Gentherm heating canisters will replace Owens and Minor canisters starting 12/16/25. Pads will remain the same.

Old product

New product

The Micro-Temp® LT Localized Heat Therapy System is intended to warm a patient's body part through conductive heat transfer. The conductive heat therapy is provided by circulating warm water through localized temperature therapy pads. The Micro-Temp® LT Unit is composed of a heater, a circulating pump, and a microprocessor. The Micro-Temp® LT is intended for use by appropriately trained healthcare professionals in healthcare facilities and in home care environments.

Supplies Needed:

- Micro-Temp® LT unit
- Thermal Pad
- Sterile water or water that has been passed through a filter less than or equal to 0.22 microns.

1. Check that the power switch is in the "O" position (unit is off).
2. Check the level of sterile water or water that has been passed through a filter less than or equal to 0.22 microns in the reservoir. To do so, twist off the cap of the water fill opening and check if the water is visibly touching the strainer. If needed, carefully add sterile water. Do not use de-ionized water. Do not overfill.
3. Insert the plug into a properly grounded receptacle.
4. Lay the localized heat therapy pad flat towards the unit.
5. If the pad is already filled, check that there are no leaks. Water leaks present a risk of infection. Leaking pads should never be used.
6. Connect the pad to the Micro-Temp® LT unit.

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OPERATING THE MICRO-TEMP® LT SYSTEM:

1. Turn power switch to the "I" ON position.
2. When started up, the Micro-Temp LT unit flashes the 42˚C default set point four times and then it will show the actual water temperature.
3. Press and hold the "SET" button, then press either the up or down arrow to change the SET temperature display to the desired patient temperature. The display can only be set between 20˚C – 42˚C. When the desired set temperature is displayed, release the arrow and SET buttons.
4. A physician's order is required for the use of the device and setting the temperature of the blanket/ pad.

At least every 20 minutes, or as directed by physician, check patient's temperature and skin condition at area in contact with blanket/pad.

TROUBLE SHOOTING:

ALARM NOTE:

Power Failure: If power is removed from the unit without actuating the power switch (I/O switch), a "Power/Failure Caution" LED flashes and audible indicator sounds. This continues until power is restored to the unit, or until the power switch is turned to the "O" (OFF) position. If power is restored to the unit, the unit will resume previous operation.

ALARM NOTE:

>1°C (2°F): If the set point temperature has been set at least 1°C (2°F) lower than the actual circulating water temperature, the display flashes the actual water temperature, an audible indicator sounds 2 beeps while flashing the red "Power/Failure Caution" LED and the heater shuts off. If the water temperature does not return to set point after 9 minutes, the 2 beep audible indicator will again sound and the red "Power/Failure Caution" LED will again flash. The actual water temperature will continue to flash until the water temperature returns to the set point.

ALARM NOTE:

HL (High Limit): If the circulating water temperature has reached the high temperature limit of 44˚C (+5˚C or -5˚C). when this occurs, the red "Power/Failure Caution" LED illuminates, an audible indicator sounds continuously, and the pump and heater shut off. This indicator condition cancels only after the unit has been powered down and the water temperature has cooled below 42˚C. The unit should not be used again until it is serviced.

ALARM NOTE:

Low Water: This indicator condition occurs when the unit is low on water. When this occurs, the yellow "Low Water" LED illuminates and the pump and heater shut off. Once sufficient water level is obtained the unit returns to previous operation.

ALARM NOTE:

Tilt Switch: This indicator condition occurs when the unit has tilted beyond approximately 20° in any direction. When this occurs, an audible indicator sounds, the red "Power Failure/Caution" LED flashes, and the heater and pump shut down. Once the unit returns to an acceptable operating angle, the unit returns to previous operation.

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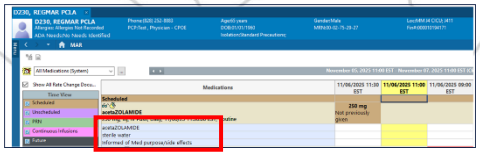
New Powder Vial Reconstitution Process Go-Live December 9th, 2025

Scan the QR Code to complete the required HealthStream module

The new process relocates sterile diluents (water for injection/saline) from the supply room to the Pyxis to ensure the correct diluent is pulled with the medication vial. It requires nurses to scan the diluent and manually adjust the final dose and volume in the electronic documentation to reflect the actual reconstituted product being administered.
The drug and diluent will both show beneath the order on the MAR.

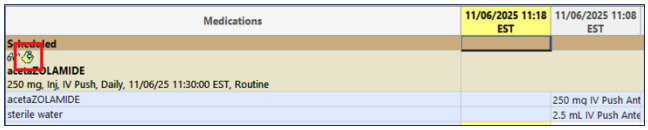


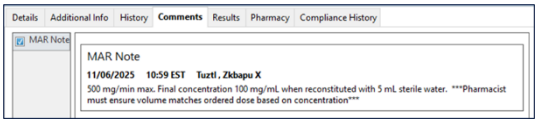
Why the Change?

- Enhance Patient Safety: This new process is designed to minimize the risk of medication errors associated with incorrect diluent usage and inaccurate dose/volume documentation.
- Ensure Correct Diluent: Moving the diluents into the Pyxis and linking them to the pull prompt creates a system-level check to help ensure the correct diluent (Sterile Water or Saline) is selected for reconstitution.

Locating Reconstitution Instructions

- Reconstitution can be found in the MAR Note. Left Click the push-pin symbol and select comments. Note the amount of the diluent needed for reconstitution. This will need to be documented when the medication is documented on the MAR.



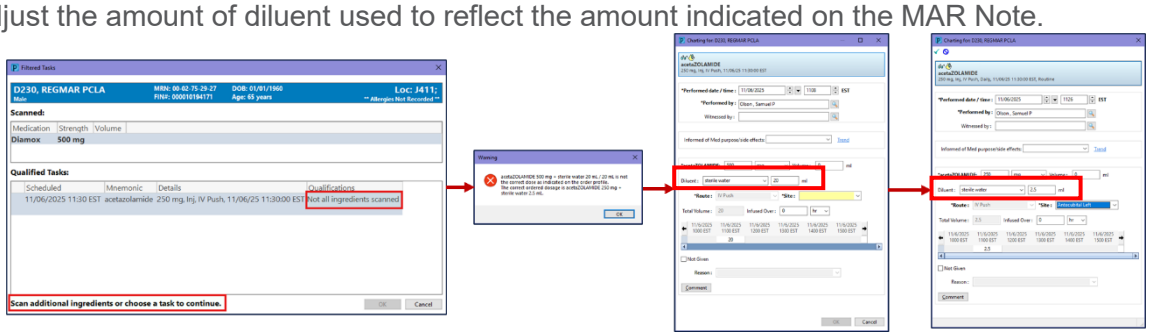


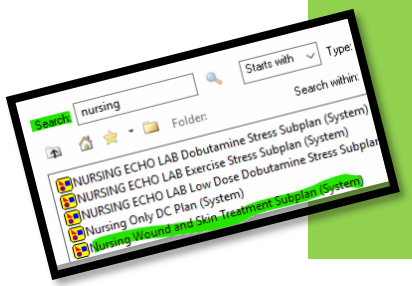
At the Pyxis

- When the medication is pulled from Pyxis, the nurse will be prompted to also remove the diluent (sterile water or sterile saline).
  - Sterile Water and Sterile Saline will no longer be available in the supply room.
- Reconstitution should occur at the patient's bedside.
- Note: If a medication is removed using the Pyxis override function, the nurse will also need to override the diluent (sterile water or sterile saline).

Using the Bar Code Medication Administration (BCMA) Process

- Prior to administration, the nurse will scan the powder medication vial and the diluent (sterile water or sterile saline).
- Adjust the amount of diluent used to reflect the amount indicated on the MAR Note.





Wound of the Week (wow!): What is it?

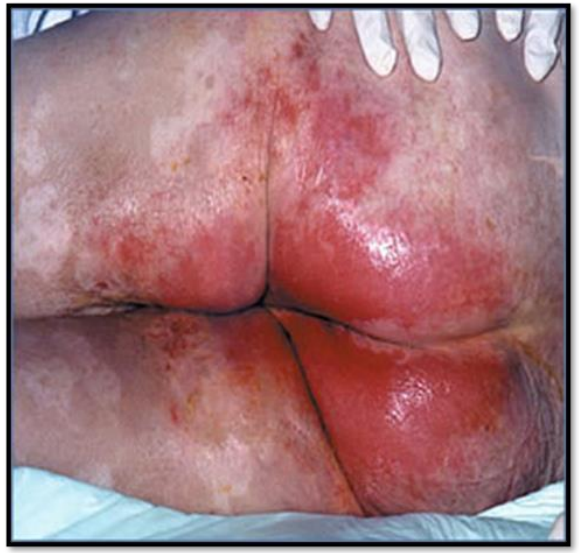
CHART IT RIGHT

- Wound Type
- Abrasion
- Avulsion
- Bite
- Blister
- Burn
- Cannulation
- Contusion
- Crush
- Denuded
- Donor Site
- Excoriation
- Friction/Shear
- Gunshot Wound
- Heel Sticks
- Hematoma
- Incontinence associated skin damage
- IV Extravasation
- Laceration
- Lesion
- Moisture associated skin damage
- Moisture Fissure
- Non-pressure
- Operative/Incision
- Penetrating
- Pin Site
- Pressure Injury
- Puncture
- Scab
- Skin Tear
- VAD Driveline

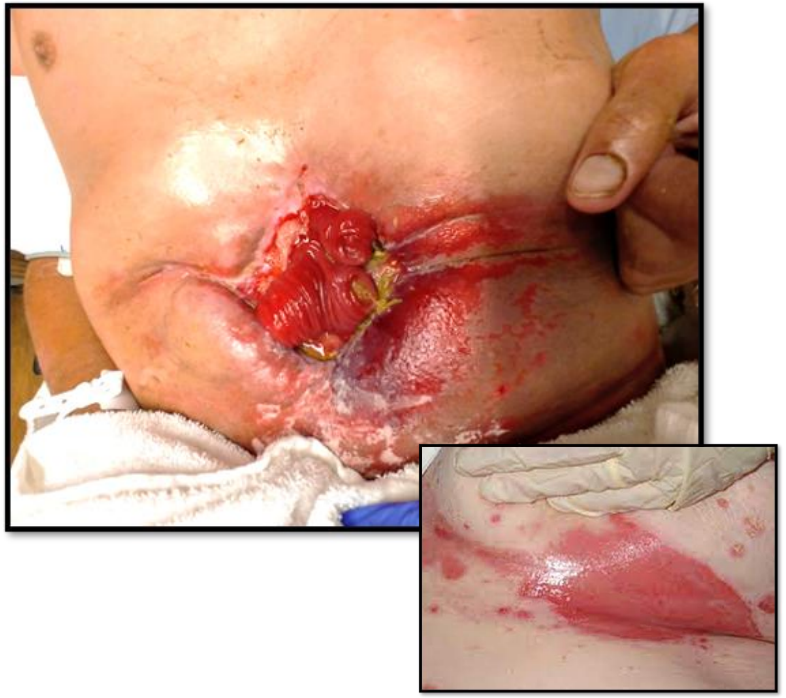
Excoriation

LINEAR SCRATCHES

Incontinence Associated Skin Damage



Moisture Associated Skin Damage



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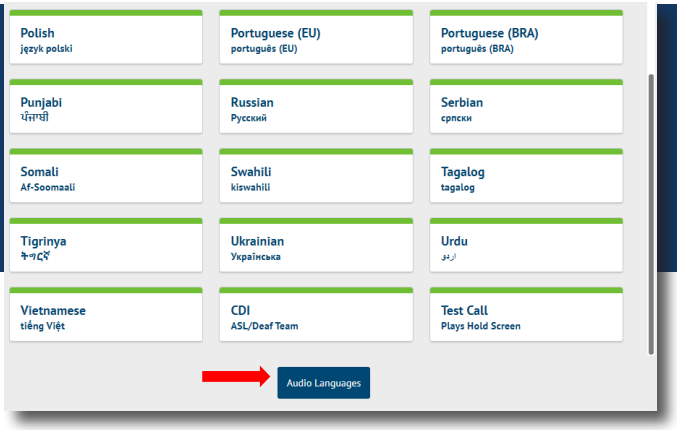
How to use the AMN Language Services Application for Audio

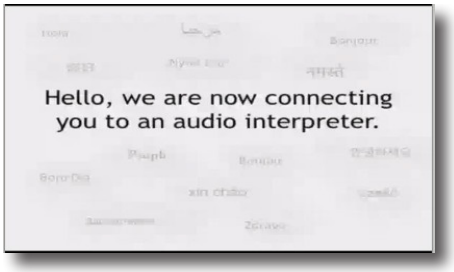
DON'T SEE THE LANGUAGE YOU NEED? MORE THAN 200 LANGUAGES ARE AVAILABLE OVER AUDIO.



Select the "Audio Languages" button.

The Video languages home screen will disappear and you will be redirected to a white hold screen confirming an interpreter will be with you shortly.

Once the operator is entering the session, another screen will appear letting you know you are being connected. Once connected, state the language you need.



While in the session, the "End" button will disappear. Tap the screen and the end button will appear at the bottom of the screen to end the call.

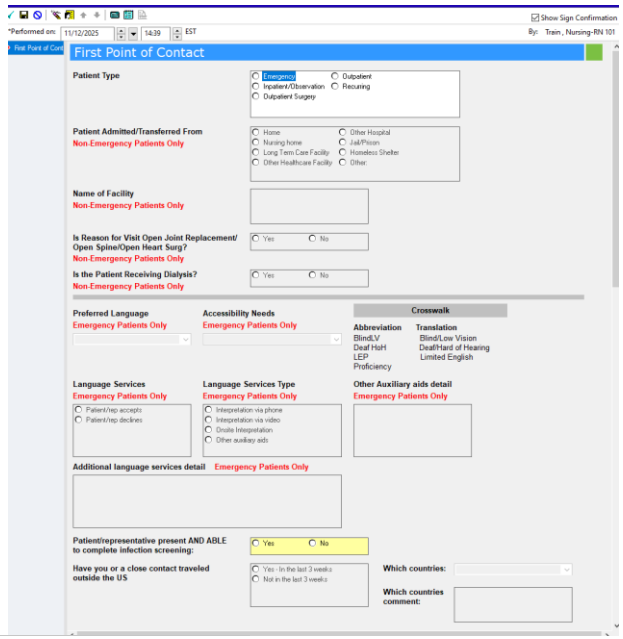
CUSTOMER SUPPORT: 855-663-1231

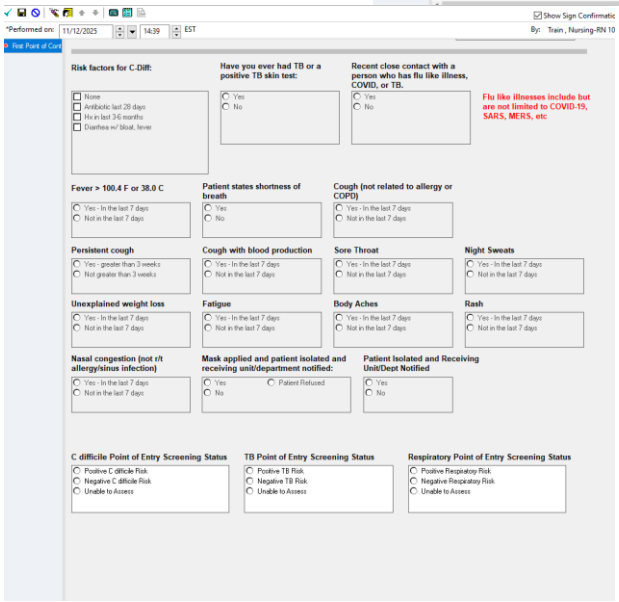
To learn more, visit www.stratusvideo.com

HUDDLE CARD

First Point of Contact Screening (FPOC)

- Complete FPOC within 24 hours:
  - Every patient must have an FPOC screening assessment completed within the first 24 hours of admission.
- Ensure accuracy and completeness:
  - All fields must be filled out thoroughly to provide a comprehensive overview of the patient's status.
  - If you are unable to obtain answers to the questions from the patient, ask the family or facility they came from to help clarify.
- Identify potential issues early:
  - Accurate documentation helps to detect possible problems promptly, supporting timely interventions, and improved patient outcomes.
  - Accurately identifying items like recent antibiotic use is critical in identifying the potential for C.Diff. Early identification leads to prompt testing, treatment, and aids in prevention.





MISSION HEALTH

Updated: 11/12/25

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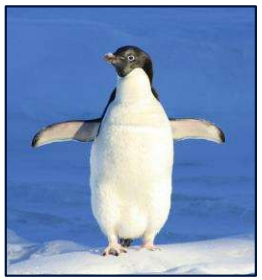
HUDDLE CARD

Traversing Wet and Icy Surfaces

Navigating wet and icy surfaces requires some careful consideration to avoid slips and falls. Here are some tips to help you stay safe:

- ❑ **Wear Appropriate Footwear:** Shoes with good traction and non-slip soles can make a big difference. Avoid smooth-soled shoes.
- ❑ **Take Small Steps:** Short, deliberate steps help you maintain better balance and reduce the risk of slipping.
- ❑ **Keep Your Hands Free:** Use your arms for balance, but avoid carrying heavy items that can affect your stability. Use the elevator when carrying bulky items.
- ❑ **Walk Slowly:** Rushing increases the risk of slipping. Take shorter steps at a slower pace.
- ❑ **Keep an Eye Out for Changing Surfaces:** Be aware of the surface you are walking on and adjust your pace when needed. If possible, walk on cleared paths or areas with gravel or sand.
- ❑ **Keep Your Feet Flat:** Walk flat-footed with your feet pointed slightly outward. This increases your contact area and stability. Penguin waddle!
- ❑ **Maintain a Wide Stance:** Spread your feet apart to increase your balance and lower your center of gravity.
- ❑ **Use Handrails:** If available, use handrails or other supports to help with balance.
- ❑ **Avoid Slippery Areas:** Look ahead to spot and avoid particularly slippery surfaces/icy patches.
- ❑ **Be Mindful of Black Ice:** Black ice is hard to see but can be extremely slippery. Be extra cautious in shaded areas or early in the morning.
- ❑ **Use Caution When Entering or Exiting Vehicles:** The areas around cars can be particularly icy. Take extra care when getting in or out.
- ❑ **Practice Falling Safely:** If you do slip and fall, try to fall with your body relaxed to reduce the risk of injury. Aim to fall on your side rather than your back or front.



**All accidents and injuries should be reported using Vigilanz. Call Mission WorkWell (828-213-9600) to be seen if medical attention is required as a result of your injury.

Updated: 9/4/24

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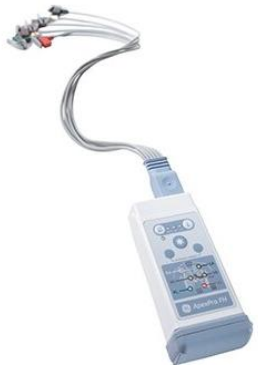
HUDDLE CARD

Central Monitoring Unit (CMU)-Bathroom Process

Go-Live 11.17.25

We must ensure that patients continue to receive the appropriate level of monitoring.

- Patients hardwired to in-room monitors (not utilizing a telemetry box), **must not be removed from the monitor to go to the bathroom**.
- **CMU will begin escalating <u>any</u> loss of visual.** The previous 15-minute “bathroom grace period” will no longer be observed.
- **What should caregivers do:**
  - If a patient needs to use the bathroom, **utilize a bedside commode** or **transition to a tele box** with a pulse oximetry cord if needed, consistent with the current monitoring order.



HUDDLE CARD

Central Monitoring Unit (CMU)-Shower Process

Adhere to the following steps when removing a patient's telemetry for a shower:

Required Action Steps

- **Order Required:** Caregivers must have a **physician order** to temporarily remove telemetry for a shower.
- **Monitor Tech Verification:** Monitor Technicians are **required** to verify the existence of the "removal for shower" order when they are notified of the removal.
- **Caregiver Supervision:** The **caregiver must stay with the patient** for the entire duration of the shower.
- **Reapplication Deadline:** Telemetry **must be reapplied** and functional **within 30 minutes** of the initial removal.
- **Notify CMU:** Caregivers must **call the CMU immediately** upon completion of the shower and reapplication of telemetry to confirm visual monitoring is resumed.

Escalation Procedure

- **CMU will begin the escalation process if telemetry monitoring has not resumed within 30 minutes of its initial removal.**

HUDDLE CARD

Broset Violence Checklist: Age Change

Go-Live 11/25/25

The Broset Violence Checklist must now be completed for **ALL patients** (exclusions: newborns admitted to MOMB or NICU). This updates the previous policy, which excluded patients under age 12.

- This is a tool used to a evaluate patient's risk upon admission, and as part of ongoing assessment for signs of violence or behaviors that may indicate a risk for impending violence.

Broset Violence Checklist	
Confusion	Disoriented, unaware of time, people, or location
Irritability	Annoyed, angry, unable to tolerate others
Verbal Threatening	Intent to intimidate or threaten another person
Attacking Objects	Throwing or kicking objects, slamming doors
Boisterousness	Overtly loud, yelling
Physically Threatening	Intent to threaten, aggressive stance, clenched fists

1. **Score of Zero (0) = Minimal risk for violence**
2. **Score of one or two (1-2) = Moderate risk for violence**
   - Preventative measures should be taken
3. **Score of greater than two (>2) = High risk for violence**
   - Preventative measures should be taken, and a plan should be created for how to manage/intervene with a violent episode.

Brøset Violence Checklist 1PC.PSYI.0093

MISSION HEALTH

Updated: 11.5.2025

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Clinical Updates

New Vial-2-bag Medication Conversions: Go-Live 12/10/25

- Amiodarone 150mg/100ml D5W (Bolus)
  - Amiodarone 150mg/3ml vial will be in Pyxis.
  - The D5W 100ml IV bag (Non-PVC bag) will be in Pyxis.
  - Vial-2-bag adapter will be in the nursing supply room.
- Amiodarone 450mg/250ml D5W (Drip)
  - Amiodarone 450mg/9ml vial will be in Pyxis
  - The D5W 250ml IV bag (Non-PVC bag) will be in Pyxis.
  - Vial-2-bag adapter will be in the nursing supply room.
- Vasopressin 20 units/100ml NS (Drip)
  - Vasopressin 20 units/1ml vial will be in Pyxis.
  - The NS 100ml IV bag and the vial-2-bag adapter will be in the nursing supply room.
- Vabomere (Meropenem/Vaborbactam) 2gm/250ml NS
  - This is a "restricted" medication and therefore will only be dispensed from the main pharmacy. It will be dispensed as a "kit" that contains the Vabomere vial, 250ml NS, and the Vial-2-bag adapter.

Methylprednisolone dose adjustment in Critical Care Plans: Go-Live 12/9/25

- Changed to reflect more standard doses of steroids for common ICU conditions. If higher doses are needed, they may be ordered outside of the standard ICU plan.
- Change from 125 mg, IV push Q6hr to 40 mg, IV push Q12H
- Change from 125 mg, IV push Q8hr to 40 mg, IV push Q24H
- Removing addition dose