**Scope:** Medical Staff, Nursing, Laboratory

**Purpose:** The patient shall be provided with blood or blood component transfusion when ordered by the physician.

**Policy:** To provide guidelines for the Ordering, Distribution and Administration of blood and blood component therapy.

- The licensed staff member shall have validation of competency in the knowledge and protocols for administration of transfusion therapies.
- The licensed staff member shall identify the patient by using at least two identifiers including, but not limited to, patient name, patient account number, patient medical records number, or date of birth; photographs, etc. prior to the initiation of therapy. Neither identifier can be the room number.
- Informed consent of the patient or legally authorized representative shall be obtained prior to the administration of transfusion therapy and shall be documented in the patient’s permanent medical record.
- Items that must be documented include the following: access device, blood or component therapy; volume, rate, vital signs, complications, patient assessment before and after therapy; the patient’s response to the therapy.
- Prior to the initiation of therapy all of the following must be verified: positive patient identification; appropriateness of therapy; check for compatibility; an order from a prescribing physician and the validation of a second clinician.
- Transfusion reactions shall require immediate intervention and shall be reported according SRMC guidelines.
- Blood and component therapy shall be filtered.
- Aseptic technique and Standard Precautions shall be observed.

**Special Considerations:**
1. Blood and blood products will be administered under the direction of an RN or Physician.
2. Consent for Authorization/Refusal for Transfusion will be provided to the patient, and/or family and documented in the medical record, by the physician ordering the blood or blood products, crossmatches, or type and screens. The Informed Consent must be signed by the patient (or their representative) prior to picking up the blood or components from the blood bank. A nurse or blood bank technologist may witness the signature on the Consent for Blood/Blood Component Transfusion form after the physician/RN has discussed it with the patient. This consent is valid the entire hospital stay.
3. Blood/Blood Components will be checked by two (2) staff members to include 1 RN or MD and another RN, MD, or LPN at the bedside.
4. All transfusions should be completed in no less than 2 hours and no greater than 4 hours unless ordered differently.
5. For blood transfusion reactions, see page 5.
6. If the patient must leave the nursing unit for x-rays, etc., notify the receiving department/unit that a transfusion is in progress.
7. If the blood is not hung within 20 minutes from the time it is signed out from the blood bank, it should be returned to the lab immediately.

8. For emergency release of un-crossmatched blood, Blood Bank is to be notified immediately. The physician will be required to sign the emergency release form. The form is returned to the Blood Bank for pathologist review. Following pathologist review, copies are made for the Blood Bank retention and the original is placed on the patient chart.

**Procedure:**
1. Ascertained that the Consent Authorization/Refusal for Transfusion has been signed and witnessed.
2. Provide Crossmatch/Transfusion Requisition (CTR) to the Transfusion Service for each blood product ordered. Enter orders in computer for ABO, Rh and antibody screen as well as number and type of blood products needed. 
   Note: Please provide on the requisition as much of the requested information as may be available, including information regarding previous transfusions, previous antibodies, previous reaction to transfusion, date of need, and diagnosis that necessitates the transfusion or type and screen.

3. Notify the lab of any special physician’s orders, for example but not limited to: request to transfuse blood greater than 4 hours, transfuse irradiated, CMV negative.

**Distribution**
1. Prior to obtaining blood or blood components from the lab, the following should be done:
2. Confirm that the Informed Consent has been obtained.
3. Establish IV access or patency.
4. Obtain vital signs (temperature, pulse, respiration, blood pressure). Notify physician of any abnormalities before obtaining the blood.
5. Present claim (yellow copy) of Crossmatch Transfusion Request to the blood bank in order to receive the unit of blood and/or blood components. In emergent situations in which the patient or family is unable to sign the consent, the reason must be documented in the Physician Progress Notes. If phone consent has been obtained or other reasons the physician/RN is not present to the sign the consent, the blood transfusion shall not be withheld provided that the patient has been informed by the physician/RN and consented to the transfusion.
6. The staff member who picks up the blood will bring the yellow claim ID. The staff member will check the blood unit information with the lab tech. The staff member calls out the required information from the Transfusion Log Book. The Blood Bank Tech and the staff member together will check the unit of blood and verify:
   - Patient’s name
   - Permanent record number
   - Blood Bank armband number
   - Blood unit number
   - Blood unit expiration date
Blood types, Red Cross donor label on compatibility tags and computer label
all patient and donor information must be identical. Any discrepancy found must
be resolved before the blood leaves the blood bank. If the discrepancy cannot
be resolved, then the blood should be re-crossmatched prior to infusion.
The staff member and lab tech signs, dates and times the logbook and
Crossmatch Transfusion Request.
The staff member will take the blood directly to the floor.
Normal Saline (0.9 NS) preservative free is the only IV fluid that can come in
contact with blood or blood products.

Administration:

*Blood should be administered immediately after leaving the Blood Bank. Blood should
never be refrigerated on the nursing units. If the blood is not hung in 20 minutes, it
should be returned to the lab at once.*

1. Prior to administering the blood/blood products, the patient should be asked about
any symptoms; for example, but not limited to: dizziness, itching, difficulty breathing,
 etc., which might be confused with a transfusion reaction. Teach patient and/or
significant other to notify nurse if any unusual symptoms or sensations are noted
during blood transfusion.

2. A RN and another licensed staff member (RN, MD, LPN) will verify at the patient’s
bedside the following:
Patient’s name
Patient’s hospital number
Permanent record number
Blood Bank armband number
Unit number
Blood type
Unit expiration on the blood bag with the compatibility tag on the unit
*Note: Do not spike the unit until all information is verified. If there is a discrepancy or the
patient is not wearing a Blood Bank armband, the blood unit must be returned to the
Blood Bank for complete verification.*

3. When verification is complete, the RN and the witness will sign the
Crossmatch/Transfusion Request.

Note:
- Blood warmers should be used for large volumes or rapid transfusions and for
patients with clinically significant conditions requiring this intervention.
- External compression devices should be equipped with a pressure gauge and
should exert uniform pressure against all parts of the blood container. Follow the
manufacturer's guidelines for best outcomes.

4. Continuous observation of the patient during the initial part of the transfusion
(approximately 15 minutes) is required because of the antigenicity of red cells.
Transfusions containing red cells are most likely to produce severe reactions.
5. Vital signs shall be taken as designated on the Blood/Transfusion Record q 15 minutes x 1 hour, then q 1 hour until complete, and then 1-hour post transfusion.

6. When the transfusion is completed, dispose of the blood unit following the Bio-Hazard Protocol.

7. The transfusionist must ensure that the original Crossmatch/Transfusion Request Record is complete and white copy filed in the patient's medical record. Return the pink lab copy of the Crossmatch Transfusion Request and any attached special bag tags as soon as possible to the Blood Bank. **Exception: for Transfusion Reactions or partially administered units, return the bag and Crossmatch request to the lab.**

8. All blood products will be Infused with a standard latex free y-type blood set with an 180 micron filter delivering 15 drops per ml (via compatible infusion pumps such as Alaris and Gemini) or by gravity. The set primes with 43ml of fluid. (Exceptions: cryoprecipitate, RHOIGG and Factor 8.

**Documentation:**

As per guidelines on Blood Transfusion Record (which includes vital signs, etc.)

Ensure that there is documentation to record patient identification and verification; education; informed consent; patient assessment; documentation of adverse events and interventions (if any).

Utilize nurse’s notes for detailed documentation of signs, symptoms, and other pertinent data related to the transfusion or transfusion reaction.

**Transfusion Reactions**

Symptoms of Transfusion Reaction Include:

- Abnormal Bleeding
- Hypotension
- Chest/Back Pain
- Itching
- Chills
- Myalgia
- Coughing
- Nausea
- Cyanosis Dypsnea
- Oliguria/anuria
- Facial flushing
- Pulmonary edema
- Fever (> 1C)
- Rales
- Headache
- Rash
- Heat at the infusion site
- Uneasy feelings
- Hemoglobinuria
- Urticaria (hives)
- Wheezing

The patient should be observed during the transfusion for reactions that may be new to the patient condition since initiation of, and possibly due to initiation of the transfusion and the prescribed protocol should be initiated in such circumstances:

1. Discontinue the transfusion and obtain vital signs.
2. Keep the vein open with normal saline.
3. Keep the patient under observation, and immediately notify the attending physician, nurse manager, and/or administrative coordinator.

4. Notify the Blood Bank immediately of possible reaction so that a post transfusion blood sample can be obtained (1-purple top labeled with patient name, medical record number, arm band number, "post-transfusion", signature, date and time). Obtain a Transfusion Reaction form and complete the top area of the form, including a description of the symptoms noted, time of onset, and initial actions taken, including name of physician who was notified.

5. Monitor and document vital signs in the nurse’s note q 15 minutes or as indicated by the severity of the suspected reaction. Continue to monitor VS until notified by the blood bank that the initial investigation is complete. This should take approximately 30 minutes from the time the post transfusion blood sample is received in the lab.

6. Collect the first post-transfusion urine and send to the lab marked “Post-Transfusion Reaction”, including the date and time of collection. DO NOT compute this urine in PBAR. **Urine output should be monitored until the laboratory investigation is complete.**

7. If it is determined by the Physician that the transfusion should be stopped, return the blood bag with the attached Administration Set to the lab with the completed Transfusion Reaction Form.

8. Blood Bank will notify the nursing unit of resulting initial investigation.


**All Blood Products - General Information**

**Platelets**

*Platelet transfusions are used to treat surgical and medical patients with active thrombocytopenia or to prevent bleeding in the thrombocytopenic patients. All platelet products are pre-filtered leuko-reduced and must be ordered from the Red Cross. Please note: One adult dose of platelets is considered to be one platelets pheresis. Platelet concentrates are no longer ordered by our facility.*

1. Administer as rapidly as patient can tolerate. Must be infused within 4 hours.
2. Platelet products do not require crossmatching.
3. Platelets must be ABO and Rh compatible except in emergencies whereby physician approval is needed.
4. All platelet infusion sets should be flushed with saline after the platelet bag empties by running 20–50 ml through the infusion line (not indicated for patients with saline or volume restrictions).
5. In emergency situations, if an Rh-negative patient receives platelets- pheresis containing 5 ml. Or more of red cells, from an Rh-positive donor, they should receive Rh immunoglobulin. One vial of Rhlg will take care of 30 ml of red cells.
6. A single donor platelets pheresis is equivalent to 4-8 platelet concentrates.
7. Vital signs pre-transfusion and 15 minutes post transfusion.
8. Occasional mixing of bags during administration is recommended to keep platelets in suspension.
Red Cells
*Red cells are the component of choice for patients with chronic anemia, liver, cardiac, or kidney disease, and patients who cannot tolerate rapid changes in blood volume. Also used for routine loss in surgery. All red cell units are pre-filtered leuko-reduced and are supplied by the Red Cross. The desirable rate of infusion depends upon the patient’s blood volume, cardiac status, and hemodynamic condition.

1. Infuse in no less than 2 hours and no greater than 4 hours, (unless otherwise indicated by the physician.)
2. Infuse with a standard latex free y-type blood set with a 180-micron filter delivering 15 drops per ml (via compatible infusion pumps such as Alaris and Gemini) or by gravity. The set primes with 43ml of fluid. The set is good for only four hours.
3. See Administration Vital Signs on page 3 #5.

Fresh Frozen Plasma
*Plasma is indicated to replace coagulation factor deficiencies.

1. Notify Blood Bank when ready to infuse. FFP takes about 20 minutes to thaw.
2. Check patient’s chart for volume or saline restrictions.
3. Infuse FFP with the standard y-type blood infusions set.
4. Infuse over 15-20 minutes when given for bleeding or clotting factor replacement.
5. Infuse over 1-2 hours when given for other reasons.
6. Should be infused within or less than 4 hours.
7. No cross-match is required. ABO compatible.
8. Rinse the bag and infusion line with normal saline after the transfusion so the primary volume is not wasted.
9. Rh factor is not a consideration – the patient may receive plasma from an Rh positive or Rh-negative donor.
10. Thawed plasma expires in 24 hours.

Purified Factor VIII
*Used in treatment of moderate to severe congenital Factor VIII deficiency (Hemophilia A).
1. Use the set provided with this product.
2. Infuse as fast as tolerated by the patient to a maximum of 6 ml/min.

Purified Factor IX
*Used primarily for treatment of patients with Factor IX deficiency (Hemophilia B).
1. Filter needle provided with product.
2. Same rate of administration as factor VIII.
Cryoprecipitate

*Indicated for bleeding associated with fibrinogen deficiencies and factor XIII deficiencies. Major indications for transfusing Cryoprecipitate AHF are Hemophilia A; von Will brands Disease, Hypofibrinogenemia and Factor VIII deficiency.

1. Call the Blood Banks to thaw units of Cryoprecipitate. Enter the order into the computer and send the required requisitions to the laboratory.
2. Obtain equipment, check patient’s vital signs and record.
3. IV certified nursing personnel must obtain cryoprecipitate from the Blood Bank.
4. At the bedside, re-check all patient information and unit information on bags, requisition and patient’s armband.
5. Close both clamps on component set.
6. Remove protective cover from port of cryoprecipitate and remove cover from spike.
7. Insert spike of set into exposed outlet, using a punch and twist motion.
8. Attach sterile plastic 20cc syringe to female adaptor of set.
9. Open clamp between plastic bag and y-connector.
10. Withdraw syringe plunger and aspirate cryoprecipitate.
11. Close clamp on tubing attached to plastic bag.
12. Open clamp on tubing that attaches it to the IV catheter.
13. Remove needle adaptor cover and expel air from the tubing.
14. Make venipuncture, connect tubing and infuse cryoprecipitate.
15. To refill syringe, reverse position of the clamp, then aspirate additional cryoprecipitate. Repeat steps 4 through 14 for each unit.
16. Following initial infusion of cryoprecipitate, each cryoprecipitate bag should be rinsed with 5ml of infusion saline and that should be infused as well to assure complete administration of cryoprecipitate.
17. Flush component infusion set with 5ml normal infusion saline after complete infusion of all cryoprecipitate.
18. Chart procedure and patient tolerance to procedure on nurse’s notes and Blood Transfusion Record. Document the number of units given and amount of saline use on MAR.
19. Completed Blood Bank copies of the transfusion requisition must be returned in the second pocket of the biohazard bag.

Albumin 12/5/50ml/100ml

*Indicated for both hypovolemic and hypoproteinemia. Used to correct large, acute losses of colloid as seen in hypovolemic shock from trauma, surgery or burns.

1. Obtain from the pharmacy.
2. Infuse within 1 hour at 2-4 ml/min.
3. Special tubing comes with this product. Does not require a filter.
Albumin 12.5/250ml

1. Obtain from the pharmacy.
2. Infuse within 1 hour at 2-4 ml/min.
3. Special tubing comes with this product. Does not require a filter.

Immune Globulin Intravenous

1. Obtain from pharmacy.
2. Administer over 3 hours.
3. Filter supplied with product, but not required.

Immune Globulin Intramuscular (Rhogam)

1. Obtain from the Blood Bank.
2. IM injection for Rh-negative women.

References:
Circular of Information for the use of Blood and Blood Products American Red Cross
Lippincott Manual of Nursing Practice
JCAHO and State Regulations
Clinical Nursing Skills and Techniques, 5th Edition
Standards of Practice for Infusion Nursing, Vol. 29. Number 1, 2006

Author/Revised/Reviewed by:
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12/06 – Kathy Mitchell, CNO, Renia Lott, Director Laboratory
1/07: Kathy Mitchell, CNO; Renia Lott, Director Laboratory
POLICY:

Hospital personnel shall be provided written guidelines for (1) assessment of the patient, (2) care of the patient, (3) the referral/reporting process and (4) the process for collecting, retaining and safeguarding information and evidence in the event of suspected physical assault, rape/sexual molestation, domestic abuse, and abuse or neglect of elders and/or children.

PURPOSE:

To provide criteria to be utilized as a guideline to assist in identification and reporting of suspected victims of physical assault, rape or other sexual molestation, domestic abuse, and abuse or neglect of elders and children.

PROCEDURE:

A. Identification and assessment of suspected victims of abuse are based on observable evidence and not allegations alone.

B. Defining terminology for identifying possible victims of abuse: Abuse means willful and unjustified infliction of pain injury or mental anguish; or deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of another person.

"Physical assault" means:
   a. Any attack of any kind

"Rape or other sexual molestation" means:
   a. Any act which violates or forces a person to submit unwillingly to sexual acts

"Domestic Abuse/Violence" - "Family Violence" means:
   a. The Georgia Code 19-13-1 defines domestic violence "Family Violence" as the occurrence of one or more of the following acts between past or present spouses, persons who are the parents of the same child, parents and children, foster parents and children, step parents and children, or other persons living in a household:
      1. a felony or:
      2. commission of the offense of battery, simple battery, assault, simple assault, stalking, criminal damage to property, unlawful restraint or criminal trespass.

"Abuse and neglect of Elders":
   a. Includes five types: physical abuse; financial abuse; psychological abuse; sexual abuse or self neglect
      1. Physical abuse - Violence that results in bodily harm or mental distress that may be active (assault) or passive (negligence). The Select Committee on Aging defines negligence to be an act of carelessness, a violation of rights, or a breach of duty resulting in injury (such as
withholding food, drink, and/or medication, or allowing the development of pressure sores.)

2. Financial abuse - Money that is stolen from an elder outright or property transferred to another by force, deceit, fraud or misrepresentation.

3. Psychological abuse - Name calling, verbal assaults, protracted and systematic efforts to dehumanize, or threats to instill fear which can be as harmful as physical violence.

4. Sexual abuse - Most often perpetrated by a family member, sexual assault may be covered up by other family members.

5. Self-abuse or Self-neglect - A range of behaviors possible from simple physical neglect to suicide. This abuse is often precipitated by the actions and attitudes of loved ones that lead to feelings of loneliness and rejection in the elder.

"Abuse/neglect of Children"

a. Includes the following types:

1. "Child" means a person under 18 years of age.

2. "Child abuse" means harm or threatened harm to a child's health or welfare, when harm occurs or is threatened through non-accidental physical or mental injury, or the commission of a crime involving physical or sexual abuse of a child.

3. Physical "neglect" means harm to a child's health or welfare by a person responsible for the child's health or welfare which occurs through negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.

4. "Physical Abuse" means:
   i. Permanent or temporary disfigurement; or impairment of any bodily function or organ of the body.

4. "Mental Injury" means an injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of his/her ability to function within his
normal range of performance or behavior.

5. "RAPE/Sexual Abuse" includes acts upon a child constituting:
   a. incest
   b. lewdness with a child
   c. molestation of a child
   d. sadomasochistic abuse
   e. sexual assault
   f. statutory sexual seduction

C. Criteria/physical indicators and behavioral indicators focused on observable evidence may include, but are not limited to:

   a. General Criteria
      - Delay in seeking medical treatment
      - History of previous unexplained or suspicious injuries
      - Injuries in various stages of healing
      - Inconsistencies in history given by victim and caregiver or spouse
      - Changes in history
      - Inconsistencies in explanation of injury and actual injuries.
      - Behavior of victim/caregiver or spouse

   b. Physical assault - physical indicators of
      - physical injuries as evidenced by bruising, lacerations, cuts, burns, bites
      - missing teeth - hair
      - trauma - fractures, breaks
      - any attack using a weapon which may include hands, knife, blunt instrument or gun

   c. Rape or other sexual molestation
      Physical indicators
      - physical trauma to genitals
      - physical trauma: cuts bruises on
      - neck, throat, breast, thighs, legs and arms
      - Genitourinary disturbances: vaginal discharge, rectal bleeding, burning on urination, itching

      Behavioral indicators
      - disturbance of mood: depressed, Anxious
      - fear, embarrassment, humiliation, self-blame, low self-esteem
      - fear of violence toward self or others
      - phobic reactions
      - sleep disturbances; nightmares
      - dysfunctional coping: alcohol, drugs

   d. Domestic abuse/violence - "Family violence"
      Physical Indicators
      - physical injury such as bruises,

      Behavioral Indicators
      - Seems cautious or afraid of spouse,
cuts, lacerations, broken bones,  
hair loss, burns, which seem  
difficult for patient  
to explain or are the results of  
"accidents"  
-Injuries in various stages of  
healing  
-Torn, stained or bloody clothes  
parents or children, or other persons  
related by blood or affinity and  
occupying a common domicile  
-Unnatural control of communication  
and/or  
environment of potential victim  
by spouse, parent, child or other  
person living in home  
-Unwilling to talk about spouse,  
parents, children or other persons  
living in home for  
fear of reprimand or being disloyal  
-Self blame  
-Suicidal  
-Appears anxious, depressed or withdrawn  
-Does partner criticize her in front of  
you, making remarks that make  
nurse uncomfortable

e. Abuse and neglect of elders

Physical Indicators

*Physical abuse*

- Injury that has not been care for  
  properly
- Any injury incompatible with  
  history
- Cuts, lacerations, puncture  
  wounds
- Bruises, welts, discoloration:  
  Bilaterally on upper arms  
  Clustered on trunk but may be  
  evident over any area  
  Morphologically similar to an  
  object
- Presence of old and new bruises  
  at the same time
- Dehydration and/or  
  malnourishment without  
  illness-related cause; loss of  
  weight
- Pallor
- Sunken eyes, cheeks  
- Evidence of inadequate care  
- Evidence of inadequate or  
  inappropriate administration of medicine  
- Eye problems, retinal detachment

Behavioral Indicators

*Family Caregiver Indicators*

- Will not let the older person speak  
  for self
- Or see others without the presence  
  of the caregiver
- Obvious absence of help, attitudes  
  of indifference, or anger toward  
  the elder
- Aggressive behavior
- Blaming the elder for things beyond  
  the elder’s control (incontinence)
- Previous history of abuse to others  
- Problems with alcohol or drugs  
- Indications of inappropriate sexual  
  relationship
- Restriction of the activity of the elder within  
  the family unit
- Conflicting accounts of incidents by  
  the family and victim
- Unwillingness or reluctance to  
  comply with  
  service providers in planning for  
  care of elder
- Withholding of security and  
  affection
Poor skin hygiene
-absence of hair and/or hemorrhage
-beneath the scalp
-soiled clothing or bed
-burns-cigarette, caustic, acid, friction, or contact with objects
-signs of confinement (tied to furniture, bathroom fixtures, locked in room)
-lack of bandages on injuries, evidence of unset bones

Financial Abuse
- unusual activity in bank accounts
- power of attorney given when the person is unable to give a valid power of attorney
- refusal to spend money on the care of the elder
- recent change of title of house in favor of a "friend" when the older person is incapable of understanding the nature of the transaction
- placement not commensurate with financial ability of the elder
- personal belongings (art, silverware, jewelry) missing
- promises of lifelong care in exchange for willing or deeding of all property and money to caretaker
- activity in bank accounts that is inappropriate to the older adult, i.e., withdrawals from automated banking machines when the person has no way to get to the bank
- concern by relatives that too much money is being spent for the care of the older person
- recent acquaintances expressing undying affection for a wealthy older person
- recent will when the person is incapable of making a will
- lack of amenities such as grooming items or clothing when the estate can afford to buy it
- isolation of elder from old friends and family so that the elder becomes alienated from those who care and so becomes overly dependent on the caretaker
- signatures of checks that do not resemble the elder's signature
- checks and documents signed when the elder cannot write

Psychological abuse
- elderly patient caregiver seems indifferent or angry
- caregiver unwilling to cooperate with health care providers
- caregiver verbally abusive
- person not being allowed to speak for oneself or outside of the presence of the suspected abuser
- appears withdrawn, isolated, depressed, demoralized or fearful

f. Abuse and Neglect of Children

**Physical Indicators**
- Physical abuse
- unexplained bruises and welts
- in various stages of healing
- clustered or forming patterns

**Behavioral Indicators**
- Physical abuse
- wary of adult contacts
- apprehensive when other children cry
- extremes of behavior; aggressiveness or...
on several surface areas
-reflecting shape of article used

unexplained burns
- cigar or cigarette burns on soles, palms, back or buttocks
- immersion burns (socklike, glovelike, doughnut shaped on buttocks or genitalia)
- rope burns on arms, legs, neck or torso

unexplained fractures
- in various stages of healing
- multiple or spiral fractures

unexplained lacerations or abrasions
- to mouth, lips, gums, eyes
- to external genitalia

Physical neglect
- consistent hunger, poor hygiene, inappropriate dress
- lack of medical or dental care
- constant fatigue, listlessness, or falling asleep in class

Sexual abuse
- difficulty in walking or sitting
- torn, stained, or bloody underwear
- genital pain or itching
- bruises or bleeding from the external genitalia, vaginal or anal areas
- venereal disease, especially in pre-teenagers
- pregnancy

Mental/emotional abuse or maltreatment
- failure to thrive
- lag in physical development
- speech disorders

D. Reporting
1. It is a requirement by law to report any case of alleged or suspected abuse, maltreatment and/or neglect. Failure to report such cases can be prosecuted as a misdemeanor. Person who reports in good faith is immune from liability. (Code 19-7-5).
2. Reports of known or suspected abuse or neglect of any patient should be made by staff members including, but not limited to: (O.C.G.A. 31-7-9)
   -physician, physician assistant
   -medical examiner
   -health or mental professional
   -nurse; registered, LPN or Advanced Registered Nurse Practitioner
   -hospital personnel engaged in the admission, examination, care, or treatment or persons
   -employees of a medical facility that have contact with patients

3. If abuse or neglect is suspected, this shall be reported as soon as possible to the Department Director (or designee) of the unit where the patient is located or house supervisor.

4. Each report of known or suspected abuse or neglect shall be made as soon as possible to the Department of Family and Children’s Services at 228-1386, the abuse registry, or to the local law enforcement agency having jurisdiction in our area.

   Any person who has reasonable cause to suspect that a child died as a result of child abuse or neglect, should report his/her suspicion to the appropriate medical examiner via the coroner’s office (Joey Connor 229-4994).

5. After evaluation and treatment in the Emergency Department, the patient may be admitted to the hospital to provide a safe and secure environment. If necessary, persons accompanying the patient to the Emergency Department may be detained by Hospital staff.

6. The special needs of patients who are receiving treatment for emotional or Behavioral disorders shall be addressed by the assessment process and referred to the appropriate discipline or facility for management of further care.

7. Non-accidental injuries (any persons). Physicians and hospital personnel are required by law to report to law enforcement officers information concerning any patient who is believed to have suffered physical injuries by other than accidental means. An oral report must be made immediately to the immediate supervisor, the administrator on call or the house supervisor, who should then report to the law enforcement agency in whose jurisdiction the hospital is located. The report must contain the patient’s name, nature of the injury and any information which might establish the cause of injury or identify the perpetrator.

E. Community Resources

   Personal Growth Center
   141 W. Solomon Street
   Griffin, Ga. 30223
   228-8892

C:\Documents and Settings\Kimberly Woodall\Desktop\Students\Orientation for NTE (Nursing Student)\Handouts\ADM--Abuse--Identification and Reporting Guidelines for suspected victims rev. 6.07.docm
### Administrative Policy and Procedure Manual

**Title:** Abuse Identification and Reporting Guidelines for Suspected Victims

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<thead>
<tr>
<th>Effective Date: 2/95</th>
<th>Last Review/Revise Date: 6/07</th>
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#### 24 Hour Emergency Services Crisis Hotline: Toll Free 1-800-282-1120

<table>
<thead>
<tr>
<th>Locality</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Christian Women’s Center</td>
<td>227-3700</td>
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<tr>
<td>738 W. Poplar Street</td>
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<tr>
<td>Griffin, Ga. 30223</td>
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<tr>
<td>Department of Family and Children’s Services</td>
<td>228-1386</td>
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<tr>
<td>317 S. 8th Street</td>
<td></td>
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<tr>
<td>Griffin, Ga. 30223</td>
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<tr>
<td>After hours - 1-800-829-2255 (listen for tone, then press 596-6035)</td>
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<tr>
<td>Griffin Police Department</td>
<td>227-2241</td>
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<tr>
<td>City Hall</td>
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<tr>
<td>Griffin, Ga. 30223</td>
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<tr>
<td>Spalding County Sheriff’s Department</td>
<td>228-9900</td>
</tr>
<tr>
<td>E. Broad Street</td>
<td></td>
</tr>
<tr>
<td>Griffin, Ga. 30223</td>
<td></td>
</tr>
<tr>
<td>District Attorney’s Office</td>
<td>647-4042</td>
</tr>
<tr>
<td>235C E. Slaton Avenue</td>
<td></td>
</tr>
<tr>
<td>Griffin, Ga. 30223</td>
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</tr>
<tr>
<td>Department of Public Health</td>
<td>227-5528</td>
</tr>
<tr>
<td>Grady Memorial Hospital Rape Crisis Center</td>
<td>659-7273</td>
</tr>
<tr>
<td>Clayton County Rape Crisis Team</td>
<td>996-HELP</td>
</tr>
<tr>
<td>Council on Battered Women, Inc.</td>
<td>873-1766</td>
</tr>
<tr>
<td>P.O. Box 54737</td>
<td></td>
</tr>
<tr>
<td>Atlanta, Ga. 30308</td>
<td></td>
</tr>
<tr>
<td>YWCA of Cobb County</td>
<td>427-3390</td>
</tr>
<tr>
<td>48 Henderson Street</td>
<td></td>
</tr>
<tr>
<td>Marietta, Ga. 30064</td>
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#### F. State and National Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>Phone Numbers</th>
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<tbody>
<tr>
<td>National Resource Center on Domestic Violence</td>
<td>800-537-2238</td>
</tr>
<tr>
<td>Family Violence Prevention Fund’s Health Resource on Domestic Violence</td>
<td>800-313-1310</td>
</tr>
<tr>
<td>Mental Health Effects of Family Violence</td>
<td></td>
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<tr>
<td>National Coalition Against Domestic Violence</td>
<td>202-638-6388 or 303-839-1852</td>
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</table>
Duluth Domestic Abuse Intervention Project
(some batterers’ treatment information too)

218-722-2781

Battered Women Fighting Back!, Inc. 617-482-9497

National Center on Women and Family Law, Inc. 212-674-8200

National Clearinghouse for the Defense of Battered Women 215-351-0010

National Clearinghouse on Marital and Date Rape 510-524-1582

Fenway Community Health Center’s Victim Recovery Program 617-267-0900

National Coalition Against Sexual Assault 202-483-7165

National Organization for Women (NOW) Action Center (202) 347-2279

425 Thirteenth St., N.W., Room 1048, Washington, D.C. 20004

Information is available on the over 200 rape task force chapters in the country.

National Center for Prevention and Control of Rape (part of NIMH), 5600 Fishers Lane, Rockville, MD. 20857. They have a rape program directory free of charge.

Child Abuse:

National Child Abuse Hot Line (Child Help USA) 800-422-4453

State Programs

(DVC = Domestic Violence Coalition)

*Georgia DVC: 800 643-1212 Director of Family and Children’s Services

404-657-3409

Department of Human Resources
Child Protective & Placement Services Unit

404-657-3408

Sources:
Georgia Code Section 19-7-5 Chapter 49-5-40. Georgia Laws Pertaining to Child Abuse and Neglect


C:\Documents and Settings\Kimberly.Woodall\Desktop\Students\Orientation for NTE (Nursing Student)\Handouts\ADM--Abuse-Identification and Reporting Guidelines for suspected victims rev. 6.07.docm

Author/Revised/Reviewed by:
2/95 - Kim Stephens ICU Dir
12/97 - K Stephens
12/00 - CNO
11/03 - CNO
6/06 - CNO
6/07 - CNO

Committee Approval:
2/95 - Administration

g/policies/nursing/administrative/abusesus
<table>
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<th>Title:</th>
<th>Abuse Identification and Reporting Guidelines for Suspected Victims</th>
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<td>2/95</td>
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<tr>
<td>Last Review/Revise Date:</td>
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