Status **Active** PolicyStat ID **7142234**

Origination	1/1/2004
Last Approved	11/4/2019
Effective	11/4/2019
Last Revised	11/4/2019
Next Review Due	11/3/2022
Owner	Kathleen Feeley-Lynch: Manager Nursing
Policy Area	Critical Care
Applicability	WA - Providence Centralia Hospital

PCU Admission Criteria

Policy Number: 61790-30-001

PURPOSE:

Outline the admission criteria for patients in the Progressive Care Unit (PCU).

APPLIES TO:

This policy applies to all Practitioners, Administrative Supervisors, Staffing Assistants, and RNs in the PCU of Providence Centralia Hospital (PCH).

POLICY STATEMENT:

Patients shall be admitted to the PCU only when beds are available, and on the direct order of the attending practitioner or his/her designee. Only practitioners with current hospital privileges are allowed to admit patients.

OBSERVATION & SAFETY FACTORS:

Adult (>/= 18 years of age) patients admitted to PCU are characterized by the presence of real or potential life-threatening health problems, require continuous observation, and/or may need emergency interventions to prevent complications and sustain life.

PROCEDURE:

1. **Guidelines for admission:** Patient needs cardiac observation and/or frequent assessments in conjunction with one of the following criteria:

A. Hemodynamically stable.
B. Stable respiratory status.
C. Chest pain not requiring continuous intervention (Chest Pain, R/O MI).
D. Uncomplicated MI - no thrombolytics.
E. Patients requiring continuous monitoring of heart rhythm.
F. Patient with syncopal episodes.
G. No cardioversions or ventilators.
H. Patient with acute CVA requiring cardiac monitoring.
I. May take patients on drips if patient is hemodynamically stable: including but not limited to Cardizem, Lasix, Bumex, Octreatide, Amiodarone, and Heparin.

AGE-RELATED CONSIDERATIONS:

Yes - applies to adult patients only.

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVALS:

- Medical Staff President (11/2019)

DEFINITIONS:

N/A

ATTACHMENTS:

N/A

OWNER:

Manager, Progressive Care Unit

PRIOR POLICY HISTORY:

- *Effective Date: August 2010 Approved without Changes: Supersedes: June 2007; January, 2004*

REFERENCES:

N/A

ADMINISTRATIVE APPROVAL:

Director, Continuum of Care/Nursing Administration

All Revision Dates

11/4/2019, 12/1/2016, 5/1/2015, 8/1/2010

Approval Signatures

Step Description	Approver	Date
Site Administrator	Carol Robinson: Patient Safety Specialist	11/4/2019
President, Med Staff	Jason Kearney: Medical Staff President [KP]	11/1/2019
Director, Continuum of Care / Nursing Support	Dona Kravis: Dir Nrsg Inpt and Spec Svcs	11/1/2019
	Kimberlee Miller: Mgr Medical Acute CCU PCU	10/30/2019

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **12114846**

Origination	9/1/2003
Last Approved	7/29/2022
Effective	7/29/2022
Last Revised	7/29/2022
Next Review Due	7/28/2025
Owner	Cynthia Sidley: Executive Director Nursing
Policy Area	Patient Care Services
Applicability	WA - Providence Centralia Hospital

Placement of Patients

Policy Number: 86100-PCS-123

PURPOSE:

To establish guidelines for determining the appropriate accommodations and care for each patient.

APPLIES TO:

Admitting Providers, Administrative Supervisor, Unit Managers; Charge Nurses, Unit Directors, Administration

POLICY STATEMENT:

The Admitting Provider, Administrative Supervisor, with the assistance of the Nurse Manager or the Charge Nurse, will determine the appropriate patient placement.

PROCEDURE:

1. All requests for inpatient beds must be placed through Epic when it is determined that patient requires admission to the hospital.
    A. Admission requests will include type of bed, admitting provider, patient diagnosis and any specialty care needs.
    B. Bed assignments should be made within 30 minutes of a complete request when

beds are available.

1. Administrative Supervisor will collaborate with the unit charge nurse in making bed assignments as able.
2. When the charge nurse is not available, the Administrative Supervisor will place patients based on criteria and consult with the charge nurse as necessary.
3. Beds will be assigned by the Administrative Supervisor.

C. Nursing units will proactively plan for the next unscheduled admission, identifying the bed and nurses to receive the admission in advance of an admission request.

D. All transfer requests for Direct Admits from outside hospitals must be made through the South Puget Sound Transfer Center. Bed availability must be confirmed with the Administrative Supervisor prior to accepting referrals from outside hospitals.

2. Placement will be determined by assessment of patient needs, Provider written order, bed availability (pt can be admitted to the designated unit per provider order or other order that can deliver the same level of care), and availability of qualified nursing staff. Considerations will include:

A. Scope of Services for each unit. See attached guidelines for inpatient units.

B. Licensed Independent Practitioner (LIP) admission order.

C. Gender and Age of the patient (*for pediatric and adolescent patients see policy on "Guidelines for Placement of Pediatric/Adolescent Patients" in reference section*).

D. Type of illness.

E. Severity of illness.

F. Requirements for specialized nursing activities or nursing skills.

G. Patient's ability to care for self.

H. Presence of infection and/or isolation needs.

I. Expected length of stay.

J. Patient and/or patient's family requests.

K. Patient's requirement for continuous supervision related to confusion, dementia, psychosis, substance withdrawal, restraints, fall risk, suicide risk.

L. Patient safety related to domestic violence, or threat.

AGE-RELATED CONSIDERATIONS:

Yes. Applies to adults only.

CONTRIBUTING DEPARTMENTS:

- ED
- Inpatient Units (CCU, PCU, Surgical and Medical Units)

DEFINITIONS:

n/a

ATTACHMENTS:

None

OWNER:

Director, Acute Care Services

ADMINISTRATIVE APPROVAL:

VP / Chief Nursing Officer SWR

All Revision Dates

7/29/2022, 3/25/2019, 12/2/2015, 1/1/2013, 2/1/2010, 1/1/2007, 9/1/2003

Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Quality Accreditation Analyst	7/29/2022
Regional Chief Nursing Officer SWR	Suzanne Scott: Chief Nursing Officer	7/28/2022
	Sharlene Higa: Dir Nrsg Inpt and Spec Svcs	7/27/2022

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **9112687**

Origination	7/1/1998
Last Approved	7/22/2021
Effective	7/22/2021
Last Revised	10/13/2017
Next Review Due	7/21/2024
Owner	Carolyn Armstrong: Manager Nursing
Policy Area	Ambulatory Services
Applicability	WA - Providence Centralia Hospital

Outpatient Surgery Services: Criteria for Admission

Policy Number: 74300-PCS-001

PURPOSE:

Provide guidelines for appropriate admission to Outpatient Surgery Services (OPS) and identify patients whose needs could be met in OPS.

APPLIES TO:

OPS Staff and Licensed Independent Practitioners of Providence Health & Services Southwest Washington Service Area (SWSA) Providence Centralia Hospital (PCH).

POLICY STATEMENT:

1. Patients requiring less than 14 hours of care between 0600 and 2000.
2. Patients capable of self care at home.
3. Children when accompanied by adults (1 to 18 years, unless emancipated).
4. Disabled adults (mental and physical) when capable of self care or when care person is available to stay with patient.
5. Inmates of penal institutions when accompanied by guards.
6. Surgical patients according to ASA Standards.

OBSERVATION &/OR SAFETY FACTORS:

See Procedure section

PROCEDURE:

1. Applies only to patients meeting the: Anesthesia Classifications Governing Admission
    A. Class I - Normal healthy patients.
    B. Class II - Patient with mild systemic disease (no functional limitations)
    C. Class III - Patient with severe systemic disease (some functional limitations)
    D. Class IV - Patient with severe systemic disease that is a constant threat to life (functionally incapacitated)
2. EXCLUSIONS
    A. Surgical and Anesthetic
        1. Any procedure carrying known possible post-anesthetic or surgical complications requiring medical treatment should not be admitted to the Outpatient Surgery Department.
            a. For example; post-operative septicemia, hemorrhage, airway problems, or procedures requiring prolonged post-operative observation.
    B. Medical
        1. Patients with significant medical illness requiring daily or frequent adjustment or evaluation and which might be altered by the stresses of starvation and surgery.
            a. For example; insulin dependent or control problem diabetes, seizure disorders, anticoagulated patients on high doses of steroids.
            b. Also patients with acute genito-urinary illness.
    C. Other
        1. Patients with infections that cannot be contained within a dressing should not be admitted to OPS.
        2. Patients with communicable disease should not be admitted to the OPS.
    D. Patients meeting Classes V and VI of Anesthesia Classifications Governing Admission
        1. Class V - A moribund patient who is not expected to survive without the operation.
            a. Examples include (but not limited to); ruptured abdominal/ thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction.
        2. Class VI - A declared brain-dead patient whose organs are being removed for donor purposes.

AGE-RELATED CONSIDERATIONS:

Yes

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVALS:

- Infection Control Committee
- Department of Anesthesia

DEFINITIONS:

N/A

ATTACHMENTS:

N/A

OWNER:

Clinical Manager, Surgical Services Dept.

REFERENCES:

- Morgan & Mikhail's Clinical Anesthesiology, 5th edition. Copyright 2013 p 295-300.

ADMINISTRATIVE APPROVAL:

Director, Surgical Services

All Revision Dates

10/13/2017, 8/1/2014

Approval Signatures

Step Description	Approver	Date
Site Administrator	Lisa Chavis: Patient Safety Specialist	7/22/2021
Director, Surgical Services	Bruce Schmidt: Dir Surg and Cardiovasc Svcs	3/23/2021

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **9112683**

Origination	4/1/2000
Last Approved	3/29/2021
Effective	3/29/2021
Last Revised	8/29/2017
Next Review Due	3/28/2024
Owner	Carolyn Armstrong: Manager Nursing
Policy Area	Perioperative
Applicability	WA - Providence Centralia Hospital

Recovery Room Svcs: Admission, Ongoing, and Discharge Assessment

Policy Number: 74270-PCS-001

PURPOSE:

Establish guidelines to assure that each patient is adequately assessed during his/her stay in the PACU.

APPLIES TO:

Post Anesthesia Care Unit (PACU, aka - Recovery Room) Registered Nurses (RN) of Providence Health & Services Southwest Washington Service Area (SWSA) Providence Centralia Hospital (PCH).

POLICY STATEMENT:

All PACU patients will be assessed on an individual basis. This assessment will be ongoing from admission through discharge.

All PACU patients will be monitored with NIBP, EKG and pulse oximetry. Two invasive lines can be monitored, if applicable.

OBSERVATION &/OR SAFETY FACTORS:

The PACU RN is responsible for ensuring that:

- All pertinent physician orders are completed.
- All patients meet discharge criteria before discharge.

- If criteria are not met, a discharge order from the appropriate anesthesia provider will be obtained, written, and noted.

PROCEDURE:

1. Initial assessment and documentation for Phase 1 should include, but is not limited to:
    A. Integration of data received at transfer of care
        1. Relative perioperative status.
        2. Anesthesia/sedation technique and agents.
        3. Length of time anesthesia/sedation administered, time reversal agents given.
        4. Pain and comfort management interventions and plan.
        5. Medications administered.
        6. Type of procedure.
        7. Estimated fluid/blood loss and replacement.
        8. Complications occurring during anesthesia course, treatment initiated, response.
        9. Emotional status on arrival to the operating room.

    B. Vital Signs
        1. Airway patency, respiratory status, breath sounds, type of artificial airway and oxygen saturation.
        2. Blood pressure - cuff or arterial line.
        3. Pulse - apical, peripheral.
        4. Cardiac monitor rhythm documented.
        5. Temperature/route.
        6. Hemodynamic pressure readings, if lines present.

    C. Pain and comfort level.
    D. Level of emotional comfort.
    E. Neurological function, to include level of consciousness.
    F. Sensory and motor function, as appropriate.
    G. Position of patient.
    H. Condition and color of skin.
    I. Patient safety needs.
    J. Neurovascular: peripheral pulses and sensation of extremity(ies) as applicable.
    K. Condition of dressing and visible incisions.
    L. Type, patency and securement of drainage tubes, catheters and receptacles.
    M. Amount and type of drainage.

N. Pupillary response as indicated.
O. Fluid therapy - location of lines, condition of IV site, and amount of solution infusing.
P. Procedure specific assessment.
Q. Post anesthesia scoring system.

2. Ongoing assessment and management for Phase 1 should include, but is not limited to:
    A. Monitor, maintain and/or improve:
        1. Respiratory function.
        2. Circulatory function.
        3. Neurological function, to include level of consciousness.
    B. Sensory and motor function, as appropriate.
    C. Monitor temperature and promote normothermia.
    D. Promote and maintain:
        1. Effective pain and comfort management.
        2. Emotional comfort.
    E. Monitor surgical site and continue procedure specific care.
    F. Document nursing action and/or intervention with outcome.
    G. Notify patient care unit of any needed equipment (as appropriate).
    H. Education/instruction based on level of consciousness.
    I. Notify patient care unit when patient is ready for discharge from PACU and provide report of all significant events in the operating room and PACU.
    J. Post anesthesia scoring system, if used.
3. Data collected and documented to evaluate the patient's status for discharge from Phase 1 include, but are not limited to:
    A. Airway patency, respiratory function, and oxygen saturation.
    B. Cardiac and hemodynamic status.
    C. Thermoregulation.
    D. Level of consciousness.
    E. Pain and comfort control.
    F. Sensory/motor function.
    G. Patency of tubes, catheters, drains, intravenous lines.
    H. Skin color and condition.
    I. Condition of dressing and/or surgical site.
    J. Intake and output.
    K. Psychological/emotional status.

L. Post anesthesia scoring system, if used.

AGE-RELATED CONSIDERATIONS:

No

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVALS:

None

DEFINITIONS:

N/A

ATTACHMENTS:

N/A

OWNER:

Clinical Manager, Surgical Services Dept.

REFERENCES:

N/A

ADMINISTRATIVE APPROVAL:

Director, Surgical Services

All Revision Dates

8/29/2017, 8/1/2014

Approval Signatures

Step Description	Approver	Date
Site Administrator	Carol Robinson: Patient Safety Specialist	3/29/2021
Director, Surgical Services	Bruce Schmidt: Dir Surg and Cardiovasc Svcs	3/23/2021

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **8772562**

Origination	1/1/2004
Last Approved	4/21/2022
Effective	4/21/2022
Last Revised	5/17/2017
Next Review Due	4/20/2025
Owner	Kathleen Feeley-Lynch: Manager Nursing
Policy Area	Critical Care
Applicability	WA - Providence Centralia Hospital

Critical Care Unit Admission Criteria Guidelines

Policy Number: 60300-30-001

PURPOSE:

Outline the admission criteria for patients in the Critical Care Unit (CCU).

APPLIES TO:

This policy applies to the Practitioner, Administrative Supervisor/Staff Assistant, and CCU Registered Nurse (RN) of Providence Health & Services Southwest Washington Service Area (SWSA) Providence Centralia Hospital (PCH).

POLICY STATEMENT:

Adult (>/= 18 yrs of age) patients admitted to CCU are characterized by the presence of real or potential life-threatening health problems, require continuous observation, and/or may need emergency interventions to prevent complications and sustain life.

OBSERVATION & SAFETY FACTORS:

1. Patients shall be admitted to the CCU only when beds are available and on the direct order of the attending physician or his/her designee.
2. Only physicians with current hospital privileges are allowed to admit patients.
3. In the event a patient outside of the CCU suddenly deteriorates, that patient may be transferred to the CCU by the Administrative Supervisor, Hospitalist and/or Emergency Department physician.

A. In such an event, if the attending physician or his/her designate is not available, an ongoing effort shall be made by the Administrative Supervisor or CCU nurse to contact him/her.

4. Patients with disruptive behavior, and/or detox patients, should not be admitted to CCU unless they require life support systems or nursing care that is in excess of what can be maintained on a general nursing floor.

PROCEDURE:

Guidelines for admission: Patient needs observation and/or frequent vital signs in conjunction with one of the following criteria:

1. Acute medical/surgical problems requiring life support equipment:
    A. Mechanical ventilation
    B. Hemodynamic monitoring with arterial lines
    C. Procedure requiring CCU setting (such as cardioversions, etc.)
2. Acute medical/surgical problems requiring continuous infusion of:
    A. Vasoactive agents
        - Dopamine
        - Dobutamine
        - Isoproterenol
        - Nitroprusside
        - Nitroglycerine
        - Epinephrine
        - Phenylephrine
        - Vasopressin
    B. Anti-arrhythmia agents
        - Lidocaine
        - Procainamide
    C. Antihypertensive agents
        - Labetalol
        - Esmolol
    D. Thrombolytic agents: Alteplase (tPA)
    E. 3% Saline
3. Abnormal lab values that are resolving and patient is stable, the patient may be downgraded with physician order.
4. Acute medical/surgical problems resulting in:

A. A hemodynamic instability
B. Continuous seizures
C. Intubation
D. Atrial/Ventricular transvenous temporary pacing
E. Abnormal lab values (this does not include patients with chronically abnormal values listed below)
    - Na < 115 mEq/L > 160 mEq/L1
    - PO2 < 50 or evidence of deteriorating ABGs
    - pH reflective of acid base imbalance
    - Toxic level of drug or other chemical substance
    - K < 2.0 mEq/L or > 7.0 mEq/L

AGE-RELATED CONSIDERATIONS:

Yes - Adult (>/= 18 years of age)

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVALS:

- Medical Executive (MEC) Committee (05/09/2017)

DEFINITIONS:

N/A

ATTACHMENTS:

N/A

OWNER:

Manager, Critical Care Unit

PRIOR POLICY HISTORY:

- *Effective Date: June, 2010 Approved without Changes: Supersedes: June, 2007; January, 2004*

REFERENCES:

N/A

ADMINISTRATIVE APPROVAL:

Director, Acute Care Services & Nursing Support

All Revision Dates

5/17/2017, 5/1/2015, 6/1/2010

Approval Signatures

Step Description	Approver	Date
Site Administrator	Erika Sherie Luat: Accred Pol Mgmt Prog Analyst	4/21/2022
President, Med Staff	Jordan Abel: Physician [HM]	3/21/2022
President, Med Staff	Sharlene Higa: Dir Nrsg Inpt and Spec Svcs	3/10/2022
Director, Continuum of Care / Nursing Support	Sharlene Higa: Dir Nrsg Inpt and Spec Svcs	3/10/2022
	Sharlene Higa: Dir Nrsg Inpt and Spec Svcs	3/10/2022

Standards

No standards are associated with this document

Status **Active** PolicyStat ID **10609014**

Origination	3/27/2015	Owner	Corrina Emch: Manager Nursing
Last Approved	12/10/2021	Policy Area	Women's Services
Effective	12/10/2021	Applicability	WA - Providence Centralia Hospital
Last Revised	12/10/2021		
Next Review Due	12/9/2024		

Admission to the Newborn Nursery

Policy Number: 74010-15-068

PURPOSE:

Define the scope of practice for the registered nurse (RN) and neonatal provider, consistent with Washington State Perinatal and Neonatal Level of Care Guidelines and appropriate to the acuity level of the patients served.

APPLIES TO:

This policy applies to all registered nurses (RNs) working within the Family Birth Center of Providence Health & Services Southwest Washington Service Area (SWSA) Providence Centralia Hospital (PCH).

POLICY STATEMENT:

The Washington State Perinatal and Neonatal Level of Care (LOC) Guidelines, published February 2013 outlines the level of care for Levels I, II, and III designated hospitals. PCH is designated as a Level I facility.

PCH Perinatology Committee has designated newborn transition time as 12 hours from birth and it is referred to throughout the policy. However on a case-by-case bases, and with a neonatologist phone consultation, if the neonate is close to transitioning at the end of the 12 hours, an additional 3 hours may be appropriate with full documentation in the record.

OBSERVATION & SAFETY FACTORS:

1. Level I care units offer basic level of newborn care to low risk infants.

A. Infants who are physiologically stable are encouraged to room in with their mothers.
    1. Some infants who are physiologically stable may need to be transferred to the nursery for additional care include but are not limited to the following:
        a. Neonates who need additional feedings and are not ready for discharge.
        b. Neonates requiring additional thermoregulation environment.
        c. Phototherapy for neonates who have not been discharged.
        d. Adopting out neonates.
        e. Child Protective Service or Administrative holds for placement.
        f. Neonates whose birth weight is ≤ 2500 grams for the first **12 hours** for observation for glucose and thermoregulation monitoring with periodic visits with mother. May be monitored in room with mother.
        g. Neonates with hypoglycemia requiring additional monitoring.
    2. The infants are physiologically stable who are born at or above 35.0 weeks gestation.
        a. Infants who are not physiologically stable, who are born less than 35 weeks gestation, are stabilized and transported to a higher level of care.

B. Borderline physiologically stable neonates who are transitioning may be observed for **12 hours with provider reassessments every 6-8 hours noting improved status.**
    1. **If the neonate is not physiologically stable and transferred out of the mother's room, or deteriorates at the end of 12 hours, the neonate must be transported to a higher level of care.**
    2. Borderline physiologically stable neonates include but are not limited to the following:
        a. Vital signs above or below the normal parameters
            1. Respirations between 40 – 60,
            2. Heart rate between 100 and 160,
            3. Temperature between 97.7 - 99.5,
                a. However, may be as high as 100.3 for mothers with chorioamnionitis.
        b. Oxygen therapy to maintain appropriate saturation of 92 – 99% with rates to not exceed 30% at 1-2 litters of flow with a hood or nasal cannula.
            1. High-flow and CPAP are used for the purposes of transport only.
        c. Initiate antibiotics for possible sepsis for 48 hours without a running intravenous fluids.

d. Hyperbilirubinemia requiring intensive phototherapy.

3. Neonates who must be transferred for higher level of care include all of the following, but not limited to:
    a. Neonates who deteriorate during the first 12 hours transitional phase.
    b. Neonates less than 35 weeks gestation.
    c. Intravenous fluids for glucose instability .
    d. Neonates requiring intubation, vascular and/or central access for medications and volume.
    e. Oxygen therapy greater than 30% and/or more than 2 liters.
    f. Stabilized sick neonates waiting for transport.
    g. Congenital abnormalities requiring resources not available at PCH.
    h. Conditions in which the borderline physiologically stable infant requires continued support after the initial 12 hours.

PROCEDURE:

1. An RN trained to care of neonates with borderline physiology will be assigned the responsibility to care for any neonates in the nursery.
    A. Respiratory distress is defined as tachypnea, grunting, flaring or having intercostal retractions.
        1. Continuous monitoring by pulse oximeter and cardio-respiratory machines until respiratory distress is resolved or transferred to a higher level of care.
        2. Cluster care for neonates who are sensitive to touch or sound.
        3. Monitor oxygen therapy documenting type (*hood or nasal cannula*) FIO2 and liter rate.

    B. Initiating antibiotics.
        1. Continuous cardio-respiratory monitoring for all neonates on IV antibiotics.

    C. Late preterm or low birth weight newborns lass than or equal to 2500 grams.
        1. Follow PCH policy: Care of the Late Preterm or Low Birth Weight Infant .
        2. Follow PCH policy: Newborn Standard of Care - Birth to Discharge

    D. Bathing is delayed until vital signs are within normal limits to decrease stress.

    E. Obtain MRSA cultures for all newborns admitted from outside PCH, including hospital to hospital transfers.
        1. Newborns born outside of facility and admitted to the Family Birth Center for care (*i.e., phototherapy*) are placed in isolation until cultures are negative.

AGE-RELATED CONSIDERATIONS:

Yes

CONTRIBUTING DEPARTMENT/COMMITTEE APPROVALS:

- Perinatology Committee

DEFINITIONS:

N/A

ATTACHMENTS:

N/A

OWNER:

Manager, Family Birth Center

PRIOR POLICY HISTORY:

Refer to Special Care Nursery policy 65390-15-006 for prior documentation

- Effective Date: 08/2011 Reviewed Date: 03/10 Revised Date: 07/2009; 08/2008; 06/2006

REFERENCES:

- PCH policy: Care of the Late Preterm or Low Birth Weight Infant
- PCH policy: Newborn Standard of Care - Birth to Discharge
- Washington State Perinatal and Neonatal Level of Care (LOC) Guidelines February 2013
- Guidelines for Perinatal Care Seventh Edition. American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2012
- Committee on Fetus and Newborn, Postnatal Glucose Homeostasis in Late-Preterm and Term Infants, Pediatrics 2011 ; 127-575; originally published online February 28, 2011; DOI: 10.1542/peds. 2010-3851.

ADMINISTRATIVE APPROVAL:

Director, Women's & Children's Services SWSA

All Revision Dates

12/10/2021, 12/4/2018, 1/24/2017, 3/27/2015

Approval Signatures

Step Description	Approver	Date
Site Administrator	Lisa Chavis: Patient Safety Specialist	12/10/2021
Director, Women and Children Services SWSA	Annette Stier: Dir Nursing	11/23/2021
	Corrina Emch: Mgr Family Birth Center	10/21/2021

Standards

No standards are associated with this document