services

I. Mission/Vision/Values Statements.....	1
II. Goals of patient care services .....	2
III. Types and ages of patients served .....	2
IV. Scope and complexity of need.....	2
V. Methods used to assess and meet customers needs .....	3
VI. Appropriateness, clinical necessity, and timeliness of support services provided directly by the organization or through referral contacts.....	3
VII. Availability of necessary staff .....	4
VIII. Recognized standards or guidelines for practice when available .....	4
IX. Methods that are used to assess and meet patient needs, including staffing effectiveness indicators as appropriate.....	4
X. Identification of MAJOR internal and MAJOR external customers .....	5
• Internal.....	5
• External.....	5
XI. Patient/significant other education .....	6
XII. Safety Management.....	6
• Pre-procedure.....	6
• Intra-procedure .....	6
• Post-procedure .....	6
XIV. Quality Initiatives .....	7

The purpose of this document is to provide the operational link to the Network Organizational Performance Improvement and Safety Plan.

## I. Mission/Vision/Values Statements

### Mission

The mission of Endoscopy Services is to be a leader in providing a full continuum of services to the community serviced by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient Endoscopy service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized Endoscopy options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest surgical care, creating an exceptional experience for physicians, patients, families, and employees.

### Vision

It is the objective of Endoscopy Services to accomplish our mission by partnering with physicians, patients, families, and employees. We will benchmark performance indicators and major processes. We will creatively develop new approaches and alternative delivery systems offering state of the art technology for the best demonstrated practices in Endoscopy services. These continuous improvements will result in a system that will provide high quality services as evidenced by total customer satisfaction.

### Values

**P**atients First: We believe that patients' needs, and the needs of their families, are our number one priority.

**R**elationships: We are inclusive, working together as partners and teams.

**I**ntegrity: We expect truth-telling and transparency.

**I**nnovation: We foster creativity and openness to new ideas.

**D**edication: We are accountable stewards of the resources entrusted to us.

**E**xcellence: We provide access to a high quality and safe environment of care, known for high performance.

Community's statement of values is all about making our organization the best it can be—providing the most exceptional experiences possible for patients and families, opening our

doors to all who desire our services, building the health care workplace of choice for central Indiana, creating exceptional experiences for physicians, ensuring that our organization is efficient and fiscally healthy. We can't succeed as a team unless we all live our values, which we remember with the acronym PRIIDE.

### *Business Growth*

We strive to continually grow our business by creating the most surgeon-oriented Endoscopy facilities in the Midwest. We provide our patients with the strongest blend of quality, service, and price, making our facilities the customer's and payer's best value for Endoscopy care.

### *Financial Performance*

We focus on the delivering of safe and cost-effective health care through efficient use of our resources.

## **II. Goals of patient care service**

The goal of Endoscopy is to be a leader in providing a full continuum of services to those individuals served by Community Health Network. We will strive to exceed our customer's expectations by continuous improvement to ensure flexibility, accessibility to our schedule, high quality, and responsible cost.

## **III. Types and ages of patients served**

Endoscopy serves both inpatient and outpatient populations for gastroenterology and pulmonary procedures. These services are tailored to the patient's needs based on age: children, over the age of 12 and weighing more than 100 lbs., adolescents, adults, and senior adults. Evidence of age specific competency is performed annually during the staff PA process.

## **IV. Scope and complexity of need**

Endoscopy procedures are provided in different locations dependent on patient needs: CHE Endoscopy Department is located in the Surgery Department.

- ERCP procedures are performed in Radiology
- Critical patients in the ICU are performed at the bedside
- Intra-operative Endoscopy procedures, pediatric patients according to policy, and any procedures requiring general anesthesia are immediately available within the department.
- Emergent outpatient procedures are performed in the Emergency Department
- Procedures involving MAC sedation are performed by anesthesia in the Endoscopy Department and/or the Operating Room.

## **V. Extents to which the level(s) of care or service provided meets patient needs/Methods used to assess and meet customer's needs:**

The patient's needs are met consistently by providing the same level of care at all times. This is accomplished by providing on call services for emergency procedures after working hours, weekends, and holidays. On call staff is available as follows:

- Monday through Friday after 1700 – one Endoscopy trained nurse available for emergent cases performed at the bedside in selected areas with the assistance of the bedside RN. At CHS two personnel are available (one Endoscopy trained nurse and the other an RN or CST trained in Endoscopy).
- Weekends and holidays – one Endoscopy-trained nurse 0700-0700, with second nurse available during 4 hour period 0800-1200 each day. The second on call nurse is available to assist with medical patients who meet the criteria and whose procedure can be safely performed in the Endoscopy Department. At CHS two Endoscopy trained personnel are available for a 24 hour period on weekend and holidays.
- On call staff at CHE can be contacted through the hospital switchboard at \_\_\_\_\_ or by the physician himself. On call staff at CHN is contacted through the hospital switchboard at \_\_\_\_\_ or by the physician himself. On call staff at CHS can be contacted through the hospital switchboard at \_\_\_\_\_ or the physician himself can call the surgery department. Information required by on call staff includes patient name, procedure to be performed, patient location, special equipment needed, and any additional information associated with the patient's care.
- On call staff has 45 minutes travel time and will begin setting up the care immediately upon arrival.

Methods to assess and meet customer's needs:

Patient surveys are performed on a random basis by the hospital marketing department, and the results are shared with the Endoscopy department and staff. Outpatient procedure patients receive a follow up phone call within four days of their procedure allowing them to express satisfaction as well as improvement opportunities. The Quality Assessment/Risk Management Department share information reported on peer review reports or in regard to risk issues. Peer review reports, patient safety issues, the patient complaint, and resolution process also provide information as to how patient needs are met.

#### **VI. Appropriateness, clinical necessity, and timelines of support services provided directly by the organization or through referral contacts**

Endoscopy services are provided by a multi-disciplinary professional staff, which includes but is not limited to:

- Endoscopists
- Pulmonologists
- Registered Nurses
- Licensed Practical Nurses
- Certified Surgical Technologists
- Support Technologist

In addition, clinical support is provided by Respiratory Care, Pharmacy, Radiology, Laboratory, Materials Management, Finance, and Information Systems as needed.

The administration for Endoscopy includes the Executive Director, Clinical Director and Nurse Manager. Other resource personnel available to the administrative team include a Financial Consultant and a Human Resource Representative.

#### **VII. Availability of necessary staff**

Pre-procedure care is provided utilizing a Primary Nursing Model. The RN's cross-trained to work in the admission, procedure, and recovery areas. All are required to maintain a level of competence. The RN is competent to admit, assess, and administer care to a pre-procedure patient of any level of acuity or complexity. The LPN is required to maintain competency to administer care to a pre-procedure patient of any level of acuity or complexity under the direction of an RN. If the patient's identified needs require more nursing resources, an additional RN is utilized to assist. Support personnel are available to assist the RN/LPN. This areas is routinely staffed by RN's Monday through Friday 0700-1700.

All procedures are assigned a minimum of one monitoring RN and one RN/LPN/CST to assist the Endoscopist. The staff is employed by Community Health Network. Demands of each procedure room schedule will be optimally matched with skills and expertise of assigned competent staff. The Endoscopy area is open for routine procedures from 0700-1700. Outside of normal working hours, emergency coverage is provided by on call nurses.

The Endoscopy admit/recovery area utilized a Primary Nursing Model for delivery of care with a 3:1 RN ratio for the care of patients in this area. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Hours of operation for Endsocopy are 0700-1700 Monday through Friday.

#### **VIII. Recognized standards or guidelines for practice when available**

Standards and guidelines for practice are utilized to provide care and include are not limited to the following:

- Patient Rights Handbook
- SGNA Standards
- ASPAN Standards
- Hospital Policy and Procedures
- External Regulatory Standards

XI. Methods that are used to assess and meet patient needs, including staffing effectiveness indicators as appropriate

- Nursing process
- Admission assessment documentation
- H&P's, ASA risk screens
- Patient satisfaction surveys
- Follow up phone calls

X. Identification of MAJOR internal and MAJOR external customers

Internal

- Employees
- Physicians
- Other departments

External

- Payers/Employers
- Patient/Significant others
- Community at large
- Physicians offices

XI. Patient/Significant other education

This education will be age specific to include the following:

- Patient rights and responsibilities
- Scheduled time for procedure
- Monitors to be utilized
- Sedations related teaching by appropriate professions, i.e. RN, Physician
- Explanation of safety procedures
- Post procedure destination
- Usual recovery time
- Possibility of O<sub>2</sub> therapy if needed
- Instructions regarding pain scale 0-10
- Documentation of understanding of education by patient/family significant other
- All education is reinforced to patient, family, and significant other prior to discharge and documented on appropriate form
- Outpatient procedures will receive a follow-up phone call within 4 days. This will give the patient customer an opportunity to voice questions, allow reinforcement of physician instructions as needed, and identify satisfaction as well as opportunities for improvement

- A letter will be sent to those outpatients who are not reached by phone. CHN & CHE Endoscopy does leave generic messages on answering machine and voicemail when performing follow-up phone calls.
- Written materials including preprinted information sheets on diagnosis, additional procedures, and diet are given at discharge
- Verbal descriptions of what procedures entail prior to procedure performance

## XII. Safety management

The safety management measures may be different at each phase of the Endoscopy experience. Handoff communication with a time to ask and respond to questions will always be a part of the process. The following are the safety measures taken for patients in the Endoscopy area:

### Pre-Procedure:

- Determine availability of responsible adult and transportation arrangement
- Apply patient identification/allergy band always using the 2 patient identifier process
- Establish and maintain IV access as necessary
- Keep side rails on cart up during patient transport, after IV sedation has been given, when cart is in position other than low, and as patient condition or mentation requires.
- Report to procedure nurse and/or MD will include allergies, and pertinent clinical information gathered during assessment.

### Intra-Procedure:

- Ensure immediate availability of necessary reversal agents and age-appropriate resuscitation equipment.
- Verify patient identification using the 2 patient identifier process and procedure planned using the site verification and "time out" process
- Remove dental prosthesis if applicable
- Review and read back all MD orders for moderate sedation
- MD and RN must be immediately available at onset of IV medication administration
- Check IV site patency prior to medication administration and every 15 minutes during procedure. Run IV fluids at a rate to facilitate medication administration or use appropriate amount of normal saline IVP with each medication.
- Transport to post procedure area with IV lock or IV fluids at keep open rate and portable oxygen as necessary
- Report to post procedure nurse to include IV drugs and dosages administered, pertinent clinical information related to procedure phase, and MD findings as appropriate

### Post-Procedure:

- Side rails to remain up on cart until patient meets discharge criteria and/or as patient condition requires
- Maintain IV access until level of consciousness improves and patient is able to tolerate fluids, as appropriate.

- Offer patient PO fluids when clinical condition indicates or as directed by MD, i.e. cough/gag reflex present, able to swallow, passing fluids, eructating, presence of normoactive bowel sounds.
- Ambulate patient initially with assistance of Endoscopy staff to determine stability. Additional activity may be assisted by responsible adult at discretion of RN.
- Observe patients who have received reversal agents for a minimum of 2 hours to ensure re sedation does not occur. Maintain IV access until patient meets discharge criteria.
- Inpatients will be offered PO fluids post endoscopy as approved by physician. Report to an inpatient's nurse will be given according to hand-off communication policy.

#### XIV. Quality Initiatives

Endoscopy will incorporate Joint Commission Patient Safety Goals into patient care and department operations and monitor staff compliance. Compliance is expected to be at 100%. Deviations will be identified and actions taken. Examples of performance measures include:

- Handwashing
- 2 patient identifiers
- Procedural time out
- Moderate sedation
- Patient satisfaction
- Quality control monitoring will be performed according to manufacturers guidelines
- Moderate sedation audits

Plan formulated by: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Approve By: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name and Title

## PACU EQUIPMENT LIST

1. Bair Huggers (each room)
2. Philips Monitors with X2 portable monitors (capable of measuring artline readings)
3. I-Stat
4. Crash Cart
5. Camino monitor
6. Verathon bladder scanner
7. Doppler x2
8. Portable pulse oximetry
9. SCD's
10. Alaris IV pumps with side channels
11. Block cart x 2
12. Isolation carts x 2
13. Wound vac pumps (UHS)



# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

### SECTION 18

## Relationship with IOPO

18. "Relationship with an organ procurement organization (OPO).

There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO."

### Narrative Response and Discussion

The requirements of section 18 are met with a signed copy of the agreement between IOPO and Community Health Network. Also included is the signed policy regarding organ donation.



INDIANA ORGAN PROCUREMENT ORGANIZATION

June 11, 2014

William C VanNess II, MD – Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

Dear Dr. VanNess,

I would like to express our sincere appreciation for the collaborative partnership with Community Hospital South in regards to the lifesaving gift of organ, tissue and eye donation.

The professionalism and enthusiasm of the Community Hospital South staff and physicians has ensured the spirit of the donation process is promoted throughout the hospital and beyond. IOPO has found Community Hospital South to be a robust advocate and partner who has consistently worked to foster a compliant and innovative approach to donation.

We thank Community's Leadership and staff for their continued support and dedication to organ and tissue donation. If you have any further questions please feel free to reach out to me directly.

Warm Regards,

A handwritten signature in black ink, appearing to read "Steve Johnson", followed by a long horizontal line extending to the right.

Steve Johnson  
Chief Operating Officer  
C – 317.775.1068



## 2014 Service Plans - Goals and Actions for 2014 Community Hospital (South Indianapolis)

### Advocate Organ Donation as the Mission with a Focus on Change, Improvement and Results

#### Establish a Strong Culture of Accountability for Results

- Seek greatest organ donation areas for the hospital and work to maximize effective process
- Utilize data to set donation outcome targets and actions

### Aggressive Pursuit of Every Donation Opportunity

#### Advocate Organ Donation as a Mission

- Provide consistent feedback regarding concerns and timely response to issues
- Educate hospital staff regarding impact of missed opportunities/families not offered

#### Focus on and Decrease/Eliminate Missed Opportunities

- Present missed opportunities to key contacts and donation council
- Consistent and timely follow up to staff on missed opportunities

### Maximize Satisfaction to Customers

#### 100% Customer Satisfaction

- Show appreciation to hospital staff for efforts made by communicating successes
- Request feedback on donation and referral events to make IOPO improvements
- Respond to hospital needs and requests

#### Maintain Relationships with Key Hospital Contacts

- Timely follow-up and information when requested
- Effective communication of successes and issues

### Maximize Tissue Donation

#### 100% of Donation Opportunities Offered by Trained Effective Requestors

- Regular review of data reports of donation key indicators with key leadership and staff

#### 100% Timely referral of all Cardiac Deaths

- Hospital unit based education and targeted core curriculum/education to referring staff

Christy Cannon

---

IOPO Professional Services Coordinator

## HOSPITAL PROCUREMENT AGREEMENT

### (ORGAN, TISSUE AND EYE)

This Hospital Procurement Agreement (Organ, Tissue and Eye) ("Agreement") is made this 1st day of November 2010 between Community Hospitals of Indiana, Inc. and its affiliates and subsidiaries ("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. IOPO conducts Tissue and Eye procurement services and is accredited by the American Association of Tissue Banks ("AATB"), and complies with requirements of the United States Food and Drug Administration ("FDA") in conducting Tissue and Eye procurement activities for transplantation, therapy, medical research or educational purposes;

E. The purposes of IOPO are to perform and coordinate the identification of donors, and facilitate the retrieval, procurement, preservation and transportation of Organs, Tissue and Eyes for transplantation, therapy, medical research or educational purposes, 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;

F. 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);

G. For the purposes of this agreement, Hospital is defined as the facilities operated by and for Community Health Network and are designated as Community Hospital East, Community Hospital North, Community Hospital South, the Indiana Heart Hospital and are located within the Donation Service Area of IOPO;

H. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs, Tissues and Eyes 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

I. 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 therefore, 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, regardless of 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.

- 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, Tissues and Eyes 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, Tissues and Eyes.

- 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), 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.
- 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) Hospital 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, Tissue and Eye Procurement. The procedures undertaken to procure donated Organs, Tissue and Eye 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, Tissue and Eye preservation, to coordinate Organ, Tissue and Eye procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ, Tissue and Eye 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, Tissue and Eye 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, Tissue and Eye 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, Tissues and Eyes 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, Tissues and Eyes from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ, Tissue and Eye recovery, provide technical assistance during recovery and initiate Organ, Tissue and Eye preservation and recovery;
- b) provide twenty-four (24) hour availability of a Family Services Coordinator and/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, Tissue and Eye 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 and Tissue 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, Tissues and Eyes 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, Tissue and Eyes, efficient placement of Organs, Tissue and Eye, and oversight of Organ, Tissue and Eye 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) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;
- l) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ or Tissue recovery;
- m) 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;
- n) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs and Tissues after their procurement;
- o) 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;
- p) utilize Tissues procured at Hospital in accordance with sound medical practice and in accordance with standards recognized by the FDA and AATB;
- 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 and Tissue donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ and Tissue donation;
  - w) 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
  - x) either directly or through a contract with an answering service, shall cause Organ, Tissue and Eye donation referrals to be referred to IOPO and its on-call staff.
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, Tissue and Eye 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, Tissue and Eye procurement, to follow procedures and protocols as specified by IOPO for Organ, Tissue and Eye 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 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 or Tissue Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ or Tissue 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 or Tissue 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, and to limit the total facilities or other charges for the procurement of Tissues to an amount not greater than \$1,200;
  - 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, Tissue or Eye 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 or Tissue donation at Hospital; and
  - o) 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)(1) 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, Tissue or Eye recipients to entities that process or distribute Tissue or Eyes, 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**

Community Hospitals of Indiana, Inc.  
1500 North Ritter Avenue  
Indianapolis, IN 46219  
Attn: Contracts Management, Network Purchasing

**IOPO:**

Lynn Driver, President/CEO  
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.

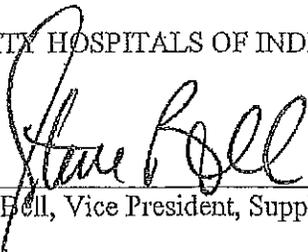
18. Discrimination. The parties hereby warrant that each party is and shall continue to be in compliance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. No person shall, on account of race, color, religious creed, national origin, ancestry, sex, handicap or age be unlawfully excluded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

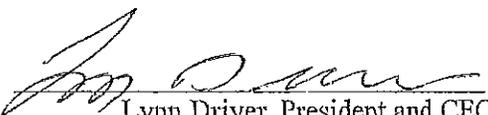
COMMUNITY HOSPITALS OF INDIANA, INC.

By:

  
Steve Bell, Vice President, Supply Chain

INDIANA ORGAN PROCUREMENT ORGANIZATION, INC.

By:

  
Lynn Driver, President and CEO

**TITLE: ORGAN AND TISSUE DONATION**

Purpose:

1. To provide guidelines for health care providers for the process of organ/tissue donation and compliance with Indiana's Uniform Anatomical Gift Act IC 29-2-16-02

Policy Statements:

1. Community Hospitals are affiliated with Indiana Organ Procurement Organization (IOPO) for organ, eye and tissue donation. **All calls are to be made to the Indiana Donor Alliance (IDA), the telephone service for IOPO.** The toll free number is
2. No mechanical support should be withdrawn from the dying patient prior to the referral call to IDA and determination of medical suitability from IOPO.
3. The option of organ or tissue donation is to be offered to families by an IOPO representative to ensure the greatest sensitivity to matters such as timing, the circumstances of the patient's death and the beliefs and desires of those families.
4. Indiana's Uniform Anatomical Gift Act IC 29-2-16-02 provides means for a written, verifiable legal declaration of a patient's intent to donate anatomical gifts upon death. Any next of kin or guardian may not, under the law, supersede a patient's decision. Without a verifiable declaration, IOPO will follow the standard protocol of seeking family consent by offering the option of donation to the next of kin.
5. The monthly audit conducted by IOPO to identify areas of potential non-compliance will be forwarded to CHNw individuals and teams for review and action and made available to regulatory and accrediting bodies.

General Information:

Definitions:

1. Death: Individual who has sustained an irreversible cessation of all circulatory and respiratory function.  
All deaths include:
  - All cardiac deaths
  - All imminent deaths or patients who meet clinical triggers as measured by:
    - o GCS of 5 or less
    - o At first mention of withdraw of care
  - All still born births (where a death certificate is required)
  - DOA's (Dead on Arrival)
2. Brain Death: a sustained irreversible cessation of all functions of the entire brain, including the brain stem.
3. Imminent Death: Individual who has a condition from which a reasonable degree of medical certainty, there can be no recovery and that death will occur within a short period of time without instituting life-prolonging procedures. A patient who meets clinical triggers for organ donation.
4. Reportable Death: Deaths requiring a death certificate or fetal death certificate as required by Indiana State Department of Health. No reporting is required for abortions, miscarriages or fetal deaths less than 20 weeks gestation.
5. Organ Donation: Donation of solid organs which includes heart, lungs, liver, kidneys, pancreas and small intestines from an individual who is brain dead or meets criteria for donation after cardiac death.
6. Tissue Donation: donation of tissues, which includes heart valves, veins, arteries, tendons, ligaments, bone, fascia, skin corneas and whole eyes from an individual whose heart is no longer beating.

The hospital recognizes the importance of allowing those who wish to donate the opportunity, in the hope that solace may be provided to the grieving family by their decision to participate in improving the quality of life for others. CHNw wishes to facilitate the donation of organs, tissue and eyes in the board interest of society and those awaiting transplantation, without infringing upon a family's deeply held beliefs, values and rights.

IOPO provides information to the family of each potential organ or tissue donor regarding the desire of the patient for organ or tissue donation as designated on his/her Bureau of Motor Vehicles license or registration through [www.donatelifelifeindiana.org](http://www.donatelifelifeindiana.org). If the patient has not designated donation on his/her Bureau of Motor Vehicles license, the family has the option to donate or decline to donate organs or tissues. There will be no cost to the family of donors once the decision has been made to donate anatomical gifts.

To facilitate the opportunity for anatomical gift donation, the following processes involved with this procedure are identified:

CORPORATE CLINICAL POLICY AND PROCEDURE (CLN)

CORP: CLN-2055

APPROVED FOR: CHE CHN CHS TIHH

Page 2 of 5

CANCELS: 4/19/11

EFFECTIVE: 1/18/12

- 1. CRITERIA for donation: See IOPO Manuals
- 2. CROSS REFERENCE:
  - Death NPP: R-009 "Care of the Patient After Death"  
See also attached Flow Chart
  - Autopsies: CORP#: CLN-2054
  - Cardiac Death CLN-3035, Donation organ – after cardiac death
  - Patient Rights Handbook

Procedure:

See attached flowchart

Owned by: Organ Donor Team

Approved by:

Organ Donor Team	12/2011
Risk Management	12/2011
Infection Prevention	12/2011
Chief Nursing Officer Designee	12/26/11

Approved: \_\_\_\_\_  
 Chief Executive Officer CHI/Chief Operations Officer CHNw

Date:

**INTRODUCTION: ORGAN DONATION**

Patients have the right to be organ or tissue donors upon their deaths, if they meet donor criteria. Indiana State Law and the Anatomical Gift Act require hospitals to offer the option of organ and tissue donation to all potential donors and/or families. In 1998 the Centers for Medicare and Medicaid, CMS required all health care organizations receiving Medicare reimbursement to call the local donor alliance organization for every anticipated and actual patient death. In Indiana, the donor alliance is the Indiana Donor Alliance, IDA confers with donor organizations to determine donor suitability and next steps.

Within the Community Health Network, staff members contact the IDA, who confers with out donor partners. For Community Hospital North, East, South and TIHH donor services are provided by the Indiana Organ Procurement Organization (IOPO). Community Anderson partners with Indiana Organ Procurement Organization (IOPO), Community Tissue Services (CTS) and Lions Eye Bank (LEB). The attached flowchart guides the caregiver through the process. Below are listed resources and experts.

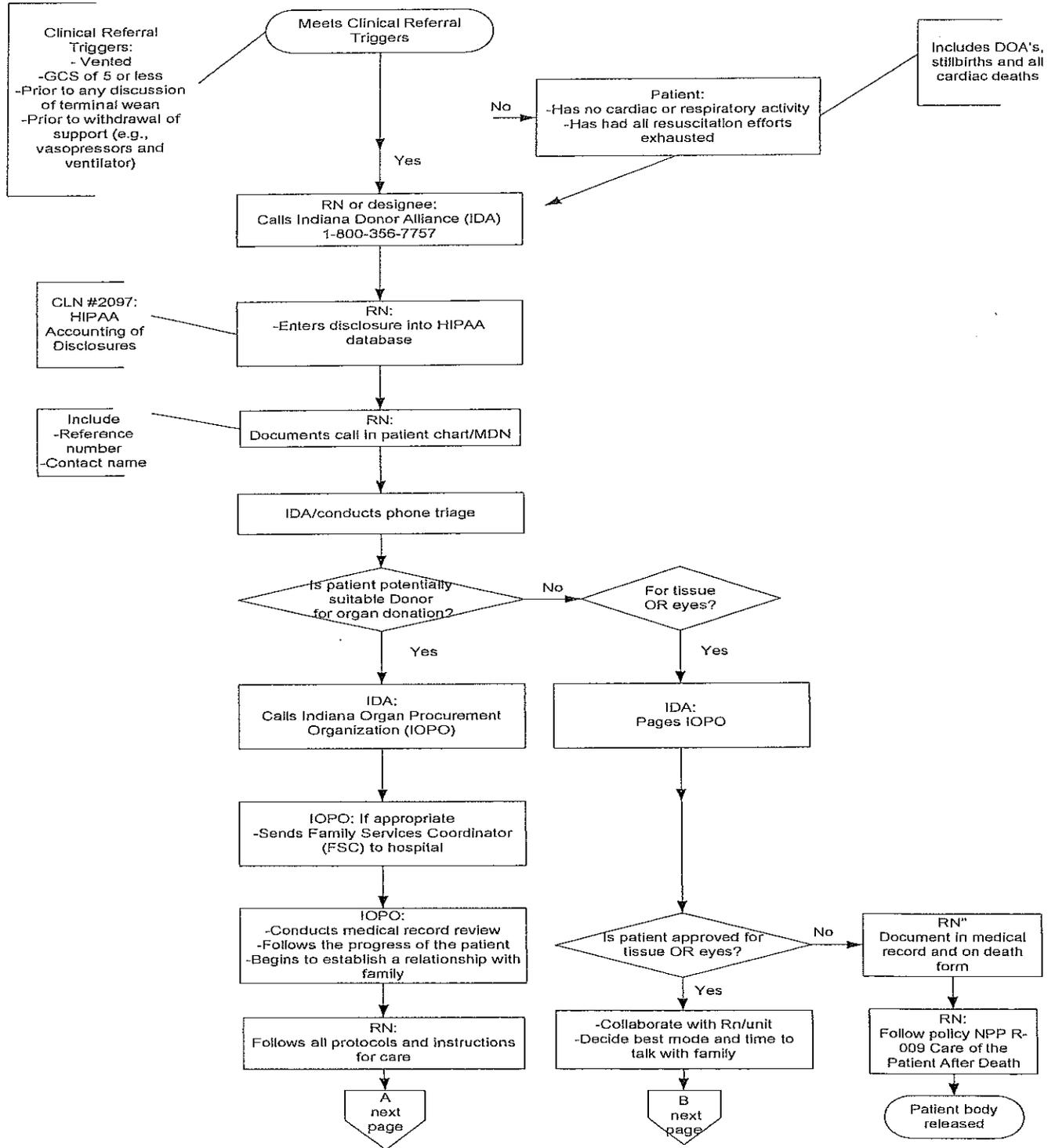
**Indianapolis**

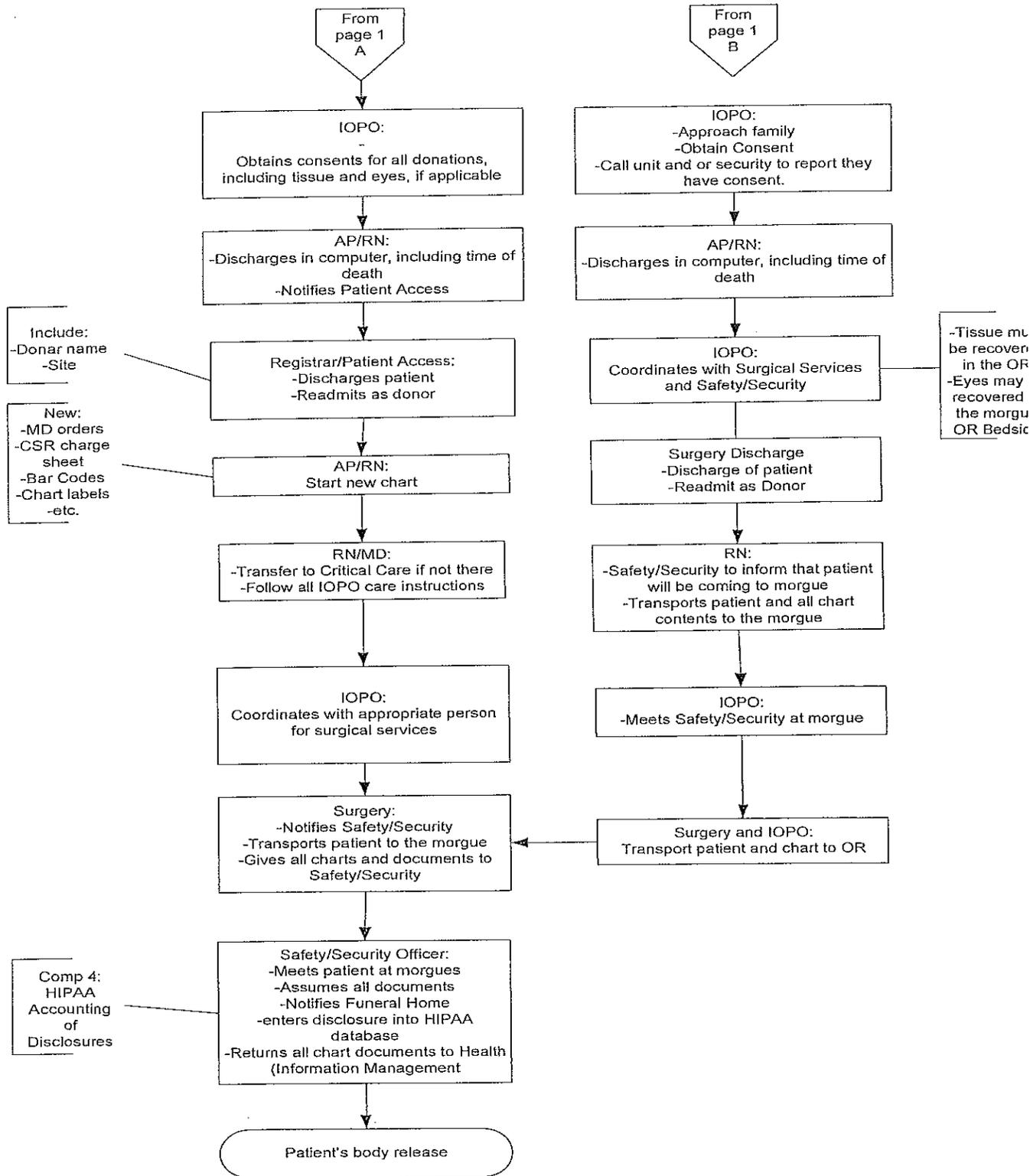
Experts/Resources	
Network Donor Council Leader	1
Chaplains	
CHE	
CHN	
CHS	
Ethics Committees (Call Medical Staff Office)	
CHE/N	
CHS	
Indiana Donor Alliance (IDA)	
Indiana Organ Procurement Organization (IOPO) iopo.org	
Corporate Clinical Policy (CLN) 2055 "Organ & Tissue Donation"	
Nursing Policy/Procedure (NPP) R-09 "Care of the Patient After Death"	
Donation After Cardiac Death (Organ) CLN-3035	

**Anderson**

Experts/Resources	
Nursing Administration Pager	
Indiana Donor Alliance (IDA)	
Indiana Organ Procurement Organization (IOPO) iopo.org	
Community Tissue Services (CTS)	
Lions Eye Bank (LEB) lionseyebank.org	
Hospital Policy H8 "Anatomical Gift Donation"	

Organ & Tissue Donation







# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

### SECTION 19

#### Diversion Policy

19. "**Diversion Policy.** The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time. The hospital's documentation must include a record for the previous year showing dates and lengths of time for each time the hospital was on diversion."

#### Narrative Response and Discussion

The requirements of section 19 are met with a signed copy of Community Health Network's Diversion Policy. Included in this section is a signed letter from the director of the Emergency Department affirming that Community Hospital South will not be on diversion for than 5% of the time.

Community  
Health Network

Community Hospital South  
Emergency Department  
1402 E. County Line Road  
Indianapolis, Indiana 46227-0963  
317-887-7200 (tel)  
eCommunity.com

June 24, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS verification Process" for Level III Trauma Center designation.

The purpose of this correspondence is to inform the committee that I serve in the role of Director of Emergency Department at Community Hospital South. Enclosed you will find Community Health Network's Diversion Policy and the record of Community South's diversion time for the past year. I affirm that Community Hospital South will not be on diversion more than 5% of the time.

Respectfully,



Shawna A. Thomas RN, BSN  
Director Emergency Department

Edward Diekhoff M.D., F.A.C.S  
Trauma Medical Director



**CORPORATE CLINICAL POLICY AND PROCEDURE**

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087

Page 1 of 6

EFFECTIVE: 1-16-14

**TITLE: READY TO SERVE/DIVERSION (AMBLUANCE DIVERSION)**

Purpose:

To provide a plan for the orderly arrangement of staffing and patient placement during any situation that has the potential to cause a break in the provision of essential patient care and services. Examples include (but not limited to): a winter storm warning, internal or external disasters, Red Light Bed Alert and ambulance diversion.

Policy Statements:

1. The provision of high quality patient care is the primary focus of the Community Health Network (CHNw).
2. All departments that support patient care will maintain a roster which includes staff phone numbers, distance from the hospital and travel time to reach the hospital.
3. Staffing level that support patient care will be addressed if there is a Red Light Bed Alert, winter storm warning, code internal or external, or ambulance diversion.
4. In rare instances the need to consider diversion may be due to untoward patient volumes, high acuities, and compromised physical and/or available resources either in acute care or in the emergency department. In these situations, when there may not be sufficient patient beds and/or patient care staff to safely care for any additional patients, the delivery of ambulance patients to a facility may be temporarily diverted. The rationale of such a diversion is to allow optimal patient care, while causing the least amount of hardship to other hospitals, including other facilities in the CHNw, or to EMS providers.
5. When diversion is being considered:
  - a. Only one (1) of the large metropolitan hospitals (excluding Eskenazi) will be on diversion at any one time; this includes Community Hospital East (CHE), St. Francis, St. Vincent, and Methodist.
  - b. Only one (1) of the CHNw hospitals – East, North, and South –will be on diversion at any one time.
  - c. In a rare instance when patient safety dictates more than one facility to divert at once negotiation and collaboration occurs between sites and leaders, eg ED Directors, Nurse Managers, and Facility President, frequently to remedy the situation. The CHE House Supervisor, after collaboration with DART is empowered to make whatever decisions are necessary to avoid diversion, this may include mandating certain patient placements or staffing patterns.
6. A recommendation for diversion is made by the Emergency Department (ED) Director after receiving data from the ED physician, the ED Patient Care Coordinator (PCC)/Charge Nurse, and the House Supervisor, The ED Director then communicates and collaborates with the Vice President (VP) of Patient Care Services or designee for that facility to finalize the decision and determine the official diversion status, ie total or critical. The Administrator on call will also be notified by the House Supervisor after hours. The cooperation of all site departments is necessary in order to implement this process. All patient care units, and all other applicable ancillary units, are expected to cooperate, negotiate in good faith, and work toward the common goal of managing patient flow and avoiding diversion.



**CORPORATE CLINICAL POLICY AND PROCEDURE**

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087

Page 2 of 6

EFFECTIVE: 1-16-14

General Information:

1. **DIVERSION (ambulance diversion):** The process of requesting EMS units to temporarily refrain from transporting incoming ambulance patients to a particular facility. Most often, diversion is due to unmanageable patient volumes, acuities, compromised physical resources or environment, Per agreement with metropolitan Indianapolis hospitals and EMS providers, there are four (4) recognized categories of diversion:
  - a. Critical Care Diversion – Diversion of patients likely to require the most intense level of care and services, and likely to be admitted to critical care beds and/or monitored beds.
  - b. Total Diversion – Diversion of all incoming ambulance patients. (NOTE: In the case of the following patients, the situation may be evaluated on a case-by-case basis: laboring mothers, patients in cardiac or respiratory arrest, patients in extremis, or ambulances which are in very close proximity to the hospital.)
  - c. Psych Diversion – At Community Hospital North (CHN), times exist when the Behavioral Health Pavilion must divert patients. In these instances, the Medical Director and/or Executive Director for Behavioral Health are in charge of making the decision and notifying the House Supervisor at CHE to initiate the diversion.
  - d. Cath Lab Diversion – Due to equipment failure in this department, diversion of patients with complaints likely to require this department's services is called and EMS units are alerted to divert those patients in order that they receive optimum care.
  - e. Specific Resource Diversion – This is not an officially recognized "diversion" status in the community at large. For example, CT scanner is non-functional or both CT scanners at CHE are not functioning. Diversion of patients with complaints likely to require that resource is called and EMS units are alerted to divert those patients in order that they receive optimum care. (in CT example, stroke, and head injury). This type of diversion lasts only until the resource/issue can be resolved.
2. **BEDS/PATIENT FLOW** - Bed Alerts are a declared situation and electronic communication is sent to alert the Network.
  - a. YELLOW LIGHT - approximately 91% occupancy of core beds.
  - b. BLUE LIGHT - indicates the number of ready/available beds exceeds the number of available staff.
  - c. RED LIGHT - nearing 100% occupancy; indicates the number of inpatients or admissions has exceeded the number of beds available.
  - d. Updated Bed Aggregation numbers for each facility are maintained at CHE in the House Supervisor's office.
  - e. The CHE House Supervisor is responsible for initiating the Network Alert daily.
3. **DART (Diversion Avoidance Response Team)**
  - a. The DART group convenes in person and/or via telephone when census/acuity is high, and diversion is a threat. The group's goal is avoiding diversion by whatever means possible, and they are empowered to do so by Senior Leadership. A meeting of this group is requested when it is felt that diversion issues may arise soon if plans are not implemented to alleviate patient overload. NOTE: If a diversion decision is needed emergently, the ED Director in consultation with the facility VP of Patient Care Services may make that decision emergently and DART can be convened forthwith to work on solutions to end the diversion status as quickly as possible.
  - b. The DART is comprised of:
    - House Supervisor
    - Emergency Department Clinical Director or designee
    - Nursing Site Leaders
    - Ancillary Site Leaders, eg., Case Management, Environmental Services
    - Facility President

357.



# Community Health Network

## CORPORATE CLINICAL POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087

Page 3 of 6

EFFECTIVE: 1-16-14

- Site-specific personnel as designated by Facility President

4. **EMERGENCY STAFFING PLAN** - consists of:
  - a. Holding essential staff over for duty on subsequent shifts
  - b. And/or recruiting staff from alternative sources within the hospital network
  - c. And/or requesting transportation service through Security Dispatch for staff essential to patient care and who are unable to provide their own transportation
  - d. And/or providing lodging quarters, supplies, food, and compensation for staff, volunteers, and contracted service employees
  - e. The hospital may provide transportation for staff needed for essential patient care and services after all efforts for self-transportation have been exhausted. When making arrangements to pick up staff, the network commits to making arrangements to take staff back home via 4-wheel drive vehicles or prepaid taxi. However, the network cannot commit to the exact time staff will be taken home. The network cannot guarantee that there will be a sufficient number of 4-wheel drive vehicles (or taxi service) available to meet the demand for pick up and return.
5. CODE INTERNAL can include, but is not limited to loss of communications, utility failure (ie electric, water, medical gas, HVAC), bioterrorist threat, chemical spill or communicable disease outbreak. A Code Internal is a situation that has potential to disrupt the normal course of business, cause damage or create casualties.
6. CODE EXTERNAL can include but is not limited to bus/plane or multiple auto accident (resulting in patient influx), release of a toxic substance, bioterrorist attack terrorist attack or incident causing multiple injuries/casualties. A Code External at one site does not mean there needs to be a Code External initiated at all sites.
7. Electronic communication devices are used to notify the network of disasters, bed alerts, etc.
8. PAY PRACTICES: refer to Community Health Network Human Resource Policy and Procedure Manual.

### Procedure:

### **DIVERSION**

1. The ED identifies that it is unable to accommodate further patient influx.
2. The charge nurse in conjunction with the ED physician contacts the ED Director/designee, who will then coordinate efforts to alleviate the situation. The Director/designee will consult with the VP of Patient Care Services and the Administrator on call as needed to get the situation relieved. If the situation is not able to be relieved, the appropriate diversion may be called at this point.
3. The department notifies the CHE House Supervisor.
4. The CHE House Supervisor pages all CHNw leadership, utilizing the network emergency alpha pagers: "Dart Meeting" with time and meeting place.
5. The DART is immediately activated, as follows (unless previously activated):
  - a. There is an immediate halt on all placements of admissions, while a rapid assessment of the situation is conducted; the halt applies to, but is not limited to the following areas/departments: ED, Operating Room (OR), Post Anesthesia Care Unit (PACU), Cardiac Cath Lab, and all inpatient and short stay/daybed units.
  - b. Guidelines for this rapid but thorough assessment may include, but are not limited to:
    - 1.) Analysis of numbers of patients throughout the facility
      - a.) in ED – total and those to be admitted
      - b.) in the Cath Lab – currently and slated
      - c.) the OR/PACU -- currently and slated
    - 2.) Assessment of number of available house beds, including pending discharges and transfers



# Community Health Network

## CORPORATE CLINICAL POLICY AND PROCEDURE

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CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087

Page 4 of 6

EFFECTIVE: 1-16-14

- 3.) Assessment of bed utilization
  - a.) Are all available beds being utilized?
  - b.) Are there any beds on the Pediatric or Family Rooms units? (Note: Pediatrics can take patients up to age 25 without special permission; Family Rooms can take non-infectious female patients)
  - c.) Does a unit (or units) need to "flex up"?
  - d.) Can patients be held in closed areas, eg, Endoscopy or Ambulatory Care?
  - e.) Can stable patients be temporarily placed in inpatient unit hallways?
  - f.) What closed beds can be re-opened immediately? in one hour? in four hours?
  - g.) Who else can be utilized to provide patient care - non-clinical and/or administrative nurses to provide direct patient care?
- 4.) Movement of patients
  - a.) Has a particular patient's condition been upgraded, qualifying the patient for a lower level of care?
  - b.) Can patients be transferred to another CHNw facility? (eg, cardiac patients going to CHVH the next morning for cardiac catheterization.)
- 6. If diversion is unavoidable, the CHE House Supervisor makes the following notifications, in this order, 24/7:
  - a. Notify EMS:
 

CHE	Mesh Indy TRAC System
Hancock County – Buck and Sugar Creek	
CHN/CHVH/Behavioral Care	Mesh Indy TRAC System
Hamilton County	
CHS	Mesh Indy TRAC System
Brown Township	
  - b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers: "Diversion" with what hospital and pertinent information related to the diversion.
- 7. CHE House Supervisor will log diversion information in the Network Diversion Log.
- 8. The entire situation will be re-evaluated, not less than every two (2) hours.
- 9. The diversion will be deactivated as soon as possible; the CHE House Supervisor will:
  - a. Notify EMS, following the above steps, see 6.a.
  - b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers stating the diversion is over.
  - c. The CHE House Supervisor will log the information in the Network Diversion Log.

### DECLARING A YELLOW, BLUE OR RED LIGHT BED ALERT

- 1. Each unit/department assesses bed availability for potential problems. Notify the House Supervisor at CHE via alpha-numeric pager of potential problems.
- 2. The CHE House Supervisor assesses daily at 0500, 1300, 2000, and PRN the number of current inpatients at all 4 Indianapolis Community Health Network hospitals
- 3. The CHE House Supervisor evaluates the information from all sites to determine if a Bed Alert needs to be called. The CHE House Supervisor will assess which are the most appropriate units to place centralized staff when supply and demand do not match, eg skill mix, on-call procedures.
- 4. When a RED LIGHT is called, departments may be notified of the potential need to hold patients.



# Community Health Network

## CORPORATE CLINICAL POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087

Page 5 of 6

EFFECTIVE: 1-16-14

### EMERGENCY STAFFING PLAN INITIATION:

1. Department Directors or designee determine staffing requirements for providing essential patient care and services (ie Nursing Service, Dietary, Laboratory, X-ray, and Maintenance) and initiate plans, which may include:
  - a. Retain current staff.
  - b. Recruit staff from alternative sources within the hospital network.
  - c. Request transportation service
  - d. For coordination, all nursing service units/departments communicate their individual nurse staffing status with Centralized Staffing ([REDACTED])

### TRANSPORTATION SERVICES

1. Leadership arranges employee transportation with Security ([REDACTED]), making the request as soon as possible but not more than three (3) hours prior to employee's scheduled start time.
2. Security determines transportation assignments, considering:
  - a. Weather and road conditions.
  - b. Employees located in close proximity to others may in some cases determine pick-up priorities.
3. Safety & Security coordinates requests for return transportation with pick up requests. Pick up requests have priority over return transportation. Return transportation is scheduled on a first come, first serve basis.
4. Transportation vehicle pool:
  - a. All hospitals owned vehicles are available to the Transportation Pool
  - b. Security Dispatch contacts the Director of Facilities Engineering or designee in regards to providing transportation assistance
  - c. All drivers are issued a two – way radio or cellular phone.
  - d. Security dispatch records driver mileage.
  - e. Expenses (mileage) is recorded when non-hospital owned vehicles are used for the reimbursement of expenses under standard travel practices.
  - f. Fuel reimbursement and hourly wages to hospital and non-hospital employees will be paid fuel reimbursement and hourly wages after receipts are turned into the Secretary of Safety and Security.

### LODGING QUARTERS AND PROVISIONS:

1. If necessary, due to the projected length of severe, inclement weather or the projected length of the Internal Disaster, lodging quarters will be provided for employees who volunteer or are requested to stay in the hospital to staff projected vacancies.
2. Lodging will be coordinate by Environmental Services and House Supervisor.
3. Toiletries are coordinated through Materials Management.
4. Food services are coordinated by Nutrition and Food Services. The Cafeteria will be available during regularly scheduled meal periods.

Owned by: CHE House Supervisor

Approved by: Infection Prevention  
 Risk Management  
 Safety and Security  
 Emergency Department Directors  
 Nutrition and Food Services  
 Environmental Services

Date: 12/13  
Date: 12/13  
Date: 12/13  
Date: 12/13  
Date: 12/13  
Date: 12/13



CORPORATE CLINICAL POLICY AND PROCEDURE

Approved For:  CHE  CHN  CHS  CHVH

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CORP#: CLN-2087

Page 6 of 6

EFFECTIVE: 1-16-14

CNO Designee

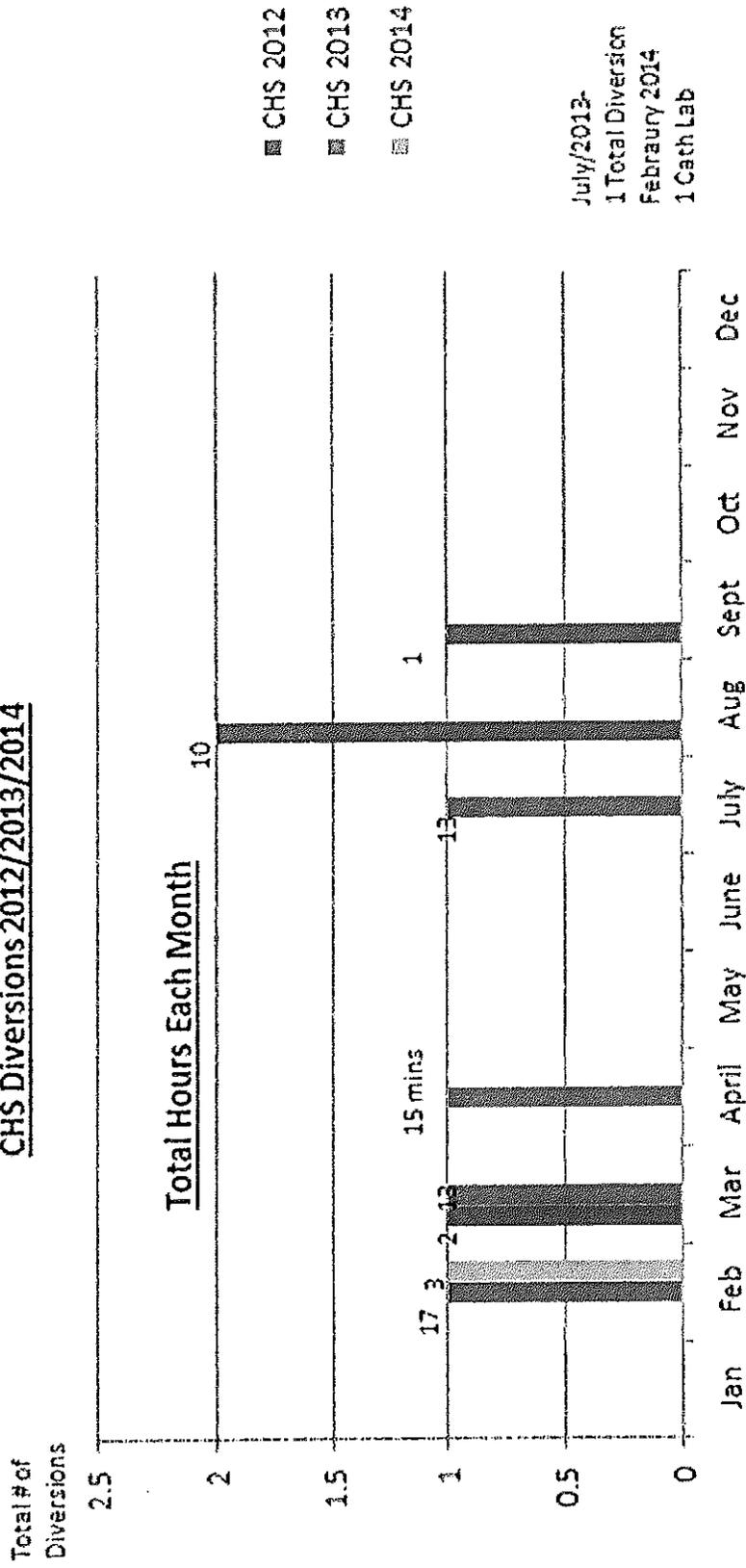
Date: 12/13

Approved:

\_\_\_\_\_  
Network President/CEO

Date:

CHS Diversions 2012/2013/2014



362



# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

### SECTION 20

## Operational Process Performance Improvement Committee

20. "Operational Process Performance Improvement Committee.

There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year."

### Narrative Response and Discussion

Performance Improvement and Patient Safety Committee has been formed and met prior to application. The agenda, power points, case reviews, and meeting minutes are included in this section. All committee members have been identified. The list of these of committee members is included in this application. As a group, we identified our quality indicators that we will use for performance Improvement for trauma at Community Hospital South.

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**Community Hospital South  
Performance Improvement and Patient Safety Committee Members  
June 2014**

Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.

Trauma Program Manager- Roxann Kondrat BSN, RN

Emergency Department Director- Shawna Thomas BSN, RN

Trauma Registrar- Mary Schober

Emergency Physician – Dr. Parker/Dr. Bence

Operating Room/PACU – Patrick Beaupre

ICU – Jeannie Blizzard/Tony Reynolds

Orthopedic Surgeon- Dr. Julian

Neuro surgery- Dr. Rendell

VPCP – Dr. Lee

Radiology – Dr. Sheets

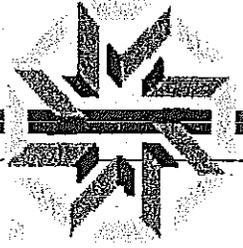
Respiratory – Ricki Shepherd

Lab/Blood Bank- Gabi Houston

EMS- Dr. Bence/John Zartman

**Agenda**  
**PIPS Meeting**  
**June, 20, 2013**

1. WELCOME /INTRODUCTIONS
2. LEVEL III TRAUMA APPLICATION PROCESS
3. WHAT IS PIPS?
4. WHO MAKES UP THE PIPS TEAM?
5. WHAT QUALITY INDICATOR MEASURES ARE WE USING FOR TRAUMA?
6. QUESTIONS?
7. NEXT MEETING FRIDAY JUNE 27, 2014 2PM-4PM IN CONFERENCE ROOM 5-6 AT CHS



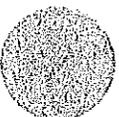
# Community Health Network

Trauma Improvement Process Team CHS  
June 20, 2014

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# AGENDA

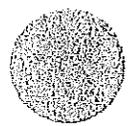
1. WELCOME /INTRODUCTIONS
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6. QUESTIONS?
7. NEXT MEETING FRIDAY JUNE 27, 2014 2PM-4PM IN CONFERENCE ROOM 5-6 AT CHS



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# WELCOME/INTRODUCTIONS

- o Trauma Medical Director- Dr. Edward Diekhoff  
M.D. F.A.C.S.
- o Trauma Program Manager- Roxann Kondrat  
BSN, RN
- o Emergency Department Director- Shawna  
Thomas BSN, RN

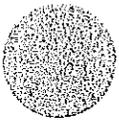


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APPLICATION PROCESS FOR LEVEL III  
TRAUMA CENTER

o Submission of application on or  
before July 7, 2014

o What Does this mean to us?



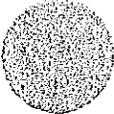
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WHAT IS PIPS?  
PERFORMANCE IMPROVEMENT AND PATIENT  
SAFETY

WHO? EVERYONE IS RESPONSIBLE FOR  
PIPS. YOU MUST HAVE A PHYSICIAN CHAMPION.

WHAT? NOT ONLY IMPROVING THE  
PERFORMANCE OF THE TRAUMA TEAM, BUT ALSO  
EVALUATING POTENTIAL AREAS FOR THE NEED  
FOR IMPROVEMENT.

WHEN? PIPS IS DONE 24 HOURS A DAY, 7  
DAYS A WEEK, 365 DAYS PER YEAR!



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## WHO MAKES UP PIPS COMMITTEE?

- ❖ Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.
- ❖ Trauma Program Manager- Roxann Kondrat BSN, RN
- ❖ Emergency Department Director- Shawna Thomas BSN, RN
- ❖ Trauma Registrar- Mary Schober
- ❖ Emergency Physician – Dr. Parker/Dr. Bence
- ❖ Operating Room/PACU – Patrick Beaupre
- ❖ ICU – Jeannie Blizzard/Tony Reynolds
- ❖ Orthopedic Surgeon- Dr. Julian
- ❖ Neuro surgery- Dr. Rendell
- ❖ VPCP – Dr. Lee
- ❖ Radiology – Dr. Sheets
- ❖ Respiratory – Ricki Shepherd
- ❖ Lab/Blood Bank- Gabi Houston
- ❖ EMS- Dr. Bence/John Zartman



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## HOW DOES THE PROCESS START?

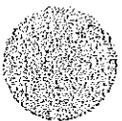
- ❑ **What am I looking for?** Find patients through daily admission records, ED logs, designated reports.
- ❑ **Where do I look?** Look through ED admits, admits to specialties, and admits to the trauma surgeons. Other sources of information could be by personal communication (phone calls to your office, social worker, other staff).
- ❑ **Why am I looking for it?** This is what “drives” the PIPS process.



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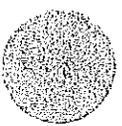
## WHAT AM I LOOKING FOR? *QUALITY INDICATORS*

- Time in ED
- Trauma Activation
- EMS Scene time
- EMS Issues
- Surgeon Response time for Code Traumas
- Surgeon on Call
- CT times
- Transferred/Where?
- Time decision was made to transfer?
- Pediatric Case
- Trauma Death
- Over/Under Triage
- Removal of Backboard
- Injury Severity Score
- Blood/Blood Products availability
- OR times



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**\*\*WHAT THINGS HAVE YOU FOUND THAT YOU FEEL NEED TO BE REVIEWED TO DETERMINE IF THE CONCERN IS A TREND, OR AN ISOLATED INCIDENT? WAS THE PATIENT CARE COMPROMISED? WAS THE OUTCOME LESS THAN OPTIMAL? \*\***



# LEVELS OF REVIEW

- **First level review:** Done primarily by the trauma coordinator who reviews the established filters and the overall case. Nursing issues are addressed by the trauma coordinator but must be communicated to the Trauma Medical Director.
- **Second level review:** Cases reviewed by the trauma coordinator needing physician review (physician champion). Keep in mind the physician cannot review their own cases so there may need to be a process for external review such as sending it to outside physician for review. The physician then decides if the case will go to PIPS for review.
- **Third level review:** Case has been reviewed by the trauma coordinator and trauma medical director and is now presented to the PIPS committee. PIPS committee will determine the final outcome of the case.

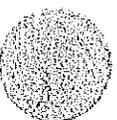
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# PIPS COMMITTEE

o **What is it?** Monitoring, evaluating, and improving the performance of your trauma program.

o **Who attends?** The PIPS committee is comprised of physicians and allied health professionals who provide care to trauma patients. This provides the opportunity for discussion about patient care to occur with all disciplines able to participate in the review of the case.

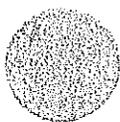
o **Loop closure?** Loop closure describes what you did to resolve the problem, and how you educated all those involved in the problem!

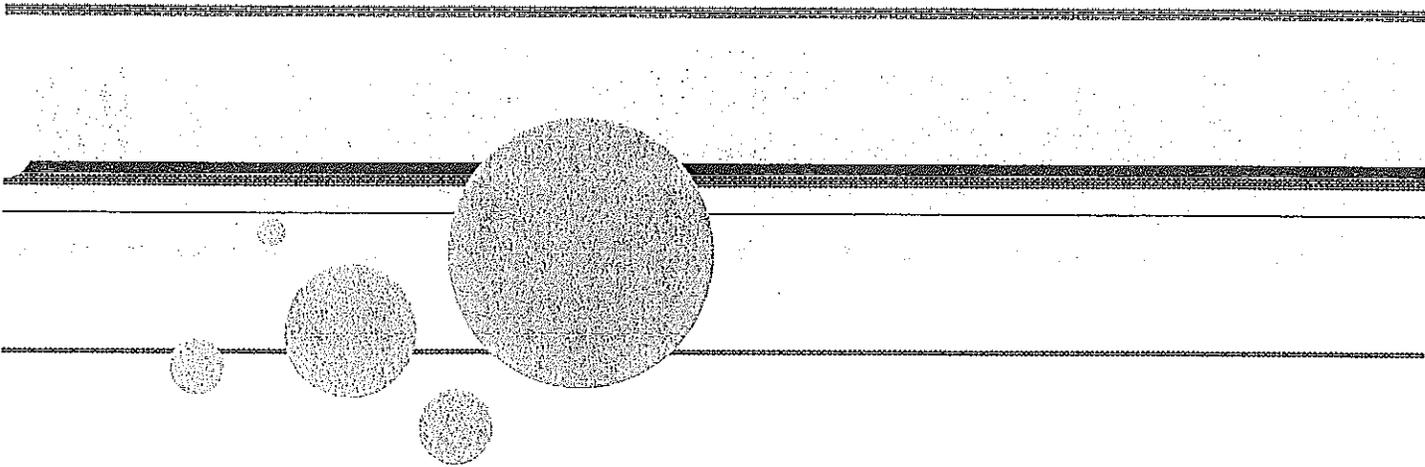


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# LOOP CLOSURE

- How do I close the loop?
- Education
- Audits
- Accountability
- Re-evaluation



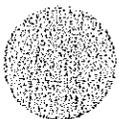


# QUESTIONS?

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# NEXT PIPS MEETING

- o Next Friday June 27, 2014 in CHS Conference Rooms 5-6



PIPS Meeting CHS  
June 20, 2014 1400

# Minutes

Present:

Trauma Director - Dr. Diekhoff	Trauma Program Manager- Roxann Kondrat RN
ER-Dr. Parker	EMS-Dr. Bence
Radiology- Dr. Sheets	Anesthesia- Dr. Corsaro
ICU-Tony Reynolds, RN	OR/PACU-Patrick Beaupre, RN
Trauma Registrar- Mary Schober	RT-Rickki Shepard
Lab/Blood Bank-Gabby Houston	Neuro Surgery- Dr. Rendel
VPCPER- Dr. Lee	ED Director- Shawna Thomas, RN

Item #	Agenda Item	Purpose	Outcome/Next Step	Follow up Responsible Individual	Due Date/Timeline
1	Welcome/Introductions	Information	Roxann Kondrat BSN, RN –new Trauma Program Manager at Community South.		
2	Level III Trauma Applications Process	Information	Shawna Thomas RN- ED Director informed the committee that Community South Application for being a Trauma Center will be submitted by July 7, 2014. We almost have our application complete.	Shawna and Roxann will finish and submit application to American College of Surgeons.	July, 7, 2014
3	What is PIPS?	Information	Roxann Kondrat- Presented a power	Power Point	

			<p>point presentation on what it means to be on a performance Improvement and Safety committee.</p>	<p>Attached to minutes for review</p>	
4	<p>Who Makes up the PIPS Team?</p>	<p>Information</p>	<p>Trauma Medical Director- Dr. Edward Diekhoff M.D. F.A.C.S.          Trauma Program Manager- Roxann Kondrat BSN, RN          Emergency Department Director- Shawna Thomas BSN, RN          Trauma Registrar- Mary Schober          Emergency Physician – Dr. Parker/Dr. Bence          Operating Room/PACU – Patrick Beaupre          ICU – Jeannie Blizzard/Tony Reynolds          Orthopedic Surgeon- Dr. Julian          Neuro surgery- Dr. Rendell          VPCC – Dr. Lee          Radiology – Dr. Sheets          Respiratory – Ricki Shepherd          Lab/Blood Bank- Gabi Houston          EMS- Dr. Bence/John Zartman          Anesthesia- Dr. Corsaro</p>		
5.	<p>What Quality Indicator Measures are we using for Trauma?</p>	<p>Information</p>	<p>Time in ED          Trauma Activation          EMS Scene time          EMS Issues          Surgeon Response time for Code Traumas          Surgeon on Call          CT times          Transferred/Where?          Time decision was made to transfer?</p>	<p>Roxann/Dr. Diekhoff will review all trauma cases using these measures and bring trauma cases for review to the</p>	

382

		<p>Pediatric Case  Trauma Death  Over/Under Triage  Removal of Backboard  Injury Severity Score  Blood/Blood Products availability  OR times</p>	committee.	
6	Questions?	Information	<p><b>LAB-Gabby</b> from lab informed us that we will have 1 Unit of Platelets in lab now. This brought up discussion about Massive Transfusion Policy. Shawna updated us, we are working on a corporate wide policy.</p> <p><b>EMS- Dr. Bence</b> discussed the subject of what EMS will be bring to our ER once we become a Level III Trauma Center. Dr. Bence stated that he will be working with EMS to educate them on what patients are appropriate to come to Community South and which patients need to be transported to higher level of care facilities. The use of a "trauma phone" with EMS was brought up. This phone would be direct access to ER physician at Community South so that EMS could discuss a Trauma Case while they were on scene of the trauma.</p> <p><b>Pediatric Patients:</b> we discussed who would admit these patients? Dr. Diekhoff stated that general surgery will be the admitting. We also discussed that ICU at</p>	

			<p>south does not admit patients less than 16 years of age. We discussed if pediatric trauma patients needed admission that they would be transferred to Higher Level of care. We will be reviewing all pediatric cases.</p> <p><b>OR and Diversion-</b> Dr. Corsaro asked about increase in OR volume with Trauma Designation. Shawna informed him that since Community Anderson became "In Process" that they have not seen and influx of OR cases. Dr. Rendell asked about neuro -surgery cases and diversion related to neuro surgery in the OR. Shawna explained in those incidents we can go on neuro surgery diversion. Patrick informed us that he would help keeping the ER up to date if we would need to go on diversion related to a surgeon being in the OR.</p> <p>Shawna also explained sitting down with Neuro-Surgeons and discussing cases that they would want to keep at Community South and what cases transferred to higher level of care.</p>		
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**Agenda**  
**PIPS Meeting**  
**June, 27, 2013**

1. Welcome
2. Update on Trauma Application
3. Review of cases
4. Trauma CME requirements for Physicians
5. Discussion of future meetings
6. Questions
7. Next Meeting Thursday July 3, 2014 will be cancelled.



PIPS Meeting CHS  
June 27, 2014 1400

# Minutes

**Present:**

Trauma Director - Dr. Diekhoff  
ER-Dr. Parker  
Radiology- Dr. Sheets  
ICU-Tony Reynolds, RN  
Trauma Registrar- Mary Schober  
Lab/Blood Bank-Gabby Houston  
ED Director- Shawna Thomas, RN

Trauma Program Manager- Roxann Kondrat RN  
EMS-John Zartman  
Anesthesia/OR- Dr. Corsaro  
RT-Ricki Shepard  
Neuro Surgery- Dr. Rendel  
VPCP- Dr. Lee  
Orthopedic Surgeon: Dr. Julian

Item #	Agenda Item	Purpose	Outcome/Next Step	Follow up Responsible Individual	Due Date/Timeline
1	Welcome	Information	Minutes were reviewed and past by motion by Dr. Corsaro and Dr. Sheets		
2	Level III Trauma Applications Process	Information	1. Shawna Thomas RN- ED Director informed the committee that Community South Application for being a Trauma Center will be submitted by July 7, 2014. We almost have our application complete waiting on one signature. 2. John Zartman-explained the application process going through	Shawna and Roxann will finish and submit application to American College of Surgeons.	July, 7, 2014

386

			<p>Homeland security and then to the EMS commission to inform ambulance services that they can bring trauma patients to community South-</p> <p>John Zartman also informed us the all ER lines are recorded for review later if needed</p>	<p>Roxann informed the group that Dr. Bence and she will work with EMS on providing education to what Trauma patients are appropriate to come to Community South.</p>	
3	Review of Trauma Cases	Evaluation and Information		<p>Trauma Case Reviews Attached to minutes.</p>	
4	Trauma CME requirement for Physicians	Information	<p>Roxann Discussed need for Trauma Surgeons, Orthopedic Surgeons, Neuro-Surgeons need 16 CME per year that will need to be tracked yearly for our Level III trauma designation.</p> <p>Dr. Julian discussed a network CME each year for all physicians to get 8hr of Trauma CME.</p> <p>Dr. Lee- asked what level CME is need Level one or two.</p>	<p>Roxann-will investigate CME requirements for Radiology and Anesthesia. She will also get CME requirements for all groups</p>	<p>Roxann will report back in next PIPS meeting.</p>
5.	Discussion of future Meetings	Information	<p>It was decided to have PIPS meetings every Fourth Thursday from 07am-08am</p>		<p>Roxann will send out a reminder</p>

387

6	Questions?	Information	<p>1. Dr. Julian — had some questions about Community South becoming a “dumping ground” from other hospitals now that we will have our Trauma III designation. He expressed concern that other hospitals do not have Orthopedic on-call daily their practice may become to dump patients at Community South.</p> <p>Dr. Parker explained if an outlying hospital does not have Orthopedic on per EMTALA we can no refuse transfer “because services are not available at other hospital” Dr. Parker stated he would work with the ER physicians to have these hospitals call Orthopedics and review case with them prior to transfer.</p> <p>Dr. Julian also stated that Dr. Macintosh will be taking call at Community South and needs to be added.</p> <p>2. Dr. Sheets and Dr. Randel are concerned about “Code Trauma” Activations on pediatric patients. Roxann and Shawna explained that pediatric patient that need to be admitted will go to Riley’s but we do see pediatric patients in our department and may get a</p>	<p>Shawna and Roxann will monitor transfer of Ortho cases to community South.</p> <p>Roxann will monitor activations for Pediatric and these cases will be reviewed.</p>	of future dates
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			<p>Trauma that walks in our front doors and is not brought in by EMS.</p> <p>Trauma activation criteria will be made into Posters. There will be education coming out about calling Trauma's and posters will be made and placed all over ER and other area's to help with calling trauma's. Dr. Julian suggested the physician lounge; Roxann will have one placed there when they are made.</p> <p>3. Dr. Diekhoff asked about FAST exam course.</p>	<p>Will work with Eskenazi on getting our physicians comfortable with this exam.</p>	
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**Case Reviews**  
**06/27/2014**  
**CHS PIPS Committee**

2014	Code Trauma's	Trauma Eval's	Transfer	Discharge	Admit	Deaths	Surgeon Response
January							
February							
March							
April							
May							
June	0	0	7		9	0	0
Total	0	0	7		9	0	0
2014		Code Traumas < 30min response	Code Trauma No response		Total Cases		Response Total
Dr. Diekhoff							
Dr. Bowlds							
Dr. Clark							
Dr. O'Neil							
Over- Triaged			Goal < 30%		Defined as any called Trauma that was discharged from the ER		
Under-Triaged			Goal < 5%		Defined as any patient with an ISS $\geq$ 15 that is not called a Trauma		

Topic	Discussion	Follow Up
Follow up/Loop Closure:		

## Systems

Demographics	Case Studies/EMS Report/ Issues/ Concerns	Discussion	Follow-up																												
<p>Name [REDACTED]</p> <p>Date of Service 05/10/2014</p> <p>MR [REDACTED]</p> <p>Image Trend # [REDACTED]</p> <p>Case #1</p> <table border="1"> <tr><td>Time in ER</td><td>2h56m</td></tr> <tr><td>Trauma Activation</td><td>N/A</td></tr> <tr><td>EMS Scene Time</td><td>No Report</td></tr> <tr><td>EMS Issues</td><td>No report</td></tr> <tr><td>Surgeon response time for T1</td><td>N/A</td></tr> <tr><td>Surgeon on Call</td><td>N/A</td></tr> <tr><td>CT time</td><td>11m</td></tr> <tr><td>Transferred/Where?</td><td>admit</td></tr> <tr><td>Time Decision was made to Transfer</td><td>n/a</td></tr> <tr><td>Pediatric case</td><td>n/a</td></tr> <tr><td>Trauma Death</td><td>n/a</td></tr> <tr><td>Over/Under triaged</td><td>Under-triaged</td></tr> <tr><td>Removal of Backboard</td><td>n/a</td></tr> <tr><td>ISS</td><td>29</td></tr> </table>	Time in ER	2h56m	Trauma Activation	N/A	EMS Scene Time	No Report	EMS Issues	No report	Surgeon response time for T1	N/A	Surgeon on Call	N/A	CT time	11m	Transferred/Where?	admit	Time Decision was made to Transfer	n/a	Pediatric case	n/a	Trauma Death	n/a	Over/Under triaged	Under-triaged	Removal of Backboard	n/a	ISS	29	<p><b>Case Summary:</b> 68 year old man presents to ER per EMS. Pt has had a few days of generalized weakness with multiple falls taking ASA, Plavix and Pradaxa daily. Pt states that 730am PTA he was driving having shortness of breath and abd/chest pain. Pt states took his b/p at home was low. Pt called EMS and EMS states enroute to ER patient went into cardiac arrest and CPR was performed with ROSC. Pt arrives to ER alert and states mild abd pain and shortness of breath. Pt seen by ER physician found on US to have free fluid in abdomen. Dr. Woodall consulted general surgery Dr. Bowlds who want a CT abd/pelvis done stat at 1219 Ct was done. Radiologist called Dr. Woodall in ER at 1231 to inform her patient has ruptured spleen. Blood ordered and hung. Pt to OR for splenectomy at 1338. Pt had 2 units of FFP, 2 units of Platelets, 8 units of RBC's in the OR. Pt admitted to ICU on levophed and intubated had prolonged recovery.</p> <p><b>EMS Report:</b> Pt was transported by BLS</p> <p><b>Issue/Concerns:</b> Questionable under triaged. Time in the ER. ILS &gt;15, Pt developed pneumonia</p>	<p>We discussed as a group why this patient was not identified as a Trauma patient. The ER/EMS was unaware till later that patient had sustained a fall down a stair case two days prior. EMS responded to a patient not feeling well. There was a question why this patient with a blood pressure of 58/palp was transported by BLS crew? Pt prolonged time in ER was related to CT scan then the need for blood and platelets prior to going to the operating room. Pt has had prolonged recovery related to his multiple comorbidities.</p>	<p>Pt was discharged on post trauma day 26 to an acute rehab facility. Pt had peg tube placed before discharge unable to take PO.</p> <p>-----</p> <p>Vent days 10 ICU days 13</p>
Time in ER	2h56m																														
Trauma Activation	N/A																														
EMS Scene Time	No Report																														
EMS Issues	No report																														
Surgeon response time for T1	N/A																														
Surgeon on Call	N/A																														
CT time	11m																														
Transferred/Where?	admit																														
Time Decision was made to Transfer	n/a																														
Pediatric case	n/a																														
Trauma Death	n/a																														
Over/Under triaged	Under-triaged																														
Removal of Backboard	n/a																														
ISS	29																														
<p>Name [REDACTED]</p> <p>Date of Service 06/12/2014</p> <p>MR [REDACTED]</p>	<p><b>Case Summary:</b> This is a 2 year old female child that was running with BBQ skewer in her mouth and fell and it lodged into her mouth. Mother tried</p>	<p>This case the Radiologist Dr. Sheets states this child had a skewer externally through her</p>	<p>Pt was admitted overnight and went to surgery</p>																												

391

Image trend# Case #2	1h35m	no	unk	unk	n/a	n/a	?	Riley	1846	yes	no	under	n/a	1	to have skewer removed from her jaw. Discharge home post trauma day 1 doing well.
<p>to remove skewer and it meant resistance and called EMS. Pt arrived per EMS, child brought to ER IV, labs drawn CT scan ordered. Pt medicated for pain, Dr. Dwyer called Riley Children's hospital for Transfer 27mins into patient's arrival to the ER. Pt transferred to Riley's per EMS.</p> <p><b>EMS Report:</b> Unable to obtain report  <b>Issue/Concerns:</b> No activation of Trauma, CT ordered not done, No Temp documented, length of transfer</p>															
<p>neck. Dr. Dwyer did get transfer going quickly to Rileys. Pt VSS entire ER visit. Multiple questions came up about activation "code trauma" on a stable pediatric patient. We discussed that if patient does not fit into tiered activation that it was up to the licensed medical professional to call it a Trauma or not. Also questions why this child was brought to Community South by EMS? Radiology states CT angio of neck was ordered on this child and this test would have needed the child be completely still and sedated with no movement to get proper test. Instead this child needs to get to Rileys for definitive care. Working with education for ER nurses and proper documentation.</p>															

392

Demographics	Case Studies/EMS Report/ Issues/ Concerns	Discussion	Follow-up
Name: [REDACTED] Date of Service 06/19/2014 MR#: [REDACTED] Image Trend#	<b>Case Summary:</b> 40 year old male, unrestrained driver with air bag deployed of an SUV that was travelling 60mph and he fell asleep at the wheel and rolled the SUV. Pt struck windshield with	The discussion on this patient was should this patient have come to us? Yes, patient was alert and oriented and was	Pt was discharged on Post Trauma day 2 stable. With dx

Case # 3	head. EMS had to extricate him with jaws of life from car. Pt was brought to the ER with mild RLQ pain. A&Ox4 during extrication and upon arrival. Pt had multiple CT scan and x-rays done. Dr. Sanders spoke with Eskenazi Trauma team at (2009) they felt CHS could handle this Trauma patient for OBS overnight and but, the Trauma MD from Eskenazi informed Dr. Sanders if she didn't feel CHS could handle this patient they would be happy to take them. (2021) Dr. Diekhoff called and accepted patient for admission overnight.		walking at scene per EMS. Pt was trying to refuse transport but EMS informed him he should go to the ER for evaluation. Pt was stable in ER his entire stay. Pt admitted overnight for observation after significant MVC. Pt was found to have severe sleep apnea and was worked up in the hospital for that while he was here. It was also discussed on getting Alcohol and Drug screens on all Trauma patients it wasn't till two days later that patient admitted to cocaine use the AM of his accident. This information would provide the physician additional information on patients need for telemetry and make them aware to monitor them for withdrawal symptoms. It was also identified need for complete charting by nursing staff. Education will be provided	of obstructive sleep apnea and having some abrasion from MVC.
Time in ER	4h2m			
Trauma Activation	none			
EMS Scene Time	unk			
EMS Issues	unk			
Surgeon response time for T1	N/A			
Surgeon on Call	Diekhoff			
CT time	16m			
Transferred/Where?	admit			
Time Decision was made to Transfer	n/a			
Pediatric case	n			
Trauma Death	n			
Over/Under triaged	under			
Removal of Backboard	Not documented			
ISS	1			

# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"  
LEVEL III TRAUMA CENTER STATUS

### SECTION 21

## RN Credentialing

21. "**Nurse Credentialing requirements.** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU."

### Narrative Response and Discussion

The requirements of section 21 are met with a copy of the Operational Guideline: Education Requirements for the Care of Trauma Patients. This covers the credentialing requirements for ED and ICU nurses. Also enclosed is a spreadsheet showing which level of additional training each RN and Paramedic have received.

**OPERATIONAL GUIDELINE: EDUCATION REQUIREMENTS FOR THE CARE OF TRAUMA PATIENTS**

**OBJECTIVE:**

To define continuing education requirements and expectations of nursing staff who care for the acute trauma patient.

**PROCEDURE:**

- A. Each associate will be responsible for maintaining their continuing education requirements. Adherence to this guideline is strongly encouraged for CHNw nursing team member that cares for patients on the Trauma Service including supplemental associates (PRN).

It is the responsibility of each nursing team member to participate in and maintain accurate documentation of their continuing education credits/units. Copies of continuing education credits/units should be given to department leadership and submitted to the appropriate credentialing organization in a timely manner.

- B. Indicated verifications are recommended within 18 months from date of hire for new nursing team member or 18 months from the effective date of this guideline, unless otherwise specified. Priority will go to new nursing team members, followed by currently employed nursing team members without trauma experience, and finally, currently employed nurses with trauma experience.
- C. See attached table for a complete list of education requirements by individual unit.

Staff	Requirement
<b>Emergency Department</b> *Nursing staff caring for patients on the trauma service.	<ul style="list-style-type: none"> <li>o Completion of organizational, departmental and job-specific orientation.</li> <li>o Four contact hours trauma-related education annually.</li> <li>o Advanced Cardiac Life Support (ACLS)</li> <li>o Trauma Nurse Core Course (TNCC) or Advanced Trauma Care Nursing (ATCN)</li> <li>o Encourage certification in the practitioner's area of specialty (i.e.- CEN, CCRN, etc.)</li> </ul>
<b>Operating Room</b>	<ul style="list-style-type: none"> <li>o Completion of organizational, departmental and job-specific orientation.</li> <li>o Four contact hours trauma-related education annually.</li> <li>o Advanced Cardiac Life Support (ACLS)</li> <li>o Encourage certification in the practitioner's area of specialty.</li> </ul>
<b>ICU/PACU/PCU</b>	<ul style="list-style-type: none"> <li>o Completion of organizational, departmental and</li> </ul>

[Type text]

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**Medical-Surgical Units**

- job-specific orientation.
  - Four contact hours trauma-related education annually.
  - Advanced Cardiac Life Support (ACLS)
  - Trauma Nurse Core Course (TNCC), Advanced Trauma Care Nursing (ATCN), or Essentials of Critical Care Orientation (ECCO)
  - Encourage certification in the practitioner's area of specialty.
  - Completion of organizational, departmental and job-specific orientation.
  - Four contact hours trauma-related education annually.
  - Encourage certification in the practitioner's area of specialty.
-

Name	Role	ACLS	PALS	TNCC	ENPC	PHTLS
Alexander, Billie J	RN	X				
Ames, Dana N	RN	X	X	X	X	
Applegate, Megan M	RN	X	X	X	X	
Brown-Fortner, Nikole M	RN	X	X	X		
Bullard, Brittany M	RN	X	X	X		
Cain, Stephanie A	RN	X	X	X		
Campbell, Kati M	RN	X	X	X		
Carlson, David W	Medic	X	X			
Davis, Angela D	RN	X	X	X		
Deckard, Robert R	Medic	X				
Dennison, Michael A	Medic	X	X			
Fields, Emily D	RN	X	X			
Findley, Kari E	RN	X	X			
Fleck, Bryan S	Medic	X	X			
Frey, Megan M	RN	X	X			
Furby, Krista R	RN	X	X			
Gill, Lori R	RN	X	X	X	X	
Goins, Betty L	RN	X	X			
Gonzalez, Amanda D	RN	X	X			
Hagerty, Valerie L	RN	X	X			
Harmon, Joshua L	RN					
Haston, Gary L	RN	X	X	X	X	
Hayes, Brittney C	RN	X	X		X	
Hendricks, Martin N	Medic	X	X			
House, Angela J	RN	X	X		X	
Huffman, Sarah G	RN	X	X			
Jarrett, Chastity J	RN	X	X	X		
Johnson, Rebecca R	RN	X	X	X		
Johnson, Sharon K	RN	X		X		
Johnson, Tiffany L	RN	X	X	X	X	
Kappes, Dawn M	RN	X	X	X		
Klingler, Christina R	RN	X	X	X		
Lavin, Jennifer L	RN	X	X	X		
Leach, Brittany E	RN					
Markov, Alex J	RN	X	X			
McCreery, Alice F	RN	X	X			
Meadors, Courtney L	RN	X	X			
Medanic, Laura M	RN	X	X	X		
Meier, Jennifer A	RN	X	X			
Olmstead, Tiffany S	RN	X	X			
Penn, Melissa A	Medic	X	X			
Petty, Julia B	RN	X	X	X		
Phillips, Christopher D	Medic	X	X			
Preston, Steven K	Medic	X	X			
Price, Pamela S	RN	X	X	X	X	

Name	Role	ACLS	PALS	TNCC	ENPC	PHTLS
Pursell, Robert G	RN	X	X	X	X	
Ramsey, Myla A	RN	X	X	X	X	
Remillard, Amy D	RN	X	X			
Reynolds, Jessica S	RN	X	X	X		
Rooksberry, Hannah S	RN	X	X	X	X	
Rushton, Tiffany M	RN	X	X	X	X	
Sanford, Timothy P	RN	X		X		
Shaffer, Jessica L	RN	X	X			
Sheffler, Jennifer D	RN	X	X	X		
Smith, Paul M	RN	X	X	X	X	
Smock, Cheryl	RN	X	X	X	X	
Soots, Diana D	Medic	X				
Swain, Mary	LPN	X				
Swann, Jolanda L	RN	X	X	X	X	
Thomas, Shawna A	RN	X		X	X	
Trusty, Marcia E	RN	X	X	X	X	
Wilson, Daneen L	Medic	X	X			
Wolf, Jessie L	RN	X	X	X		
Wood, Amanda L	Medic		X			
Zawada, Melissa R	RN	X		X		



# Community Hospital South

## Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

### SECTION 22

## Governing Body and Medical Staff Commitment

22. "Commitment by the governing body and medical staff. There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within one year of this application and the achieve ACS Verification within two years of the granting of "in the process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within two years of granting "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void and have no effect whatsoever."

### Narrative Response and Discussion

The requirements of section 21 are met with a signed letter from the Chairman of the Board of Directors affirming understanding of "in the process" for Level III Trauma designation as well as the requirements for obtaining ACS verification.



# Community Health Network

June 9, 2014

William C. VanNess II, M.D., Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

Subject: Application for hospital to be designated "In the ACS Verification Process"

Indiana State Trauma Care Committee:

The Community Health Network Board of Directors endorses the establishment of a Level III trauma center at Community Hospital South. It is our understanding that a favorable approval recommendation from the EMS Commission will allow any EMS Provider to take trauma patients to this facility, thus, providing Community Hospital South the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Board of Directors understands that if the hospital does not pursue verification within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of "In the ACS Verification Process" status that the hospital's "In the ACS Verification Process" status will immediately be revoked, become null and void and have no effect whatsoever.

We will provide the leadership and corporate culture to continue to deliver excellent patient care and more specifically demonstrate an exemplary trauma care system to achieve and maintain American College of Surgeons verification as a Level III Trauma Center. Thank you for the consideration of this application.

Respectfully,

Mike Peterson  
Chairman, Board of Directors  
Community Health Network

MP/jch

401

Community  
Health Network

Community Hospital South  
Emergency Department  
1402 E. County Line Road  
Indianapolis, Indiana 46227-0963  
317-887-7200 (tel)  
eCommunity.com

June 23, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner  
Indiana State Trauma Care Committee  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The Medical Executive Committee of Community Hospital South supports the establishment of a Level III trauma center. It is our understanding that a favorable approval for recommendation from the EMS Commission will allow any EMS provider to take trauma patients to the facility, thus providing Community Hospital South the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Medical Executive Committee understands that if the hospital does not pursue verification within one year of application and/or does not achieve ACS verification within two years of the granting of "in the ACS verification process" status, that the hospital's "in the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.

Respectfully,



Kevin Julian M.D.

Chief of Staff