Children Services

Nursing Procedure Manual

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Nursing Structure and Standards

Nursing is defined as the practice in which a nurse assists the individual, sick or well, in the performance of activities contributing to health or recovery. A licensed physician directs all medical care and personnel. The Kansas Nurse Practice Act defines the scope of practice at Lakemary PRTF.

The Children's Residential Nursing Department functions within Lakemary is to oversee and coordinate health issues of the residents within the PRTF program, under the guidance and direction of the physician/Medical Director. Each resident at Lakemary has access to medical care, treatment and services within the scope of practice for Lakemary Center, regardless of their race, religion, beliefs, culture, values, sex, age, or financial status. The Nursing Department works closely with the entire Lakemary team to provide supports for the residents. Specifically, the Nursing Department/Nurse Practitioner/Nurses will:

- Be involved in developing, implementing, and updating the medical aspects the Treatment Plan and individual Health Care Plans for each resident.
- Understand the resident's personal health, psychological history, and response to medication and medical services prescribed or provided in the past.
- Provide assessment and observation of the residents in their living environment in order to provide feedback to the physician/psychiatrist for the ongoing medication adjustment and for any medical treatments or consultations.
- Oversee the distribution and administration of prescribed medications to meet resident's individual health needs and to promote highest level of functioning, health, and comfort.
- Be available on-grounds or on-call 24 hours a day, 7 days a week to ensure support for health or safety situations.
- Maintain documentation of health records to ensure continuity of care before, during, and after an admission to Lakemary.
- Maintain certification in a nationally recognized therapeutic safety intervention technique. This will allow nurses to maximize safety for the residents during the display of aggressive and self-harm behaviors by assuring interventions by staff are safe, proportionate, and appropriate to the severity of the behavior and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history.
- Be responsive to requests from a resident for support relating to a health issues.

Activating Licensed Provider's Orders

Lakemary ensures that all orders from licensed providers, which will include Nurse Practitioners (NP) orders, are implemented accurately in a timely manner and documents this implementation as follows:

- All licensed provider's orders must be entered in the electronic record
  - by the licensed provider
  - indicated as a "phone order (PO)" to a nurse if the order has been received by phone
  - indicated as a verbal order (VO) to a nurse if the order was given to the nurse verbally by the ordering provider in-person.

- Phone orders received and written by the nurse will be identified and logged in the electronic medical record with their specific electronic identity.

- All verbal and phone orders must be verified electronically by the licensed provider when the licensed provider is next on site at the facility or otherwise able to do so through the Electronic Medical Record.

- When available an electronically produced order with an appropriate electronic signature shall also suffice.

- The licensed supervising provider will review orders from outside licensed providers/consultants with the nurse by phone or when on site at the facility. The order will need to be signed as above.

- All orders will be confirmed in the Electronic Medical Record by the nurse

  - The nurse will enter the order into the EMR, unless the provider has already done so.
  - The nurse will check that any medication orders are activated and reconciled in the EMR and notify the medication technician.
  - If the need is immediate, the nurse or med tech, will call the pharmacy to have the medication filled and arrange for pickup by staff or delivery by pharmacy

Admission of a Resident

Admission Health Assessment

This can be done by any nurse on admission (especially admissions occurring outside normal business hours when the nurse practitioner may not be onsite) but should be reviewed by the physician or nurse practitioner as soon as possible after admission.

This assessment serves as a starting point to identify immediate medical and dental needs, identify follow-up appointment needs, and obtain documentation from previous caregivers to bridge any information needs.

Admission Laboratory Work

If an outside physician does not provide laboratory work, then the following will be ordered for the next "lab day" after admission:

- CBC w/differential
- Comprehensive Metabolic Panel
- Lipid Panel
- TSH, Free T4
- Serum levels for any medications that require monitoring
- UA dipstick and drug screen (if applicable)
- Hemoglobin A1C
- Vitamin D
- Any additional testing as deemed appropriate by the nurse practitioner or medical director

Drug and Alcohol Screening

At admission, the nurse may screen for acute intoxication. See section on drug and alcohol use in this manual

Electronic Medical Record (EMR)

Upon admission, each member of the medical team is required to be familiar with the therapeutic information for each resident with whom he/she works with directly. To facilitate this process, a treatment plan will be maintained electronically, containing the most up to date information on the client. The EMR houses the current treatment plan, behavior support plan, medical information, and other information from the many different disciplines involved in the child's care at Lakemary.

Nursing's responsibilities for completion upon admission include:

- Current Medications
- Medication Allergies (or adverse effects)
- Medical Diagnoses and associated care plan (e.g., Seizure plan, etc.)

The Nursing department will prepare and update this information as changes in medications or treatments occur.

Nursing Progress Notes

The nursing department develops and maintains a health care plan for each medical (i.e., non-psychiatric) diagnosis and any other temporary medical condition. This plan outlines the medical condition and Lakemary's response to the condition in an effort to promote the health and safety of the child. This health care plan is maintained in the child's electronic health record.

Kan-Be-Healthy Exams/Admission History and Physical Examination/Annual History and Physical

If a KBH Exam or other physical exam was completed prior to admission, the legal representative/guardian is to submit a copy of that exam prior to the date of admission. This exam will be reviewed for inclusion in the medical record and incorporation into the admission history and physical. An annual history and physical will be completed around the anniversary date of the admission.

Tuberculosis Screening

Included in the physical assessment shall be a screening for symptoms of tuberculosis. A Mantoux test, a tuberculin blood assay test, or a chest x-ray shall be required if any of the following occurs:

- The resident has a health history or shows symptoms compatible with tuberculosis.
- Significant exposure to an active case of tuberculosis occurs, or symptoms compatible with tuberculosis develop (i.e. fever, night sweats, unexplained weight loss, persistent cough, or blood in sputum).

If there is a positive reaction to the diagnostic procedures, proof of proper treatment or prophylaxis shall be kept on file in the resident health record and the county health department shall be informed of the results.

Adverse Incident Reporting

Adverse incidents are defined as any of the following:

- **Death** – Death involving a resident, who is currently receiving services from Lakemary, occurring from suspected criminal act, suicide, medication overdose, or other unnatural cause.
- **Physical abuse** – Any allegation of intentionally or recklessly causing physical harm to a client by any other person.
- **Inappropriate sexual contact** – Any allegation of intentional touching of a sexual nature, of any resident.
- **Misuse of medications** – The incorrect administration or mismanagement of medication by a Lakemary employee which results or could result in serious injury or illness to a resident.
- **Psychological abuse** – A threat or menacing conduct directed toward an individual that results in or might reasonably be expected to cause emotional distress, mental distress, or fear to an individual.
- **Neglect** – The failure or omission by one's self, caretaker, or another person with a duty to supply or to provide goods or service which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
- **Suicide attempt** – A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- **Serious injury** – An unexpected occurrence involving the significant impairment of the physical condition of a client. Serious injury specifically includes loss of limb or function.
- **Elopement** – The unplanned departure from Lakemary where a resident leaves without prior notification or permission or staff escort.
- **Natural disaster** – Any closure or evacuation of a facility due to fire, storm damage, or mechanical system failure that may result in major expenditures or work stoppage or any significant event affecting clients.

All adverse incidents will need to be reported immediately to the nurse on duty, the APRN, or medical director, who will complete necessary internal reporting protocols. (Refer to PRTF Procedure Manual Critical Incident Reporting)

Appointment Outside of Lakemary Including Emergency

The clinical office specialist in the PRTF nursing office houses and oversees the appointment book. The clinical office specialist will enter appointments in the book as they coordinate those appointments. A consultation form for each child will be generated prior to the appointment. This will include the individual's demographic information, insurance information, current medication list, copies of signed consents, and a form to be completed by the consultant at the completion of the visit.

If a Lakemary nurse examines a child and determines an external appointment is in the best interest of the child, the nurse may request an appointment be scheduled after consulting with the nurse practitioner or physician.

Lakemary documents all physician/consultant visits and associated interventions. Prior to staff leaving with a child for a physician's visit:

- The clinical office staff prepares the consult form in the EMR attaching any documentation or consultation notes/requests from the medical director or nurse practitioner and/or nurse. Additional information includes individual data sheet, insurance information, signed releases, and current medication list along with list of risks (elopement, injury, physical limitations). These forms are taken on the appointment by staff accompanying the child and given to the physician/consultant.

- The external provider will be asked to document findings and results of testing, including diagnosis and follow-up needed on this form.

- The form will return with the accompanying staff.

- After returning from the appointment, nursing staff will follow-up on all instructions and recommendations and will file this form in the client's electronic medical record.

Appointments for Follow-Up or Maintenance Care by External Providers

If a physician or clinician from outside of the Lakemary center indicates needed follow-up care, the clinical office specialist and nurse will:

- Make note of requested date of follow-up or of recommended interval for maintenance care, when informed by the physician.

- Make an appointment with the appropriate physician at the earliest time available.

- Schedule/reserve a vehicle to transport the child to the physician's office.

- Notify classroom, residential staff, and kitchen of the child's appointment time and any special requests (no food, no liquids, etc.).

- Prepare consultation forms and any requested medical records for the appointment.

- Arrange any additional staff support with residential staff or assistance team staff as needed

The clinical office specialist will notify the appropriate departments and staff advising them of the upcoming appointment as soon as the appointment is scheduled. All appointments are maintained in the PRTF nursing office appointment log.

All consultation forms that are returned will be maintained in the electronic health record. Any orders or instructions will be given to the PRTF nursing staff for review by the nurse and communicated to the nurse practitioner and/or medical director for decisions on implementation.

Planned support staff absences (PTO) are also noted in the appointment book as soon as they are scheduled in order to avoid scheduling conflicts/transporting issues

Authorization to Release Medical Information

Health information cannot be shared outside of Lakemary without a release of information signed, or by phone consent documented, from the Primary Legal Decision Maker for the child. Emergency treatment can be started in emergent situations, but the Primary Legal Decision maker must be contacted as soon as possible. This Release of Information will document the entity to whom the information can be released and what specific information will be shared.

Sharing health information inside Lakemary organization should be done only when necessary to maintain continuity of care of the child.

Communication Protocol

Nursing staff will make every effort to communicate with relevant parties regarding medical information, keeping in mind HIPPA related issues. Communication may take the form of face-to-face interactions, secure emails, nursing notes, phone conversations, etc. Every effort should be made to ensure these communications are timely, private, succinct, and contain relevant information only.

Death of a Resident

Detailed procedures are outlined in the Children's Residential Treatment Program Handbook. Please reference this handbook for all protocol associated with death of a resident.

Delegation of Nursing Tasks or Procedures

Delegation Process

The nurse practitioner and nurse oversee nursing care and delegation of nursing tasks. The nurse practitioner assesses each child's preliminary nursing care needs from admissions information, initial assessment, medical history, the latest physical examination, and verbal exchange at time of admission. Nursing may delegate tasks or procedures that can be performed properly and safely, and which do not require the person to exercise nursing judgment or intervention by an unlicensed person after providing the needed training to the designated unlicensed person.

The nurse will be accountable for the delegated tasks or procedures, will participate in evaluations of the services rendered, will record services performed, and will adequately supervise the performance of the delegated nursing task or procedure, per current professional standards.

Medication Administration

Only medication-trained staff will dispense any medication to residents, including prescribed and over-the-counter medications and treatments. Many of the children admitted to Lakemary take psychotropic medication. Designated unlicensed staff are trained by a nurse using an approved medication curriculum, which includes classroom training and practical application. A list of those trained will be kept with employee relations department and held electronically in a nursing file. The designated medication technician will dispense the majority of medications to residents, but medication-trained residential staff may dispense specific doses to accommodate off grounds activities and PRN medications as prescribed under the PRN standing orders. Medication administration delegation occurs under the authority of the nurse on duty at the time the medication is administered.

Health Care Plans

The nurse, in collaboration with the nurse practitioner and the medical director develops the health care plan for medical care. Health care plans are developed for all medical diagnoses requiring nursing interventions. health care plans are also developed for temporary medical conditions that a resident encounters. These individualized health care plans are maintained in the child's electronic health record.

All certified Medication Technicians and medication-trained staff are trained in CPR, First Aid, as well as subjective and objective observational methods to detect changes in health. Emergency care plans (seizure, asthma, severe allergies) are noted with alerts in the electronic medical record and reports can be created to identify specific individuals. The nurse on duty should be notified of a change in health situations, instructions are given to staff, and the occurrence is documented within the resident's electronic medical record.

Post-Restraint Assessment

The assessment after a safety assist can only be completed by an RN, NP, LPN, or Physician and cannot be delegated to another person.

Post-Injury Assessment

Assessment of any serious injury should involve the nurse on duty. Calling for an ambulance should not be delayed if the nurse is not immediately available for consultation for potential serious injury or illness.

Dental Care

Dental care is provided through local dental offices. Residents who, upon admission, have not had a dental examination within the year before admission to Lakemary are scheduled within 30 days and annually thereafter. A plan for good hygiene including oral health education and supervision of each resident is practiced in the residence and in school.

Each child receives emergency dental care, as needed. Emergency dental care will be secured for trauma to the teeth, unexplained bleeding, or discomfort to the teeth for identified or unidentifiable causes. The nurse will identify if the resident has an urgent or emergent need. Some emergent examples are inconsolable pain or trauma to the teeth with loose or knocked out teeth.

If a permanent (adult) tooth is knocked out with the root intact this is a time sensitive emergency. Control the bleeding with mild pressure if possible and the tooth should be placed in a small amount of milk after rinsing in warm water holding only the crown or placed in a sterile gauze and placed between the cheek and gum of the child to prevent the root from drying out and arrange immediate transport to the dentist or the emergency room within two hours. The resident’s guardian, nurse practitioner, medical director,

Dietary Referrals

Children at risk for needing a specialized dietary plan are identified at admission or at any stage of treatment. The nurse practitioner or nurse evaluates changes in height, weight, lab values, and any changes in other conditions that may be related to nutritional or GI issues. The nurse practitioner/medical director, and nutritionist will collaborate and identify the need for further intervention. The medical director, the primary care physician, or the parent/guardian can also make a referral. This may include but not limited to continued food logs, bowel logs, supplementation, food preference assessments, etc.

Discharge

A comprehensive discharge summary shall be completed and sent with the child at the time of discharge, which includes sections specifically for medical updates and interventions. In cases of emergency discharges, the discharge summary shall be completed within two business days of discharge.

Documentation of the child's care shall be submitted to the parent/guardian who will be providing aftercare at the time of discharge. The components to be included in these documents are:

- Response to medical intervention while at Lakemary.
- Medical needs, including allergies.
- Medication, including dosage, reason for medication, and prescribing physician.
- Discharge diagnoses.
- Height and weight at discharge.
- Last dental, vision, hearing, and code status.
- All medications currently prescribed.
- Notes for consideration.
- Pending health care appointments and follow-up with the provider's date, time, and place.
- Other health care needs and concerns ie: diet, lab values, and GeneSight results or the like

Any resident discharging from Lakemary who has received psychotropic medication during their stay at Lakemary will have documentation for each medication in their psychiatric discharge summary or final evaluation. Each resident who is currently receiving psychotropic medications at the time of discharge will leave Lakemary with at least a three-day supply of medication and a prescription for at least a 30-day supply of medication. Lakemary will ensure proper identification of individuals who pick up the resident and their medication at discharge.

In an emergency situation when a resident is discharged to other than acute hospital, during non-business hours, Lakemary will pack the current supply of medication (minimum of 3 days) and include a list of current prescribed medications (similar to a home visit) and any other medical information as directed by the nurse practitioner/ medical director. Lakemary staff will direct the parent/guardian taking the resident to contact Lakemary during business hours to arrange for completion of the discharge process.

Drug or Alcohol Use

Although Lakemary does not provide alcohol and drug treatment, Lakemary will provide support for a child that appears to be intoxicated. If this occurs at any point, the nurse shall be contacted immediately. The nurse will assess the matter for health and safety concerns. The Chief Program Officer for Children Services, Clinical Director, Nurse Practitioner, and the resident's guardian will be contacted. The Nurse Practitioner or Medical Director, if the nurse practitioner is not available, will provide orders with regards to support, up to and including transport to a medical facility.

Elopement

Elopement is defined as physically moving off Lakemary property without official approval and being without staff supervision.

As soon as the resident is located, the nurse on-grounds or on-call will be notified to complete a nursing assessment. The nurse will complete a physical and psychological assessment of the resident and document all findings. If necessary, the resident will be transported to the local emergency room for additional medical assessment. This assessment should be document in the resident's electronic health record. Documentation of the assessment should also include the following types of information:

- How long the child was out of line of sight of staff.
- Contact with non-Lakemary staff.
- Potentially traumatic experiences (e.g., police involvement).
- Injury

This information will help to assess for risk of unsafe behaviors or trauma the child may have experienced

Emergency Evacuation

Please refer to Lakemary's emergency preparedness manual

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Emergency Room Visits

See appointments outside of Lakemary

First Aid Kits

First aid kits are kept in a designated easily accessible staff area of each dormitory. The kits are protected from child access by use of a locking mechanism and their placement in the area.

Staff is to notify the nurse of all use of the emergency materials. Injury reports are to be entered in the child's medical record for follow up by nursing by the staff who applied the first aid. After an emergency kit is used by the staff, the nurse on duty will, as soon as reasonable, assess the child, restock the cabinet, and replace the plastic locking device.

A designated medication technician will monitor first aid kits to ensure they are kept stocked with non-expired supplies on a weekly basis.
first-aid kits shall include the following:

- Assorted adhesive strip bandages.
- Adhesive tape.
- A roll of gauze.
- Scissors and tweezers. .(will be locked in the med room for child safety)
- gauze squares.
- Liquid soap.
- An elastic bandage.
- Rubbing alcohol pads
- Disposable nonporous gloves in assorted sizes.
- Warm pack and Cold Pack

Flu Vaccines

Lakemary routinely monitors the health and safety of children served. During flu season, Lakemary PRTF, in conjunction with Lakemary School, arrange for the flu vaccine to be made available to the students. When this occurs, the following protocol will be used:

- The nursing department in collaboration with the school nurse will make arrangements for the date/time of the flu clinic.
- Nursing department staff contact parents/guardians of each resident each year to request consent for the flu vaccine. This consent will give the parent the option to agree or disagree to consent. Consents are mailed, faxed, or emailed to parents, depending on their preference.
- Lakemary must receive consents prior to clinic day, or the child will not receive the vaccine.
- A copy of this consent goes into each child's electronic health record.
- These consents must be obtained annually.
- Nursing support staff will prepare a list of children, separated by classroom, whose guardians have given consent.
- On the day of the clinic, nursing support staff will take the list and accompany residents, one classroom at a time, to the clinic.
- One at a time, nursing staff will check the identification of the resident and the consent for immunization and review current immunization record prior to passing the resident to the provider administering the flu immunization.
- Once residents receive their immunization, they will be walked back to their classroom.
- The list of all residents who received immunizations will be forwarded to residential staff who will be instructed to watch for side-effects, including headache, body aches, redness or pain at the injection site, fatigue, etc.
- If staff notice a side-effect, they will notify the nurse on duty and follow the outlined protocol. If significant side effects or changes/worsening in side effects occur, staff will immediately notify nursing who will provide appropriate follow up

Home Visits Medication Packing

The nursing department will receive notification of planned home visits by e-mail from the resident's therapist/ case manager. Ideally, notification should be 2-5 days prior to the visit to allow for preparation of the needed home medications for the duration of the home visit. Once notification is received, the following will occur:

- The med tech writes the child's name on the calendar in the medication room.
- The med tech fills out the home visit sheet that goes home with the child, along with the medication.
- The med tech calculates the exact number of doses (days and times) the child will require medications while on the home visit, away from Lakemary.
- A second med tech (or nurse if a second med tech is not available) will verify the medications and co-sign the home visit sheet with date and time verified.
- The med tech removes each dosage packet from the medication cards and packs each day's medication in a zip-lock bag with the time of day noted on the zip-lock bag.
- The bags for each day are placed inside a brown paper sack with the resident's name clearly written on the front. The dates of the home visit and each medication are also detailed on the front of the bag.
- The med tech notes, in the MAR, that the child is on a home visit.
- The med tech highlights the resident's name on the calendar, indicating the meds were packed
- The med tech completes the electronic packing record or signs the visit form and places it in the brown paper bag with meds and the visit pack.
- All home visit medications are kept in a designated double locked location in the medication room located in the administrative building.
- Residential staff will contact a nurse or med tech before the resident leaves for his/her visit so that the meds can be retrieved. Home visit medications are never taken to the resident's Lakemary residence.
- The med tech who packed the medications will sign the home visit sheet. The body checks will be done at the med room to maintain privacy for the child. The parents and guardians should remain up front in the lobby until all is prepared for the visit when the med tech or designated med trained staff take the child and medications to the parent/guardian. They will also give specific information regarding medications being sent home. The parent/guardian is expected to review the medications in the bag and must sign the home visit form indicating their receipt of those medications or parent's refusal to review.
- If any medication is returned with the resident, the nurse on duty or med tech will be notified and arrangements will be made for the medications to be returned to the med room.

- Any medications that were not administered during the home visit should be documented by the completion of a med variance report.

EKG, Radiology, or Other Labs

Lab work will be scheduled as requested by the medical director or nurse practitioner or at the request of an outside licensed provider:

- Laboratory orders obtained from the physician or nurse practitioner.
- Obtain guardian consent, if needed, for lab tests.
- Complete the laboratory form for QUEST Diagnostics per Quest.
- Notify clinical/residential/school staff of the date/time of testing.
- Arrange a time for the child to come to the clinic for lab work to be done.
- If needed to be drawn fasting, notify the residential staff of nothing to eat or drink (other than sips of water) after midnight.
- Any additional staff to accompany child, if needed for safety.
- Nursing/phlebotomy staff to draw labs and handle specimens per Laboratory Procedures Book (to be kept in lab area).
- Contact Quest to notify for pickup of specimens using QUEST procedures.
- File lab order and results in the child's medical record after review and date/initialed by the nurse practitioner or physician.
- If the onsite staff are unable to complete the test, then the child will be transported to Miami County Medical Center or other designated facility to have the tests completed.

Medical Appointments

See appointments outside of Lakemary

Medical Records

KAR 28-4-1200 defines “resident record” as “any electronic or written document concerning a resident admitted to a PRTF that is created or obtained by an employee of the PRTF.” Records of each child’s treatment and records supporting that treatment are maintained in a confidential manner. Each program area maintains portions of the record for which they are responsible within the resident’s electronic health record. Access to each area of the electronic record is limited and made available only to those necessary and confidentiality is strictly maintained.

Medical Restrictions and/ or Isolation

A medical provider's order is required for any situation in which a resident requires a medical restriction (e.g., limited sun exposure) or use of restrictive medical equipment (e.g., wheelchair).

Medical isolation will also be determined at the discretion of the nurse practitioner or medical director and is decided on a case-by-case basis.

Medical Supplies and Storage

Any item classified as hazardous is stored in a locked manner and is either not made available to the children or is made available only under supervision. Hazardous materials include (but are not limited to) the following:

- Medications (prescribed and OTC).
- Alcohol-based products.
- Cleaning agents.
- Laundry products.
- Personal hygiene products (including shampoo/conditioner, body spray, safety razors, etc.).
- Maintenance items and tools.
- Glass (including containers).
- Ladders.
- Keys to motor vehicles.
- String/rope greater than six inches in length.
- Sharps

Medications requiring disposal are disposed of by two nurses according to standards issued by the CDC and FDA.

Sharp objects, such as disposable razors, broken CDs and plastic, and sharp wires, are disposed of in a sharps box located in each residence's medication room. When the box becomes full, nursing staff will dispose of it via the bio-hazard disposal system and replace it with a new sharps box.

First aid supplies are stored in the nursing clinic in a locked cabinet. Each residence maintains a first aid kit in a staff-accessible and supervised area. The med tech routinely monitors these supplies to ensure an adequate supply exists. All staff who use first aid supplies will maintain the kits in an orderly manner and advise the med ech of any needs. The med techs will check the kits on a weekly basis and as needed to ensure that supplies are up to date. Supplies included are for treatment of the children in the program. If staff need any first aid supplies, they should contact the onsite nurse.

Nursing and residential staff, as deemed necessary, carry keys to medical and first aid supplies

PRTF– Prescribing Information

Standards and Guidelines
Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

A facility that provides Residential Mental Health Treatment is either a stand-alone mental health facility or a physically and programmatically distinct unit within a facility licensed for this specific purpose and that includes 7 days per week, 24 hour supervision and monitoring.

- Facilities that provide Residential Mental Health Treatment for Children and Adults are staffed by a multidisciplinary treatment team under leadership of a Board Certified/Board Eligible Physician.

- The program provides for the mental health and physical health needs of the individual.

- Individual therapy will occur at least weekly or more frequently as clinically indicated.

- A nurse is available 24 hours per day, 7 days per week to provide psychiatric nursing services including observation, monitoring and crisis intervention, as well as, administer or oversee medication administration as clinically indicated.

- Psychiatric clinic visits will occur at least monthly or more frequently as clinically indicated.

- A Provider (NP/PA and/or MD) is available 24 hours per day, 7 days per week to assist with crisis intervention and assess and treat medical and psychiatric issues, and prescribe medications as clinically indicated.

- Treatment is focused on stabilization and improvement of functioning and reintegration with family or guardians.

- Residential treatment is transitional in nature for the purpose of returning the individual to the community with continued treatment services at less restrictive levels of care, as needed.

Prescribing Practices:

- Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant.

- The psychiatric nurse practitioner or medical director will make note in the initial psychiatric consultation and monthly thereafter of the child's residential status. Noting specifically if the child is in foster care, their health history if known, trauma history if applicable, and current functioning.
    - This will be considered before a psychotropic medication is initiated. Therapy will continue in conjunction with treatment.
    - Medication compliance, target symptoms, and treatment goals will be identified and documented.
    - Side effects and overall benefit to risk to ratio of pharmacotherapy will be evaluated.
    - Informed consent will be obtained from the appropriate party prior to the initiation of a medication except in an emergent situation.

Dosing information

- Designed to make prescribing treatment with medications straightforward by listing prescribing instructions, including requirements for baseline lab work.

- The dosing protocol includes a starting dose, an initial target dose, a typical dosage range, and a maximum dose, where appropriate.

- Where appropriate, dosing instructions are listed for multiple indications and for off-label use. With some medications, an FDA recommended tapering protocol is listed. In most case, general tapering recommendations are provided.

- Medication interactions and side effects are reviewed prior to prescribing each medication through a standard process in the EMR.

- Designed to emphasize the importance of tracking metabolic parameters, QTc prolongation, as well as drug levels when available.

- Medications are reviewed monthly and PRN. Labs will occur within 4 weeks of admission, if able, to monitor medication therapeutic levels and other lab values. This will occur bi-annually and PRN based on the clinical response and lab evaluation.

The Following information is reviewed prior to prescribing medications:

- Mechanism of action—describes the commonly accepted mechanism of action of a drug recognizing that our understanding of how a psychotropic medication works is often incomplete.

- Indications— lists FDA indications for a medication.

- Off-Label indications—describes well-accepted and often evidence-based off-label uses for a medication.

- Pharmacokinetics—lists the T½ for a medication from the FDA label information, when available.

- Primarily includes information about the parent compound, but where appropriate (e.g., fluoxetine) includes information about metabolites.

- Common Side Effects—lists common side effects by percentage, when available, from label information on the FDA website. In general, the side effect is listed if it occurs at a frequency above 5%, is twice placebo, or is clinically relevant. In medications with multiple indications side effects are listed for more than one indication for the most common uses of the medication.

- Black Box Warning—summarizes the black box information for a medication.

- Contraindications—summarizes the contraindications for a medication. For all medications, a known hypersensitivity is a contraindication.
- Warning and Precautions—lists specific medication-related warnings and precautions found in the FDA label information together with clinically significant medication concerns where appropriate.

- Metabolism/Pharmacogenomics—lists information about metabolism and significant pharmacogenomics concerns as mentioned in the FDA label or in the research literature, e.g., the use of fluoxetine in CYP2D6 poor metabolizers.

- Significant drug-drug interactions—lists significant drug-drug interactions. Given the complexity of drug-drug interactions with some medications in some individuals, it may be appropriate to consult with a pharmacist before prescribing a medication.

- Reproductive potential, Pregnancy, Lactation — As of June 2015, Pregnancy Categories for medications (A, B, C, D, X) are no longer used by FDA to communicate risk. New FDA Classification of risks and benefits associated with medication treatment include considering an individual's status in three categories:

    - 1) Females and Males of Reproductive Potential – Includes when pregnancy test or contraception is required or recommended; or effects on fertility such as valproate (PCOS)

    - 2) Pregnancy – Also includes labor and delivery. Consider risks in terms of A) Obstetric, B) Congenital, C) Neonatal, and D) Child long-term neurodevelopmental. Consider need to increase dose of certain medications with advancing pregnancy.

    - 3) Lactation – Most psychotropic medications are secreted in breastmilk. Consider concentration of medication in breastmilk and safety of medications during breastfeeding. For some individuals, consider prioritizing sleep over breastfeeding, due to risk of mood episode recurrence associated with poor sleep.

- Dosage information— lists the available medication forms, e.g., tablet vs. capsule, etc.

- Generic Available— reports whether a generic form of a medication is available.

- Cost—medication cost (accessible at https://www.goodrx.com/) is reported in four categories: Inexpensive (¢) < $20, moderately expensive ($) $20 - $100, expensive ($$) $101-250, and very expensive ($$$) > $250

Use of Medications by Females of Childbearing Age and/or During Pregnancy

As a part of the informed consent process for medications, any adverse effects toward a person's reproductive system or dangers associated with using a medication while attempting to get pregnant, will be discussed with the individual and his/her guardian.

It is not anticipated that any of the residents in the PRTF will be pregnant while receiving services. However, should a resident be found to be pregnant, Lakemary's physician/ nurse practitioner will complete a review of all prescribed medications and will take appropriate medical action if any are found that may complicate or be a danger to the pregnancy process.

Consult with Family

Consultation with the family as to medications tried in the past, side effects experienced from medications in the past and discussing future medications is completed at admission and every time a new medication is prescribed.

Medication Discontinuation

Lakemary's Nurse Practitioner in collaboration with our Medical Director will monitor for changes in behavior and mental status and make recommendations for medication adjustments or discontinuation as necessary.

Special Considerations

For Illinois Students only, Lakemary will adhere to 105 ILCS 5/22-30, 23 IAC 1.540 and 225 ILC 65/50-75(b).

Medication Administration - Onsite

Medication can only be administered to residents by medication technicians or other staff who have successfully completed medication administration training, including required medication passes after consultation with the nurse on duty. See the medication administration training manual for further detail.

Over-The-Counter (OTC) Medications

OTC non-prescription medications may be administered to residents, in compliance with physician or nurse practitioner orders, by medication trained staff after they call the on-duty nurse for instruction.

- Staff will record the administration of all non-prescription medications in the medical record.
- Staff must use caution when administering over the counter medications and monitor how the child responds to the medication after consulting with the nurse on duty

Prescription Medications

Prescription medications can only be administered as prescribed by the physician or nurse practitioner and as directed in the medication directions.

- Medications will be administered per licensed provider's orders.
- Medication administration will be accurately documented in the medical record
- Should any adverse reaction occur with any medication, nursing should be notified immediately and all observations and "steps taken" should be carefully documented.
- All medication questions and concerns should be immediately directed to the nurse onsite or on-call.
- Any adverse event regarding the administration of any medication should be documented as an incident and reported to the on-duty/on-call nurse, as well as the director of health and clinical services, when applicable.

Medication Administration

The basic steps for administering medication to children are as follows:

- Wash hands and wipe surface before preparing medication
- Check that the medications in the Medication Strip Pack are the same as noted on the medication administration record
- Check that the Medication Strip Pack has the same date as the date of administration, then tear it off at the perforated edges.
- Check that the pill cup has the correct child's name and medication printed on the cover.
- Hand the child the pill cup and 8oz of water.
- Watch to verify the child swallows all the pills.

Some children take liquid or powdered medication that are not in the Medication Strip Pack. Those medications are administered as follows:

- Check the medication is the same as noted on the medication supervision record.
- Check the dosage is the same as noted on the medication supervision record.

- Adequately mix or shake the container before measuring liquids to ensure proper mixing of the active ingredient with the carrier liquid. Measure the prescribed dose using a medication cup, syringe, or other designated method.
- Transfer the medication into a pill cup, if necessary.
- Hand the child the pill cup and 8oz of water or alternative fluid.
- Watch to verify the child swallows all the medication.

In the event mediation is being transported from main med room to another living environment, med room, or cart; the following process will occur:

- Med techs will pack all necessary medication for the children in the living environment. The med pouches are put into a plastic zip bag that is labeled with the date and time of administration.
- Med techs will then follow the medication administration onsite procedure and the med pouch disposal procedure.

If for any reason a child does not receive or refuses his or her medication, or if the medication is delivered outside of the prescribed window of time; report to the on-duty nurse as well as med tech supervisor refusals of medications after 3 attempts. Medication variance forms are to be filled out and routed to nurse on duty, the med tech supervisor, the training nurse, and the nurse practitioner or medical director (for final review).

See the appendix for the medication variance form.

Medication Documentation

For all medications, the following information shall be maintained in the individual's file on the medication administration record:

- The name of the person administering the medication.
- The name of the medication.
- The dosage/ route
- The date and time it was given.
- Any change in the individual's behavior, response to the medication or adverse reactions.
- Any change in administration from that on the label or order.

Each record must be signed by the employee administering the medication.

Medication Storage

Prescribed medication for Lakemary children is strip-packed by the pharmacy. Medication is stored in locked cabinets in the locked medication room. All oral medications are kept separate from other medications. All medications are accessed only by medication trained staff. All unused medication is discarded via bio-hazard waste protocol suggested by the FDA.

Medication Administration - Offsite

In the event that a resident is off grounds for a planned activity or appointment during typical or prescribed medication administration times, the following process will occur:

- Direct care staff will notify med techs, in advance, of all outings scheduled during normal medication administration times.
- Med techs pack all necessary medications for specific children going on outings. The medication pouches are put into a brown paper bag that is labeled with the date and time of administration.
- Med tech initials and circle the initials on the MAR.
- Med tech notes on the back of the MAR the time, date and med-trained staff whom the meds are being sent with.
- Medication pouches are picked up by medication trained staff from the med tech in the medication room.
- Medication trained staff picking up the medication pouches legibly sign and initial the back of the MAR form.
- The medication trained staff responsible for the medication pouches put the medications in a secure location and maintain responsibility for the safety and security of the meds.
- Medication trained staff administer medications at the prescribed time.
- The used Med-on-Time pouch is returned to a Lakemary med tech for disposal, per medication pouch disposal procedure.
- Any medications that are refused are put back in the bag for return to med techs.
- These refused meds are returned immediately upon return to Lakemary.
- The responsible medication trained staff fill out a medication variance form and turn it into the nurse on duty. In addition, the administration time slot is circled and the reason the meds were not administered is documented on the back of the form.

Medication Delivery/Acceptance

Auburn's Long Term Care Pharmacy works very closely with Lakemary to ensure all medications delivered for children utilizing the PRTF program are delivered timely, in accurate dosages and in a manner that facilitates an uninterrupted flow of services.

- Pharmacy delivery will call the med tech phone upon arrival at Lakemary, between 3pm and 6pm, Monday through Friday only.
- The med tech compares the medications and the new MSRs to the delivery sheets that are delivered with the medications. (The pharmacy will deliver 2 copies of each MSR.)
- The med tech will sign both sets of delivery sheets. One copy of the delivery sheet goes to the delivery person and the med tech retains the other copy.
- The med tech will place the MSR they keep into the binder labeled "pharmacy refills."
- The med tech will check medications to determine if medications were refill medications or if a child has a newly prescribed medication.
- To check in a refill, the med tech must compare the medication to the MSR book and then put the medication in the proper place, either in the med cart or the med cabinet, which is alphabetized by residence.
- If there was a medication change, the script for the medication will be in the MSR book in the child's folder. The med tech compares the medication to the script and then to the MSR. There may not be an actual "prescription" as some meds are called in or faxed to the pharmacy. A notification is made to the Medication Notification Group for med changes. Controlled substances can be ordered electronically by the provider (C-II – V), called in (CIII-V), or by written prescription. If by written prescription the original prescription will be in the med room to be given to the pharmacy delivery person.
- If it is correct, the med tech will put away medication in the proper slots, which is alphabetized by residence. med techs must double check the current meds and the new order.
- If the order was incorrect, the med tech will notify the med tech supervisor and put the medication in the cabinet where the home passes are kept with a note explaining the error.
- The med tech MUST ensure that the correct medications are delivered and that the meds match the MSR or electronic MAR. They must also ensure that meds, as ordered by the physician/ nurse practitioner, are available and in the correct location as to facilitate accurate administration.
- The med tech will compare the new MSRs to the electronic MAR (or old MSRs) to ensure accuracy. (This also helps prevent documentation errors.)
- After the check, distribute one copy of each MSR to the following locations: med room MSR book, nursing office file, house reference MSR book and the med tech MSR book that is kept in each residence med room.

Over the counter and outside medication container acceptance

- Each prescription medication container that is brought in from an outside pharmacy shall have a label that was provided by a dispensing pharmacist or affixed to the label by a dispensing pharmacist. The container must have a description of the pill, and it must not be expired. The full name of the recipient must also be correct.

- Over the counter medications may be accepted only if the medication is in its original, unbroken manufacturers package. The full name shall be placed on the original manufacturers package and container, bottle, or tube,

Medication Disposal Procedure

All medications requiring disposal will be disposed of by two nurses in accordance with the CDC and FDA guidelines. These guidelines are found in the controlled substance medication disposal record.

Medications that are not controlled can be mixed in cat litter, coffee grounds, zip lock bagged and put into the regular trash per CDC and FDA guidelines. Controlled substances can be flushed down the toilet, due to our distance from an authorized return pharmacy. The small number of controlled medications that we would flush would not endanger the water supply. When available the nurses will utilize a medication disposal system (ie: Medline Drug Buster) that deactivates and contains the active ingredients in non-hazardous medications

Medication Expiration Checks

A designated med tech or nurse will monitor all over-the-counter medication expiration dates monthly to ensure that medication has not expired. Medication expiration checks for stock meds in the med room will be carried out monthly by the med tech supervisor or an assigned med tech.

Medication expiration checks in the nursing office will be carried out by the nurse or med tech. As an expiration date approaches, the med tech replaces the medication. The soon to be expired over-the-counter medication is taken to the nursing office for disposal, per the medication disposal procedure.

Medication Pouch Disposal

To comply with HIPPA regulations, med techs and other medication trained staff will dispose of medication pouches in a manner that protects the identity of the child and what medications they take. All staff will engage in the following:

- Med techs will carry an extra zip lock bag with them when they go to the residences to administer medications.
- After removing the medications from the pouch, med techs will place the pouch in the extra zip lock bag.
- When the administration process is complete, the med tech will take the zip lock bag of empty pouches back to the med room where they will collect the empty pouches and return to the pharmacy for destruction.
- If someone other than a med tech administers a medication, they must ensure that they return the empty medication pouch to the med tech for proper collection and destruction.

Medication Storage

Prescription Medications

Prescription medications are stored in locked cabinets inside a locked medication room in the administration/school building. This location has limited lighting, is cool and dry, and is up and off the floor. Meds are organized by dormitory and administration times.

PRN Medications

PRN medications are stored in a location that has limited lighting, is cool and dry, and is up and off the floor. The cabinets are labeled and locked inside a locked room in the following locations:

- Administration/school building medication room
- School nurse’s office
- PRTF clinic
- Medication rooms in each residence

Medication Training

Medication can only be administered to residents by the nurse, med tech, and/or staff who have successfully completed medication administration training and who successfully pass an annual recertification. See the medication administration training manual for further detail.

Medication administration training is offered on a routine basis. Supervisors follow the standard protocol outlined by the teaching nurse to sign staff up for this training.

Medication Variances

A medication variance is defined as errors or omissions in the ordering, obtaining, monitoring, oversight, administration and/or documentation of all medications prescribed or approved for the resident. Should a medication variance occur, the following steps need to be taken:

- Nursing will be notified immediately upon detection of an administration type error. The nurse will give direction to the BHT or other staff person reporting the error. The nurse will immediately contact the prescribing provider and, if needed, poison control for instructions. Those instructions will be forwarded to BHTs to carry out. The nurse will monitor follow up to ensure the child's safety.

- After notifying nursing staff, the medication error is documented on a medication variance report form by the staff person who first detected the error. This form will be completed and routed to the author's immediate supervisor by the end of the author's work shift. The immediate supervisor will review the report and send it to the nurse on duty. The nurse will document nursing follow-up in a nursing report.

- If there are concerns regarding the medication variance and possible abuse/neglect, this needs to immediately be reported to the Nurse Practitioner and/or Physician, the Chief Program Officer, and Risk Manager. Child protective services may also be notified if deemed appropriate in the situation.

See appendix for Medication Variation Report Form.

Nursing Assessment

The nurse may complete a nursing assessment for a resident in any situation he/she deems appropriate, This may include but is not limited to:

- Following a restraint.
- Following a reported injury.
- Following reported seizure activity.
- Following a reported illness.

The nurse will complete his/her assessment within a timely manner. All physical restraints will be assessed by the nurse within one hour of initiation of the restraint.

Admission Nursing Assessment

At the time of admission, a "nursing admission assessment" is completed to document both health history and the immediate health status of the resident. This includes:

- pre-existing health conditions
- review diagnosis at admission or during first clinic
- health history,
- current infectious or contagious diseases
- suicidal thoughts/actions,
- immunizations,
- physical disabilities,
- menstrual history,
- sexually transmitted diseases,
- history of pregnancy if applicable
- allergies,
- pain,
- emotional status, including mood and affect,
- visual skin assessment,
- acute medical needs,
- AIMS
- current medications including count of medication provided and notification to pharmacy of any medications needed immediately and entry into MyEvolv/Order Connect system.
- identify if there are restrictions that need to be identified, ear plugs, no swimming
- update seizure, allergy, asthma alerts in Evolve and send out to staff, residential and education (update on universal document)

Safety Assist Assessment:

. This assessment includes:

- Reason for restraint.
- Review of child's psychological state post-restraint.
- Review of child's physical state post-restraint, including breathing, circulation, and other physical signs as appropriate.
- Any complications or injuries to the child as a result of the restraint.

Inappropriate Sexual Contact Procedure (Consensual or Non-consensual):

- Do not interrogate. Explain gently that you are there to help them feel safe and make sure they are ok.
  - Stay calm, keep discussion to a minimum, present with concern and care.

- Notify the nurse, the nurse will notify the Nurse practitioner or medical director, the NP or medical director will notify QA and the Chief Program Officer, Children Services, the Chief Program Officer will notify the therapist, the therapist will hotline the incident.

- Nurse will offer to send to both children to Children's Mercy Hospital
  - Same clothes, no shower, separate vehicles, nothing to eat or drink, do not allow them to use the restroom.
  - If they go to the hospital the nurse will contact the guardian with general information. This will include but is not limited to the following:
    - Child was involved in a sexual contact incident with another peer.
    - Ensure the child is safe and give current general status, injury if any, and any other relevant information that is factual.
    - Nurse will notify Children's Mercy Sane Nurse
      - (800) 466-3729 – ask for the **SANE** Resource **Nurse**

- The child(ren) may decline going to the hospital. If they do go to the hospital, they are able to decline there as well. However, you may still send within 72 hours of the incident if deemed necessary or they change their mind.

- If client declines going to the hospital:
  - A general nursing assessment will be performed with 2 nurses present (if available) and a therapist/clinical milieu (if available). Otherwise, a campus coach or ignite mentor may be present if there is not a nurse or therapist/clinical milieu available. This will provide support for the assessing staff. There is not to be any discussion of the incident.
  - The nursing assessment will be performed with permission from the child after gently explaining that we are there to make sure they are safe and there are no injuries.
    - This may include but is not limited to assessing for pain, discharge, and/or bleeding.
    - If an injury is found, follow the steps above to send them to Children's Mercy Hospital for evaluation by the SANE resource nurse.

- If the incident occurs with one or both children being non-verbal.
  - If there is not an immediate concern to send them out. The nurse will contact the guardian for their input regarding whether they want to send the child to the hospital.
    - The nurse will provide the guardian with general information. This will include but is not limited to the following:
      - Child was involved in a sexual contact incident with another peer.
      - Ensure the child is safe and give current general status, injury if any, and any other relevant information that is factual.

*Reference Critical Incident Sexual Assault- Victim Support in Lakemary PRTF Procedure Manual

During any assessment, the nurse may provide basic care if needed. The nurse will report findings for recommendations to the nurse practitioner and/or medical director, which may include continued monitoring, scheduled follow-up appointments, or emergency care.

Any time there is visible injury, decreased range of motion, significant joint pain, either verbalized or noted by observation, the nurse will assess and immediately seek advanced medical care for that child.

The Nursing Assessment will be documented by the end of shift within the resident's electronic medical record.

Physician/Consultant Visit Sheets

See appointments outside of Lakemary Center section in this manual

Pharmacy – After Hours/Emergency Medication Reordering

- Contact the nurse, nurse practitioner, or med tech supervisor who will contact Auburn Long Term Care Pharmacy for any needed medications.

- Staff may be designated to meet the pharmacist or delivery driver to obtain the needed medications when they are ready for pick up.

- Receiving the emergency/after-hours medication follows the same procedure as routine delivery.

PRN Psychotropic Medications

Lakemary Center is invested in ensuring quality of life for each child. If a child's behaviors are severe enough that their safety is significantly challenged, the child's treatment team will work closely with Lakemary's nurse practitioner and medical director to determine if a PRN Standing order for a psychotropic medication would positively influence the child's safety and increase quality of life. If it is determined that a PRN would meet those qualifications, the following conditions must be met and documented in the child's medical record:

1. Responsibility of nursing department:
    a. Did the child admit to Lakemary with a current PRN psychotropic medication or is this a new order? If the child did admit with an order, what was the Rx?
    b. The medication is ordered specific to the individual clinical need of the child.
    c. The specific, detailed, reason the medication was prescribed is documented, including ALL behavioral symptoms, i.e., specific injury to self or staff, etc.
    d. Documentation of the general reason the child is exhibiting these severe behaviors. What function do they serve? What triggers influence the occurrence of the behaviors?
    e. Documentation of history of agitation, psychosis, aggression or mood stabilization or, if no history, the clinical opinion of the nurse practitioner or physician that the child could become aggressive quickly or engage in severe self-harm.
    f. Oral administration of this medication is always used, unless the nurse practitioner or physician clinically determines the safety of the child demands the medication be administered intra-muscularly (may only occur during school hours). If this is the case, document the reason for this determination.
    g. The nurse will monitor the effect of the medication and side-effects exhibited and document on a nursing note
    h. The nurse authorizing the administration will notify the nurse practitioner or medical director prior to the end of the shift.
    i. Each administration is reviewed by the medical director or nurse practitioner.
    j. If safety conditions exist necessitating administration of three doses within seven days, the nurse practitioner or medical director will engage in a face-to-face assessment of the child to review and document the appropriate course of action.

2. Responsibility of Primary Therapist:
    a. Documentation of other, less restrictive, de-escalation techniques have been tried. This information will be gathered from residential staff.
    b. Baseline target behavior, frequency and severity, is documented. Specifically, how often and how severe is the behavior prior to the team determining a PRN psychoactive medication may be warranted?
    c. A specific, per use protocol is documented and followed, including:
        i. Targeted behavior exhibited
        ii. Targeted frequency and severity level
        iii. BHTs notify residential leadership who will then validate target behavior, frequency and severity
        iv. Notify nurse who will also validate target behavior, frequency and severity
        v. Nurse will authorize PRN medication administration
        vi. Med trained staff will administer PRN medication and document accordingly on MSR

3. Responsibility of residential staff:
    a. BHT staff will monitor the child for effect of medication and potential side effects.
    b. BHT will document any observed potential reactions or side effects by calling the nurse and communicate directly with nursing staff during their shift of these observations.

Progress Notes

See nursing assessments

Refrigerator Temperature Monitoring

Med techs monitor the refrigerator temperature each morning and evening. This information will be documented and maintained in an electronic file X:\PRTF\01. Nursing\05. Fridge Temperature Monitoring. The form can be found at: K:\Nursing\Refrigerator Temp Forms

The nurses on duty monitor the temperature of the vaccine/medication refrigerator in the lab area. This information will be documented and maintained in an electronic file. This form can be found at: K:\Nursing\Refrigerator Temp Forms

The temperature in the refrigerator must be maintained between 38'F and 42'F. The temperature in the freezer must be maintained below 30' F.

If the temperature is found outside of this temperature, the maintenance department is notified so that it can be immediately repaired.

An additional record will be kept on the vaccine refrigerator in the PRTF lab area.

Reportable Incidents

- See adverse incident reporting section in this manual

Residential Medication Rooms

All residences have a designated medication room that remains locked except when authorized staff persons are actively using the room. Each medication room contains:

- Medication administration record documents (MARs)
- Extra first aid supplies (tweezers and scissors)
- PRN over-the-counter medications
- PRN documentation book for use only when the electronic MAR is not available
- Medication reference book
- Surface sanitizer, water cups, med cups, ink pens, markers, thermometer, hand sanitizer
- Medication should ideally be set up and passed from the medication room.

Safety Assists: Assessment & Monitoring

When a PRTF staff person initiates a safety assist, the nurse on duty must be immediately contacted.

As soon as possible, the nurse goes to the location of the assist (see nursing assessments for details included in the assessment). Within 1 hour of the initiation of the safety assist, an assessment of the child's physical and emotional well-being must be conducted by the nurse.

The nurse's assessment will be entered into the EMR and attached to the restraint report.

If the nurse determines the child has sustained a significant injury which requires more in-depth medical care, the nurse will ensure the child receives emergency medical care and will contact nurse practitioner and/or medical director as early as it is safe and feasible to do so.

Critical Response Time

Lakemary schedules 24-hour onsite nursing support to ensure a quick response to all emergent issues. While on duty, response time should be immediate unless the nurse is involved in another safety assist assessment or other critical medical situation. Non- emergency calls should not take priority over safety assist calls or emergent medical needs.

Safety Assists Orders: Requesting, Receiving, and Monitoring

- Standing or as-needed orders (e.g., "PRN") for restraints are not allowed.

- Every use of a safety assist restraint must have a corresponding order.

- Orders for restraints must be by the medical director or a licensed mental health practitioner as permitted by the state and facility, and who is trained in the use of emergency safety interventions. The order should be for the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation.

- If the order for restraint is verbal, the order must be received by an nurse while the emergency safety intervention is being initiated by BHTs or immediately after the emergency safety situation ends. This order must be entered into the child's record as soon as possible, but no later than end of shift. The licensed practitioner ordering the restraint must be available for consultation, at least by telephone, throughout the period of the emergency safety intervention. The verbal order must be verified in writing in the child's record, as soon as possible by the licensed practitioner.

- Each order for restraint must be limited to no longer than the duration of the emergency safety situation and will not last longer than 1 hour unless authorization is secured.

- Each order for restraint must include the name of the LMHP or medical director, the date and time the order was obtained and the emergency safety intervention ordered, including the length of time for which the intervention is authorized.

- The ordering physician or licensed practitioner must sign the restraint order as soon as possible.

- If the ordering person is not the resident's treatment team physician, the ordering person must consult with the treatment team physician as soon as possible and inform him/her of the emergency safety situation that required the person to be restrained. The date and time of this consultation must be documented in the resident's record.

- If a restraint appears to be approaching 60 minutes in duration, the nurse will contact the medical director and/or the LMHP to receive further instructions. Except in extreme situations, restraints should end prior to 60 minutes.

Safety Assist: Contact Parent/Guardian

Each safety assist must be reported to the parent or guardian, unless another contact has been established or if parents have requested (and documented the request in writing) a different contact schedule.

The nurse notifies the child's primary contact to inform them of the safety assist and reason the assist was needed for safety.

If the primary contact asks questions other than those directly related to the safety assist, the nurse recommends they contact the child's therapist to ask the questions.

The contact date and time are documented on the nursing assessment form.

Safety Assists: Individualized Safety Assist Restrictions

If a child’s medical assessment documents that he or she has a medical or psychiatric condition/history that would contraindicate the use of personal restraints/safety assists, or when the child’s current condition contraindicates the use of personal restraints/safety assists, intervention procedures will be developed in consultation with the nurse practitioner, medical director, or the client’s medical provider to ensure the highest level of safety while maintaining their medical/psychiatric integrity. This may, however, include the use of very short duration safety holds to interrupt the behavior, or similar types of intervention. Should a medical provider deem physical restraint/safety assists medically unsafe for a child and orders such prohibited, then the child’s Lakemary Therapist will work towards timely discharge to a more appropriate and effective placement to meet the needs of the child in a medically safe manner.

Sick Call/Clinic

When the nurse practitioner is onsite, children who are sick can be seen in the office, classroom, or any site on campus for evaluation and treatment. To request or schedule a visit, classroom or residential staff will contact the nursing office. The staff will be provided a time based on the nurse practitioner's availability with location specified. The nurse practitioner will document the visit and results in the child's EMR record.

Seizure Protocol

If a child is known to have experienced seizures, that child with have a detailed and individualized health care plan as part of their treatment plan that is kept in the child's medical record as an alert and posted in each med room. Each staff person will have read that plan and know how to implement that plan, specific to the child.

If a child experiences a seizure and does not have a health care plan for seizures, staff will follow the general guidelines sent out routinely by nursing. If the child has no known seizure history, but experiences a seizure, the nurse will be called immediately who will direct care for that child, including calling 9-1-1.
Each time a child experiences a seizure, nursing will contact the child's parent or guardian. If the child routinely has multiple seizures each day the parent or guardian will be contacted at least once per day, per the parent/guardian's wishes.

A current list of children with seizure history is to be kept posted in a secure and private location, both in the nursing office and in each residence. This list will detail the seizure response protocol listed below to aid the staff on standard seizure first response safe practices. Extra safety precautions and awareness should be exercised for children with seizure history, especially around water and climbing equipment.

Lakemary seizure protocol includes:

- Remain calm and immediately notify the nursing department.
- Note the time seizure began
- Stay with the child to maintain safety, clearing the area of any hard, sharp, or dangerous objects.
- If the child is sitting or standing, gently lower the child to the ground to prevent a fall.
- Turn the child on their side, if possible, to prevent aspiration, but do not impede their movements. You may place a pillow or blanket under their head. Do NOT put anything in their mouth. Turning them on their side should help keep their airway clear.
- Monitor breathing.
- Note the time that the seizure ends.
- Check for level of awareness, any loss of control of urine or stool, and for any injuries.
- Allow time for recuperation, and sleep, if needed. Sometimes this may last a while.
- Document activity before, during, and after the seizure. Use the "seizure documentation record" in MyEvolv. Nursing will complete an assessment as well.
- If any seizure is prolonged (more than 4-5 min) and does not respond to the ordered medication protocol, or if a cluster of seizure activity is observed, or if a child IS NOT on the seizure list—call 911 and call the nurse on duty.

Seizure Precaution List

See previous section

Serious Occurrence Reporting

See children's program procedure manual and adverse events in this manual

Shift Reports

The electronic medical record is to be consulted for events of the prior shift(s). The nursing progress notes will be in the Health Information - visits section of the chart. The off-going nurse should report any ongoing issues to the oncoming nurse. Staff should relay any health concerns to the nurse.

Sick Trays

When the nurse determines that a child's condition requires a meal different from that which is normally served, the nurse will notify the food service staff of this need. Reasons for the change might include:

- Child is vomiting
- The child has a fever
- Child has diarrhea

Sick trays will be prepared by food service staff, as directed by the nurse practitioner or nurse, during daytime hours.

During evening hours, sick trays will be secured by nursing staff and will include: a can of soup, 2 packages of crackers, small can of Sprite or similar beverage, and a small bottle of sports drink.

Suicidal Ideation/Gestures/Attempts

Whenever a staff member hears and/or observes a perceived serious or "severe" threat or intentional action in which a child may harm him or herself, that staff person must immediately ensure the safety of the child. If additional help is needed, staff will call for assistance on the walkie-talkie.

The staff will then report it to their campus coach, or on-grounds manager.

On-grounds leadership will immediately report the concern to the PRTF clinical director.

Continuous line of sight observation of the child will be maintained by staff.

Leadership staff will further assess the situation to determine if there is additional potential for concern. This assessment will be addressed with the nurse on duty and the clinical director and/or chief program officer, children services.

The clinical director/or chief program officer or the nurse will contact any additional personnel, such as the nurse practitioner or medical director as needed for further evaluation and/or direction, such as immediate access to hospitalization.

In the event of an attempt the nurse will complete an assessment in the medical record, detailing all physical and psychological findings. If necessary, the nurse and on-site leadership staff will arrange for transportation to the local health center's emergency room services.

Following any immediate emergency actions, a detailed incident report must be written.

All suicidal attempts are considered a serious occurrence. The Senior Director of Corporate Compliance will complete a serious occurrence report form and notify all necessary entities.

*Reference: Critical incident reporting PRTF procedure manual.

The PRTF clinical director will notify the child's therapist who will then notify the child's parents of the potential incident.

Supply Ordering

Supply ordering is completed through the supply ordering process developed by the finance department. Forms and procedures are found on the G drive or at the copy area in A building.

All requests for non-routine supplies are to be routed through the nurse practitioner (in the absence of the NP the designated nurse will assist).

Staff Medical Needs

PRTF nursing staff role is primarily for the children that are current residents at Lakemary. At times nursing will be asked by other staff, parents, and/or community members for medical consultation for their personal needs. Nursing care and advice should be limited to first aid and stabilization care. Workman's compensation injuries may be evaluated by the onsite nurse, who can provide initial first aid and should be referred to the employee relations department. Any critical illness or injury should be immediately referred to the emergency room. CPR and pre-ambulance stabilizing care are encouraged. Any other health advice or care is not covered under Lakemary nursing job description and will be that nurse’s personal, professional liability.

Transportation Reservations

The nursing department utilizes Lakemary's vehicle pool when scheduling transportation to external appointments.

The clinical office specialist informs education, children's nursing, therapists, residential staff, campus coaches, ignite mentors, and transportation department when the appointment is scheduled. Prior to leaving for the physician's appointment, the driver checks the vehicle reservation calendar to determine which vehicle has been assigned for them, takes the key from the key box, and follows through with the appointment. Nursing has designated vehicles with keys maintained in the main med room.

When returning from the visit, the staff person returns the key to the key box or designated place for safekeeping.

If emergency care is needed on the weekend, staff will check out a vehicle via the vehicle reservation calendar. Upon return to Lakemary the vehicle key is returned to the key box.

All transportation protocol is followed with regards to vehicles and their use.

Vision Care

Children who, upon admission, have not had a vision examination within a year before admission to Lakemary are screened by use of a SpotVision screening. If a deficit is noted the parent/guardian is notified of the need for further assessment. Once consent is granted by the parent/guardian then the child will be seen by a community provider and annually thereafter. Each child receives emergency eye care, as needed.

Wellness Checks - Home Visit and Discharge

The Lakemary nursing department is committed to ensuring the wellness of all children and will document each child's medical condition prior to a home visit and when they return.

When a home visit notification is received by the nursing department, the PRTF med tech packing the home visit medications initiates the wellness check form by documenting medications packed and being sent home with the child.

If a last-minute notification occurs and the PRTF med tech is not available, the nurse packs the medication and initiates the wellness check form by documenting medications packed and being sent home with the child.

The nurse or med tech completes a wellness check by observing the child and any exposed body parts, including stomach, back, arms and legs. The nurse or med tech also documents any additional information that is known from previous nursing reports and may be pertinent, such as wounds, scratches, bruising, etc. that may be hidden under clothing and not available for viewing during the wellness check. This check is done at the med room or other designated area while the parent or guardian waits in the lobby area. This is to provide the child privacy.

If the nurse is not available, due to an emergency or safety assist assessment, this task is delegated by the nurse to a designated person who has been specifically trained by an nurse to adequately complete this task.

Once the pre-visit wellness check is completed, the form will be maintained in a folder by PRTF nursing staff or in the appropriate section of the electronic medical record.

Upon the child's return to Lakemary, residential staff will notify the nurse or PRTF med tech checks in any medications that are returned from the home visit and documents on the post wellness check section. The nurse or med tech will also complete a visual wellness check and documents findings, including suspicion of drug or alcohol use or abnormal behavior.

The completed form will be maintained by the Lead med tech or nurse and filed in the child's medical record.

PLEASE NOTE: The wellness check consists of a visual check of exposed body parts only. The nurse or med tech will ask the child if they can look at their back, stomach, arms and legs however, it does not involve removal of under garments, pants or shirts.

Copies of blank forms will be maintained in the main med room.

Copies of blank forms can be downloaded from the K:\Nursing\Nursing\3. Forms\Wellness Checks

Appendix

Discharged Wellness Check

External Provider List

Hospitals with SANE services and Advocacy

KDC Medication Room Refrigerator Temperature Monitoring Form

Lab Procedure Book

Medication Variance

Packed Medication Wellness Check

School Medication Room Refrigerator Temperature Monitoring Form

Vaccination Refrigerator Temperature Monitoring Form

Discharge Medications and Visual Body Check

Childs Name: ______________________________ **Date of Discharge:** ________________

Medication Sent:

Medication Name	Dosage	Time of Dosage	Number of Doses Sent

Treatments and/or PRN Medications Sent:
☐ ***Check if Not Applicable***

Name of Controlled	Time of Dosage	Number of Doses Sent
☐ ***Check if Not Applicable***		

Medications Packed By: ____________________________ Medications Reviewed By: ________________________

<u>I affirm that I have received and checked the packed medications and agree that all of the above listed medications are present and accounted for.</u>

***Parent/Guardian Signature**____

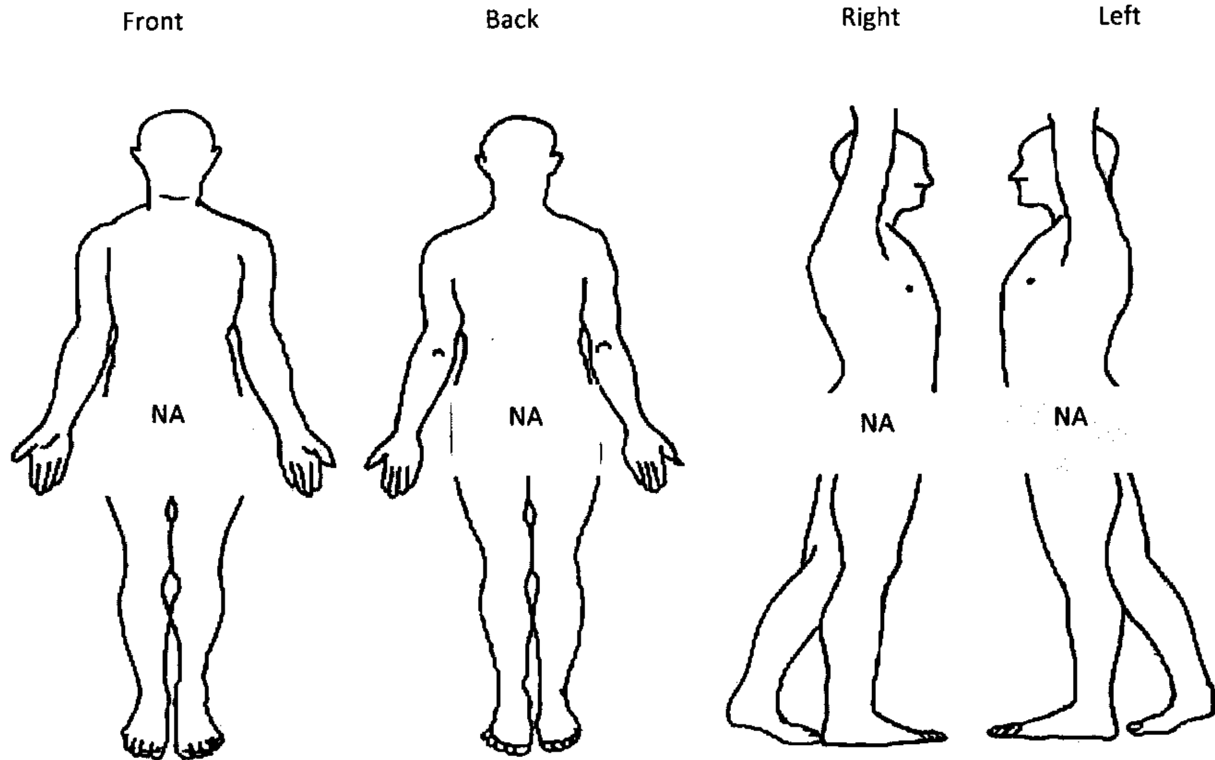
Date and Time: ______________________

K:\Nursing\Nursing\3. Forms\Wellness Check\Discharge Wellness Check Form
Revised October 23, 2024

Discharge Medications and Visual Body Check

A Registered Nurse (or, in the absence of an available nurse, a designated Med Tech) will perform a visual body check, making note of any and all injuries, marks, and noticeable issues on the hands, arms, abdomen, back, legs, neck and face. This check will be performed before discharge.

Before Discharge



Nursing Comments:

Nurse/ Med Tech Signing Out Child:____________________________

Date and Time:_____________________

This form is not sent home with the child: it will be initiated and maintained by Children's Nursing. ***Please return to Children's Nursing.***

PRTF External Provider List
(Not all inclusive)

Pharmacy:

Auburn Long Term Care Pharmacy
401 W. Frontier Ln.
Suite 300
Olathe, KS 66061
P: 913.294.9125

Vision:

Eye Care Associates of Osawatomie
524 Brown Ave.
Osawatomie, KS 66064
P: 913.256.2176

Dental:

Iron Horse Dental
1258 W. Amity St.
Louisburg, KS 66053
P: 913.837.3096

Paola Family Dentistry
21 West Wea St.
Paola, KS 66071
P: 913.210.5464

Community Health Center of Southeast Kansas
924 N. Broadway
Pittsburg, KS 66762
P: 620.231.6788

Sedative Dental:

Crown Town Dental
6302 Monrovia St.
Shawnee, KS 66216
P: 913.341.6767

Emergency:

Miami County Medical Center
2100 Baptiste Dr.
Paola, KS 66071
P: 913.294.2327

Overland Park Regional Medical Center
10500 S Quivira Rd
Overland Park, KS 66215
P: 913.541.5000

Children's Mercy Adele Hall Campus
2401 Gillham Road
Kansas City, MO 64108
P: 816.234.3000
1.800.GO.MERCY

Children's Mercy Hospital Kansas (South)
5808 W. 110th St.
Overland Park, KS 66211
P: 913.696.8000
1.800.GO.MERCY

Hospitals with SANE Services and Advocacy Available

Kansas Hospitals

- **AdventHealth Shawnee Mission**
  9100 W. 74th Street, Shawnee Mission, KS 66204
  ER Phone Number: (913) 676-2218
- **AdventHealth Lenexa**
  23401 Prairie Star Parkway, Lenexa, KS 66227
  Phone number: (913) 676-8500
- **AdventHealth South Overland Park**
  7820 W. 165th Street, Overland Park, KS 66223
  Phone number: (913) 373-1100
- **Children's Mercy South** (victims 13 and older)
  5808 W 110th Street, Overland Park, KS 66211
  ER Phone Number: (913) 696-8000
- **COVERSA at Olathe Medical Center**
  2033 W 151 St, Olathe, KS 66061
  ER Phone Number: (913) 791-4357
- **COVERSA at Overland Park Regional**
  10500 Quivira Road, Overland Park, KS 66215
  ER Phone Number: (913) 541-5338
- **HCA ER of Olathe**
  13505 S. Alden St., Olathe, KS 66062
  Phone: 913-397-1000
- **HCA ER of Shawnee**
  10310 W. 63rd St., Shawnee, KS 66203
  Phone: 913-227-8400
- **KU Medical Center**
  3901 Rainbow Boulevard, Kansas City, KS 66160
  ER Phone Number: (913) 588-6500
- **St. Luke's Leawood**
  13200 State Line Road, Leawood, KS 66209
  ER Phone Number: (913) 222-8380
- **St. Luke's Legends**
  10544 Parallel Parkway, Kansas City, KS 66109
  ER Phone Number: (913) 222-8325
- **St. Luke's North Overland Park**
  7246 W 75th Street, Overland Park, KS 66204
  ER Phone Number: (913) 222-8370
- **St. Luke's Olathe**
  13405 S. Black Bob Rd., Olathe, KS 66062
  ER Phone Number: (913) 222-8390
- **St. Luke's Roeland Park**
  4720 Johnson Dr., Roeland Park, KS 66205
  ER Phone Number: (913) 222-8399
- **St. Luke's South**
  12300 Metcalf Avenue, Overland Park, KS 66213
  ER Phone Number: (913) 317-7466

Missouri Hospitals

- **Children's Mercy Hospital** (victims 13 andolder)
  2401 Gillham Road, Kansas City, MO 64108
  ER Phone Number: (816) 234-3430
- **COVERSA at Belton Regional MedCenter**
  17065 S. 71 Highway, Belton, MO 64012
  Phone: (816) 348-1200
- **COVERSA at Cass Regional Med Center**
  2800 Rock Haven Rd, Harrisonville, MO64701
  Phone: (816) 380-3474
- **COVERSA at Centerpoint Medical Center**
  19600 East 39th Street, Independence, MO 64057
  ER Phone Number: (816) 698-7170
- **COVERSA at Lee's Summit Hospital**
  2100 SE Blue Parkway, Lee's Summit, MO 64063
  ER Phone: (816) 282-5000
- **COVERSA at Liberty Hospital**
  2525 Glen Hendren Drive, Liberty, MO 64069-1002
  ER Phone Number: (816) 781-7200
- **COVERSA at North KC Hospital**
  2800 Clay Edwards Dr, North Kansas City, MO 64116
  ER Phone Number: (816) 691-2098
- **COVERSA at Research Medical Center**
  2316 E. Meyer Boulevard, Kansas City, MO 64132
  ER Phone Number: (816) 276-4155
- **COVERSA at Research Medical Center-Brookside**
  6601 Rockhill Rd, Kansas City, MO 64132
  ER Phone Number: (816) 276-7380
- **COVERSA at St. Joseph Medical Center**
  1000 Carondelet Drive, Kansas City, MO64114
  ER Phone Number: (816) 942-4400
- **St. Luke's East**
  100 NE St. Luke's Boulevard, Lee's Summit, MO 64086
  ER Phone Number: (816) 347-4400
- **St. Luke's North**
  5830 NW Barry Road., Kansas City, MO 64154
  ER Phone Number: (816) 891-6010
- **St. Luke's Plaza**
  4401 Wornall Road, Kansas City, MO 64111
  ER Phone Number: (816) 932-5871
- **St. Luke's Smithville**
  601 US 169, Smithville, MO 64089
  ER Phone Number: (816) 532-3700
- **Truman Medical Center**
  2301 Holmes, Kansas City, MO 64108
  ER Phone Number: (816) 404-1587
- **Truman Lakewood Medical Center**
  7900 Lee's Summit Road, Kansas City, MO 64139-1236
  ER Phone Number: (816) 404-7500

Referenced from: Lakemary PRTF Procedure Manual

KDC Medication Room Refrigerator Temperature Monitoring

__________Month/Year

Date	AM Time	Fridge	Freezer	Initials	PM Time	Fridge	Freezer	Initials
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
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31								

Laboratory Procedures

Preparing for the Phlebotomy Procedure

1. Gather Your Supplies

Before starting the phlebotomy procedure, ensure you have all your supplies ready. Here's what you'll need:

- **Evacuated Collection Tubes:** These tubes collect blood and have different additives for various tests.
- **Personal Protective Equipment (PPE):** Gloves, masks, and gowns protect everyone from infection.
- **Needles and Syringes:** You might need different sizes depending on the patient's vein size and the amount of blood needed.
- **Tourniquets:** These are used to slow down blood flow and make the veins stand out more.
- **Hand Sanitizer:** Keeps your hands clean before and after the procedure.
- **Alcohol Swabs:** Cleans the spot where you'll insert the needle to stop infections.
- **Laboratory Specimen Labels:** Make sure each blood sample is correctly labeled.
- **Gauze:** Used to press on the spot where the needle was after you take it out.
- **Blood Transfer Devices:** These help move the blood from the syringes to the collection tubes.
- **Tape or Adhesive Bandages:** Helps hold the gauze in place over the spot where you drew blood.
- **Laboratory Forms:** These forms list the tests you need to do.
- **Bio-Hazard Leak-Proof Transportation Bags:** These are for safely moving blood samples to the lab.
- **Puncture-Resistant Sharps Containers:** A safe place to throw away needles and other sharp things.

Having everything ready ahead of time helps avoid delays and makes the patient more comfortable. Always double-check your supplies before you begin to ensure smooth operation.

2. Verify Patient Information

It's very important to ensure you have the right patient before starting. Always use two ways to check who they are, like their name and birthday. This step makes sure you're working with the correct person for the tests they need. Checking this carefully stops any mix-ups and keeps the patient safe. It also makes sure the test results are accurate.

3. Explain the Procedure

Before you start, tell the patient what will happen during the blood draw. Explain why it's needed and what steps you'll follow. This helps the patient understand better and might make them less worried. Answer any questions they have. Patients who know what to expect might feel more comfortable and work better with you during the procedure. This can help lower their stress or fear.

Performing the Phlebotomy Procedure

1. Position the Patient

Make sure the patient is seated or lying down comfortably with their arm extended and supported. The vein you choose should be easy to reach. This setup helps prevent the patient from fainting and makes the blood draw easier for the phlebotomist.

2. Apply the Tourniquet

Put a tourniquet around the upper arm, a few inches above where you'll draw blood. It should be snug enough to slow blood flow but not so tight it hurts. Watch the time—don't leave the tourniquet on for more than two minutes. Keeping it on too long could change the blood and affect test results.

3. Choose the Site

The best place to draw blood is usually the median cubital vein in the elbow crease. You can also use the cephalic or basilic veins. Avoid any area that looks swollen, scarred, or bruised. Choosing a good vein helps avoid problems and makes the draw go smoothly.

4. Clean the Site

Wipe the area with an alcohol pad for about 30 seconds and let it dry on its own. This step keeps germs away and prevents infections.

5. Clean Hands and Wear PPE

Wash your hands or use hand sanitizer. Always wear gloves and other protective gear to keep you and the patient safe.

6. Anchor the Vein and Insert the Needle

Hold the vein steady below where you'll insert the needle. Put the needle in at a slight angle. If done right, you'll see blood enter the tube, which means you're in the vein.

7. Collect the Blood Sample

Connect the tubes needed to gather the blood. Remember to use them in the right order to avoid mixing up the additives. Remove the tourniquet once you start filling the last tube. This helps ensure the blood test results are accurate.

8. Remove the Needle and Apply Pressure

Take out the needle smoothly and press down on the spot with gauze to stop any bleeding. Keep pressing until it stops. This helps prevent bruising and other issues.

9. Dispose of Used Materials

Throw away the needle and other used items in special containers for sharp objects and biohazards. Safe disposal helps avoid accidents and keeps the place clean.

10. Label the Samples

Mark each blood sample with the patient's details and what tests are needed. Labeling right away helps make sure there are no mix-ups.

11. Prepare Samples for the Laboratory

Put the labeled samples in special bags after processing and schedule a pick up. Proper handling is key to keeping the samples good for testing.

Post-Procedure Care

After you remove the gauze, put a bandage on the spot where you drew blood. This keeps the area clean and helps protect it. Taking good care of the spot where the needle went in prevents infections and helps it heal faster. Tell the patient to keep the bandage on for at least 15 minutes and not to do any heavy activities with that arm for a few hours. Ask them to let you know if they notice anything unusual, like bleeding heavily or experiencing a lot of pain.

Telling patients what to do after the procedure helps them take care of themselves and know when they might need to see a doctor.

Essential Phlebotomy Tips

- **Stay Calm and Confident:** Patients can tell how you're feeling. Being calm and confident can make them feel more relaxed.
- **Use Proper Technique:** How you insert the needle determines if you get blood. This includes how deep and at what angle.
- **Be Ready for Tough Veins:** Some people's veins are hard to find. You might need to warm the area or adjust the patient.
- **Talk to the Patient:** Tell the patient what you do as you go. This helps them know what to expect and feel more at ease.
- **Practice Good Hygiene:** Always wash your hands and wear the right protective gear to stop infections.

Specimen Collection & Transport Guide 2018-2019

QuestDiagnostics.com

The CPT® codes provided in this document are based on AMA guidelines and are for informational purposes only. CPT® coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

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Specimen Collection and Handling

The meaningfulness of clinical laboratory results are directly related to the quality of the specimen submitted for analysis. Specimens can be collected by you and by your staff, or at a Quest Diagnostics Patient Service Center (PSC). Specimen requirements for each test are included in the **General Test Listing** section. Expanded instructions for selected tests are included in this **Specimen Collection and Handling** section. If needed, please contact the laboratory for clarification prior to specimen collection.

It is critical that an adequate specimen volume is submitted for analysis. The volume requested in this Directory is sufficient for initial analysis and for any confirmatory tests that might be needed. If initial, repeat or confirmatory tests cannot be performed, the laboratory report will indicate that the specimen quantity submitted was QNS (Quantity Not Sufficient for testing).

Health and Safety Precautions

Use standard precautions when handling specimens containing blood or other potentially infectious material. Work areas contaminated with potentially infectious material must be disinfected immediately with an appropriate disinfectant such as a 10% dilution of household bleach (0.5% hypochlorite at final concentration). In the event of an exposure, administer first aid immediately, notify your manager or supervisor and seek prompt medical attention. First aid includes washing cuts and needle sticks with soap and water; flushing splashes to the nose, mouth, or skin with copious amounts of water; and irrigating eyes with clean water, saline, or sterile irrigants.

Specimens should be handled in a safe manner and according to applicable legal requirements or guidance. Information on safe specimen handling may be obtained from the U.S. Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC). In handling human specimens, the goal is to protect healthcare workers from exposure to blood and to other potentially infectious body fluids.

Supplies

We provide certain supplies necessary to collect and submit specimens for analysis by our laboratories. The type and quantity of items must correlate with the number of specimens you submit to us for testing. Please refer to the supply ordering options on page 8 for instruction.

Specimen collection devices supplied by us are to be used only for the collection of specimens processed by us. Such supplies are not to be used to store or dispose of biological materials, including sharp instruments, or for any activity not connected with the collection of specimens for processing by us.

Patient Preparation

Many tests require specific patient preparation (e.g., fasting, diets, urinary voidings). If you have questions about patient preparation for any test, please consult this Directory or call Client Services for further assistance.

Fasting Requirements

A fasting specimen is preferred for the majority of tests performed on serum, plasma or whole blood. Non-fasting specimens often contain fat particles that can interfere with many analytical procedures. See Common Causes of Unacceptable Blood Specimens and Inaccurate Test Results (Turbidity) in the **Blood, Urine and Stool** section. Fasting is defined as no consumption of food or beverage, other than water, for 9–12 hours before testing. When fasting is required as part of patient preparation, the patient should also be advised to refrain from strenuous exercise during the fasting period; individuals should not become dehydrated, create acute inflammation, or other alterations that may alter the interpretation of a test.

Note: Quest performs the Martin-Hopkins calculation for the Lipid Panel (test code 7600), the Lipid Panel with Reflex to Direct LDL-C (test code 14852) and all other LDL-C containing tests. The methodology is not affected by food, so the fasting requirement is not necessary prior to the blood draw for an LDL-C containing test.

Provocation Tests

Some tests require the patient to ingest a substance. The most common tests are the Glucose Tolerance Tests, where the patient drinks a solution containing glucose, and blood specimens are obtained before and at various times after the drink, to measure the concentration of glucose in plasma or serum. In the standard Glucose Tolerance Tests, adults ingest 75 g (10 ounces) of a glucose solution (Glucola™). Children ingest an amount of glucose proportional to their body weight (1.75 grams of glucose per kilograms of body weight, up to 75 g of glucose).

Weight of Patient (in pounds)	Glucola* (in fluid ounces)
24 to 32	3
33 to 42	4
43 to 51	5
52 to 61	6
62 to 70	7
71 to 80	8
81 to 89	9
90 to 95	10

* From a 10-ounce Glucola bottle containing 75 g glucose.

See Glucose Tolerance Testing in the General Test Listing.

Important note: If patient is to be drawn at Quest Diagnostics PSC for a Lactose Tolerance Test (NTC 7675), the test must be scheduled at a PSC capable of administrating the dose. Please call 866-MYQUEST (866-697-8378) to schedule.

Proper Identification of Specimens

Specimen Labels

All specimens should be labeled at the time of collection with at least **2 patient identifiers that must also appear on the requisition.**

1. The patient's name (full last name, then full first name or initial) or a unique ID code is always required.

Transport

2. The second patient identifier may be one of the following:

- Date of birth (month/day/year)
- Other unique patient identifier, e.g., hospital or office ID code or file number
- Quest Diagnostics requisition number or specimen barcode label provided on our requisition
- Other barcode labels can be used if barcode matches the unique identifiers on the printed requisition

NOTE: Location-based identifiers are NOT acceptable, e.g., hospital room number or street address.

Each specimen must have a securely affixed label with the following information:

- The patient's name written exactly as it appears on the test requisition (e.g., Doe, Jane)
- A second patient identifier as noted above

If the label is handwritten, use a ballpoint pen. Do not use a felt tip pen. If glass slides are submitted, use a pencil for labeling the frosted end. Two identifiers are preferred, although patient's name alone is acceptable.

When using one of our electronically generated test requisitions, place the label lengthwise on the tube. When submitting a specimen in a container other than the tube used to draw the sample (e.g., transfer vials), also indicate specimen type on the label (e.g., serum, plasma, urine). When submitting specimens for microbiological testing (e.g., cultures, bacterial antigen, microscopic examination), the nature and anatomic source of the sample and the specific organism(s) to be detected, if any, should be specified.

Test Requisition

Specimens must be accompanied by a paper requisition, prepared either by hand or printed from an electronic ordering system. At a minimum, the requisition should contain the following information:

- Adequate patient identification (e.g., name, address, telephone number, medical record number)
- Patient gender
- Patient date of birth, or age
- Name and address of physician ordering the test
- Test(s) requested
- Date of specimen collection, when appropriate
- Source and type of specimen and time of collection, when appropriate
- Clinical information, when appropriate

Complete the "Patient Information" and "Insurance Information" sections on the requisition. Select the tests to be performed. Legibly print patient information and indicate with a check mark which party will be responsible for payment in the "Bill To" section of the requisition. Enter the ICD diagnosis code that reflects the patient's symptoms, condition, or diagnosis and provide medical justification for the tests ordered. Complete billing information.

When ordering **tests in a series** (e.g., growth-hormone stimulation, glucose tolerance):

1. Use one test requisition.
2. Label each specimen with the patient's name, date and time of collection, or site (if applicable).
3. Write the number of specimens on the test requisition.
4. Submit all specimens within a series together in one specimen bag.

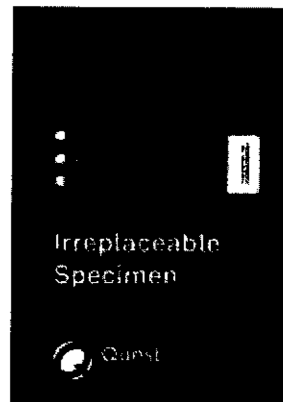
Specimens that are improperly labeled will be rejected.

Irreplaceable Specimen Handling

We define an irreplaceable specimen as one which requires an invasive procedure for specimen collection, or one that cannot be recollected. This would include:

- Tissue biopsies or bone marrow submitted for testing (other than routine histopathology)
- Fine needle biopsies / aspirations
- Body cavity fluids (amniotic, pleural, synovial, ascites)
- Products of conception
- Lavages, washings or brushings
- Cerebrospinal fluid
- Cord blood
- Kidney stones
- Meconium for drug screening

1. Place the collected specimen into the front pocket of the purple bag labeled "Irreplaceable Specimen."
2. Fold the requisition and place it into the rear pocket of the bag so the barcode label is viewed in the envelope window; this is critical to enable tracking.
3. Your specimen will be tracked accordingly.



Purple Bag for Irreplaceable Specimens

Notes:

- The current routine tissue tracking process for histopathology will not change. Introduction of the purple bag applies to all other irreplaceable specimens.
- If you have run out of your supply of Irreplaceable Specimen bags and have a specimen to submit to the laboratory, please place the specimen and requisition into a routine bag that is separate from other routine specimens for pickup. Inform the Logistic staff that it

is an Irreplaceable Specimen, so it may still be tracked as such during transport into the testing laboratory.

4. When ordering through our Quanum site for Healthcare Professionals, please use the purple bag, as well as, the "Irreplaceable Specimen" labels.
5. For Nichols direct clients, place the purple bag containing the irreplaceable specimen inside a routine specimen bag with the appropriate Nichols location. Ensure that the proper temperature bag is selected.

2 Options to Request Irreplaceable Specimen bags

- Order through Quanum for Healthcare Professionals (supplies section)
- Call Client Services at 1-866-**MYQUEST (1-866-697-8378)**; select Option #1, followed by Option #4, and ask for Item 170704

Packaging

The following are the minimum specimen packaging guidelines that should be followed when submitting specimens using one of our couriers.

1. Ensure that all specimen container caps and lids are properly tightened to prevent leakage.
2. Properly complete the requisition.
3. Collect the specimen(s) and transfer to a proper transport container, if needed. Double check the specimen container to ensure that the device is not beyond its stated expiration date.
4. If using a manual test requisition, remove a self-stick label from the bottom of the pre-printed paper test requisition and affix this label to the specimen transport container. Place on the container so that the label does not cover the handwritten patient name.
5. Fold the top copy (original) of the test requisition in half widthwise (top to bottom) with the patient's name and bar code facing out. Retain the second copy for your files.
6. The specimen transport bag has two pouches. Place the specimen container(s) in the front pocket. Insert the requisition into the rear pocket The requisition bar code must be visible through the bag to allow for proper scanning.
7. Frozen specimens should be transported in plastic screw-cap containers only. Frozen specimens must be placed **in a separate specimen bag** along with **a separate test requisition. Frozen specimens cannot be split for other tests.** If more than one test is ordered on a single frozen sample, we will call you to authorize which of the tests ordered you want performed before testing can proceed.
8. Remove the protective strip and seal the specimen bag. The protective strip must not obstruct the bar code. This will protect the test requisition from leakage and help ensure that the patient information can be entered directly into the laboratory computer by scanning of the bar code.
9. If the specimen has been classified as an "infectious substance," transport in a bag designed to withstand 95kPa of pressure to meet the ICAO/IATA and DOT requirements. These boxes are available from the local laboratory (see the Infectious Substances in the **Microbiology** section). Please inform Quest Diagnostics prior to or at the time of our Logistics Representative pickup, so that proper transport arrangements can be made.
10. Any updates to these guidelines (or to the specimen transport supplies) will be communicated through your local sales or logistics representative.

Holding and Securing Specimens

While awaiting pickup by one of our Logistics Representatives, maintain specimens at room temperature or on cold packs, unless otherwise noted under the "Transport Temperature" or other specimen requirement in this section or in the **General Test Listing** section.

We will provide a lock box for specimens awaiting pickup by one of our Logistics Representatives. However, customers are responsible for the security of specimens prior to pickup.

Frozen Specimens

Frozen specimens must be transported in insulated containers surrounded by an ample amount of dry ice to keep the specimen frozen until it reaches the laboratory. Thawed specimens are unsuitable for analysis. In the event a thawed specimen is received, you will be asked to resubmit an adequate specimen.

If you would like more information about sending specimens to us, please contact your Client Service Representative. Any updates to these guidelines will be communicated through the Laboratory Update and/or by your local Sales Representative.

Needles, Sharps or Medical Waste

Do not send any needles or other sharp or breakable objects. Do not send medical waste as a diagnostic specimen; it may violate the law and create a health hazard. Properly discard used needles or other sharps prior to transport.

Please note that for tests requiring the submission of syringes, the needle must be removed and the syringe capped before sending to the laboratory. Ensure that there is no leakage from or visible contamination outside the specimen container.

Blood, Serum or Plasma

Phlebotomy

Most blood specimens can be obtained using routine phlebotomy techniques; however, there are some exceptions. The use of a tourniquet can cause stress and is not recommended in some cases. Patients should be instructed not to clench their fist(s) prior to or during the phlebotomy procedure as this may alter some of the patient's laboratory results, such as the concentration of potassium in serum. The patient's posture (sitting, standing or supine), or the time of day of phlebotomy can be important factors for some tests (e.g., therapeutic drug monitoring and hormone tests). If in doubt, please consult this section and the **General Test Listing** section of this Directory before scheduling the patient for phlebotomy. **The inside front and back covers of this Directory display blood collection tube types and important details of proper phlebotomy technique.**

Blood

Serum, Plasma or Whole Blood Collection

Draw blood in the color-coded Vacutainer® tube indicated in the alphabetical test listing. For serum or plasma, draw approximately 2 1/2 times the requested volume. For serum, completely fill the Vacutainer® and allow the blood to clot in an upright position for at least 30 minutes, but not longer than 1 hour before centrifugation. For plasma and whole blood, completely fill the Vacutainer® whenever possible to eliminate dilution from the anticoagulant or preservative and immediately mix the blood by gently and thoroughly inverting the tube 5 to 10 times. Separate plasma by centrifugation. Transfer the serum, plasma, or whole blood to a plastic transport tube (see the **Standard Maximum Blood Draw for Patients Under 14 Years** chart for pediatric collections). To prevent injury and exposure to potentially infectious material, do not ship frozen serum, plasma, or whole blood received in glass tubes or SST® (glass or plastic).

The color-coded Vacutainer® tubes on the inside cover are recommended unless otherwise indicated in the alphabetical test listing. Vacutainer® tubes are designed for use for both Pediatric and Adult populations.

Handle all biologic samples and blood collection "sharps" (lancets, needles, Luer adapters and blood collection sets) according to the policies and procedures of your facility. Obtain appropriate medical attention in the event of any exposure to biologic samples (for example, through a puncture injury), since they may transmit viral hepatitis, HIV, or other infectious diseases. Use any safety engineered single use needle protector, if the blood collection device provides one. Reshielding/recapping of used needles is prohibited. Discard any blood collection "sharps" in biohazard containers approved for their disposal.

Pediatric Collection Volumes

When infants and children are to be drawn for laboratory testing, consideration should be given to collect the necessary and minimum volume needed for requested tests. To ensure that the circulatory integrity of the younger patient is not compromised, follow the recommended maximum draw volumes in the following table.

Standard Maximum Blood Draw for Patients Under 14 Years

Weight (lbs)	Weight (kg)	Maximum Amount Drawn at One Time (mL)	Maximum Amount Drawn at One Month (mL)
6.0–7.9	2.70–3.62	2.5	23
8.0–9.9	3.63–4.53	3.5	30
10.0–15.9	4.54–7.25	5	40
16.0–20.9	7.26–9.52	10	60
21.0–25.9	9.53–11.78	10	70
26.0–30.9	11.79–14.05	10	80
31.0–35.9	14.06–16.32	10	100
36.0–40.9	16.33–18.59	10	130
41.0–45.9	18.60–20.86	20	140
46.0–50.9	20.87–23.12	20	160
51.0–55.9	23.13–25.39	20	180
56.0–60.9	25.40–27.66	20	200
61.0–65.9	27.67–29.93	25	220
66.0–69.9	29.94–32.20	30	240
70.0–75.9	32.21–34.46	30	250
76.0–80.9	34.47–36.73	30	270
81.0–85.9	36.74–39.00	30	290
86.0–90.9	39.01–41.27	30	310
91.0–95.9	41.28–43.53	30	330
96.0–100.9	43.54–45.80	30	350

Adapted from Becan-Mcbride K: Textbook Of Clinical Laboratory Supervision, New York, Appleton-Century-Crofts, 1982, with permission.
Phlebotomy Handbook, By Diane Garza and Kathleen Becan-McBride. Copyright 1984 By Appleton-Century-Crofts, East Norwalk, CT.
Nelson Textbook of Pediatrics, 16th Edition, Edited by R.E. Behrman, R.M. Kliegman, and H.B. Jenson, © 2000 by W.B. Saunders Co., Philadelphia, PA.
Saunders Manual of Pediatric Practice, Edited by L. Finberg, Copyright 1998 by W.B. Saunders Co., Philadelphia, PA.
Children's Hospital of Seattle Maximum Allowable Blood Draw Volumes, by Rona Jack, Ph.D.
Maximum Amounts of Blood to be Drawn From Patients Younger than 14 Years, available online at Drgreene.com/article/how-much-blood-too-much-guideline

Whole Blood

The most common test using anticoagulated whole blood is the Complete Blood Count (CBC) and blood morphology, which should be collected using a lavender-top (EDTA) plastic vacuum tube. Other tests might require anticoagulants such as heparin (green-top) or sodium citrate (light blue-top) tube. Follow instructions for the individual test.

Collect an adequate volume of blood. Fill the tube to capacity, since partial filling will result in distortions caused by the osmolality of the anticoagulant. Under filled or overfilled blood collection tubes will not be accepted for testing.

Immediately mix the blood thoroughly with the additives by gently **inverting eight (8) times, or four (4) times when using light blue-top (sodium citrate) tubes.** Incomplete mixing or delay in mixing after phlebotomy will result in microscopic partial clotting of the sample, which can cause spuriously low platelet counts.

Maintain the specimen at room temperature or on cold packs before submitting to our laboratory, unless instructed otherwise by the specimen requirement information in this Directory or by the laboratory. Never freeze whole blood unless it is specifically instructed in the specimen requirement instructions.

If you store cold packs in the freezer, be sure to allow sufficient time for them to warm to refrigerator temperature before placing whole blood specimens near them. To minimize the risk of hemolysis, do not place whole blood specimens in direct contact with cold packs.

Plasma

Evacuated tubes used to collect plasma specimens contain anticoagulant (e.g., light blue-top tubes contain sodium citrate, green-top tubes contain sodium or lithium heparin, lavender-top tubes contain potassium EDTA). Consult the individual test specimen requirements to determine the correct additive/tube to use.

Collect a volume of blood that is 2–2½ times the volume of plasma needed for the test. Fill the tube to capacity, since partial filling will result in dilution of the sample. Do not overfill the tube since it will result in a lower concentration of anticoagulant and activation of clotting. Under filled or overfilled collection tubes may not be acceptable for testing.

1. Following the blood collection, immediately mix the tube by inverting the tube gently **four (4) times when using light blue-top (sodium citrate) tubes** (further inversions might cause activation of clotting factors) and **eight (8) times for all others.**
2. Centrifuge for at least 10 minutes (horizontal) or 15 minutes (fixed-angle) in a device with a rotor diameter and speed [RPM] capacity able to develop a relative centrifugal force equivalent to 1250–1600 times g [the force of gravity: 9.80665 m/s^2]. Centrifuges supplied by us can develop a relative centrifugal force equivalent to between 1450 (fixed-angle rotor) and 1600 times g (horizontal rotor) when operating within the instrument manufacturer's specifications. If using other centrifuges, determine RCF by referring to the following formula:

$$g = 11.18 \times r \times \left(\frac{n}{1000}\right)^2$$

   where: r = radius in centimeters
   n = speed in RPM
3. Transfer plasma to a properly labeled, clean plastic and tightly capped vial and attach the label from the lower portion of the Test Requisition, if applicable. Do not transfer red cells to the vial. Assure cap is firmly in place to prevent leakage.
4. Write "PLASMA" on the plastic screw-cap vial label and on the Test Requisition.

Serum

For most analyses performed on serum other than therapeutic drug monitoring, we recommend the use of plastic Serum Separator Tubes (SST®s) or plain red-top tubes. **Please check individual specimen requirements for restrictions.** SST®s should not be used to collect specimens for drug testing. See Therapeutic Drug Monitoring or Toxicological Analysis in this section.

1. Perform venipuncture.
2. Collect a volume of blood that is 2–2½ times the volume of serum needed for the test in an appropriate collection tube. Fill the tube to capacity, since partial filling will result in higher serum concentration of tube additives, which are known to alter the results of some tests.
3. Immediately mix by inverting the tube gently **no less than eight (8) times and no more than ten (10) times. Less than five inversions will result in incomplete clotting** and incomplete separation of red cells from serum. Hemolysis of even a small number of red cells remaining above the gel in contact with serum will spuriously elevate results of tests, such as serum potassium and LD.
4. Do not remove the stopper at any time. Do not centrifuge immediately after drawing blood. Allow the blood to clot in an upright position for at least 30 minutes, but not longer than 1 hour before centrifugation.
5. Centrifuge for at least 10 minutes (horizontal) or 15 minutes (fixed-angle) at 1250 to 1600 RCF (relative centrifuge force) within 1 hour of collection. Centrifuges supplied by us produce between 1450 (fixed-angle rotor) and 1600 RCF (horizontal rotor) when operating within the instrument manufacturer's specifications. This equates to 3450 and 3380 +/– 50 RPM (revolutions per minute), respectively. If using other centrifuges, determine RCF by referring to the following formula:

   where: r = radius in centimeters
   n = speed in RPM

$$g = 11.18 \times r \times \left(\frac{n}{1000}\right)^2$$

6. Spun SST® tubes may be submitted without transfer to vials for most room temperature and refrigerated transport temperatures.
7. Transfer the clear serum to a properly labeled and tightly capped vial. Attach the label from the lower portion of the Test Requisition, if applicable.
8. Write "SERUM" on the plastic capped vial label and on the Test Requisition.

Therapeutic Drug Monitoring or Toxicological Analysis

Do not use Serum Separator Tubes (SST®s) for therapeutic drug monitoring, LC/MS/MS or toxicological analysis. The polyester in the separator gel can extract lipophilic substances (most drugs), and can cause a falsely low drug concentration result. Instead, collect the specimen in a red-top tube containing no gel. Collect and process as described above and after centrifugation, transfer the serum with a pipette to a properly labeled plastic vial. Serum should be clear and free of red cells.

Frozen Serum or Plasma Specimens

Serum or plasma specimens need to be frozen when specifically stated. It is essential to freeze the plasma or serum as soon as it is separated from the cells and transferred to a plastic vial. Allow 1-2 mL of space to allow for expansion during freezing. Do not freeze

specimens in glass tubes; **always freeze them in plastic vials or tubes—unless instructed otherwise.** Do not freeze plastic Serum Separator Tubes (SST®s).

Lay the tube at a 45° angle to avoid tube breakage caused by expansion during freezing. Hold the specimens before pickup in a freezer or dry ice container. **Do not use frost-free freezers.** The automatic defrost cycle will cause the specimen to partially thaw, and then freeze again. The results of many tests are affected by such freeze-thaw cycles.

Extreme cold may cause ordinary plastic labels to become brittle and detach from the specimen tube. Use clear tape to secure the label to a specimen transport tube.

If more than 1 test is requested on a frozen specimen, split the specimen prior to freezing. Use separate Test Requisitions when submitting more than 1 frozen specimen; frozen and non-frozen specimens must not be submitted on the same Test Requisition. Indicate on the specimen container and on the Test Requisition whether a specimen is plasma or serum.

If more than 1 test is ordered on a single frozen specimen, only 1 of the tests requested will be performed. We will call you to choose which test you want performed before testing can proceed.

Common Causes of Unacceptable Blood Specimens and Inaccurate Test Results

Hemolysis

Hemolysis occurs when the membrane surrounding red blood cells is disrupted and hemoglobin and other intracellular components escape into the serum or plasma. Hemolyzed serum or plasma varies in color from faint pink to bright red, rather than the normal straw color. Grossly or moderately hemolyzed specimens may necessitate a new specimen for some tests. Even slight hemolysis that might not be obvious on visual examination of the serum, or plasma, may significantly alter certain test results (e.g., serum potassium, serum LD). Refer to the **General Test Listing** section for the particular test to determine the effect of hemolysis.

Hyperbilirubinemia

Icteric serum or plasma varies in color from dark to bright yellow, rather than the normal straw color. Icterus may affect certain test results and might necessitate a new sample to assure results of diagnostic value.

Turbidity (Lipemia)

We recommend that patients fast for 9–12 hours before a blood specimen is obtained. Eating prior to blood collection produces a transient presence of fatty substances (lipids) in the blood resulting in turbid, cloudy or milky serum. Moderately or grossly lipemic specimens may alter certain test results (see Fasting Requirements in the **Patient Preparation and Specimen Transport** section).

Urine

Urine Collection

Many urine chemistry tests require a 24-hour collection. Record on the Test Requisition any medications that the patient is receiving. If a preservative is required, it is important that the designated preservative be in the urine collection container at the start of the collection. When the 24-hour urine output is less than 1 liter, 4 grams of boric acid can be used when boric acid is the specified preservative or 10 mL of 6N HCl can be used when HCl is specified. The patient (or responsible individual) should be cautioned that the preservative may be toxic and caustic, and not to spill or discard the preservative.

On the day of the collection, discard the first morning urine void, and begin the collection after this void. Collect all urine for the next 24 hours so that the morning urine void on the second day is the final collection. Measure and record the total urine this volume collected on the Test Requisition and on the urine transport vial (see Pediatric Specimen Tubes below). After mixing the container well, transfer the requested volume into the labeled urine transport vial. Do not send the entire urine collection.

Random (Spot) Urine

The normal composition of urine varies considerably during a 24-hour period. Submit a first morning voided specimen whenever possible because it has a more uniform volume and concentration; its lower pH helps preserve formed elements. To reduce contamination, the specimen submitted should be a "mid-stream" sample. Urine for pregnancy testing should be first morning void, or a random specimen with a specific gravity of at least 1.010. Note the time of collection of the specimen on the Test Requisition and on the container label.

For some urine tests, there are dietary restrictions. For others, some drugs must be avoided prior to obtaining the specimen. This information is included as part of the specimen requirements for the individual tests in the **General Test Listing** section in this Directory.

Since the concentration of urine varies widely, a convenient way of normalizing test results is to divide the result by the concentration of creatinine in the same aliquot. The amount of creatinine excreted daily in the urine is fairly constant (around 1 gram per day; see Creatinine, 24-Hour Urine in **General Test Listing** in this Directory) and thus, the amount of creatinine in a random/spot sample is a good estimate of the fraction of the total daily urine volume that the random/spot sample represents. For specific urine tests that are reported as a creatinine ratio, see **General Test Listing** in this Directory.

Lakemary Center Children's Medical Services
Medication Variance

Person Served: ______________________________

Person Responsible for Variance: ______________

Reported by (print)___________________________

Supervisor Notified: ___________________________

On Duty RN ________________________________

Date of Variance: _______________

Time of Variance: _______________

Area Variance Occurred: __________

Date Notified: __________________

Date/Time Notified: ______________

Medication(s)

May list more medications on the back of this page.

Medication	Dose	Time Ordered

Variance Type

Check all that apply:

__Person received wrong medication.
__Discontinued medication given.
__Extra dose was given.
__Incorrect dose was given.
__Medication was not given.
__Medication was given at incorrect date/time.
__Medication was given by incorrect route.

__Medication documentation not completed.
__Medication documented incorrectly.
__Spare Medication given.
+Explain why medication was missing.
__Medication or treatment refused by person served.
+ Explain what happened prior to attempted administration.

Description

Description of variance and how it occurred:

____

____

Reporter's signature: _________________________ Date: _______________

Responsible Staff signature: ___________________ Date: _______________

Supervisor's signature: _______________________ Date: _______________

Duty Nurse's signature: ______________________ Date: _______________

Training Nurse signature: _____________________ Date: _______________

Nursing Supervisor/NP: _______________________ Date: _______________

Lakemary Center Children's Medical Services
Medication Variance

Additional Information:

Medication	Dose	Time Ordered

Additional Explanation: ____

____

____

____

Instruction: Immediately call on duty RN noting the date, time and name of Nurse. Follow the RN instructions. Notify your supervisor. Initiate the written report.

If you are the person who also was involved in the variance put your name on both lines.

Forward the report to your supervisor to be signed and reviewed.

Your supervisor is then responsible for filing the report with the Med RoomSupervisor. They will ensure that the variance is tracked for audit/reporting purposes.

Once reviewed, the report will be sent to the appropriate training/oversight RN (School Nurse or PRTF Nurse).

Once the reviews are completed then the variances are forwarded to the Nurse Practitioner for final review and signature.

Packed Medications and Visual Body Check

Child's Name: ______________________________

Date of Visit: ______________________

Medications Sent	Dosage	Number of Doses	Medication Times

☐ Check if more medications are listed on separate sheet.

Treatments and/or PRN Medications Sent:	Dosage	Number of Doses	Medication Times

☐ Check if Not Applicable

Name of Controlled	Dosage	Number of Doses	Medication Times

☐ Check if Not Applicable

Dates on Visit:	Medication Times:

Date of Return: ______________________

Medications Returned	Dosage	Number of Doses Returned

☐ Check if no medications returned

Treatments and/or PRN Medications Returned:	Dosage	Number of Doses Returned

☐ Check if no medications returned

Name of Controlled	Dosage	Number of Doses Returned

☐ Check if no medications returned

Return Medications Reviewed By: ____________________
Date &Time: ________________

Return Medications Reviewed By: ____________________
Date &Time: ________________

Medications Packed By: ____________________ Date &Time: ________________

Medications Reviewed By: ____________________ Date &Time: ________________

I affirm that I have received and checked the packed medications and agree that all the above listed medications are present and accounted for. Reviewed Medication with Responsible Party: ◯ Yes ◯ Responsible Party Refused Medication Review

***Med Trained Staff Signature:** ____________________ Date &Time: ________________

***Responsible Party Signature:** ____________________ Date &Time: ________________

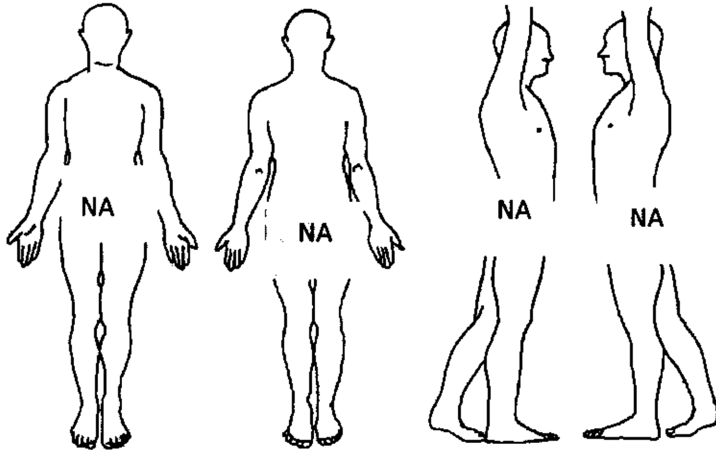
Packed Medications and Visual Body Check

Child's Name: ______________________________________

A Registered Nurse (or, in the absence of an available nurse, a designated Med Tech) will perform a visual body check, making note of all injuries, marks, and noticeable issues on the hands, arms, abdomen, back, legs, neck and face. This check will be performed before and after a visit.

Before Visit

Front Back Right Left

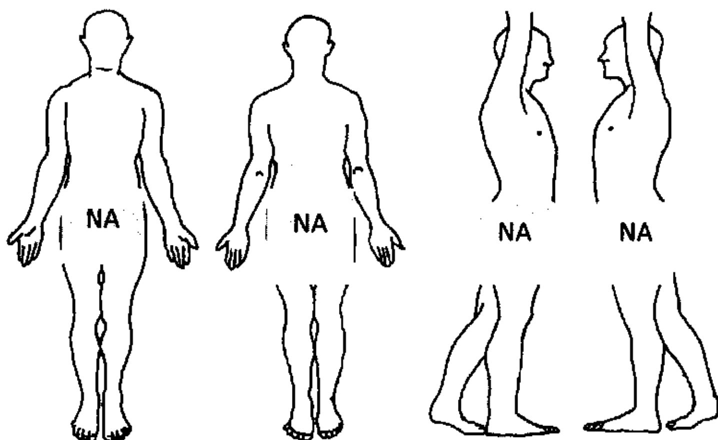


Nursing Comments:

Nurse/ Med Tech Signing Out Child: ______________________ Date and Time: ________________

After Visit

Front Back Right Left



Nursing Comments:

Nurse/Med Tech Signing in Child: ______________________ Date and Time: ______________

This form is not sent home with the child: it will be initiated and maintained by Children's Nursing. ***Please return to Children's nursing.***

School Medication Room Refrigerator Temperature Monitoring

__________Month/Year

Date	AMTime	Fridge	Freezer	Initials	PM Time	Fridge	Freezer	Initials
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
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29								
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31								

Vaccine Refrigerator Temperature Monitoring

__________Month/Year

Date	AM Time	Temp	Initials	PM Time	Temp	Initials
1						
2						
3						
4						
5						
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