HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Radiology Department		
Document:	Multidisciplinary Policy and Procedure		
Title:	Contrast Media Policy		
Applies To:	All Radiology Staff , Physicians and Nurses		
Preparation Date:	January 05, 2025	**Index No:**	RD-MPP-009
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1. PURPOSE:

1.1 The purpose of this policy is to address the proper review, storage and safe administration of radiographic Contrast Media.

2. DEFINITIONS:

2.1 **Contrast Media** – a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography.

3. POLICY:

3.1 Contrast Media are considered medications and must be provided to patients in a safe manner and in accordance with all pertinent state and federal regulations and applicable accreditation standards.

4. PROCEDURE:

4.1 Appropriate consent must be obtained per hospital consent policy.
4.2 The patient will be advised regarding appropriate use of Contrast Media and potential side effects that if they occur, must be communicated with the patient's physician.
4.3 The process for safe administration of Contrast Media begins prior to administration and will include:
- 4.3.1 Presence of risk factors identified and addressed.
- 4.3.2 Verification of correct agent, dosage.
- 4.3.3 Verification of correct patient.

4.4 Orders for Contrast Media include the following information:
- 4.4.1 Contrast to be used.
- 4.4.2 Radiographic examination to be performed
- 4.4.3 Administration instruction.

4.5 Contrast Media will be stock in Radiology Department with maintained temperature.
4.4 An appropriate inventory level will be maintained at all times as determined by the department that stocks the Contrast Media.
4.5 Contrast Media must be stored in accordance with manufacturer.
4.6 When applicable, if warmers are used, temperature logs shall be maintained.
4.7 Radiographic material will be secured.
4.8 Retrieval of the Contrast Media from the secured storage area shall be as needed per patient need.
4.9 When appropriate, a recent (within the last 30 days) serum creatinine (SCr) shall be obtained and reviewed for potential contraindications in use of contrast. In the event a recent SCr is not available, an order to obtain a SCr prior to the scheduled procedure will be obtained.
4.10 In the event the screening process determines that the patient is at-risk for an adverse event due to administration of radiographic contrast media, the technologist/nurse is required to contact the physician for next step orders. At-risk patients can include, but are not limited to, those patients that:

4.10.1 Are Diabetic.
4.10.2 Have reduced renal function, renal disease or a solitary kidney.
4.10.3 Are pregnant.
4.10.4 Have had a previous history of allergy or reaction to contrast media.
4.10.5 Have had a clinically significant drug-contrast interaction.
4.10.6 Have significant respiratory or cardiovascular disease.

4.11 If hypersensitivity/allergy is noted to a radiographic contrast media, the physician or licensed independent practitioner will be notified prior to procedure for subsequent orders.

4.12 A Radiologist will inject intravenous contrast agents for the purpose of the radiological procedure.

4.13 A physician shall be readily available to the patient before and during IV contrast administration in the event an adverse contrast event were to occur.

4.14 Prior to administration, appropriate labelling will occur unless contrast is for immediate use. Labelling will include name of contrast, strength of contrast, amount of contrast, and expiration date/time.

4.15 If an adverse event/reaction was to occur, the physician/licensed independent practitioner will be notified immediately. Treatment will be rendered

4.16 Documentation of adverse events/reactions will be entered into the medical record.

4.17 In the event of an emergency situation, crash carts shall be readily available for use.

5. MATERIALS AND EQUIPMENT:

5.1 Contrast media.

6. RESPONSIBILITIES:

6.1 Nurse
6.2 Radiographer
6.3 Radiologist
6.4 Physician

7. APPENDICES

7.1 MOH General Consent Form: GDOH-COR-GC-351

8. REFERENCES:

8.1 Prescription drug information for consumers and Professionals (www.drugs.com).
8.2 The comprehensive resource for physicians, drug and illness information (www.rxmed.com).
8.3 Contrast Medium Reactions, Recognition and Treatment (www.emedicine.com).

9. APPROVALS:

	Name	Title	Signature	Date
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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: رقم الملف الطبي:

Name: الاسم:

Nationality: الجنسية:

Age: العمر: يوم Days ☐ شهر Months ☐ سنة Years ☐

Date of Birth: تاريخ الميلاد: ____ / ____ / 14____ H ____ / ____ / 20____

Gender: ☐ Male ☐ Female الجنس:

GENERAL CONSENTS إقرارات عامـــة

I (for Named Patient) signed below, authorize and give consent to my attending physician and/or his/her assistant to provide medical, nursing care and other clinical diagnostic or therapeutic procedures with the exception of surgical and invasive procedures, induction of anesthetics, infusion of blood and blood products and other procedures that require special consent.	أنوه أنا (المريض) الموقع أدناه، وأعطي موافقتي للطبيب المعالج ولمن يختار لمساعدته وذلك لتقديم عناية طبية وتمريضية وأي تشخيصات سريرية أو أية طرق علاجية بإستثناء العمليات الجراحية والإجراءات التداخلية حقن الدم أو مشتقاته أو أي عمل آخر يتطلب موافقة خاصة.
I understand that Dr. _____ _____ is attending physician and is the person responsible for the assessment of my medical condition & my care plan & he/she will have the responsibility according to my medical condition, to Discharge or Transfer.	لقد تم إعلامي أن الطبيب المعالج د. _____ _____ هو الشخص المسؤول عن تقييم حالتي الطبية وخطة علاجي وتقع عليه/ عليها مسؤولية أمر خروجي من المستشفى أو تحويلي الى أية جهة عناية صحية أخرى وذلك بناء على ما تستدعيه حالتي الصحية.
I understand that the hospital and its employees will respect my rights and privacy at all times and that the confidentiality of my medical information will be guarded carefully and released only to authorized person.	أفهم وأعي أن المستشفى وموظفيه سوف يحترمون خصوصياتي في كل الأوقات وأن سرية المعلومات الطبية الخاصة بي سوف يحافظ عليها بعناية وسوف تستخدم فقط وحصريا لأجل العلاج وأن تعطى فقط لهؤلاء الأشخاص الذين يقومون على رعايتي. ولن يتم إعطاء المعلومات لأي شخص أو جهة إلا في حالة موافقتي الشخصية أو موافقة الشخص المصرح كبديل عني.
I shall abide by the hospital rules and regulations.	سوف التزم واطيع كل القوانين والنظم الخاصة بالمستشفى.
I understand that the hospital is not responsible for the loss or damage of my money, valuables and other personal property and that in case of emergency or no alternative situations the items should be handed over to the security for safekeeping.	أفهم إن المستشفى لا تتحمل مسؤولية فقدان النقود، المقتنيات الثمينة أو أية ممتلكات خاصة بي الا في الحالة الطارئة أو في حالة عدم وجود بديل للحفاظ على ممتلكاتي حيث ان هذه الممتلكات يجب أن تعطى لمسؤولي الامن في المستشفى للحفاظ عليها.
If it is found that I am not eligible for free treatment, I am obligated to pay for all services rendered as per my healthcare needs, I agree that the authorities and Kingdom's courts will decide any dispute in connection with such costs.	إذا اتضح إني غير مؤهل للعلاج المجاني فإني أتفهم إني مطالب بدفع كل المصاريف المتعلقة بعلاجي وأوافق أن الجهات المختصة والمحاكم بالمملكة العربية السعودية هي التي تقرر مسؤولية الدفع في حالة وجود خلاف حول المصاريف الواجب دفعها.
In case of emergency, where I am not coherent or conscious and unable to make my healthcare decision, I hereby grant the following person (s) the right to take decision of my medical treatment on my behalf:	إذا كان هناك طارىء أو حالة عيبوبة أو عدم تركيز وكنت غير قادر على إتخاذ قرار بشأن حالتي الصحية فأني أمنح حق إتخاذ القرار بالنيابة عني بشأن حالتي الصحية إلى الاشخاص التالية أسمائهم.
1. Name: _____ Relation to the Patient _____ Date: ____/____/____ Time: _____	الإسم: _____ صلة القرابة: _____ تاريخ: ____/____/____ وقت: _____

Name:_____ الاسم:	MRN: رقم الملف الطبي:
I acknowledge that my signature on this form signifies that I am in agreement with all the statements. Signature of Patient:_____ Date: ____/____/____ Time: _____	أقر أن توقيعي على هذه الاستمارة يعني إنني موافق على كل بنودها وإنني قرأتها بالكامل قبيل توقيعي هذا. توقيع المريض: _____ تاريخ: ____/____/____ وقت: _____
Substitute Decision Maker	**من ينوب عن المريض (أو صانع القرار البديل)**
In case of emergency and the patient is unable to make decision and not granted any person to sign on his behalf. Substitute Decision Maker Name_____ Relation to the Patient _____ Signature: _____ Date: ____/____/____ Time: _____ Reason for Patient not signing to Consent: _____	في الحالة الطارئة وحين يكون المريض غير قادر على إتخاذ القرار ولم يمنح أحد حق التوقيع بالنيابة عنه. إسم من ينوب عن المريض:_____ صلة القرابة:_____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ سبب عدم توقيع المريض: _____
In case of emergency and no Substitute Decision Maker and patient not granted any person to sign on his behalf We certify that, we have examined the patient and it is our professional opinion that this patient lacks decision capacity to take health care decision and any delay providing medical treatment will endanger his life or lead to serious body harm. **1. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____ **2. Physician Name & ID No.:** _____ Position: _____ Signature: _____ Date: ____/____/____ Time: _____	**في الحالة الطارئة وغياب من ينوب عن المريض.** وكون المريض لم يمنح أحد حق التوقيع بالنيابة عنه. نحن نأكد ونوثق أنه عند فحص المريض وحسب رأينا المهني أن هذا المريض غير قادر على إتخاذ القرار بشأن حالته الصحية وأن أي تأخير في تقديم العناية الطبية اللازمة سوف يعرض حياته للخطر أو قد يؤدي الى عواقب وخيمة إسم الطبيب والرقم الوظيفي: _____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____ إسم الطبيب والرقم الوظيفي:_____ وظيفته: _____ التوقيع: _____ تاريخ: ____/____/____ وقت: _____

WITNESS شاهد

Name (الإسم)	Signature (التوقيع)	Date & Time (التاريخ والوقت)
1.)		
2.)		
3.)		