TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 31 – 1:30 o'clock p.m.
Assembly Room 1 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 2&3
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: CNA		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		
	d. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		
	e. Approval of prior Closed Session Minutes 1) Regular Board of Directors Meeting – July 27, 2017 2) Special Board of Directors Meeting – August 1, 2017		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	f Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d)2 (2 Matters) g. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (2) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523 (3) Larry Anderson Employment Claims		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Introduction – Susan Bond, Director of Legal Services	3 min.	CEO
13	Community Update – 1) Presentation on the DaVinci Xi – Dr. Adam Fierer, Dr. Jason Phillips and Dr. Dhruvil Ghandi 2) AHA Heart Walk – David Bennett, Chief Marketing Officer	15 min 5 min.	COO CMO
14	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Acting Chief Financial Officer	10 min.	Standard
17	New Business		

	Agenda Item	Time Allotted	Requestor
	a. Presentation by National Demographic Corporation, Douglas Johnson, President relative to redistricting	20 min.	General Counsel
	b. Public Hearing Regarding Change from At Large to District Based Election - Elections Code §10010(a)(1) *Pursuant to Elections Code Section 10010(a)(1), before drawing a draft map or maps of the proposed boundaries of the districts, the political subdivision shall hold at least two public hearings over a period of no more than thirty days at which the public is invited to provide input regarding the composition of the districts*	30 min.	General Counsel
	c. Consideration of Neurosurgery Services	5 min.	Chair
18	Old Business b. Update on LAFCO Application/Annexations	10 min.	General Counsel
19	Chief of Staff a. Consideration of August 2017 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 28, 2017 b. Consideration of Rules & Regulations: 1) Division of General Surgery 2) Division of Cardiology c. Consideration of Privilege Cards: 1) Pediatrics 2) Subspecialty of Surgery - Otolaryngology 3) Cardiology 4) OBGYN 5) Ophthalmology	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *(No meeting held in August, 2017)* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *(No meeting held in August, 2017)*	5 min.	Standard HR Comm. Emp. Fid. Subcomm.

	Agenda Item	Time Allotted	Requestor
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats – 2 *(No meeting held in August, 2017)*		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)*		FO&P Comm.
	1) Approval of an agreement with Camfil USA, Inc. for supplying and maintaining the air handler unit filters, for a total contract cost of $288,340.		
	2) Approval of an agreement with Locum Tenens Vendors, with flexibility to add or delete agencies, for supplemental physician staffing of Allied Health Providers for the duration of the remaining 20 month term, beginning August 1, 2016 through March 31, 2018, for a total cost for the term of $1,748,000.		
	3) Approval of an agreement with Pacific Registry for Cancer Committee and Cancer Registry for a term of 12 months, beginning October 1, 2017 through September 30, 2018, for an annual cost of $268,068 and a total cost for the term of $268,068.		
	4) Approval of an agreement with San Luis Rey Medical Group to provide medical oversight for the TCHD Supportive/Palliative Care Program for a term of 12 months, beginning September 1, 2017 through August 31, 2018, not to exceed an average of 40 hours per month, not to exceed 480 hours annually, at an hourly rate of $150 for a term cost of $72,000.		
	5) Approval of an agreement with Veronica Deatrick, APNP to provide medical care under the supervision of the UCSD Psychiatrists for the term of 12 months beginning July 1, 2017 through June 30, 2018, not to exceed an average of 110 hours in total per month, for a total term cost of $200,000.		
	6) Approval of an agreement with VP-MA Health Solutions, Inc. for billing and coding audit services for a term of five (5) months, beginning July 25, 2017 through December 1, 2017 for a total cost for the term of $40,000.		
	7) Approval of an agreement with Info US, Inc. for the upgrade of Cloverleaf Interface engine for a term of 12 months, beginning September 1, 2017 through August 31, 2018, for an annual cost of $56,400 and a total cost for the term of $338,400.		

	Agenda Item	Time Allotted	Requestor
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* 1) **Administrative Policies and Procedures** a. Cellular Phones and Other Electronic Digital Device Usage Policy b. E-Mail Access c. Remote Access: Physicians and Physician Office (DELETE) 2) **Unit Specific – Infection Control** a. Department Specific Wound Care Center (DELETE) b. Ebola Plan Policy c. Mold Abatement d. Prion Diseases: Transmissible Spongiform Encephalophaties e. Standard and Transmission-Based Precautions f. Disease Index: Type and Duration of Precautions for Selected Infections and Conditions (DELETE) 3) **Unit Specific – Medical Staff** a. NP - Cardiology Standardized Procedures b. Credentialing Standards for Vertebral Augmentation c. Focused Professional Practice Evaluation- Proctoring d. NP - Hospitalist Standardized procedures e. NP - Neonatal Standardized Procedures f. NP - OB/ GYN Standardized Procedures g. NP – Oncology Oncology Standardized procedures h. NP - Orthopedic and Spine Institute Standardized Procedures i. NP - Pediatrics Standardized Procedures j. Psychiatry Division Standardized Procedures 4) **Unit Specific - NICU** a. Developmental Supportive Care in the NICU 5) **Unit Specific – Outpatient Behavioral Health** a. Abbreviations b. Admission and Eligibility Criteria c. Admission Assessment d. Attendance & Leaving Early Without Notifying Staff (DELETE) e. Clinical Assessment f. Community Meetings (DELETE) g. Community Outings (DELETE) h. Contraband i. Daily Progress Notes j. Destructive or Potentially Violent Behavior k. Disaster Plan l. Discharge Planning and Discharge m. Disclosure of Information Over the Telephone (DELETE) n. Dress Code for Patients (DELETE) o. Family Involvement p. Involuntary Patient Detention		PAC

	Agenda Item	Time Allotted	Requestor
	q. Laboratory Services r. Medical Emergencies s. Medically Excused Absences (DELETE) t. Medicare Additional Development Request (DELETE) u. Non-Compliance with Program Rules(DELETE) v. Organizational Structure w. Patient Complaints (DELETE) x. Physician Admission Order y. Physician and Nurse Practitioner Orders (DELETE) z. Plan for Professional Services and Staff Composition 1. Positive Reinforcement Techniques (DELETE) 2. Psychiatric Emergencies 3. Referral and Admission Screening 4. Release of Information (DELETE) 5. Role of Therapist 6. Smoke Free Environment 7. Standards for Clinical and professional practice 8. Summary of Care List 9. Telephone Use by Patients (DELETE) 10. Treatment Planning 6) **Unit Specific – Outpatient Infusion Center** a. Medical Emergencies 7) **Rehabilitation** a. Aphasia Group 800 8) **Unit Specific – Telemetry** a. Monitoring Telemetry Patients Using the DASH 3000 b. Skin and Wound Team Rounds **F. Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 1 *(No meeting held in August, 2017)* **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in August, 2017)* (2) Minutes – Approval of: a) Regular Board of Directors Meeting – July 27, 2017 b) Special Board of Directors Meeting – August 1, 2017 (3) Meetings and Conferences – NONE (4) Dues and Memberships - a) Trustee Magazine Subscription - $472.00		Audit, Comp. & Ethics Comm. Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (July, 2017)	0-5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(d) Reimbursement Disclosure Report – (July, 2017) (e) Seminar/Conference Reports - None		
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3 hours	
28	Oral Announcement of Items to be Discussed During Closed Session		
29	Motion to Return to Closed Session (if needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 9, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/01/2017 – 7/31/2019)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 9/01/2017 through 7/31/2019:

- **ANTOUN, David M.D. / Internal Medicine (Coastal Hospitalist Group Inc.)**
- **KANEL, Jason M.D. / Anesthesiology (ASMG)**
- **MELLOS, Nick M.D. / Psychiatry (UCSD)**
- **NOEL, Sophonie M.D. / Anesthesiology (ASMG)**
- **PEREZ, Ronald M. D. / Family Medicine (Solo Practice)**
- **PORTER, Anthony M.D. / Orthopedic Surgery FELLOW Assist ONLY (Orthopedic Specialist N. Co)**
- **YAGER, Craig M.D. / Orthopedic Surgery FELLOW Assist ONLY (Orthopedic Specialist N. Co)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
August 09, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 9/01/2017 –8/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 9/01/2017 through 8/31/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AMINLARI, Ardalan, MD/Ophthalmology/Provisional**
- **BIEDERMAN, Bruce, MD/Diagnostic Radiology/Active**
- **CASTREJON, Joseph, MD/Family Medicine/Refer and Follow**
- **CHEUNG, Philip, MD/Anesthesiology/Active**
- **DOUGLASS, Alan, MD/Endocrinology/Active**
- **ESFANDIARI, Raheleh, MD/Obstetrics and Gynecology/Active**
- **FRASIER, Bradley, MD/Urology/Active**
- **HEINLE, Erin, MD/Anesthesiology/Active**
- **KORFF, Gary, MD/Family Medicine/Refer and Follow**
- **LIU, Alice MD/Dermatology/Refer and Follow**
- **MALHOTRA, Arati, MD/Pediatrics/Provisional**
- **MENDOZA, Jorge, MD/Teleradiology/Active Affiliate**
- **MIROW, Arvin, MD/Psychiatry/Active**
- **MOAZZAZ, Payam, MD/Orthopedic Surgery/Active**
- **MOZAYAN-ISFAHANI, Arash, MD/Ophthalmology/Provisional**
- **NIELSEN, Amy, DO/Neurology/Active**
- **OH, Bismark, MD/Emergency Medicine/Active**
- **OLSON, Scott, MD/Interventional Neuroradiology/Active Affiliate**

Attachment B

- ORR, Robert, MD/Cardiology/Active Affiliate
- PAROLY, Warren, MD/Oncology/Active
- PATEL, Sheila, MD/Family Medicine/Active Affiliate
- POSADAS, Emerito, MD/Pediatrics/Provisional
- SLOWIK, Sharon, MD/Wound Care/Active
- TRACY, David, DDS/Oral & Maxillofacial Surgery/Active Affiliate
- VARSHNEY, Neeta, MD/Ophthalmology/Active
- WAILES, Robert, MD/Pain Medicine/Active

RESIGNATIONS: (Effective date 8/31/2017 unless otherwise noted)

Automatic:

- BESSUDO, Alberto, MD/Oncology
- CARDENAS, Carrie, MD/Family Medicine
- TASWELL, Carl, MD/Psychiatry

Voluntary:

- ADAMCZAK, Joanna, MD/Obstetrics and Gynecology
- CASELE, Holly, MD/Obstetrics and Gynecology
- CATANZARITE, Valerian, MD/Obstetrics and Gynecology
- DALFORNO, Victor, MD/Pediatrics
- EVANS, David, MD/Radiology
- DANESHMAND, Sean, MD/Obstetrics and Gynecology
- FAKSH, Arij, MD/Obstetrics and Gynecology
- HOWDEN, Frederick, MD/Cardiothoracic Surgery
- KNECHT, Lauren, MD/Anesthesiology

Attachment B

- **LAI, Arij, MD/Obstetrics and Gynecology**
- **SCHWENDEMANN, Wade, MD/Obstetrics and Gynecology**
- **SINGH, Mandeep, MD/Anesthesiology**
- **SMITH, Angela, MD/Anesthesiology**
- **TITH, Tevy, MD/Obstetrics and Gynecology**
- **ZAAYER, Todd, MD/Emergency Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
August 9, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 9/1/17, unless otherwise specified)

• BIRHANIE, Melaku M.D.	Internal Medicine
• COHEN, David M.D.	Cardiology
• DILLMAN, Ariana M.D.	Emergency Medicine
• KUSHNARYOV, Anton M.D.	Otolaryngology
• MAHIL, Amreesh MD	Anesthesiology
• PREGERSON, Heather PAC	Allied Health Professional
• SCOTT, Katie PAC	Allied Health Professional
• TRULLENDER, Brett MD	Emergency Medicine
• WANG, Joyce M.D.	Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 9, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 8/31/2017.

- GABRIEL, Steven MD — Emergency Medicine

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by February 28, 2018 would result in these privileges automatically relinquishing.

- EBRAHIMI ADIB, Tannaz MD — OB/GYN

ADDITIONAL PRIVILEGE REQUEST (Effective 09/01/2017, unless otherwise specified)

The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- D'SOUZA, Gehaan M.D. — Plastic Surgery
- GRAMINS, Daniel M.D. — Cardiothoracic Surgery

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 09/01/2017, unless otherwise specified)

The following practitioners have voluntarily relinquished the following privileges.

- CALHOUN, Chanelle M.D. — Pediatrics
- PARK, Ronald M.D. — Pediatrics
- PARK, Sue Ann M.D. — Pediatrics
- STUPIN, Jeremy M.D. — Diagnostic Radiology

CHANGE IN PRIVILEGE CARD (Effective 9/1/2017, unless otherwise specified)

The following practitioners are transitioning to the new version of the Neurosurgery Privilege Card.

- STERN, Mark MD — Neurosurgery

I. **MEMBERSHIP**

The Department of Surgery consists of physicians in the Divisions of:

A. Cardiac Thoracic
B. General Vascular
C. Neurosurgery~~Subspecialty~~
D. ~~Podiatry~~Ophthalmology
E. ~~Urology~~Orthopedics
F. ~~Neurosurgery~~Podiatry
G. ~~Orthopedics~~Subspecialty
H. ~~Ophthalmology~~Urology

II. **FUNCTIONS OF THE DEPARTMENT**

The general functions of the Department of Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the division and approve indicators for use in the evaluation of patient care and on-going professional practice evaluation (pursuant to Medical Staff Policy #509);

B. Recommend to the Medical Executive Committee granting of clinical privileges and the performance of specified privileges within the Department of Surgery;

C. Conduct, participate in and make recommendations regarding Continuing Medical Education programs to include the Department of Surgery clinical practice;

D. Review and evaluate Surgery Department adherence to:
   1. Medical Staff Policies and Procedures
   2. Sound principles of safe clinical practice

E. Submit minutes to the QA/PI/PS Committee and Medical Executive Committee concerning:
   1. Department's review and evaluation of activities, actions taken thereon, and the results of such action;
   2. Recommendations for maintaining and improving the quality and safety of care provided in the department and the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when problems in patient care, safety, and clinical performance or opportunities to improve patient care are identified;

H. Formulate recommendations for departmental / division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

I. Recommend/Request Focused Professional Practice Evaluation as indicated for Medical Staff members to include initially appointed members (pursuant to Medical Staff Policy #509).

J. Approval of On-Going Professional Practice Evaluation Indicators.

III. DEPARTMENT MEETINGS

The Department of Surgery shall meet quarterly or as needed and at the discretion of the chair to consider the findings from the ongoing monitoring and evaluation of the quality, safety and appropriateness of the care and treatment provided to patients. Regular minutes shall be transmitted to the QA/PI/PS Committee and the Medical Executive Committee.

Quorum: Twenty-five percent (25%) of the Active Department ~~members, but not less than two members, shall~~members shall constitute a quorum at any meeting. When there are twelve or less Active members in the department, a minimum of three (3) members are required to constitute a quorum.

IV. DEPARTMENT OFFICERS

A. The Department shall have a Chairman and a Vice-Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrate ability in at least one of the clinical areas covered by the Department.

B. The Active Staff members of the Department who are eligible to vote at the Department meeting shall elect the Department Chairman and Vice-Chairman every two years on the even numbered years. The nominee receiving the highest number of votes will be elected as the Chairman. The nominee receiving the second highest number of votes will be elected as the Vice Chairman. Vacancies of any officer for any reason shall be filled ~~by~~ for the unexpired term through a special election.

C. The Department Chairman and Vice-Chairman shall serve a ~~one~~two-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIRMAN

The Department Chairman, and the Vice-Chairman, in the absence of the Chairman, shall assume the following responsibilities of the Department:

A. Be accountable for all professional administrative activities of the Department;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

C. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;

D. Recommend clinical privileges for each member of the Department;

E. Assure that the quality, safety, and appropriateness of patient care provided within the Department are monitored and evaluated;

F. Continuously assess and improve the quality and safety of care provided in the Department;

G. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;

H. Other duties may be assigned, in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests for privileges in the Department of Surgery shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring. Practitioners will practice only within the scope of their privileges, ~~as defined within the respective Division's Rules and Regulations.~~ Recommendations for privileges are made to the Division Chief, Surgery Chair, Credentials and Medical Executive Committees.

B. Each practitioner's privileges will be assessable on Tri-City's Intra-net (MD-Staff) which is located in each patient care area. A paper copy is maintained within the ~~Nursing Administration Office~~Medical Staff Department ~~and the Main Operating Room~~.

C. The Department of Surgery has established the following classifications of surgical privileges:

1. Board Certification Any member of ~~The~~ the Department of Surgery who was Board Eligible when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification within thirty-six (36) months of his/her appointment to the Medical Staff. Failure to obtain timely certification and maintain certification shall be considered in making recommendations regarding applications for reappointment and renewal of clinical privileges.~~consists of physicians who are Board Certified or in the first thirty six (36) months of Board Eligibility and actively pursuing certification by their retrospective specialty boards or able to demonstrate comparable ability, and training.~~ Such surgeons may act as consultants to others and may, in turn, be expected to request consultations when:

   a) Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
   b) Unexpected complications arise which are outside this level of competence;
   ~~c)~~ c) Specialized treatment or procedures are contemplated in which they are not familiar or privileged.~~**PHYSICIAN ASSISTANTS**~~

~~A. Physician Assistants may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a~~

supervising physician who is responsible for the patients cared for by that physician assistant.

1. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition.

A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures to be delegated to the physician assistant until assured competency.

A physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care.

A physician assistant may also act as first or second assistant in surgery, under supervision of an approved supervising physician, including acting as a second assist during cardiac procedures using cardiopulmonary bypass.

Perform open harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery under the direct supervision of surgeon (no separated proctoring required).

Requests for additional privileges must be accompanied by documentation of training and/or experience. Proctoring is required for all additional privileges and will be determined by the Department/ Division Chair/Chief.

Harvesting of saphenous vein for use as bypass conduit for cardiac and vascular surgery using endoscopic techniques. This privilege requires approval of Cardiothoracic Surgery Division.

Refer to the AHP rules and regulations for further delineation of sponsoring physician's supervision requirements.

A physician assistant may not admit or discharge patients.

Medical / Surgical Units: Documentation of an examination of the patient by the sponsoring physician(s) every third day if care is given by the Allied Health Professional(s).

Non-Scheduled Admission(s): Examination of the patient by the sponsoring physician(s) the same day as care is given by the AHP.

B. The Department of Surgery requires a physician co-signature as delineated in the AHP's Rules and Regulations:

~~Order(s) and telephone Order(s) may be immediately implemented and physician co-signature required within 24 hours of AHP's order.~~

~~Any medical record of any patient cared for by a physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within 24 hours.~~

~~The sponsoring physician must review and authenticate any progress note within the medical record of any patient(s) documented by a physician assistant within 24 hours.~~

~~Non-Scheduled admissions: The H&P must be dictated by the sponsoring physician(s) within 24 hours.~~

~~ACCU/AMC Units: Examination of the patient by the sponsoring physician(s) the same day care is given by the Allied Health Professional(s).~~

VII. REQUIREMENTS FOR INITIAL AND REAPPOINTMENT

A. Active certification by the appropriate certifying board or board eligible ~~within~~ by the appropriate certifying board ~~or demonstration of comparable ability, training and experience~~ shall satisfy the requirements for receiving privileges for all categories as well as for admitting privileges to Tri-City Medical Center.

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. Proctored cases must be completed within six months of the date of the last reappointment otherwise privileges will automatically expire. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. CATEGORIZATION OF SURGICAL PRIVILEGES

A. Divisions and Privileges

All ~~new~~ medical staff members requesting staff privileges shall be members of one of the ~~following~~ Surgery Department divisions based on their training and surgical competence. Criteria for privileges are listed on each division's/specialty's privilege card.

1. Cardiac Thoracic Division and Privileges
2. General & Vascular Surgery Division and Privileges
3. Neurosurgery Division and Privileges
4. Ophthalmology Division and Privileges
5. Orthopedic Surgery Division and Privileges

6. Podiatry Division and Privileges
7. Sub-Specialty Division; General Dentistry and Oral & Maxillofacial Surgery Privileges
8. Sub-Specialty Division: Plastic and Reconstructive Surgery Privileges
9. Sub-Specialty Division; Otolaryngology Privileges
10. Urology Division and Privileges

~~The Divisions and applicable privileges are as follows: (In all instances where Board certified or eligible is stated, this refers to the applicable American Board for the surgery specialty.)~~B. Cross-Over Surgery Privileges

1. It will be the responsibility of any surgeon requesting privileges within another specialty or division to do any such procedure to notify the Chief(s) of the division(s).

2. Each division so contacted will then review the individual's qualifications to perform the procedure, Pursuant to Medical Staff Policy # 526 Requesting New Privileges.

3. If the privilege is approved, the medical staff member may then perform the procedure in accordance with the proctoring requirements set forth within the respective division's privilege card or medical staff policy.

4. Qualified proctors for procedures in question shall be any surgeons on the active medical staff at TCMC, ~~who has~~with current unrestricted privileges to ~~do~~ perform the procedure.

5. In order for the new medical staff member to be removed from proctoring of the procedure, the division chief~~,~~ or the surgical chair must sign off on the proctoring form. At the discretion of the division chief or department chair, additional proctoring may be recommended.

6. Current staff members who are on record as doing a given procedure ~~would~~ will be grandfathered for that procedure. Any current staff member who would like to begin to do any crossover procedure would be required to follow the above guidelines.~~**Laser Privileges**: See "Laser Privileges" in each designated division.~~

IX. PROCTORING OF PRIVILEGES

A. Requirement of Proctors

Each new medical staff member granted initial surgical privileges shall be evaluated by a proctor ~~for six (6) major surgical cases~~ until his surgical privilege status is established by a recommendation from a) the Division Chief; b) ~~and subsequently~~ the Department of Surgery Chair; c) ~~and to~~ the Credentials Committee; ~~and~~ d) ~~to~~ the Medical Executive Committee (this is to include extensive surgical procedures treated in the Emergency Department). Each of the divisions within the Department of Surgery will define criteria requirements on the privilege card for proctoring. ~~requirements for their defined privileges within their rules and regulations~~. At the discretion of the respective division chief(s), proctoring may be extended for 1) procedures, 2) intra-operative care, 3) post-operative care, and 4) documentation deficiencies. If a member of the division is unable to proctor assigned privileges, outside proctors will be utilized.

B. Selection of Proctors

~~1.~~

2 1. The medical staff member shall select an appropriate member with like surgical privileges for each surgical case admitted. He shall contact the monitor and inform him of his plans for the case. Supervision of the member by the proctor will include concurrent or retrospective chart review of cognitive processes and direct observation of procedural techniques. THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEDICAL STAFF MEMBER SURGEON'S COMPETENCE. ~~OR MAY REVIEW THE CASE DOUMENTATION (i.e. H&P, Op Note and Video) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE MEDICAL STAFF MEMBER SURGEON'S COMPETENCE. An associate~~ One or all of the medical staff member's associates may monitor up to 50 % of the required proctoring.

3 2. In elective cases, all such arrangements shall be made prior to scheduling (i.e. the proctor shall be designated at the time the case is scheduled for surgery ~~or~~ or invasive procedure~~or for admission non-operative cases~~.) In emergency cases, the monitor shall be contacted prior to, and designated at, the time of scheduling.

4 3. Proctor shall observe the medical staff member in each surgical case for an indefinite period~~, which will cover at least six major surgical cases~~.

4. If performance issues are identified ~~on initially appointed member(s) of the Medical Staff~~ during proctoring, a Focused Professional Performance Evaluation ~~(~~pursuant to Medical Staff Policy # 509) may be initiated.

5. The medical staff member shall have free choice of suitable consultants and assistants.

C. Reports of Proctors

1. A form shall be prepared on which will be spaces for comment by the proctor on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e. qualified, needs further observation, not qualified).

2. Forms will be ~~made up by the medical staff member scheduling the case for surgery and immediately forwarded~~ available at the front desk in the OR and provided to the proctor for completion.

3 3. It is the responsibility of the medical staff member to notify ~~the~~ Operating Room ~~Supervisor~~ personnel of the proctor for each case.

4. The proctor's report shall be completed and promptly returned to the Medical Staff Department for filing in the individual physician's confidential file.

3 5. It will be the responsibility of the Division Chief to inform the monitored new medical staff member, whose proctoring is being continued, whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique, and/or d) postoperative care.

X. EMERGENCY DEPARTMENT CALL:

A, Medical Staff Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy #520.

B. Provisional or courtesy member(s) are able to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

C. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. For a different future surgical problem, there is no obligation on the part of the physician to provide care.

APPROVALS:

Department of Surgery:	~~6.18.2015~~	3/30/2017
Medical Executive Committee:	7.27.2015	
Governance Committee:	8.04.2015	
Board of Directors:	8.27.2015	

I. **MEMBERSHIP**

A. The Division of Cardiology consists of physicians who are initially board certified in Cardiovascular Disease by the American Board of Internal Medicine or are progressing toward certification.

B. Applicants who are progressing toward board certification in Cardiovascular Disease by the American Board of Internal Medicine must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become board certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

C. Board certified members who were issued certificates in Internal Medicine and Cardiology after 1989 are required to become re-certified in order to maintain board certification status. Continued board certification may be in Cardiovascular Disease and/or a sub-specialty (e.g. Cardiac Electrophysiology) by the American Board of Internal Medicine or by the National Board of Physicians and Surgeons.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Hospital;

C. Conduct, participate in, and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the QA/PI/PS Committee and Medical Executive Committees concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in Hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Establish privileging criteria for participation on the Non-Invasive Cardiology panels and oversee the administration of such panels;

H. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

I. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

J. Approval of On-Going Professional Practice Evaluation Indicators; and

K. Formulate recommendations for Division rules and regulations reasonable necessary for the proper discharge of its responsibilities subject to approval of the Department of Medicine Chiefs, the Medical Executive Committee, and Board of Directors.

III. **DIVISION MEETINGS**

The Division of Cardiology shall meet at least annually or at the discretion of the Chief. The Division will consider findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness

of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/PS Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the active Division members, but not less than two members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be board certified in Cardiovascular Diseases and qualified by training, experience, and demonstrated ability in the clinical areas covered by the Division.

B. The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

C. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. The Division officers shall be eligible to succeed themselves;

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;

C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;

D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;

E. Recommend clinical privileges for each member of the Division;

F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and

G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. **CLASSIFICATIONS**

The Division of Cardiology has established the following categories:

A. Physicians - Cardiology

Refer to Membership section above. Physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
2. Unexpected complications arise which are outside their level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

B. Nurse Practitioner (NP) – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements. (An ACLS is required for Nurse Practitioners in Cardiology.) Nurse practitioner means a registered nurse who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures and any protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician, who shall be a cardiologist, shall develop the standardized procedures and any protocols to be approved by the Division of Cardiology, Department of Medicine, Credentials Committee, Interdisciplinary Practice Committee, Medical Executive Committee, and Board of Directors.

C. Physician Assistant (PA) – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements. (An ACLS is required for Nurse Practitioners in Cardiology.) A physician assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

1. A supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients.
2. The supervising physician shall delegate to the PA only those tasks and procedures consistent with the supervising physician's specialty or usual customary practice and with the patient's health and condition.
3. The supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured competency.
4. The physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care.
5. The supervising physician must see patients cared for by the physician assistant at least once during their hospital stay.
6. A physician assistant may not admit or discharge patients.
7. Refer to the AHP rules and regulations for detailed explanation of supervising physician supervision requirements and co-signature requirements.
8. The following Cardiac Catheterization Laboratory procedures are to be performed only by board certified cardiologists or those cardiologists who are progressing toward certification. All procedures are to be monitored by the Director of Invasive Cardiology or his/her designee.
9. Cardiac Catheterization Laboratory procedures will be reviewed by the Director of Invasive Cardiology, who will evaluate the applicant's technical skills and clinical judgment. The Director will submit a written report to the Cardiology Division, with the Division's recommendations to be forwarded to the Credentials Committee and to the Department of Medicine.
10. The Director of Invasive Cardiology will review the Percutaneous Transluminal Coronary Angioplasty program at least semi-annually and will report to the Cardiology Division and the Annual Summary to the QA/PI/PS Committee.

11. Current fluoroscopy certification is required for the following procedures:
    a) Cardiac Catheterization, including Angiography
    b) Insertion of Permanent Pacemaker
    c) Intra-Aortic Balloon Pump Insertion
    d) Myocardial Biopsy
    e) Electrophysiologic Testing
12. Procedure reports, per the Medical Records Policy & Procedures # 518, are to be dictated or written immediately following the procedure and is to be authenticated and signed by the physician

VII. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. Request for privileges in the Division of Cardiology shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and monitoring. Recommendations for privileges are made to the Division of Cardiology/Department of Medicine, Credentials Committee, the Medical Executive Committee, and the Board of Directors.

C. Invasive Procedures by Non-Cardiologists
1. The Cardiology Division will monitor invasive procedures performed by Internal Medicine physicians who request privileges to perform the following procedures:
    a) Right Heart Catheterization with Swan-Ganz Pulmonary Artery Catheter;
    b) Central Venous Catheter Placement
    c) Temporary Transvenous Pacemaker Insertion
    d) Arterial Line Insertion
    e) Elective Cardioversion; and
2. To gain privileges for the above procedures, the Internal Medicine Physician must submit documentation of having performed at least five (5) of the requested procedures during residency training or during staff membership at another hospital.
3. The Director of Invasive Cardiology or his/her designee will monitor the first two (2) procedures performed. The Director of Invasive Cardiology or his/her designee shall submit a written report to the Division of Internal Medicine stating that:
    a) The applicant is qualified and competent to perform the procedure, or
    b) Further monitoring is recommended

D. Non-Invasive Procedures by Cardiologists
The following non-invasive procedures are to be performed only by board certified cardiologists or those cardiologists who are progressing toward certification. All procedures are to be monitored by the Director of Non-Invasive Cardiology or his/her designee.

E. Response Time:
1. Requirements
    a) **Availability:** Panel member will be available to the department until 12:00 p.m.
    b) **ECG's**: Should be interpreted daily by the attending cardiologist. Unassigned ECGs are to be interpreted twice daily on weekdays and at least once daily on weekends and holidays by the assigned panel member or his/her designated panel member.

c) **Echocardiogram**: The final report is to be dictated within twenty-four (24) hours of the performance of the study.

d) **Exercise or Pharmacological Stress Test**:
If the scheduled cardiologist cannot be available within twenty (20) minutes of the scheduled start time to supervise the test, it is his/her responsibility to assure that another cardiologist can do so. The technician will page the cardiologist in a timely fashion before the test is scheduled to begin. If a cardiologist is not available, the patient will either be sent back to their room or to the outpatient area to wait for the cardiologist and it is the cardiologist's responsibility for communicating to the patient the timeliness issue. The final report is to be dictated the day of the study.

e) **Phone Consultations:** Requests for phone consultations should be answered within 30 minutes. Answering service should be advised to offer to call back-up physician if no response from the originally requested physician is received within that time frame.

Sanctions for the INTERPRETATION OF Echocardiogram Exercise or Pharmacological Stress Test and ECG's:
To assure quality patient care, it is imperative that all members adhere to the above requirements. All deviations from these requirements are to be documented and communicated immediately to the Non-Invasive Medical Director and the Chief of the Cardiology Division.

a) Cardiologists who consistently fail to dictate or authenticate and sign reports within a timely manner will receive two (2) written warnings. The third offense occurring in a twelve (12) month period will trigger an automatic sanction of six (6) months ineligibility for reading panel non-invasive studies in the Department of Cardiology. Division members sanctioned twice in a three-year period will be ineligible for reading any non-invasive study in the Department of Cardiology for a minimum of one (1) year, after which time he/she may apply to the Cardiology Division for reinstatement.

VIII. **REAPPOINTMENT**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the reappointment requirements (this shall not supersede privilege-specific requirements as outlined in this document). If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Proctors are obligated to make themselves available either to proctor the

member concurrently when applicable, or to thoroughly evaluate the practitioner's performance through retrospective chart review within seven (7) days after a proctor request has been made by the member. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued of noted deficiencies.

a) The Director of Invasive Cardiology, or his/her designee, will monitor invasive procedures.
b) Supervision of the applicant by the proctor will emphasize concurrent or, if needed, retrospective chart review and include direct observation of procedural techniques.
c) The cardiologist should not be granted Active Medical Staff privileges within the Division until the proctoring has been satisfactorily completed.

C. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

D. The practitioner must notify the Director of Invasive Cardiology at the time a procedure is scheduled. If the Director of Invasive Cardiology is not available to observe the procedure, he/she should appoint a designee to observe the procedure.

E. If the procedure must be done as an emergency without proctoring, the Director of Invasive Cardiology must be informed at the earliest appropriate time following the procedure.

F. A form shall be completed by the proctor, and should include comments on preprocedure workup, diagnosis, preprocedure preparation, procedural technique, judgment, postprocedure care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

H. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

IX. EMERGENCY DEPARTMENT CALL

A. Active Division members of the Cardiology Division may participate in the Emergency Department Call Roster on a voluntary basis. Refer to Medical Staff Policy and Procedure 8710-520.

B. When a need is demonstrated, the Division Chief may request Courtesy and Associate staff members to participate in the Emergency Department Call Roster.

C. When it is discovered that a patient has been previously treated by a Cardiology Division staff member, that member should be given the opportunity to provide further care unless the patient or primary care physician requests otherwise.

D. If a physician has discharged a patient from his practice and the patient comes to the Emergency Department when the physician is on call, the physician is responsible for the disposition of the patient.

E. A physician on-call, who provides care for a patient in the Emergency Department, is responsible for the disposition of that patient for forty-eight (48) hours and must accept responsibility if said patient is readmitted to the Emergency Department within forty-eight (48) hours.

X. NON-INVASIVE CARDIOLOGY INTERPRETATION PANELS

A. Eligibility

The following is eligibility criteria for Cardiology Interpretation Panels:

1. The applicant must be an Active Medical Staff member of the Division of Cardiology; and,
2. Must use Tri-City Medical Center as his/her primary hospital; and
3. Must execute a standard agreement with the Tri-City Hospital District, after which he/she will be placed at the end of the panel rotation.

B. Panel Rotation

A panel will be created of eligible Cardiology Division members with Active Medical Staff privileges, as delineated above, who request for such duties. At the discretion of the Division Chief, Provisional or Courtesy Division members may participate on the panel rotation with majority Division member approval.

1. One section will be to interpret the ECGs, signal average ECGs, and Holter Monitor examinations of patients not assigned to another Cardiology Division member (i.e., "unassigned" patients for which the attending physician does not specify a cardiologist).
2. A second section will be to interpret echocardiographic studies of "unassigned" patients for which the attending physician does not specify an interpreting cardiologist.
3. A third section will be to interpret stress tests for "unassigned" patients for which the attending physician does not specify an interpreting cardiologist.
4. Panel members will be scheduled for one-week periods from Monday at 0700 hours to the next Monday at 0700 hours during which they will be responsible for personally supervising or interpreting these tests on a timely basis. The term "timely" is defined in the "Interpretation Response Time" Section or by assigning another panel member to do so.

C. Conditions

The Cardiology Panel is restricted to seven (7) panel members unless there is an annual volume increase of 12.5% allowing sufficient volume for panel members to maintain expertise and provide quality of interpretations.

XI. CARDIOLOGY CONSULTATIONS

The Division of Cardiology accepts consultation requests for patients over the age of 18 years. Individual exceptions may be made at the discretion of the Cardiologist.

Approvals:

Division of Cardiology: 10/07/15; 11/04/15; 02/01/17
Department of Medicine: 10/21/14; 11/20/15; 04/20/17
Medical Executive Committee: 11/27/14; 11/23/15; 05/22/17
Governance Committee: 11/4/14; 12/01/15; 05/11/17
Board of Directors: 11/6/14; 12/10/15; 05/25/17

Tri-City Medical Center

Delineation of Privileges

Pediatrics - ~~6/14~~7/17

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible, having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification.
Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

Level 1 and Level 2 Newborn Criteria:
Initial: Training and evidence of current NRP/NALS or PALS certification
Proctoring: Six (6) cases (Any combination of proctoring from Admit patients, Consultation, Newborn Care, or H&P)
Reappointment: Evidence of current NRP/NALS or PALS certification

___ Newborn care, Level 1 and Level 2 ___

___ Admit patients, Level 1 and Level 2 newborns ___

___ Perform medical history and physical examination (newborn), including via telemedicine (F) ___

___ Consultation, including via telemedicine (F) ___

___ Refer and follow ___
Physicians with this privilege may refer patients to the hospital and follow their progress, but an attending physician would provide necessary care. This privilege will allow the physician to visit patients, read records, and refer patients to specialists. SELECTION OF THIS PRIVILEGE IS EXCLUSIVE. NO OTHER PRIVILEGES MAY BE REQUESTED IN CONJUNCTION WITH THE REFER AND FOLLOW PRIVILEGE. *REFER AND FOLLOW IS NOT A CLINICAL PRIVILEGE*

___ ~~Attendance at C-sections and vaginal deliveries, including newborn resuscitation~~ ___

~~Attendance at C-sections and Vaginal Deliveries, Including Newborn Resuscitation Criteria:~~
~~Initial: Training and Evidence of current NRP/NALS Certification~~
~~Proctoring: One (1) case~~
~~Reappointment: Evidence of current NRP/NALS certification~~

___ **INVASIVE PEDIATRIC PROCEDURES** - By selecting this privilege, you are requesting the Invasive Pediatric privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Invasive Pediatric Procedures Criteria:
Initial: Training and as indicated for specific privileges below
Proctoring: ~~Five (5)~~Three (3) cases from Invasive Pediatric Procedures category
Reappointment: See privileges below

Circumcision
Initial and Reappointment: Case documentation showing five (5) procedures over the past 24 month period.
~~Intubation, infant~~
~~Initial and Reappointment: Evidence of current NRP/NALS certification~~

~~Intubation, pediatric~~
~~Initial and Reappointment: Evidence of current PALS certification~~

~~Laryngoscopy~~
~~Initial and Reappointment: Evidence of current NRP/NALS certification~~

Provider Name:

Request	Privilege	Action MSO Use Only

~~Lumbar puncture~~

~~Suprapubic aspiration~~

___ **PEDIATRIC CARDIOLOGY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Cardiology privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Pediatric Cardiology Procedures Criteria:
Initial: Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology
~~*Holter monitor and Treadmill privileges - Successful completion of a residency in Pediatrics and a fellowship training program in Pediatric Cardiology~~
Proctoring: Two (2) cases from this category
Reappointment: Ten (10) cases from this category per two-year reappointment cycle

Cardiac defibrilation, to include neonates

Consultation, Pediatric Cardiology, to include neonates

Echocardiography, to include neonates

Elective cardioversion, to include neonates

Electrocardiography (EKG/ECG), to include neonates

Pericardiocentesis, to include neonates

~~Holter monitor* - 12 years and older~~

~~Treadmills* - 12 years and older~~

___ **PEDIATRIC SURGERY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Pediatric Surgery Privilege Criteria:
Initial: Board certified by the American Board of Surgery in Pediatric Surgery
Proctoring: One (1) cases from this category
Reappointment: Evidence demonstrating activity performing pediatric surgery at another healthcare facility

Consultation, Pediatric ~~Cardiology~~Surgery, to include neonates

___ Moderate Sedation ___

Moderate Sedation Criteria:
Initial and Reappointment - Refer to Medical Staff policy 8710-517 and evidence of current NRP/NALS certification

_____
Print Applicant Name

_____
Applicant Signature

_____

Provider Name:

Request	Privilege	Action MSO Use Only

Date

Approval:

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Subspecialty of Surgery - Otolaryngology 9/14

Provider Name:

Request	Privilege	Action MSO Use Only

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at either TCMC or 3925 Waring Road, Suite C, Oceanside CA 92056.

Proctoring for Admit patients, Consultation, and Perform medical history & physical examination, including via telemedicine: Six (6) cases

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform Medical History & Physical Examination, including via telemedicine (F) ___

BASIC OTOLARYNGOLOGY CRITERIA
Initial:

- Successful completion of an ACGME or AOA-accredited residency in otolaryngology
- Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.

Proctoring: As stated in each category below
Reappointment: Fifty
(50) cases reflective of the Basic Otolaryngology privileges requested

___ **Basic Otology Category** ___

By selecting this privilege, you are requesting the Basic Otology Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Otology Category Criteria:
Proctoring: Two (2) cases from this category

All
forms of surgery on the auditory canal, the tympanic membrane (i.e. tympanoplasty, ossiculoplasty), and the contents of the middle ear

Mastoidectomy

___ **Basic Rhinologic Category** ___

By selecting this privilege, you are requesting the Basic Rhinologic Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Rhinologic Category Criteria:
Proctoring: One (1) case from this category

Caldwell
Luc procedure

Excision
of tumor ethmoid/cribriform

Fracture
repair - nose

Provider Name:

Request	Privilege	Action MSO Use Only

Nasal
polypectomy

Septoplasty,
and turbinate surgery

___ **Basic Head and Neck Category** ___

By selecting this privilege, you are requesting the Basic Head and Neck Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Head and Neck Category Criteria:
Proctoring: Two (2) cases from this category

Excision
of lesions of skin, subcutaneous tissue, mucosa

Extraction
of teeth incidental to tumor resection or repair of traumatic injury

Fracture
repair – mandible, closed

Harvesting
and grafting of alloplasts, bone, cartilage, fascia, fat, nerve, or skin

Ligation
of head and neck vessels

Local
skin flap reconstruction, including harvest

Parathyroidectomy

Reduction
of facial fractures, closed and isolated open

Repair
of branchial cysts, ducts, fistulas

Repair
of lacrimal system

Repair
soft tissue – lacerations, avulsions, abrasions

Salivary
gland and duct surgery

Skin/Soft
tissue flap, including harvest

Skin
grafting procedures, full thickness or split thickness

Surgery
of the lymphatic tissues of the head and neck

Provider Name:

Request	Privilege	Action MSO Use Only

Thyroidectomy

___ **Basic Orthognathic Surgery Category** ___

By selecting this privilege, you are requesting the Basic Orthognathic Surgery Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Orthognathic Surgery Category Criteria:
Proctoring: One (1) case from this category

Osteotomy

Grafting

Implantation
of the upper and lower jaws for treatment of dentofacial and congenital deformities, and obstructive sleep apnea

___ **Basic Aerodigestive Tract Category** ___

By selecting this privilege, you are requesting the Basic Aerodigestive Tract Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Aerodigestive Tract Category Criteria:
Proctoring: One (1) case from this category

Bronchoscopy/Endoscopy
of the airway (larynx, trachea, and bronchial tree) both diagnostic and therapeutic

Endoscopy
of the upper digestive tract (nasopharynx, hypopharynx, esophagus), both diagnostic and therapeutic, including endoscopic treatment of Zenker's

Lip
surgery including lip shave, partial or total resection with primary repair or by local or distant flaps, Cleft lip, and Pedicle lip flap reconstruction

Surgery
on the oral cavity, including soft palate, tongue, mandible, maxilla

Surgery
of the upper aerodigestive tract

Tonsillectomy,
adenoidectomy

Tracheotomy

ADVANCED OTOLARYNGOLOGY CRITERIA:
Initial:

- Successful completion of an ACGME or AOA-accredited residency in otolaryngology
- Documentation of twenty (20) cases from the previous twenty-four (24) months representative of the privileges requested

Proctoring: As stated in each category below

Provider Name:

Request	Privilege	Action MSO Use Only

Reappointment: Twenty (20) cases reflective of the Advanced Otolaryngology privileges requested

___ **Advanced Otology Category** ___

By selecting this privilege, you are requesting the Advanced Otology Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Otology Category Criteria:
Proctoring: One (1) case from this category

Acoustic
Neuroma Surgery

Surgery
of the inner ear and stapes

Temporal
bone resection

___ **Advanced Rhinologic Category** ___

By selecting this privilege, you are requesting the Advanced Rhinologic Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Rhinologic Category Criteria:
Proctoring: One (1) case from this category

Hypophysectomy

Orbital
exenteration

Sinus
surgery, endoscopic and open

___ **Advanced Head and Neck Category** ___

By selecting this privilege, you are requesting the Advanced Head and Neck Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Head and Neck Category Criteria:
Proctoring: One (1) case from this category

Cleft/Craniofacial
Surgery

Correction
of primary cleft lip and palate

Correction
of residual deformities, fistulae

Correction
of palatal incompetence

Craniofacial
reconstruction

Provider Name:

Request	Privilege	Action MSO Use Only

Facial
nerve repair, grafting, and facial reanimation

Facial
plastic surgery:

Blepharoplasty

Chemical peel

Dermabrasion

Liposuction

Mentoplasty

Otoplasty

Repair of lacerations

Rhinoplasty

Rhytidectomy

Implantation of autogenous and homologous grafts, and allografts

Fracture
repair - multiple, open, including LeFort

Infratemporal
fossa/deep parotid lobe tumor excision

Myocutaneous
flap, including harvest

Neck
dissection

___ **Advanced Aerodigestive Tract Category** ___

By selecting this privilege, you are requesting the Advanced Aerodigestive Tract Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Advanced Aerodigestive Tract Category Criteria:
Proctoring: One (1) case from this category

Composite
resection

Esophageal
surgery including diverticulectomy and cervical esophagectomy

Management
of oral sinus cavity and pharyngeal malignancy

Surgery
of the larynx, including biopsy, partial or total laryngectomy, fracture repair

Provider Name:

Request	Privilege	Action MSO Use Only

Tracheal resection

___ ~~**Minor Procedures—Forensic Outpatient Clinic Category**~~ ___

~~By selecting this privilege, you are requesting the Minor Procedure privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.~~

~~Minor Procedures—Forensic Outpatient Clinic Criteria:~~
~~Initial: As required for general specialty specific privileges~~
~~Proctoring: Proctoring complete when released from specialty specific proctoring~~

~~Anterior Nasal Packing (F)~~

~~Collection of Specimens: Nasopharyngeal, throat, and wound (F)~~

~~Nasopharyngeal Endoscopic Procedures (F)~~

~~Removal of impacted cerumen~~

SPECIAL PRIVILEGES:

___ Bone anchored hearing aid (BAHA) implant ___

Bone anchored hearing aid (BAHA) implant Criteria:
Initial:
- Documentation of completion of training course in bone anchored hearing aid implantation; if training was completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying performance of BAHA procedure
- Concomitant mastoidectomy privileges

Proctoring: One (1) case
Reappointment: Concomitant mastoidectomy privileges and one (1) case per two-year reappointment

Energy Sources Category:

Energy Source Criteria:
Initial: Documentation of completion of training for specific energy source(s) to be used; or two (2) cases per energy source requested
Proctoring: Included in general procedural proctoring
Reappointment: Included in general reappointment volume requirements

___ Use of energy sources as an adjunct to privileged procedures: Argon ___

___ Use of energy sources as an adjunct to privileged procedures: CO2 ___

___ Use of energy sources as an adjunct to privileged procedures: KTP ___

___ Microvascular flaps and grafts/free tissue and bone transfer, including harvest ___

Microvascular flaps and grafts/free tissue and bone transfer, including harvest Criteria:
Initial:

Provider Name:

Request	Privilege	Action MSO Use Only

- Successful completion of a training program that included training in microvascular surgery
- Eight (8) cases within the previous 24 months

Proctoring: Two (2) cases
Reappointment: Eight (8) cases two-year reappointment cycle

___ Moderate sedation - Refer to Medical Staff policy 8710-517 ___

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Cardiology - ~~12/16~~ 8/17

Provider Name:

Request	Privilege	Action MSO Use Only

Please check the box next to the privilege bundle(s) you wish to request. Please strike through any procedure within your requested bundle that you do not wish to request.

CRITERIA: The Division of Cardiology consists of physicians who are Board Certified in Cardiovascular disease by the American Board of Internal Medicine or are actively progressing toward certification.
Applicants who are progressing toward Board Certification must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become Board Certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

By virtue of appointment to the Medical Staff, all physicians are authorized to perform occult blood testing and order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

COGNITIVE PRIVILEGES:

Initial Requirement: Must meet basic qualifications as outlined above.
Proctoring Requirement: A minimum of 6 cases proctored resulting in any combination of H&P'sand/or Consultations.
Reappointment Criteria: Documentation of 6 cases within the past two years is required.

___ Admission of a Patient to Inpatient Services ___

___ Performance of a History and Physical Examination, including via telemedicine ___

___ Performance of a Cardiac Consultation, including via telemedicine ___

___ Operation of Fluoroscopy Equipment ___
Prerequisite Criteria: Requires Current Fluoroscopy certificate.

ALLIED HEALTH PRACTITIONER SUPERVISOR PRIVILEGES

___ Supervision of an approved category of Allied Health Practitioner ___

SEDATION/ANALGESIAPRIVILEGES:

___ Moderate Sedation/Analgesia ___

Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

___ Deep Sedation Sedation/Analgesia ___
Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

BASIC INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and have performed at least four (4) of each privilege requested within the previous 24 month period is required.
Proctoring Requirements: ~~Three (3)~~One (1) of each privilege requested.
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of four (4)cases of each procedure requested within the previous 24 month period is required.

___ ~~Pericardiocentesis~~ ___

___ Venous cut-down & Percutaneous Central Venous Pressure Catheters ___

___ Insertion of Temporary Transvenous Cardiac Pacemaker ___

Provider Name:

Request	Privilege	Action MSO Use Only
___	Elective Cardioversion	___
___	Swan-Ganz Catheter Insertion & Monitoring	___

CARDIAC CATHETERIZATION PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and provide training and show current competency of have performed at least three-hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application is required.
Proctoring Requirements: Five (5) cases
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of forty (40)cases within the previous 24 month period is required.

___	RIGHT Cardiac Catheterization	___
___	LEFT Cardiac Catheterization	___
___	Coronary Arteriography	___

SPECIAL PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and the specific criteria indicated below.

Permanent Pacemaker Insertion (single/dual/biventricular chamber) and/or intra-cardiac defibrillator (ICD) (single/dual/biventricular chamber) requires proof of completion of fellowship training or twenty-five (25) cases.
Percutaneous Angioplasty (PTCA) requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application.
Pericardiocentesis requires a fluoroscopy certificate.
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Rotational Atherectomy requires meeting PTCA criteria and Boston Scientific Certificate documenting training (FDA requirement).
Transesophageal echocardiography (including passing the probe) requires documentation of training or a course.

Proctoring Requirements:

Permanent Pacemakers/ICDs: two (2)
Percutaneous angioplasty (PTCA): ~~twenty five (25)~~five (5)
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: ~~three (3)~~two (2)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: ~~three (3)~~two (2)
Rotational Atherectomy: three (3)
Transesophageal echocardiography: ~~five (5)~~two (2)

Reappointment Criteria:

Permanent Pacemaker/ICD cases: ten (10)
Percutaneous Angioplasty (PTCA): seventy five (75) cases of which twenty (20) must be done at TCMC

Provider Name:

Request	Privilege	Action MSO Use Only

Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: Twenty (20)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: Twenty (20)
Rotational Atherectomy: six (6)
Transesophageal echocardiography: ten(10)

___	Permanent Pacemaker/ICD Insertion	___
___	Percutaneous Angioplasty (PTCA)	___
___	Pericardiocentesis	
___	Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation	___
___	Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation	___
___	Rotational Atherectomy	___
___	Transesophageal echocardiography	___

NON-INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and be a cardiologist with fellowship training and is an active reading panel participant and has sufficient case volumes to fulfill reappointment volume requirements as outlined below for each procedure requested.

Proctoring Requirements:

EKG: twenty five (25)
Stress ECHO: two (2)
Thoracic ECHO: two (2)
Holter Monitor: two (2)
Treadmill: two (2)

Reappointment Criteria:

EKG: five hundred (500) or active reading panel member as attested by Division of Chief or designee.
Stress Echo: five (5) Documentation of Stress Echos performed at other facilitiues (including the physician's office) will count towards this requirement.
Thoracic Echos: two hundred (200) or active reading panel member as attested by Division of Chief or designee.
Holter Monitor: forty (40), of which ten (10) must be performed at TCMC or active reading panel member as attested by Division of Chief or designee.
Treadmill: fifty (50) or active reading panel member as attested by Division of Chief or designee.

___	EKG	___
___	Stress Echo	___
___	Thoracic Echo	___
___	Holter Monitor	___
___	Treadmills	___

Tri-City Medical Center
Delineation of Privileges
Cardiology -~~12/16~~ 8/17

Provider Name:

Request	Privilege	Action MSO Use Only

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

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Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Obstetrics/Gynecology 12/16

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Department of Obstetrics and Gynecology consists of physicians who are board certified or actively progressing towards certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-accredited residency training program in Obstetrics and Gynecology.

SITES:
Privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.
All practitioners who currently hold the privilege to "consult" and/or "perform a history and physical examination" may also perform these privileges via telemedicine

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform history and physical examination (includes pelvic exam and cultures), including via telemedicine (F) ___

___ **OBSTETRICAL CATEGORY:** ___

By selecting this privilege, you are requesting the Obstetrical Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN.
2. Documentation of fifty (50) cases reflective of the scope of privileges requested within the previous twenty-four (24) months.
Proctoring: Ten (10) cases, including five (5) concurrent vaginal deliveries, two (2) C-sections.
Reappointment: Fifty (50) cases to include: two (2) C-sections and ten (10) vaginal deliveries within the previous twenty-four (24) months.

Amniocentesis

Basic obstetrical ultrasound

Breech vaginal delivery

Cesarean Hysterectomy

Cesarean section

Episiotomy, vaginal repair, sphincter repair

Evacuation of hydatidiform mole

Evacuation of pelvic hematoma

External cephalic version

Hemorrhoid excision

Hypogastric artery ligation

Induction of labor

Management of intra-uterine fetal demise

Management of medical complications of pregnancy, preterm labor, pregnancy induced hypertension/eclampsia, pre-eclampsia, and multiple gestation

Provider Name:

Request	Privilege	Action MSO Use Only

Manual removal of placenta

Operative vaginal delivery - forceps/low-forceps/vacuum delivery

Perineal laceration, first (fourchette) & second-degree

Perineal laceration, third & fourth degree

Postpartum hemorrhage

Suction D&C for termination of pregnancy

Transvaginal cervical cerclage

Vaginal Deliveries (Spontaneous and precipitous term deliveries), and vaginal birth after previous C-section

___ **GYNECOLOGY CATEGORY** ___

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN.
2. Documentation of twenty-five (25) cases from the Gynecological Category (including at least five (5) major abdominal cases) reflective of the scope of privileges requested within the previous twenty-four months.
Proctoring: Ten cases (10) from the Gynecological Category,
including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic laparoscopies
Reappointment: Twenty-five (25) cases from the Gynecological
Category, including two (2) total vaginal hysterectomies, two (2) total abdominal hysterectomies, and two (2) diagnostic
laparoscopies reflective of the scope of privileges requested

___ **Gynecological Category: Vaginal/Vulvar Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Vaginal/Vulvar Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Anterior/Posterior repair, with or without placement of mesh

Biopsy of cervix, vulva, vagina

Bladder neck suspension

Cervical cryotherapy

Closure of vaginal fistula

Conization of cervix

Culdocentesis

Cystoscopy

Dilation and curettage (D&C)

Dilation and evacuation (D&E)

Endometrial ablation

Provider Name:

Request	Privilege	Action MSO Use Only

Hymenectomy

Hymenotomy

Hysterosalpingogram (HSG)

I&D - Bartholin's Gland cyst, abscess, marsupialization

Incision and drainage wound abscess/hematoma

IUD insertion/removal

Loop electrical excision procedure (LEEP)

Perineoplasty

Repair incidental cystostomy

Repair of recto-vaginal fistula

Repair vesico-vaginal fistula

Sacrospinous ligament fixation

Simple vulvectomy

Total vaginal hysterectomy

Trachelectomy

Transvaginal enterocele repair

Urethral dilation

Urethral sling (ex. TVT, TVOT)

Urethroscopy

Vaginal bilateral tubal ligation

Vaginectomy

___ **Gynecological Category: Abdominal Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Abdominal Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Abdominal sacrocolpopexy

Adhesiolysis

Bilateral tubal ligation

Evacuation of pelvic abscess

Evisceration repair

Exploratory laparotomy

Provider Name:

Request	Privilege	Action MSO Use Only

Incisional hernia repair, concomitant

Microtubal surgery

Myomectomy and metroplasty

Oophorectomy

Ovarian cystectomy

Paravaginal repair

Pelvic and/or Para-aortic Lymphadenectomy

Pelvic lymph-node sampling

Pre-sacral neurectomy

Repair of enterocele

Repair surgical rent of bladder/bowel

Retropubic urethropexy

Salpingo-oophorectomy

Salpingostomy / Salpingectomy

Suprapubic cystotomy

Total abdominal hysterectomy

Tumor debulking

Wedge resection of ovaries

___ **Gynecological Category: Endoscopy/Hysteroscopy-Laparoscopic Surgery** ___

By selecting this privilege, you are requesting the Gynecology Category: Endoscopy/Hysteroscopy-Laparoscopic Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Appendectomy (incidental)

Aspiration of cyst

Bladder neck suspension

Colposuspension

Diagnostic laparoscopy

Endometrial ablation

Fulguration of lesions

Laparoscopic Assisted Vaginal Hysterectomy (LAVH)

Provider Name:

Request	Privilege	Action MSO Use Only

Laparoscopic Supracervical Hysterectomy (LSH)

Laparoscopic treatment of ectopic pregnancy

Laparoscopic Tubal Ligation

Lysis of adhesions

Myomectomy

Ovarian cystectomy

Removal of adnexal structure

Removal of Meckel's diverticulum (w/consultation)

Repair of cystotomy/enterotomy

Resection
of other uterine masses

Surgical
with or without D&C

Thermal
balloon ablation

Total Laparoscopic Hysterectomy (TLH)

Treatment
of ectopic pregnancy

Tubal
occlusion for sterilization

___ **GYNECOLOGIC-ONCOLOGY SURGERY CATEGORY:** ___

By selecting this privilege, you are requesting the Gynecologic-Oncology Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Gynecologic-Oncology Surgery
Initial Criteria:
1. Successful completion of an ABOG- or AOA-approved fellowship in Gynecologic Oncology
2. Board certification in Gynecologic Oncology
3. Documentation of twenty-five (25) cases either from fellowship (if within previous twenty-four (24) months) or another acute care facility
Proctoring: Ten cases (10) from the Gynecologic-Oncology Surgery Category, including at least two (2) Diagnostic and four (4) Therapeutic procedures
Reappointment: Twelve (12) representative blend of cases from Diagnostic and Therapeutic categories

DIAGNOSTIC

Diagnostic Cytoscopy with biopsy

Diagnostic Liver Biopsy

Diagnostic Proctoscopy with biopsy

Provider Name:

Request	Privilege	Action MSO Use Only

Diagnostic Staging laparotomy

THERAPEUTIC

Bladder/ureter/urethra surgery, concomitant

Chemotherapy administration

Colpectomy

Cystectomy, concomitant

Cytoreduction for cancer

Exenteration

Flap closure of perineal defects, myocutaneous flaps, skin grafting

Gastrostomy, concomitant

Ileostomy, concomitant

Insertion of suprapubic tube

Intestinal Surgery, concomitant

Lymphadenectomy; pelvic, aortic, inguinal, femoral, scalene node

Medical management of the cancer patient

Radical hysterectomy

Radical vaginectomy

Radical vulvectomy

Repair of vascular injury

Salpingoplasty

Splenectomy, concomitant

Urinary diversion, concomitant

Ventral hernia repair, concomitant

___ **MATERNAL-FETAL MEDICINE (Perinatology)**

By selecting this privilege, you are requesting the Maternal-Fetal Medicine (Perinatology) Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Initial:
1. Successful completion of an ACGME- or AOA-accredited residency in OB/GYN, and;
2. Successful completion of an ABOG- or AOA-approved fellowship in Maternal-Fetal Medicine.
Proctoring: Two (2) cases from this category, not including Admit patient or Consultation
Reappointment: Two (2) cases from this category, not including Admit patient or Consultation

Admit patients

Provider Name:

Request	Privilege	Action MSO Use Only

Consultation

Genetic Amniocentesis

Chorionic villus sampling

Cordocentesis

Intrauterine fetal transfusion

OTHER:

___ Moderate Sedation - Refer to Medical Staff policy 8710-517 for Initial, Proctoring, and Reappointment credentialing criteria. ___

___ **INTRA-ABDOMINAL LASER SURGERY:** ___
Initial:
1. Documentation of completion of laser training for each wavelength requested
2. Documentation of clinical experience with specialized laser surgery or hands-on laboratory experience for each wavelength requested
Proctoring: One (1) case per wavelength
Reappointment: One (1) case per wavelength

CO2 Laser

Nd Yag Laser

___ **Robotic Surgery (da Vinci) (Refer to Credentialing Policy, Robotic Assisted Surgery #8710-563 for Initial, Proctoring, and Reappointment criteria)** ___

By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ Robotic surgery (da Vinci) - Multiple Port ___

___ Robotic surgery (da Vinci) - Single Port ___

___ Xi Robotic Privileges ___

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

___ Assist in robotic surgery (da Vinci) ___

___ Assist in Xi Robotic ___

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

___ ~~**FORENSIC OUTPATIENT SITE-SPECIFIC PRIVILEGES**~~ ___

Provider Name:

Request	Privilege	Action MSO Use Only
	~~By selecting this privilege, you are requesting the Forensic Outpatient Site Specific privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.~~	
	~~Biopsy: Endometrial (F)~~	
	~~Biopsy: cervical, vulvar, vaginal (F)~~	
	~~Perform history and physical examination (includes pelvic exam and cultures) (F)~~	

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

Ophthalmology - 1/13

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Division of Ophthalmology consists of Physicians who are Board Certified or are in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Ophthalmology (or equivalent Osteopathic board), or able to demonstrate comparable ability, training and experience in Ophthalmology.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit Patients ___

___ Consultation, including via telemedicine (F) ___

___ Perform Medical History & Physical, including via telemedicine (F) ___

___ Refer and Follow ___

Physicians with this privilege may refer patients to the hospital and follow their progress, but an attending physician would provide necessary care. This privilege will allow the physician to visit patients, read records, and refer patients to specialists. SELECTION OF THIS PRIVILEGE IS EXCLUSIVE. NO OTHER PRIVILEGES MAY BE REQUESTED IN CONJUNCTION WITH THE REFER AND FOLLOW PRIVILEGE. *REFER AND FOLLOW IS NOT A CLINICAL PRIVILEGE*

___ Ocular Examination ___

___ **GENERAL OPHTHALMOLOGY CATEGORY**- By selecting this privilege, you are requesting the General Ophthalmology Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

General Ophthalmology Cateogry Criteria:
Initial: Board certified, eligible, or demostrated comparable ability, training, and experience.
Proctoring: Six (6) surgical cases from either the General Ophthalmology or Retina and Vitreous Surgery Categories.
Reappointment: Twenty-four (24) cases per every two-year reappointment cycle.

WHOLE EYE SURGERY:

Eye enucleation with or without implant

Eye evisceration with or without implant

Repair of extensive ocular trauma

Revision of surgical wounds

ANTERIOR SEGMENT SURGERY:

Cataract surgery, with or without IOL implant

Vitrectomy, anterior approach

Refractive corneal procedures

Pterygium excision simple

Pterygium excision with autograft

GLAUCOMA SURGERY:

Provider Name:

Request	Privilege	Action MSO Use Only

Seton procedures

Trabeculectomy

EYELID SURGERY:

Ectropion repair

Entropion repair

Blepharoplasty of upper eyelids

Blepharoplasty of lower eyelids

Total, full thickness, eyelid repair

___ **RETINA AND VITREOUS SURGERY CATEGORY** - By selecting this privilege, you are requesting the Retina and Vitreous Surgery Category privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Retina and Vitreous Surgery Category Criteria:
Initial: Board certified, eligible or demonstrated comparable ability, training, and experience, and successful completion of a fellowship in vitreo retinal surgery or the equivalent in training and experience.
Proctoring: As stated in the General Ophthalmology Category above.
Reappointment: As stated in the General Ophthalmology Category above.

Sclerotomy, posterior, foreign body, with or without magnet removal

Vitreous and retina procedures for retina subspecialists

Aspiration or release of vitreous, subretinal, or choroidal fluid, pars plana approach (posterior sclerotomy)

___ **LASER PRIVILEGES** - By selecting this privilege, you are requesting the Laser privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Laser Privileges Criteria:
Initial: Completion of an ACGME accredited Residency Program

Argon laser

YAG laser

Diode laser (Includes Transscleral cyclophotocoagulation)

___ ~~**FORENSIC OUTPATIENT CLINIC PRIVILEGES:** By selecting this privilege, you are requesting the Forensic Outpatient Clinic privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.~~ ___

~~Cultures~~

~~Foreign body removal~~

~~Biopsy~~

~~Eye lash removal~~

~~Rust ring removal~~

Tri-City Medical Center

Delineation of Privileges

Ophthalmology - 1/13

Provider Name:

Request	Privilege	Action MSO Use Only
	SPECIALIZED PROCEDURES:	
___	Temporal Artery Biopsy	___
___	Strabismus Surgery	___
___	Mid Face Lift through a subciliary lower lid blepharoplasty incision	___
___	Brow Lift, Coronal	___
___	Peri-orbital and facial resurfacing procedures including laser and chemical peels	___
___	Peri-orbital and facial tumescent liposuction and fat transfer	___
___	Orbital exenteration	___
___	Orbital Surgery	___
	OTHER:	
___	Moderate Sedation Proctoring: (2) cases need to be proctored Reappointment: Documented completion of three (3) cases of procedural sedation to meet reappointment criteria. Supplemental Requirements: (Policy #517) a) Completion of current Moderate Sedation Policy and the Moderate Sedation Self-Study Guide. b) Successful passing grade (at least 80%) of the Moderate Sedation Post-Completion Test.	___

_____
Print Applicant Name

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Applicant Signature

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Date

_____
Division/Department Signature

_____
Date

Human Resources Committee
(No meeting held in August, 2017)

Employee Fiduciary Subcommittee
(No meeting held in August, 2017)

Community Healthcare & Alliance Committee
(No meeting held in August, 2017)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 22, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Dr. Mark Yamanaka, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Scott Livingstone, Interim CCO
Others:	Director Jim Dagostino, David Bennett, Jane Dunmeyer, Maria Carapia, Kristy Larkin, Mary Diamond, Charlene Carty, Glen Newhart, Tom Moore, Colleen Thompson, Sharon Schultz, Susan Bond, Eva England, Norma Braun, Jeremy Raimo, Chris Miechowski, Priya Joshi, Scott Worman, M.D., Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:33 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Dr. Contardo, Mr. Lingenfelter seconded, and it was unanimously approved to accept the agenda of August 22, 2017.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of July 18, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Kellett, Director Mitchell seconded, that the minutes of July 18, 2017 are to be approved.**	
5. Old Business			
6. New Business			

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
a. Introduction – New Physician Committee Member • Mark Yamanaka, M.D.	Director Nygaard introduced Dr. Mark Yamanaka as the new Physician Member to the Finance, Operations and Planning Committee, replacing Dr. John Kroener. Also introduced at this time was Susan Bond, the new Director of Legal Services.		Chair
b. Air Handler Unit Filter Supplier & Maintenance Agreement • Camfil USA, Inc.	Chris Miechowski detailed that this proposal is for the vendor Camfil USA to supply, maintain and replace filters in 44 air handlers within the hospital. It was also conveyed that of the three bids received, Camfil USA's was the most competitive.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize an agreement with Camfil USA, Inc. for supplying and maintaining the air handler unit filters, for a total contract cost of $288,340.**	Chris Miechowski
c. Locum Tenens Contracts for Crisis Stabilization & Behavioral Health Units	Sharon Schultz explained that this agreement was with locum tenens vendors for supplemental physician staffing. This proposal is essential due to the increased need for coverage in both the Behavioral Health and Crisis Stabilization Units.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of allied health providers for the duration of the remaining 20 month term, beginning August 1, 2016 and ending March 31, 2018, for a total cost for the term of $1,748,000.**	Sharon Schultz

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
d. Pacific Registry Agreement	Sharon Schultz explained that this agreement was a 12 month renewal of an existing agreement with Pacific Registry, with a 5% rate increase.	**MOTION** **It was moved by Dr. Kellett, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Pacific Registry for Cancer Committee and Cancer Registry for a term of 12 months, beginning October 1, 2017 and ending September 30, 2018 for an annual cost of $268,068 and a total cost for the term of $268,068.**	Sharon Schultz
e. Physician Agreement for Supportive Care Program Medical Director • San Luis Rey Medical Group	Sharon Schultz detailed that this agreement would provide for a Medical Director for Supportive Care, and they would assume overall responsibility for clinical oversight of all patients receiving Supportive/Palliative Care services.	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize San Luis Rey Medical Group to provide medical oversight for the TCHD Supportive/Palliative Care Program for a term of 12 months beginning September 1, 2017 and ending August 31, 2018. Not to exceed an average of 40 hours per month, not to exceed 480 hours annually, at an hourly rate of $150 for a term cost of $72,000.**	Sharon Schultz
f. Nurse Practitioner for Inpatient BHU & CSU Services • Veronica Deatrick, APNP	Sharon Schultz outlined that this agreement was for nurse practitioner services for the Behavioral Health and Crisis Stabilization Units, to provide medical care to this patient population under the supervision of	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Veronica**	Sharon Schultz

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
	the physician psychiatric staff. Director Nygaard, on behalf of the Committee, requested an update from Sharon Schultz at the September meeting, regarding the current status of the Behavioral Health and Crisis Stabilization Units.	**Deatrick, APNP to provide medical care under the Supervision of the UCSD Psychiatrists for the term of 12 months beginning July 1, 2017 and ending June 30, 2018. Not to exceed an average of 110 hours in total per month, for a total term cost of $200,000.** **Barbara Hainsworth to add this item to the Work Plan for September**	
g. Ortho Billing and Coding Audit Proposal • VP-MA Health Solutions, Inc.	Scott Livingstone explained that this agreement was to provide an assessment of the accuracy of ICD-10-CM and CPT pertinent documentation and coding for Orthopedic Specialists of North County (OSNC) for a term of 5 months.	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with VP-MA Health Solutions, Inc. for Billing and Coding Audit Services for a term of 5 months, beginning July 25, 2017, and ending December 1, 2017, for a total cost for the term of $40,000.**	Jeremy Raimo / Scott Livingstone
h. Cloverleaf Proposal • Infor US, Inc.	Kapua Conley conveyed that this proposal is for an upgrade to current software releases, including licensure for an interface engine which allows information systems to send critical data elements and data streams to one another. This upgrade includes 12 months of product support services.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Infor US, Inc. for the upgrade of Cloverleaf interface engine for a term of 12 months, beginning September 1, 2017 and ending August 31, 2018 for an annual cost of $56,400 and a total cost for the term of $338,400.**	Mark Albright

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
i. Financials	Ray Rivas presented the financials ending July 31, 2017 (dollars in thousands) **TCHD – Financial Summary** **Current Month** Operating Revenue $ 29,600 Operating Expense $ 30,419 EBITDA $ 898 EROE $ (394) **TCMC – Key Indicators – Current Month** Avg. Daily Census 170 Adjusted Patient Days 9,221 Surgery Cases 511 Deliveries 210 ED Visits 5,542 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 44.2 Days in Net A/R Avg. 47.7 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay • TCMC-Emergency Department Visits		Ray Rivas
j. Work Plan – Information Only • Wellness Center	David Bennett reviewed the update document including the membership status, as well as advising the Committee that the general manager at the Wellness		David Bennett

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	Center had been replaced as of 8/21/17. Significant discussion ensued, during which Mr. Lingenfelter requested to see an income statement for the Wellness Center. In addition, Eva England and Priya Joshi gave a short PowerPoint presentation pertaining to the Medical Integration Programs and the collaboration of Physical Therapy and Cardiac Rehabilitation at the Wellness Center.		
• Medical Director – Surgery	Mary Diamond gave a short PowerPoint presentation reflecting the outcome performance metrics for Monthly First Case-On Time Starts, Total Block Utilization Percentage by Month and the Monthly Average Turnover & Close to Cut Intervals.		Mary Diamond
• IT Physician Liaison	Dr. Scott Worman, supported by Kapua Conley gave a brief PowerPoint presentation reflecting two major projects, Cerner Optimization for ED, Hospitalist, Surgery and Cardiology and Data Management for Quality Improvement. Also discussed were the pillars for Clinically Integrated Care as they apply to the Institute for Clinical Effectiveness.		Mark Albright
• ICD-10 Update	Colleen Thompson gave a brief	Barbara Hainsworth to ensure the annual	Colleen Thompson

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
	PowerPoint presentation, reflecting the current status since implementation of ICD-10. Director Nygaard made the recommendation, and the committee concurred that this item no longer required updates and could now be removed from the Work Plan.	ICD-10 Update is deleted from the Work Plan.	
• Update on Institutes - Cardiovascular - Neuroscience - Orthopedic	Jeremy Raimo gave a brief PowerPoint presentation, including the total FY2017 cost profile for the three institutes. In addition, he provided a timeline for the implementation of the Institute for Clinical Effectiveness (ICE).		Jeremy Raimo
• Dashboard	Brief discussion ensued.		Ray Rivas
7. Comments by committee members	None		
8. Date of next meeting	September 19, 2017		Chair
9. Community Openings (3)			
10. Adjournment	Meeting adjourned 1:50 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
Air Handler Unit Filter Supplier and Maintenance Agreement

Type of Agreement		Medical Directors		Panel	X	Other: Replace & Maintain Air Filters
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Camfil USA, Inc.

Area of Service: Entire Hospital

Term of Agreement: 72 months

Maximum Totals: $288,340

Description of Services/Supplies:

- Vendor will supply, maintain and replace filters in 44 air handler units at the hospital.
- Currently, work is performed on an as-needed basis. By contracting for the service, we lock in the price for six years.
- Camfil USA, Inc. was the lowest responsive bidder. Bid results below:

Bidder:	Amount:
Camfil USA	$288,340
American Air Filter	$306,119
ETC	$556,911

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Chris Miechowski, Director of Facilities / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize an agreement with Camfil USA, Inc. for supplying and maintaining the air handler unit filters, for a total contract cost of $288,340.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
Locum Tenens Contracts for Crisis Stabilization Unit and Behavioral Health Unit

Type of Agreement		Medical Directors		Panel	X	Other: Amendment
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Locum Tenens Vendors (NP/PA)

Area of Service: Crisis Stabilization Unit (CSU) and Behavioral Health Unit (BHU)

Term of Agreement: 20 months, Beginning, August 1, 2016 – Ending, March 31, 2018

Maximum Totals:

Average Monthly Cost	Average Annual Cost	Total Term Cost
$92,000	$1,104,000	$1,748,000

Description of Services/Supplies:

- Started at $24,000/month in September 2016 for 8 hours day shift; increasing to $59,000 in November 2016 due to Locum Tenens rates after 15:00 (3 p.m.)
- Increased need of coverage since March, 2017; 24/7 vs. 12-16 hours in CSU
- Based on current and anticipated usage of Locum Tenens, until the full physician complement is hired. Only 2 have been hired so far, vs. 3 expected. Minimum of 4 needed for full-time coverage. We have only 1 per diem nurse practitioner hired (very difficult to retain as employee)
- Rates range from $150-250/hr., depending on the shift

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement: Per San Diego County Contract	X	Yes		No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Locum Tenens vendors, with flexibility to add or delete agencies, for supplemental physician staffing of allied health providers for the duration of the remaining 20 month term, beginning August 1, 2016 and ending March 31, 2018, for a total cost for the term of $1,748,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
Pacific Registry Agreement

Type of Agreement		Medical Directors		Panel	X	Other: Service
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Pacific Registry

Area of Service: Cancer Committee / Cancer Registry

Term of Agreement: 12 months, Beginning, October 1, 2017- Ending, September 31, 2018

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$22,339	$268,068	$268,068

Description of Services/Supplies:

- 5% increase from previous rate of $21,275 per month
- The Program requires 3 Full time employees to collect, analyze, and report out data
- Cancer Committee Chair
- Prepares, organizes and facilitates the Commission on Cancer Survey every 2 years
- Coordinates and leads all Cancer Committees

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Pacific Registry for Cancer Committee and Cancer Registry for a term of 12 months, beginning October 1, 2017 and ending September 30, 2018 for an annual cost of $268,068 and a total cost for the term of $268,068.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
PHYSICIAN AGREEMENT for Supportive Care Program Medical Director

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: San Luis Medical Group
Area of Service: Supportive Care/Palliative Care
Term of Agreement: 12 months, Beginning, September 1, 2017 – Ending, August 31, 2018
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Average Hours per Month	Hours per Year Not to Exceed	Monthly Cost	Annual Cost Not to Exceed	12 month (Term) Cost
$150	40	480	$6,000	$72,000	$72,000

Position Responsibilities: SUPPORTIVE CARE MEDICAL DIRECTOR SERVICES

- This service will effectively reduce readmissions, lower length of stay, and improve patient care
- Physician shall serve as the Supportive Care Medical Director and assume overall responsibility for clinical oversight of all patients receiving supportive care services. As Supportive Care Medical Director, Physician will ensure that these areas consistently meet patient and family needs including, but not limited to the following matters:
  - Physician shall serve as a member of the supportive care interdisciplinary team (IDT), attend IDT meetings and participate in its activities.
  - Physician shall participate with attending physicians of patients and the interdisciplinary team in establishing plans of care and shall review and update them on a periodic basis.
  - Provides Clinical oversight to nurses
  - Leads quality assurance initiatives and participates in peer review as needed.
- Additional Supportive Care Medical Director Duties and Responsibilities:
  - Conduct and oversee clinical training of SC/PC physicians
  - Assistance and oversight of physician scheduling when needed
  - Mentor and provide guidance to PC physicians
  - Interface with community partners including Tri-City Medical Center leadership, physicians & staff

Board Approved Physician Contract Template:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:		Yes	X	No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize San Luis Rey Medical Group to provide medical oversight for the TCHD Supportive/Palliative Care Program for a term of 12 months beginning September 1, 2017 and ending August 31, 2018. Not to exceed an average of 40 hours per month, not to exceed 480 hours annually, at an hourly rate of $150 for a term cost of $72,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
Nurse Practitioner for Inpatient BHU & CSU Services

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Allied Health Professional: Veronica Deatrick, APNP / Achieve Medical
Area of Service: Inpatient Behavioral Health Unit and Crisis Stabilization Unit
Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate/Hour	Average Hours per Month		12 month (Term) Cost Not to Exceed	
Day Shift $130 PM Shift $150 Night Shift $180	CSU 70	BHU 40	CSU $137,600	BHU $62,400
TOTALS:	**110**		**$200,000**	

Position Responsibilities:

- One weekend shift per month if needed.
- Provide holiday and vacation coverage as requested.
- Provide clinical assessment, H & P, progress notes, orders, consultation as requested by the TCHD psychiatrist.
- Ensures that all medical and therapy services are consistent with the Division of Psychiatry and Hospital mission and vision.
- Ensure a medical notation on each patient seen, when working.
- Ensure compliance of Regulatory bodies, the Department and Division rules and regulations

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Veronica Deatrick, APNP to provide medical care under the Supervision of the UCSD Psychiatrists for the term of 12 months beginning July 1, 2017 and ending June 30, 2018. Not to exceed an average of 110 hours in total per month, for a total term cost of $200,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
ORTHO BILLING AND CODING AUDIT PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other: Addendum
Status of Agreement		New Agreement	X	New Rates		Same Rates

Vendor's Name: VP-MA Health Solutions, Inc.

Area of Service: Orthopaedic Specialists of North County (OSNC)

Term of Agreement: 5 months, Beginning, July 25, 2017 – Ending, December 1, 2017

Maximum Totals:

Total Term Cost
$40,000

Description of Services/Supplies:

- Assess accuracy of ICD-10-CM and CPT-pertinent documentation and coding for 20 encounters
- Evaluate selection and accuracy of first-listed diagnosis codes, additional diagnoses code and procedures
- Compare record to claim for outpatient encounters
- Conduct up to two days of onsite interviews and observations with providers and billing personnel assessing documentation, coding, staffing and billing operations

Document Submitted to Legal:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with VP-MA Health Solutions, Inc. for Billing and Coding Audit Services for a term of 5 months, beginning July 25, 2017, and ending December 1, 2017, for a total cost for the term of $40,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 22, 2017
CLOVERLEAF PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other: Amendment
Status of Agreement		New Agreement	X	Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Infor US, Inc.

Area of Service: Information Technology

Term of Agreement: 12 months, Beginning, September 1, 2017 – Ending, August 31, 2018
Plus cost of the upgrade.

Maximum Totals:

One Time Cost	Annual Cost	Total Term Cost
$282,000	$56,400	$338,400

Description of Services/Supplies:

- Cloverleaf is an interface engine which allows information systems to send data elements and data streams to one another such as patient charges and other mission critical data. These data streams are critical for patient care delivery and the financial success of the organization. TCMC currently has approximately 80 such data streams to many different systems.
- Budgeted upgrade of Cloverleaf interface engine to current software release with licenses. Includes 12 months of product support services.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	No
Budgeted Item:	X	Yes		No

**Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.*

Person responsible for oversight of agreement: Mark Albright, Vice President, Information Technology / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Infor US, Inc. for the upgrade of Cloverleaf interface engine for a term of 12 months, beginning September 1, 2017 and ending August 31, 2018 for an annual cost of $56,400 and a total cost for the term of $338,400.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
August 10, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. Contardo, Dr. Souza, Dr. Ma and Dr. Johnson.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, Rick Barton, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director Quality and Regulatory.

Others Present: Lisa Mattia, Tori Hong, Kathy Topp, Diane Sikora, Sharon Davies, Nancy Myers, Amy Hardt, Eva England, Mary Diamond, Kelli Kelli Larose, Robert Flores, Kevin McQueen, Sherry Miller, Steve Young, Jeremy Raimo, Patricia Guerra and Karren Hertz.

Members Absent: Scott Livingstone, Interim Chief Compliance Officer

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:08 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

4. Ratification of minutes of July 2017.	Director Mitchell called for a motion to approve the minutes from July 13, 2017 meeting. There were a number of corrections made by some members of the Committee.	The minutes were ratified and were approved by the group with the recommended amendments. Director Dagostino moved and Director Grass seconded the motion to approve the modified minutes from July 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Administrative Policies and Procedures:** 1. Cellular Phones & Other Wireless Electronic Digital Devices Usage Policy	There was a recommendation to put smartphones in replacement of the brand names IPad and IPod. PDAs were deleted too from the list of electronics mentioned in this policy.	**ACTION:** The Administrative policies and procedures except for the Policy Approval were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. E-Mail Access	A designated font is used for hospital email as it is a regulatory (CMS) requirement as per Jami Piearson.		
3. Policy & Procedure Approval- Administrative Process	Director Dagostino inquired about the Department Manual Coordinating Committee composed of Patricia and Natalie; they are the ones who oversee the compilation and modification of policies and procedures in the hospital.	**ACTION:** This policy is being pulled out as verbiage regarding the review timeline of policies needs to be further reviewed.	Patricia Guerra

Unit Specific **Behavioral Health Services** 1. 14 Day Certification Review Hearings	It was recommended to put California Welfare and Institutions Code 5150 as a reference for this policy because that is where the definition of 5150 is fully explained.	**ACTION:** The committee agreed to pull out all the BHU policies for further review. These policies need to have the same information as what is stated in the California Institutional Code.	Joy Melhado/ Patricia Guerra
2. 14 Day Involuntary Holds 5250	California Welfare and Institutions Code 5250 should also be referenced in this policy for exact definition of statutory requirements. The committee agreed that this policy should be referred to Legal Department before coming back to this committee.		
3. 5270 - 30 days of Additional Intensive Treatment	California Welfare and Institutions Code 5270 should be referenced in this policy for exact definition of statutory requirements.		
4. Advisement of Legal Status 72 Hour Hold	California Welfare and Institutions Code 5150 should be referenced in this policy for exact definition of statutory requirements.		
Infection Control 1. Bloodborne Pathogen Exposure Control Plan	This policy is being pulled out for re-evaluation. It was noted that the regular trash bag and the hazardous waste red bag should be defined clearly as some type of wastes need to be re-classified for potentially infectious effects.	**ACTION:** The Infection Control policies were approved with the exception of the Bloodborne Pathogen Exposure Control plan policy. Dr. Contardo moved and Director Dagostino seconded the motion to approve the policies moving forward for Board	Lisa Mattia/ Patricia Guerra
2. Department Specific			

Wound Care Center	This policy is a deletion.	approval.	
3. Ebola Plan Policy	There is a specific protocol that the hospital use when dealing with patients of suspected Ebola. It was also mentioned that there is a room in ED (C-26) with negative pressure and a door to the outside that suspected Ebola patients would come through.		
4. Mold Abatement	Director Mitchell made a minor correction on the section that says do not mix out bleach with solutions containing ammonia.	**ACTION:** Policy verbiage correction.	Patricia Guerra
5. Prion Diseases: Transmissible Spongiform Encephalopathies	This policy is currently being worked on; the term embalming was taken out on this policy as this process is not done at the hospital.		
6. Standard and Transmission-Based Precautions	There is no discussion on this policy.		
7. Disease Index: Type and Duration of Precautions for Selected Infections and Conditions	There is no discussion on this policy.		
Medical Staff			

1. Nurse Practitioner (NP)-Cardiology Standardized Procedures	There was a recommendation to add "Medical Staff" in the cover page of each policy that addresses NP. Sherry Miller added that the Medical Staff Dept. still has NPs undergo the same credentialing process as physicians. The peer review process for NPs includes a review of competencies, scope of practice and privileges, and audits and observations by their supervising physician.	**ACTION:** The Medical Staff policies and procedures were approved except for Physician Formats and Prevention of Fire in Head and Neck Surgery. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Credentialing Standards for Vertebral Augmentation	There is no discussion on this policy.	**ACTION:** Change statement on the last page to "supervising signature" and not "sponsoring signature".	Patricia Guerra
3. Focused Professional Practice Evaluation-Proctoring	Minimal discussion to clarify.	**ACTION:** The details on this policy are being revised as well the dates and references are being updated.	Sherry Miller
4. NP- Hospitalist Standardized Procedures	The qualification of CNOR for NPs shall be taken out in this policy.	**ACTION:** Add NRP certification.	Patricia Guerra
5. NP-Neonatal Standardized Procedures 6. NP- OB/ GYN Standardized Procedures	The qualification for ACLS and CNOR for NPs should be deleted. The NP functions as First Assist on surgery cases relating to OB-GYN surgeries.	**ACTION:** Add NRP certification.	Patricia Guerra

7. NP- Oncology Standardized Procedures	NPs do not need to be certified to order chemotherapy. The RNs are chemo-certified to do chemotherapy.		
8. NP- Orthopedic and Spine Institute Standardized Procedures	There no discussion on this policy.		
9. NP- Pediatrics Standardized Procedures	The CNOR and PALS qualifications for NP should be taken out. It was stated that pediatrics NPs round on normal newborns.	**ACTION**: Remove ACLS.	Patricia Guerra
10. Physician Formats Approval Process	This policy is being pulled out for further review. The Medical Records Department may have a department policy on dictation that this policy can be consolidated there.		
11. Prevention of Fire in Head and Neck Surgery	The information contained in this policy need be compared with the OR policy.	**ACTION:** Compare to current OR Policy.	Patricia Guerra
12. Psychiatry Division Standardized Procedures	It was clarified that NPs can admit inpatients to CSU only.		
NICU			
1. Developmental Supportive Care in the NICU	There was no discussion on this policy.	**ACTION:** The NICU procedure was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Outpatient Behavioral Health 1. Abbreviations 2. Admission and Eligibility Criteria 3. Admission Assessment 4. Attendance & Leaving Early Without Notifying Staff 5. Clinical Assessment 6. Community Meetings	These abbreviations are specific to BHU Department. The policy on Use of Hospital Abbreviations was added as a related document. The CMS Local Coverage Determination was added to this policy as a reference. Sarah clarified to the group that this policy reflects the current CMS standards. Director Dagostino brought up the issue of insurance coverage determination which is partly covered under this policy. Sarah mentioned that the Outpatient Behavioral Health has their own billing system and denied payments rarely happen. Patients are always provided the treatment and intervention required regardless of insurance denial. This is a policy deletion. The CMS Local Coverage Determination was added to this policy as a reference. This policy serves as a guideline that the department adheres to when it comes to	**ACTION:** The policies and procedures for Outpatient Behavioral Health except for Denied Payment and Substance Abuse were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

7. Community Outings	community meetings.		
8. Contraband	There is no discussion on this policy.		
9. Daily Progress Notes	There is no discussion on this policy.		
10. Denied Payment	This policy was updated and the CMS Local Coverage Determination was added as a reference to this policy.	**ACTION:** This policy will be brought back to this committee.	Sarah Jayyousi
11. Destructive or Potentially Violent Behavior	This policy is pulled; a further explanation is needed on how the department handles their denied payments in conjunction with hospital policy.		
12. Disaster Plan	All the staff in Behavioral Health undergoes CPI trainings which are mostly de-escalation techniques. This training is provided by the hospital so they can address harmful behaviors on the unit.		
13. Discharge Planning and Discharge	The policy on Hospital Disaster was added as a related document for this policy.		
	The CMS Local Coverage Determination was added to this policy as a reference. There was a correction on the completed discharge summary; it should have said AHP instead of MD.		

14. Disclosure of Information Over the Telephone	This is a policy deletion.		
15. Dress Code for Patients	This policy serves as a guideline to define the dress code for patients attending the Outpatient Behavioral health services.		
16. Family Involvement	There is no discussion on this policy.		
17. Involuntary Patient Detention	The definition of 5150 according to the California Institutional Code should be referenced into this policy.		
18. Laboratory Services	The Outpatient Behavioral Health Department uses the hospital phlebotomist for patients needing lab services.		
19. Medical Emergencies	This policy outlines the Code Blue procedures on offsite locations.		
20. Medically Excused Absences	There is no discussion on this policy.		
21. Medicare Additional Document Request	There is no discussion on this policy.		
22. Non-Compliance with Program Rules	There is no discussion on this policy.		
23. Organizational Structure	There is no discussion on this policy.		

24. Patient Complaints	The hospital policy addressing patient complaints will be added as a related document for this policy.		
25. Physician Admission Order	The CMS Local Coverage Determination was added to this policy as a reference.		
26. Physician and Nurse Practitioner Orders	This policy will be consolidated into the hospital policy addressing physician and NP orders.		
27. Plan for Professional Services and Staff Composition	Policy name changed to "Scope of Services". Patients in Outpatient Behavioral Health usually receive no more than twelve (not eleven) units of service per week.		
28. Positive Reinforcement Techniques	This policy serves as a guideline to provide parameters for use of positive reinforcement techniques in behavioral health patients.		
29. Psychiatric Emergencies	This policy needs a reference.	**ACTION:** Add a reference.	Sarah Jayyousi
30. Referral and Admission Screening	There is no discussion on this policy.		
31. Release of Information	This is a policy deletion.		
32. Role of Therapist			

	It was identified that the therapists in Outpatient Behavioral Health act as licensed professional clinicians for each patient being seen in the department. The responsibilities of a therapist are outlined and mostly cater to the population that the Program serves. Medical Directors are in attendance daily.		
33. Smoke Free Environment	The smoke-free policy of the hospital will be added as a related document to this policy.		
34. Standards for Clinical and Professional Practice	There is no discussion to this policy.		
35. Substance Abuse	This policy is being pulled as the group agreed there needs to be a solid definition of substance abuse as it pertains and relates to the Behavioral Health patients.	**ACTION:** Define substance abuse.	Sarah Jayyousi
36. Summary of Care List	This policy is more of a transfer document; the summary of care list of each patient is included in the patient's medical record.		
37. Telephone Use by Patients	This is a policy deletion.		
38. Treatment Planning	There is no discussion on this policy.		
Outpatient Infusion Center			

1. Medical Emergencies	There is no discussion on this policy	**ACTION:** The procedure for Outpatient Infusion Center was approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation 1. Community Outreach Groups	There was a minor correction on the purpose of the Parkinson's group; the purpose is to help maintain, not restore maximum function of the patient.	**ACTION:** The procedure for Rehabilitation was approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Telemetry 1. Monitoring Telemetry Patients Using the DASH 3000	Dr. Johnson asked for clarification on monitoring of invasive lines. He was unaware we had this capability because PACU RNs informed him that the Telemetry staff cannot "have" these patients and therefore he writes orders for the A-line to be removed when he would rather leave it in overnight or sends them to ICU when they do not need to be in the ICU. Dr. Souza also stated he was not aware Tele has the capability to monitor invasive lines and that the educator need to get the word out to the physicians. Priscilla responded that the volume of these patients is low and some staff may have refused to accept the	**ACTION:** Remedial education to be provided to Tele RNs regarding invasive lines so that their comfort in providing care for these patients will be realized in their acceptance from PACU. **ACTION:** The Telemetry policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Priscilla Reynolds Patricia Guerra

	patients from PACU because of their comfort level. She and the Tele management team are not aware of the staff refusing to accept these patients.		
2. Skin and Wound Team Rounds	This policy needs more references.	**ACTION:** Add appropriate references.	Patricia Guerra
6. Clinical Contracts	It was reported there are no clinical contracts for review this month.	**ACTION:** None.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:15 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:20PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:22 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
August 10, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Administrative Policies & Procedures		
1. Cellular Phones and Other Electronic Digital Device Usage Policy 257	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2. E-Mail Access 604	3 Year Review, Practice Change	Forward to BOD for Approval
3. Policy Approval-Administrative 240	3 Year Review, Practice Change	Pulled for Further Review
4. Remote Access: Physicians and Physician Office Employees	DELETE	Reviewed at PAC 07/13/17: Forward to BOD for Approval
Unit Specific		
Behavioral Health Services		
1. 14 Day Certification Review Hearings	3 Year Review	Pulled for Further Review
2. 14 Day Involuntary Holds 5250	3 Year Review	Pulled for Further Review
3. 5270 - 30 Days of Additional Intensive Treatment	NEW	Pulled for Further Review
4. Advisement of Legal Status 72 hr hold	3 Year Review	Pulled for Further Review
Infection Control		
1. Bloodborne Pathogen Exposure Control Plan	Practice Change	Pulled for Further Review
2. Department Specific Wound Care Center - IC 7	DELETE	Forward to BOD for Approval
3. Ebola Plan Policy	NEW	Forward to BOD for Approval
4. Mold Abatement IC 13.3	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
5. Prion Diseases: Transmissible Spongiform Encephalopathies IC 6-5	Practice Change	Forward to BOD for Approval with Revisions
6. Standard and Transmission- Based Precautions - IC 5	Practice Change	Forward to BOD for Approval with Revisions
7. Type and Duration of Precautions for Selected Infections and Conditions IC 5-1r11	DELETE	Forward to BOD for Approval
Medical Staff		
1. Cardiology Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
2. Credentialing Standards for Vertebral Augmentation 8710-534	3 Year Review, Practice Change	Forward to BOD for Approval
3. Focused Professional Practice Evaluation - Proctoring 8710-542	3 Year Review	Forward to BOD for Approval with Revisions
4. Hospitalist Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
5. Neonatal Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
6. OB/GYN Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions

PROFESSIONAL AFFAIRS COMMITTEE
August 10, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
7.	Oncology Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
8.	Orthopedic and Spine Institute Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
9.	Pediatrics Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
10.	Physician Formats Approval Process 8710-557	3 Year Review, Practice Change	Pulled for Further Review
11.	Prevention of Fire in Head and Neck Surgery 8710-560	3 Year Review	Pulled for Further Review
12.	Psychiatry Division Standardized Procedures	2 Year Review	Forward to BOD for Approval with Revisions
	NICU		
1.	Developmental Supportive Care in the NICU	3 Year Review, Practice Change	Forward to BOD for Approval
	Outpatient Behavioral Health		
1.	Abbreviations	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2.	Admission & Eligibility Criteria	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
3.	Admission Assessment	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
4.	Attendance & Leaving Early Without Notifying Staff	DELETE	Forward to BOD for Approval
5.	Clinical Assessment	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
6.	Community Meetings	DELETE	Forward to BOD for Approval
7.	Community Outings	DELETE	Forward to BOD for Approval
8.	Contraband	3 Year Review	Forward to BOD for Approval
9.	Daily Progress Notes	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
10.	Denied Payment	3 Year Review, Practice Change	Pulled to be Converted to a Procedure
11.	Destructive or Potentially Violent Behavior	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
12.	Disaster Plan	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
13.	Discharge Planning & Discharge	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
14.	Disclosure of Information over the telephone	DELETE	Forward to BOD for Approval
15.	Dress Code for Patients	DELETE	Forward to BOD for Approval
16.	Family Involvement	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
17.	Involuntary Patient Detention	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions

PROFESSIONAL AFFAIRS COMMITTEE
August 10, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
18.	Laboratory Services	3 Year Review	Forward to BOD for Approval with Revisions
19.	Medical Emergencies	3 Year Review	Forward to BOD for Approval with Revisions
20.	Medically Excused Absences	DELETE	Forward to BOD for Approval
21.	Medicare Additional Development Request	DELETE	Forward to BOD for Approval
22.	Non-Compliance with Program Rules	DELETE	Forward to BOD for Approval
23.	Organizational Structure	3 Year Review	Forward to BOD for Approval
24.	Patient Complaints	DELETE	Forward to BOD for Approval
25.	Physician Admission Order	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
26.	Physician and Nurse Practitioner Orders	DELETE	Forward to BOD for Approval
27.	Plan for Professional Services and Staff Composition	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
28.	Positive Reinforcement Techniques	DELETE	Forward to BOD for Approval
29.	Psychiatric Emergencies	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
30.	Referral and Admission Screening	3 Year Review	Forward to BOD for Approval
31.	Release of Information	DELETE	Forward to BOD for Approval
32.	Role of Therapist	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
33.	Smoke Free Environment	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
34.	Standards for Clinical and Professional Practice	3 Year Review	Forward to BOD for Approval with Revisions
35.	Substance Abuse	3 Year Review, Practice Change	Pulled for Further Review
36.	Summary of Care List	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
37.	Telephone Use By Patients	DELETE	Forward to BOD for Approval
38.	Treatment Planning	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Outpatient Infusion Center		
1.	Medical Emergencies	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Rehabilitation		
1.	Aphasia Group 800	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Telemetry		
1.	Monitoring Telemetry Patients Using the DASH 3000	3 Year Review, Practice Change	Pulled for Further Review
2.	Skin and Wound Team Rounds	NEW	Forward to BOD for Approval with Revisions

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~

ISSUE DATE: 05/07

SUBJECT: CELLULAR PHONES & OTHER WIRELESS ELECTRONIC DIGITAL DEVICES USE OF

REVISION DATE: 10/08; 08/13; 11/14

POLICY NUMBER: 8610-257

Department Approval:	**05/17**
Administrative Policies & Procedures Committee Approval:	**~~12/13~~06/17**
Medical Executive Committee Approval:	**~~01/14~~07/17**
Professional Affairs Committee Approval:	**~~04/14~~08/17**
Board of Directors Approval:	**04/14**

A. **PURPOSE:**

1. **To a**Avoid potential disruption to patient care caused by audible cellular phone, pager tones, and users in clinical areas.
2. **To r**~~R~~educe the risk of **wireless electronic digital device** interference with patient care equipment.
3. **To p**~~P~~rotect and respect the privacy of our patients.
4. **To r**~~R~~emind employees of their personal responsibility for appropriate use of cellular phones in the work place and when driving.
5. **To e**~~E~~stablish cellular phone tablet and laptop etiquette guidelines.

B. **DEFINITIONS:**

1. **Electronic Digital Device: Cellular/smart-phones, laptops, tablets, MP3 Players, ~~IPod, IPAD, PDA,~~ or pagers, ~~Smartphones, or Blackberry technology~~.**

~~1.~~2. Hospital ~~Cellular Phones and Wireless~~ Electronic Digital Device: a device used by **employees or** individuals **associated with ~~the District~~Tri-City Healthcare District (TCHD)** for the purpose of mobile communications; can be either analog or digital technology.

~~a. Examples: Cellular phones, laptops, tablets, MP3 Players, IPod, PDA, pagers, Smartphones, or Blackberry technology~~

~~2.~~3. Personal ~~Cellular Phones and Wireless~~ Electronic Digital Device: personally owned or Bring Your Own Device (BYOD).

~~a. Examples: Cellular phones, laptops, tablets, MP3Players, IPod, PDA, pagers, Smartphones, or Blackberry technology.~~

~~3.~~4. Two-Way Radio: wireless mobile radio commonly used by Police, Fire, and Ambulance staff. ~~District~~ **TCHD** employees within the Security and Engineering departments utilize this technology.

~~4.~~5. Voice over Internet Protocol (VoIP): a technology that allows a person to make voice calls using a broadband Internet connection instead of using a regular (or analog) telephone line.

~~5.~~6. Electromagnetic Interference (EMI): electrical interference generated by ~~cellular phones~~**Electronic Digital Devices** and two-way radios that can interfere or alter the performance of medical equipment used to supply monitoring and therapeutic care to patients.

7. Medical Devices and Medical Equipment: any life-critical electrical equipment and/or wireless equipment used to diagnose, monitor, or treat patients who may be at risk for electrical signal interference

~~6.~~8. **Patient Care Areas: space within TCHD's facilities where patients are intended to be examined or treated.**

~~7. Health Insurance Portability and Accountability Act (HIPAA): Federal regulations that protect the privacy of protected health information and the privacy rights of patients~~

C. **POLICY:**

~~1.A.~~ ~~All Tri-City Healthcare District (TCHD) employees should be professional in their conduct and use of hospital and personal cellular phones and devices and only use them as needed to conduct their work and be efficient and productive.~~

1. ~~Cellular phone use in Patient Care Areas is limited to hospital issued use:~~**Electronic Digital Device use generally at ~~District facilities~~TCHD:**
   - a. **Electronic Digital Devices ~~Laptops or other electronic devices~~ may not be used to send, post, download, or intentionally receive pornographic material.**
   - b. **Electronic Digital Devices~~Laptops or other electronic devices~~ may not be used to display materials that violate TCHD harassment or confidentiality policies.**
   - ~~2.~~c. **Electronic Digital Devices ~~Laptops or other electronic devices~~ may not be used to engage in illegal activities (violators may be subject to prosecution by local, state and/or federal authorities).**
   - d. **~~District~~TCHD ~~e not unplug hospital~~ equipment may not be unplugged to plug an Electronic Digital Devices ~~laptop/electronic device in~~ without authorization from hospital staff. ~~Try to use the battery in the device as much as possible.~~**
     - i. **A patient or guest must check with hospital staff if an Electronic Digital Device ~~laptop/electronic device~~ needs to be plugged into an electrical outlet.**

~~3.~~2. **Electronic Digital Device use in Patient Care Areas is limited to the following uses:**
   - a. **Persons using an Electronic Digital Device must stay at least 10 feet away from Medical Devices and Medical Equipment.**
     - i. **Ringers shall be set to silent or vibrate.**
     - ii. **Patients and/or visitors must receive verbal-permission from healthcare personnel.**
     - iii. **Signs shall be posted at the entrance of patient care areas communicating the following:**
       - 1) **Notice: Cellular phones shall be set to silent/vibrate within this area.**
     - iv. **Exceptions:**
       - 1) **Use of Electronic Digital Device audio or recording abilities is prohibited.**
       - 2) **Photos taken with an Electronic Digital Device is limited to the patient and/or family and should be close up in nature to prevent other individuals being inadvertently captured in the background of the picture.**
       - 3) **Pictures may not include any private or sensitive information of other persons at the TCHD facility.**
       - 4) **Recording glasses such as Google glasses are prohibited.**
       - 5) **The Patient Handbook communicates ~~the District~~TCHD's policy relating to cellular phone use in the facility and should be consulted by patients and visitors.**
   - ~~a.~~b. **Electronic Digital Device ~~Cellular phone~~** use by **TCHD staff and others affiliated with TCHD (e.g. physicians, Case Managers, nurses, etc.) ~~Medical, Hospital, and/or Contract staff (i.e. External Case Managers)~~** is permitted for official ~~district~~ **TCHD** business (e.g. patient care) **~~and only to those with hospital issued cell phones.~~.**
   - c. **Use of an Electronic Digital Device is not permitted for personal use in a patient care area at any time. ~~Use of cellular phone by patients and visitors in District facility is acceptable provided the ringer is to be set to silent or vibrate to support our noise abatement procedures and has received verbal permission from healthcare personnel.~~**

~~Exceptions:~~

~~Use of cellular phone audio or recording abilities is prohibited which includes audio and video~~

~~Photos taken with the cellular phone is limited to the patient and/or family and should be close up in nature to prevent other individuals being inadvertently captured in the background of the picture.~~

~~Pictures may not include any PHI.~~

~~Recording glasses such as Google glass are prohibited.~~

~~b.i. Hospital issued cellular phones and digital devices shall be centrally managed and encrypted.~~

~~i. Users must not circumvent the security of mobile devices by removing limitations designed to protect the device. (e.g. jailbreaking).~~

~~ii.i. Applications must be kept updated with the latest vendor software releases.~~

~~c.a. Personal cellular phones and digital devices:~~

~~i. TCHD assumes that all mobile devices are untrusted unless TCHD has properly secured the mobile device. When approved by TCHD management, users are allowed to use personally owned mobile devices only if the following conditions are met:~~

~~1) Password protected~~

~~2)1) No Personal Health Information (PHI)~~

~~3)1) No Patient photographs/videos~~

~~ii.i. Storing TCHD data outside of TCHD approved, encrypted devices are prohibited.~~

~~d. Cellular phones recommended to be kept 3 meters away from patient care equipment and devices~~

~~i. Ringers shall be set to silent or vibrate~~

~~ii. Signs shall be posted at the entrance of patient care areas communicating the following:~~

~~1) Notice: Cellular phones shall be set to silent/vibrate within this area.~~

~~2) Personal Cell Phones are to be kept in their lockers, they are not allowed in the work area. Purpose of hospital issued cellphone/electronic device use by staff is for health care business.~~

d. Physician and employee usage of:

~~e.~~i. ~~c~~Camera, video, or audio recording features of a **Personal Electronic Digital Device**~~cellular phone/electronic device~~ is not permitted at any time.

~~i. A District provided device (e.g. camera/tablet) located in the patient care area shall be used to photograph, videotape, or record when required for patient care/clinical documentation.~~

~~1) Appropriate consent and documentation requirements must be consistent with policy.~~

~~f.~~ii. **Personal Electronic Digital Devices** ~~Wireless devices (e.g., computer, laptop, smart phones, and portable devices)~~may be utilized within the guidelines **set forth in this Policy**.

iii. Texting may not include any patient ~~PHI~~ **protected health** information~~, only generic information necessary to communicate information necessary for continuity of District work~~.

e. **~~A District~~TCHD provided Hospital Electronic Digital Device (e.g. camera/tablet) located in the patient care area shall be used to photograph, videotape, or record when required for patient care/clinical documentation.**

~~g.~~i. **Appropriate consent and documentation requirements must be consistent with ~~District~~TCHD policies.**

3. **Non-Patient Care Areas:**

a. **Employees may use ~~p~~Personal Electronic Digital Devices ~~cellphones, electronic devices~~ if approved by their management, as long as utilization does not impact ~~District~~TCHD work ~~They should not be used for District communications.~~ and only if the following conditions are met:**

i. **Password protected**

ii. **No personal health information**

iii. No patient photographs/videos

b. Contractors in non-clinical areas may use ~~p~~Personal Electronic Digital Device~~cellphones, electronic devices~~ as needed, to conduct their business as approved by the immediate manager.

4. Suspected Medical Equipment Interference (EMI):
   a. If any hospital staff member suspects that medical equipment is being affected by an Electronic Digital Device, ~~electronic device~~ they should:
      i. Attend to immediate patient needs and correct function of medical device in use.
      ii. Scan the area quickly for source of interference~~, such as cellular phone or hand-held radio~~.
      iii. Remove source of interference.
      iv. Notify BIOMED of medical device of malfunction.
      v. Initiate a Quality Review Report (QRR) in RL solutions and clarify if the event resulted in injury to the patient.
         1) Injury to the patient shall be communicated to Risk Management immediately.

5. Two-Way Radios:
   a. May not be used by patients or visitors.
   b. Staff may use when transmitted over 25 feet away from medical devices.
   c. Volume must be set at a level low enough as to not disturb patients.
   d. Headphone style speakers are preferred alternative to radio speakers to minimize patient disturbance.
   e. ~~District~~TCHD employees may use two-way radios without restrictions on distance during an emergency (e.g. activation of a code).

~~4. Patients/Visitors:~~
   ~~a. The patient handbook communicates the organization's policy relating to cellular phone use in the facility.~~
   ~~b.a. Use of cellular phone by patients and visitors in District facility is acceptable provided the ringer is to be set to silent or vibrate to support our noise abatement procedures and has received verbal permission from healthcare personnel.~~
      ~~i. Exceptions:~~
         ~~1) Use of cellular phone audio or recording abilities is prohibited which includes audio and video~~
         ~~2)1) Photos taken with the cellular phone is limited to the patient and/or family and should be close up in nature to prevent other individuals being inadvertently captured in the background of the picture.~~
         ~~3)1) Pictures may not include any PHI.~~
         ~~4)1) Recording glasses such as Google glass are prohibited.~~

~~5.~~6. Employees:
   a. All ~~Tri-City Healthcare District (District~~TCHD~~)~~ TCHD employees should be professional in their conduct and use of ~~h~~Hospital and ~~p~~Personal Electronic Digital Device~~cellular phones and devices~~ and only use them as needed ~~to conduct their work and be efficient and productive~~.
   ~~a. Employee usage of cellular phones in the patient care areas is limited to District/Patient Care activities, when hospital issued.~~
      ~~i. The ringer shall be set to silent or vibrate.~~
   b. Employees are not allowed to use ~~personal~~ Personal Electronic Digital Devices ~~cellular phones for personal use~~ during work time. Employees may use ~~personal~~ Personal Electronic Digital Devices ~~cell phones~~ during breaks away from the work area.
   c. Employees using Hospital ~~personal~~ Electronic Digital Devices ~~or assigned electronic/digital device equipment by the District~~ are responsible for safeguarding the equipment and controlling the use.

i. An individual may retain restricted/confidential protected health information ~~(PHI)~~ or business data on ~~portable equipment~~**Hospital Electronic Digital Devices** only if protective measures (i.e. encryption) are implemented to safeguard the confidentiality or integrity of data in the event of theft or loss.
   1) Examples: Plato Pocket PCs, Wound Care cameras

d. Employees are expected to avoid using **Electronic Digital Devices** ~~cellular phone~~ under any circumstances where such use might create a hazard (e.g. driving, including security and EVS golf carts). Compliance with state vehicle laws is required.

e. Employees are prohibited from using any recording glasses such as Google glasses.

f. Hospital Electronic Digital Devices ~~issued cellular phones and digital devices~~ shall be centrally managed and encrypted.

i. Users must not circumvent the security of Hospital Electronic Digital Device ~~mobile devices~~ by removing limitations designed to protect the device (e.g. jailbreaking).

ii. Applications must be kept updated with the latest vendor software releases.

g. Personal Electronic Digital Device~~cellular phones and digital devices~~:

i. TCHD assumes that all Electronic Digital Devices ~~mobile devices~~ are untrusted unless TCHD has properly secured the mobile device. When approved by TCHD management, users are allowed to use ~~personally owned mobile devices~~Personal Electronic Digital Devices for ~~District~~TCHD business only if the following conditions are met:
   1) Password protected
   2) No ~~P~~personal ~~H~~health ~~i~~information ~~(PHI)~~
   3) No ~~P~~patient photographs/videos

~~e.~~**ii. Storing TCHD data outside of TCHD-approved, encrypted, ~~encrypted devices~~Hospital Electronic Digital Devices is ~~are~~ prohibited.**

~~6.1. Non-Patient Care Areas:~~

~~a. Employees may use personal cellphones, electronic devices if approved by their management as long as utilization does not impact District work.~~

~~b.~~**a.** ~~Contractors in non-clinical areas may use personal cellphones, electronic devices as needed to conduct their business as approved by the immediate manager.~~

~~7.1. Suspected Medical Equipment Interference (EMI):~~

~~a. If any hospital staff member suspects that medical equipment is being affected by an electronic device they should~~

~~i. Attend to immediate patient needs and correct function of medical device in use~~

~~ii.~~**i.** ~~Scan the area quickly for source of interference, such as cellular phone or hand held radio~~

~~iii.~~**i.** ~~Remove source of interference~~

~~iv.~~**i.** ~~Notify BIOMED of medical device of malfunction~~

~~v.~~**i.** ~~Initiate a Quality Review Report (QRR) in RL solutions and clarify if the event resulted in injury to the patient~~

~~b.~~**a.** ~~Injury to the patient shall be communicated to Risk Management immediately.~~

~~c.~~**h.** TCHD personnel shall provide guidance to employees; patients, physicians, and visitors observed utilizing **Electronic Digital Devices** ~~cellular phones~~ outside of compliance with ~~District~~ **TCHD** policy.

~~d. Appropriate signage shall be displayed within the District facilities to communicate to the appropriate use of cellular phones (set silent/vibrate).~~

~~e.~~**i.** TCHD personnel have a duty to stop anyone observed using a**n Electronic Digital Device** ~~cellular phone~~ camera ~~that is not supportive of the restriction of taking a picture outside of the acceptable situation~~**in violation of this Policy**~~s~~.

~~f.~~**i.** TCHD personnel shall notify a leadership representative of potential violation and report it by initiating a QRR in RL Solutions or by calling the Values Line (1-800-273-8452).

~~g.~~**ii.** Violations ~~will~~ **may** result in disciplinary actions in coordination with Medical Staff By-laws and/or Human Resource policies up to and including termination of employment based on the severity of the violation.

~~2.~~**7.** Cellular Phone Etiquette Guidelines:

a. Set of recommended practices for those utilizing a cellular phone/electronic device within ~~the District~~**TCHD.** **(See Cellular Phone/Electronic Device Etiquette Guidelines**~~**Attachment 1**~~**).**

~~3.1. Two-Way Radios:~~

~~a. May not be used by patients or visitors.~~

~~b.a. Staff may use when transmitted over 25 foot away from medical devices~~

~~c.a. Volume must be set at a level low enough as to not disturb patients~~

~~d.a. Headphone-style speakers are preferred alternative to radio speakers to minimize patient disturbance~~

~~e.a. District employees may use two-way radios without restrictions on distance during an emergency (e.g. activation of a code).~~

~~4.~~**8.** Laptop or Electronic Device Etiquette Guidelines:

a. Set of recommended practices for those utilizing a laptop or electronic device within ~~the District~~**TCHD** (See **Laptop or Electronic Device Etiquette Guidelines**~~Attachment 2~~).

D. **RELATED DOCUMENT(S):**

1. Administrative Policy: 8610-372 Consent for Photography/Videotaping

E. **ATTACHMENT(S):**

1. Cellular Phone/Electronic Device Etiquette Guidelines
2. Laptop or Electronic Device Etiquette Guidelines

F. **REFERENCE(S):**

1. NIST 800 -53 Written Information Security Program (WISP) (v2016.4)

Cellular Phone Etiquette / Guidelines

A. **Be fully engaged**
   1. When in a meeting or other busy area, let calls go to voicemail to avoid a disruption.
   2. Don't use your cellular phone/electronic device to conduct other (unrelated) business during business meetings.
   3. If you must take a call, leave the meeting room
   4. Turn the device off

B. **Excuse yourself**
   1. If you are expecting a call that can't be postponed, alert your colleagues ahead of time and step out of the room when the call comes in.
   2. The people you are with should take precedence over calls you want to make or receive.

C. **Keep it private**
   1. Be aware of your surroundings and avoid discussing patient medical information or other private/confidential information in public.
   2. You never know who may be in hearing range.

D. **Set cellular phone ringer to silent or vibration mode**
   1. Use your wireless device's silent or vibration settings in patient care areas and public places, so that you do not disrupt your surroundings with distracting cellular phone ringers.

E. **Be sensitive to your voice level**
   1. Remember to use your regular conversational tone when speaking on your wireless device.
   2. People tend to speak more loudly and often don't recognize how distracting they can be to others.

F. **Send a text message**
   1. If an urgent call requires a response during a meeting, another alternative to avoid disturbing a business meeting is to send a text message.

G. **Focus on driving**
   1. Practice wireless responsibility while driving.
   2. Don't make or answer calls while driving or send text messages
   3. Place calls when your vehicle is not moving and use a hands-free device to help focus attention on safety.
   4. Always make safety your most important call
   5. 7/1/08 (Cal SB 1613 Chapter 290) – drivers are prohibited from using a hand-held phone while driving.

Laptop or Electronic Device Etiquette Guidelines

~~A. Laptops or other electronic devices may not be used to send, post, download or intentionally receive pornographic material.~~

~~B.~~A. ~~Laptops or other electronic devices may not be used to display materials that violate TCHD harassment or confidentiality policies.~~

~~C. Laptops or other electronic devices may not be used to engage in illegal activities (violators may be subject to prosecution by local, state and/or federal authorities).~~

~~D.~~A. Users are forewarned that public wireless Internet access is provided over an unencrypted connection, which may not be suitable for transmitting confidential information.

~~E.~~B. Users are to be considerate of space in the room that the nurse or physician may need to place their equipment or do their work

~~F.~~C. If using the hospital wireless network, be courteous of bandwidth, save large downloads for home

~~G. Do not unplug hospital equipment to plug a laptop/electronic device in without authorization from hospital staff. Try to use the battery in the device as much as possible.~~

~~H. A patient or guest must check with hospital staff if a laptop/electronic device needs to be plugged into an electrical outlet.~~

~~I.~~D. Mute the sound on the laptop/electronic device or wear headphones.

~~J.~~E. Be mindful of what those around you can see.

~~K.~~F. Please respect those nearby or in your room at all times.

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Information Technology

ISSUE DATE: 12/00 **SUBJECT:** Email Access

REVISION DATE: 05/03, 02/05, 11/08, 05/10, 08/10, 6/12 **POLICY NUMBER:** 8610-604

Department Approval:	~~10/15~~07/17
Administrative Policies & Procedures Committee Approval:	~~10/15~~07/17
Professional Affairs Committee Approval:	~~07/12~~08/17
Board of Directors Approval:	07/12

A. **PURPOSE:**

1. To provide electronic mail to all employees and other ~~authorized individuals (~~Authorized Email Users~~)~~ associated with Tri-City Healthcare District (TCHD).

B. **DEFINITION(S):**

1. Email: Any form of electronic messaging currently sanctioned for use at TCHD. It encompasses electronic messaging among TCHD employees and to/from TCHD and external organizations or individuals.

C. **POLICY:**

1. This policy addresses Email, informs Authorized Email Users of their rights and obligations, and formally notifies Email Users of usage monitoring. With advance notice, Authorized Email Users will not be put in an embarrassing situation, and are notified that TCHD reserves the right, without notice, to:
   a. Monitor, access, retrieve, download, copy, listen to, or delete anything stored in, created, received or sent via Email, and
   b. Limit and/or restrict any Authorized Email User's use of Email Services, and to inspect, copy, remove or delete any unauthorized use, and
   c. Use and disclose any information in the system, including to law enforcement officials.
2. Authorized Email Users may communicate with each other or with outside persons or organizations via Email. Authorized Email Users should not have any expectation of personal privacy for information stored in, created, received, or sent via Email.
3. Email Services are intended for TCHD business related purposes only. TCHD encourages the use of Email to improve communications, to improve reliability of computer systems, and to improve productivity. However, Email Services are TCHD property, with the purpose of facilitating TCHD communications. Each Authorized Email User has a responsibility to maintain and enhance TCHD's public image and to use Email in a productive and legal manner. Electronic stationary or auto-signature with images is prohibited. Auto-signatures will be in TCHD standard format.
   a. EMAIL BODY AND SIGNATURE EXAMPLE
      i. Email body – Century Gothic font, size 10
      ii. Email signature – Century Gothic font, size 10
      iii. All fonts in black
      iv. Approved TCHD Confidentiality Notice must be added to the bottom of your email signature.
      v. Century Gothic font, size 8
      vi. "CONFIDENTIALITY NOTICE" in all caps and in all bold
      vii. Example:
      First Name Last Name | TCMC Official Title

Tri-City Medical Center | Department Name
Address of office | City, CA Zip Code
P 760.940.XXXX | F 760.940.xxxx
emailaddress@tcmc.com | www.tricitymed.org
CONFIDENTIALITY NOTICE
This message and any included attachments are from the Tri-City Healthcare District and are intended only for the addressee. The information contained in this message is confidential and may constitute non-public information under international, federal, or state securities laws and is intended only for the use of the addressee. Unauthorized forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error by e-mail.

4. All TCHD policies and practices apply to Email Services, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality. In addition, any communication that is sent via Email is a communication on behalf of TCHD. Therefore, any TCHD Email communication must be professional and business-related. E-mail should have a TCHD standard confidentiality notice.
5. Each individual granted Email Services at TCHD is provided with a written copy of this policy. The Authorized User of Email Services must submit an approved System Access Request Form **(SAR)**. To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement annually on his/her review date.
6. While use of Email offers significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each Email user is personally accountable for any action that results in a breach of TCHD security or confidentiality.
7. The transmission of any kind of sexually explicit information on any company system is a violation of our policy on sexual harassment. In addition, sexually explicit material may not be accessed, archived, stored, distributed, edited, or recorded using our network resources.
8. TCHD's Email facilities and computing resources must not be used knowingly to violate the laws and regulations of the United States or any other nation. Use of any company resources for illegal activity is grounds for corrective action or immediate dismissal, and we will cooperate with any legitimate law enforcement activity.
9. It is the Authorized User's responsibility to periodically purge old e-mail from their Inbox/Sent/Deleted boxes. The e-mail system is not a storage system. Proper long term storage methods and locations shall be used such as email archive. Mailbox size limits will be enforced using the following size limits.
   a. 1GB – Executives and high-end users
   b. 500MB – Directors/Managers/Supervisors
   c. 50MB – Non-management staff
10. The distribution list All E-mail Users includes every e-mail user in the TCHD email system. This list was developed to distribute hospital-related information that truly affects everyone, rather than for distributing personal messages or non-TCHD sponsored events and advertisements.
11. Do not overuse Reply to All. Only use Reply to All if a message is needed to be seen by each person who received the original message.
12. Use of the "All E-Mail Users" distribution list is restricted from all staff except for members of the C-Suite (CEO, COO, CNE, CFO, CHRO, etc.), individuals authorized by C-Suite and IT personnel.

D. **PROCEDURE:**

1. The System Access Request Form **(SAR)** is used to request Email Access provided by the TCHD Information Technology Department. Blank forms are attached to this Policy.
2. Employee:
   a. A Department ~~Director~~ **Manager/Supervisor** may request Email Access for an employee by filling out, signing and submitting a System Access Request Form **(SAR)** –

Non-Provider ~~(see EMPLOYEE attachment to this Policy)~~, to the Information Technology Department. "Outlook," "Webmail (Full)" or "Webmail (Internal)" must be checked.

b. An Information Technology representative will provide instructions and password information to the requestor.

c. To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement annually on his/her review date.

3. Business Partners:

a. An external case manager, authorized physician, vendor, or other person engaged in legitimate business at ~~Tri-City Healthcare District (~~TCHD~~)~~ who believes he/she has a legitimate need for Email Access may obtain a System Access Request Form **(SAR) – Provider/Provider Office** ~~(see BUSINESS PARTNER attachment to this Policy)~~. The form is to be filled out, signed by a Department Director, and submitted to the Information Technology Department. "Outlook," "Webmail (Full)" or "Webmail (Internal)" must be checked.

b. An Information Technology representative will provide instructions and password information to the requestor.

E. **MANAGEMENT AND ADMINISTRATION:**

1. The TCHD Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department provides all network access, and must approve all requests for Email Services. All requests for hardware and software must be approved by Information Technology.
2. The TCHD Information Technology Department provides software virus protection. Notify the Information Technology Department immediately if a software virus is detected.
3. Remote control software, such as PC Anywhere, is prohibited from being installed on any network-attached computer without the prior approval of the Information Technology Department.

a. Official Records:

i. All messages, message audit reports, and records of Email Services are official records and are the property of TCHD. TCHD reserves the right to access and disclose, at any time, all documentation of Email Services.

b. Copyrighted Materials:

i. Copyrighted materials belonging to entities other than TCHD may not be transmitted by employees via Email Services. All employees obtaining access to other companies' or individuals' materials must respect all copyrights and may not copy, retrieve, modify, download or forward copyrighted materials, except with permission, or as a single copy to reference only.

ii. Computer programs are copyrighted material, and may not be copied without adhering to the requirements listed on the purchased product's software licensing agreement.

c. User IDs and Passwords:

i. User IDs and passwords help maintain individual accountability for Email usage. The Information Technology Department will assign a single password to a person to be used for Network Services, Email, and Internet access. Any employee who obtains a password or ID must keep that password confidential. Company policy prohibits the sharing of passwords.

d. Security:

i. The TCHD Information Technology Department may review Email activity and analyze usage patterns, and distribute periodic reports of this data to the Compliance Committee and Department Directors to assure that TCHD's Email resources are devoted to maintaining the highest levels of productivity. TCHD can monitor and record all Email usage. TCHD security systems are capable of recording Email messages for each user, and TCHD reserves the right to do so at any time.

ii. Employees should not assume that Email Messages are totally private. E-mail communication within ~~Tri-City Medical Center~~**TCHD** (all addresses currently within our "Global Address Book") is considered secure and is permitted for the purpose of sharing clinical information with or without patient identifiers. The use of e-mail for communication of clinical data internal to ~~Tri-City~~**TCHD** should follow guidelines similar to those related to other forms of communication. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of appropriate safeguards, such as encryption, for e-mail of patient-specific information transmitted via the Internet (outside of the ~~Tri-City Medical Center~~**TCHD** Global Address Book). ~~This technology is not routinely deployed at Tri-City Medical Center.~~ **Internal** ~~E~~email communication **using the TCMCHD Global Address Book, is by default encrypted.** eExternal to ~~Tri-City Medical Center~~**TCHD** containing patient-specific information**, or other sensitive information,** is not considered secure and therefore is strictly forbidden, unless using encryption technologies specifically approved and authorized by the Information Technology Department. **(See Attachment A)**

iii. TCHD has installed a variety of firewalls, proxies, and Internet address screening programs and other security systems to assure the safety and security of the networks. Any employee who attempts to disable, defeat, or circumvent any security facility will be subject to appropriate corrective action as defined by policies.

e. Violations:

i. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative Policy: 424~~,~~ Coaching and Counseling for Work Performance. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.

f. Legal Notice:

i. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

g. Notification of Improper Use:

i. Each employee is expected to report unauthorized use or violation of this policy.

h. All E-Mail Users Distribution List:

i. Emails that need to be sent to all email users must be approved by any member of the C-Suite. Approved emails will be sent out by IT.

F. ATTACHMENT(S):

~~ii.~~1. **Attachment A: How to Send Encrypted Email**

~~F.~~G. FORM(S):

1. System Access Request Form **(SAR) – Non-Provider**
2. **System Access Request Form (SAR) - Provider/Provider's ~~Staff~~ Office**

~~G.~~H. RELATED DOCUMENT(S):

1. **Administrative Policy: 8610-424~~,~~ Coaching and Counseling for Work Performance**
2. **Administrative Policy: 8610-585~~,~~ HIPAA Administration**

~~How to Send Encrypted Email~~

~~H.~~I. REFERENCE(S):

1. **California Penal Code 502**

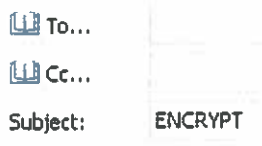
~~1.~~2. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Attachment A: How to Send Encrypted Email

Email Security Encryption
MS Outlook or MS Outlook Web Access

Compose New Email

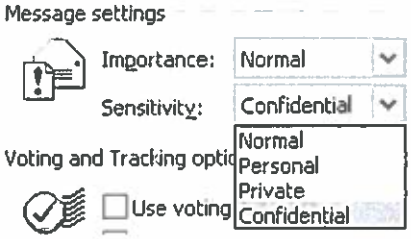
Type in the Subject field: ENCRYPT *Add subject after the ENCRYPT*



e.g ENCRYPT Let go get some food

Click Options in the tool bar

Click Sensitivity drop down menu
Click Confidential
Click Close



Type an **external email account**: example **@yahoo.com or @gmail.com**

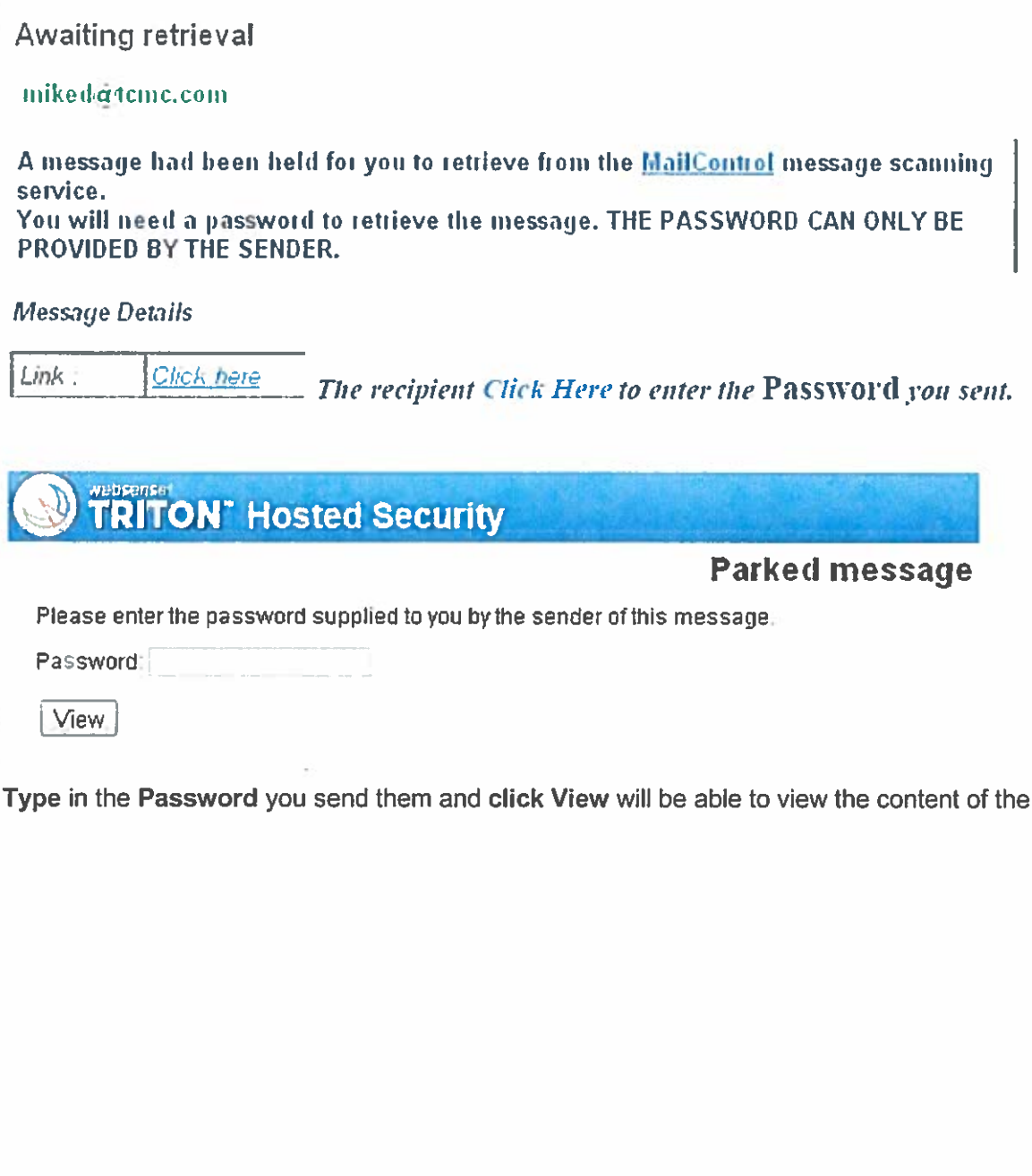
Click Send
Your email notice will look like this:

A message sent by you has been held by the MailControl message scanning service for secure retrieval. The recipient(s) will require the following password to retrieve the message. YOU MUST COMMUNICATE THIS PASSWORD TO THE RECIPIENT.

Message Details

Password : *Provide the* Password *to your recipient to view the email.*

Your recipient of your email will see this:



Awaiting retrieval

mikeb@tcmc.com

A message had been held for you to retrieve from the MailControl message scanning service.
You will need a password to retrieve the message. THE PASSWORD CAN ONLY BE PROVIDED BY THE SENDER.

Message Details

Link : Click here *The recipient Click Here to enter the* **Password** *you sent.*

websense TRITON Hosted Security

Parked message

Please enter the password supplied to you by the sender of this message.

Password:

View

Type in the **Password** you send them and **click View** will be able to view the content of the email body.

System Access Request Form (SAR) – Non-Provider

Tri-City Medical Center — ADVANCED HEALTH CARE FOR YOU

TRI-CITY HEALTHCARE DISTRICT
System Access Request Form (SAR)

☐ Employee ☐ Registry ☐ Volunteer ☐Contract/Vendor ☐ Student ☐Temp/Non-District Employee

☐ New Account ☐ Modify Existing Account as follows: _____

Requestor Name:	Phone:	Start Date:

Note: If mobile device email sync is required, manager approval is needed and an Exchange license will be charged to the departments cost center.

E-MAIL DISTRIBUTION LIST: *Please check the Distribution list desired*

☐ 1Assistant Nurse Manager	☐ 1ExeCouncil	☐ 3Directors	☐ 6Leadership Committee	☐ RN
☐ 1Admin Super	☐ 2Administration	☐ 4Management	☐ 9Clinical Educators	☐ Other

Account User Information:

Last Name:_____ Middle Initial (Required or NA):_____

First Name:_____ Business Phone:_____

Department Name:_____ Nurse Units (Required for Staff Assignment):_____

Job Title:_____ Cost Center:_____

Role/Position:_____

Access Requested for the following System Modules/Position	YES	Access Requested for the following System Modules/Position	YES
Abstracting/Coding (Access HIM)		PACs	
Cerner		Patient Accounting (Affinity)	
E-Mail (Outlook)		Patient Throughput (Aionex)	
Finance (Alliance)		Payroll (Kronos)	
Finance (Lawson)		Plant Operations	
Home Health (Home Care/Home Base)		Report Writing (Power Insight)	
Human Resources (Lawson, ICIMs)		Risk Management (RL)	
Internet ☐ Full access ☐ Restricted		Social Service / Case Management (All Scripts/ECIN)	
Managed Care (Alliance)		Transcription (3M)	
Materials Management (Proclick / Reptrax)		WFAN	
Other:			

I am aware of and agree to abide by the privacy and security policies of Tri-City Healthcare District and its affiliates as it applies to the protected health information as well as organizational information. I understand that I must only access that information which is the minimum necessary for me to carry out my duties within the organization and any other access is strictly forbidden.

- *Never share my password or access information that is not required for my assigned duties.*
- *Always log in and off appropriately when using a workstation.*
- *Never access or disclose organizational or protected health information except within the scope of my position.*
- *Only copy information from the organizational data bases as authorized.*
- *Always take reasonable precautions when originating, receiving or transferring database information (virus).*
- *Never remove organizational or protected health information from the organization (paper or electronic) unless authorized.*

I understand that violations of Tri-City Healthcare District (TCHD) privacy and security policies are grounds for disciplinary action to include, but not limited to loss of privileges, termination, or possible criminal prosecution.

_____ _____

Account User Signature **Date**

MANAGER/SUPERVISOR APPROVAL OF REQUEST

I authorize the above named individual to have access to the information. Additionally I have reviewed with this individual organizational privacy and security policies and the consequences of failure to comply.

_____ _____

Signature **Date**

_____

Print Name

PLEASE EMAIL THE COMPLETED FORM TO: SARIT@TCMC.com

INFORMATION SYSTEMS REVIEW & IMPLEMENTATION OF REQUEST

Implemented by: (IT representative) _____ **Date:** _____

Staff Member Notified/Educated as to Log In Process/Password Selection

IT USE ONLY:
Initial User Login Name and Password_____**Entered by:** _____ **Date:**_____

System Access Request Form (SAR) - Provider/Provider~~'s Staff~~ Office

Tri-City Medical Center — ADVANCED HEALTH CARE FOR YOU

TRI-CITY HEALTHCARE DISTRICT
System Access Request Form (SAR)

Please check one: ☐ Provider ☐ Provider Office Staff

☐ New Account ☐ Modify Existing Account

Requestor Name:	Phone:	Start Date:

Account User Information:

Last Name:_____ Middle Initial (Required or NA):_____

First Name:_____ Access Start Date Requested:_____

Business Name:_____ Contact Information:_____

Job Title: (Office Staff)_____ Dictation Code (Required for Staff Physicians):_____

Physician Specialty _____ eMail:_____

Access Requested for the following System Modules/Position	YES	Access Requested for the following System Modules/Position	YES
Remote Access		PACs	
Cerner		Mailbox Account (MD only)	
Powerchart Touch		MedStaf	
Dragon			
Comments:			

I am aware of and agree to abide by the privacy and security policies of Tri-City Healthcare District and its affiliates as it applies to the protected health information as well as organizational information. I understand that I must only access that information which is minimum necessary for me to carry out my duties within the organization and any other access is strictly forbidden

-Never share my password or access information that is not required for my assigned duty
-Always log in and off appropriately when using a workstation
-Never access or disclose organizational or protected health information except within the scope of my position
-Only copy information from the organization data bases as authorized
-Always take reasonable precautions when originating, receiving or transferring database information (virus)
-Never remove organizational or protected health information from the organization (paper or electronic) unless authorized

Print Name:_____ Date:_____

Signature:_____

For Office Staff Access Requests, someone in an authoritative position, must sign below:

Name:_____ Title:_____

Signature:_____ Date:_____

IT USE ONLY:
Initial User Login Name and Password_____Entered by: _____
Date:_____

PLEASE EMAIL THE COMPLETED FORM TO: SARIT@TCMC.com or FAX to: (760)-940-4038
One User/Account per SAR

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

DELETE – Combined policy with Policy 8610-622, Electronic Health Record (Cerner) Access, Physicians and Physicians Office Employees.

ISSUE DATE: 3/04

SUBJECT: Remote Access: Physicians and Physician Office Employees

REVISION DATE: 2/05, 01/09

POLICY NUMBER: 8610-620

Department Approval Date(s):	~~04/16~~05/17
Administrative Policies & Procedures Committee Approval:	~~11/08~~06/17
~~Operations Team Committee Approval:~~	~~12/08~~
Professional Affairs Committee Approval:	~~01/09~~07/17
Board of Directors Approval:	~~01/09~~07/17

~~A. **PURPOSE:**~~

~~1. To provide Remote Access to Tri-City Healthcare District's (TCHD) Clinical Information System (Compass) and other TCHD applications, while meeting audit and regulatory requirements for confidentiality and security of information, to each Authorized Physician or Physician Office Employee associated with the TCHD.~~

~~B. **DEFINITIONS:**~~

~~1. Compass: TCHD's clinical information system.~~

~~2. Remote Access: Physician devices, from home or office, which access Compass and other TCHD applications.~~

~~C. **POLICY:**~~

~~1. Remote Access is provided to Authorized Physicians or Physician Office Employees associated with the TCHD.~~

~~2. A Physician Office Employee may be granted Remote Access upon request from the employing physician. Access by a Physician Office Employee is restricted to only the assigned patients of the physician or group by which they are employed.~~

~~3. Each Authorized Physician or Physician Office Employee has a responsibility to use Remote Access in a legal manner.~~

~~4. All TCHD policies and practices apply to Remote Access, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.~~

~~5. Each Authorized Physician or Physician Office Employee is provided with a written copy of this policy. Each Authorized Physician or Physician Office Employee must complete and sign the Remote Access Agreement.~~

~~6. While Remote Access offers significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each Authorized Physician or Physician Office Employee is personally accountable for any action that results in a breach of TCMC security or confidentiality.~~

~~7. An Authorized Physician or Physician Office Employee User must not use Remote Access to knowingly violate the laws and regulations of the United States or any other nation.~~

~~8. Access for each Physician Office Employee is categorized by the clinical or administrative duties, to ensure that access is limited to appropriate types of patient information.~~

~~D. **PROCEDURE:**~~

~~1. An Authorized Physician or Physician Office Employee who has a legitimate need for Remote Access should request it in the following manner:~~

~~a. Obtain a Remote Access Agreement from the TCHD Information Technology~~

Department.

b. Submit the completed and signed Agreement to the Information Technology Department.

c. Each Authorized Physician or Physician Office Employee is assigned a TCHD Network Login and Password. No generic or multi-user network logins are permitted and sharing of passwords are strictly prohibited. If a Physician has multiple employees authorized for Remote Access, it is the responsibility of that Physician to notify the Information Technology Department of any changes (new employees, terminated employees, change in employee classification)

d. An Information Technology representative will provide instructions to the requester.

E. MANAGEMENT AND ADMINISTRATION:

1. The TCHD Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department must approve all requests for Remote Access.
2. The Information Technology Department will provide instructions regarding the Remote Access method to connect to the TCHD Network. Each Physician or Physician Office Employee is entrusted with access to the TCHD Network, and this is the sole method to be used to connect to the Network. Each Physician or Physician Office Employee will receive instructions from the Information Technology Department regarding security controls for Remote Computing. The Physician or Physician Office Employee must secure the Remote Desktop PC according to directions provided by the Information Technology Department.
3. To access the TCHD Network, the Physician or Physician Office Employee may have to access the Internet. While the TCHD Information Technology Department provides security controls for Network access, there are many potential dangers inherent in Internet access. Each Physician or Physician Office Employee will receive guidance from the Information Technology Department regarding the use and regular updating of anti-virus and firewall software to protect the Remote Desktop PC.
4. The TCHD Information Technology Department provides software virus protection. Notify the Information Technology Department immediately if a software virus is detected.
5. Remote control software, such as PC Anywhere, is prohibited from being installed on any Remote Access workstation without the prior approval of the TCHD Information Technology Department.
6. Physicians or Physician Office Employees should use Remote Access as intended by the assigned Login and Password. COMPASS files are not to be sent to the Physician Office or any external entity unless approval and assistance is obtained from the TCHD Information Technology Department.
7. TCHD has installed a variety of firewalls, proxies, and Internet address screening programs and other security systems to assure the safety and security of the networks. Any Physician or Physician Office Employee who attempts to disable, defeat, or circumvent any security facility will be subject to appropriate corrective action as defined by policies.
8. Adherence to this Remote Access policy is neither voluntary nor optional. Violation of this policy could lead to disciplinary action based on guidelines established in the Medical Staff Bylaws. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations (Legal Notice – California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony). Each Physician or Physician Office Employee is expected to report unauthorized use or violation of this policy to a TCHD Vice President or to the Information Technology Department.
9. Physicians are responsible for notifying the Information Technology Department whenever a physician office employee is no longer employed by their office in order to disable the user login.
10. The Medical Staff Department is responsible for notifying the Information Technology Department if a physician is no longer authorized to access Compass.

F. ENFORCEMENT:

1. ~~Unauthorized Remote Access may be discovered via system monitoring, audit reports, or observation of others.~~
2. ~~A TCHD Vice President or the Director, Information Technology Department who receives a report of unauthorized use or violation of this policy, will submit a request for an investigation, in writing, to the Medical Executive Committee, with supporting documentation, referencing the specific activities or conduct alleged. Recommended Violation Levels and Action Steps are listed on page 4.~~

RECOMMENDED VIOLATION LEVELS

If necessary, TCMC reserves the right to advise appropriate legal officials of any illegal violations. Legal Notice – California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

Level and Definition of Violation	Examples of Violations	Recommended Action
Accidental violation due to lack of proper education	• Failing to sign off a PC when not using it • Accessing own record in COMPASS	• Retraining and re-evaluation • Discussion of policy and procedures • Oral warning, reprimand, or notification
Purposeful violation or **an unacceptable number** of previous violations	• Accessing the record of a patient without having a legitimate reason to do so • Using another user's access code • Allowing another user to access COMPASS via your password	• Retraining and re-evaluation • Discussion of policy and procedures • Written warning and acknowledgment of consequences of subsequent infractions
Continued purposeful violation, an unacceptable number of previous violations and/or **unauthorized disclosure** of COMPASS Information	• Accessing the record of a patient without having a legitimate reason to do so • Using another user's access code • Allowing another user to access COMPASS via your password • Disclosure of confidential patient information • Disclosure of confidential TCMC financial information	• Revocation of Medical staff privileges • Possible legal action

TRI-CITY HEALTHCARE DISTRICT

REMOTE ACCESS REQUEST FORM
Physician or Physician Office Employee

LAST NAME: _____

FIRST NAME: _____ **MIDDLE INITIAL:** _____

I will use Remote Access as intended by my assigned Login Name and Password. I understand that all messages and records of COMPASS and other are official records and are the property of the Tri-City Healthcare District (TCHD), which reserves the right to access and disclose, at any time, all Remote Access documentation.

TCHD has installed a variety of firewalls, proxies, and Internet address screening programs and other security systems to assure the safety and security of the networks. I will not attempt to disable, defeat or circumvent any security facility.

I understand that it is important to maintain a secure password. I will not share my password with anyone, nor will I reveal my password to anyone via email or phone. If I believe that someone has learned my password, I will immediately change the password and report the incident to the Information Technology Help Desk.

I understand that violation of these rules is grounds for corrective action. If necessary, TCHD reserves the right to advise appropriate legal officials of any illegal violations. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

I will report any unauthorized use of COMPASS to the Information Technology Department.

I have received a written copy of the TCHD's Information Technology Policy 620. I fully understand the terms of this Policy and agree to abide by them.

_____ _____

SIGNATURE – Physician or Physician Office Employee Date

_____ _____

SIGNATURE – TCHD Vice President Date

FOR INFORMATION TECHNOLOGY DEPARTMENT USE ONLY

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

DELETE- Duplicate Policy of Wound Care: Infection Control

ISSUE DATE: 10/07

SUBJECT: Department Specific: Wound Care Center

REVISION DATE(S): 07/ ~~2011~~, 07/~~2014~~

POLICY NUMBER: IC.7.1

Infection Control Department Committee Approval:	~~07/14~~04/17
Infection Control Committee Approval	~~07/14~~04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/14~~07/17
Professional Affairs Committee Approval:	~~08/14~~08/17
Board of Directors Approval:	08/14

~~A. **PURPOSE:**~~

~~1. Comprehension of and compliance with infection control principles is an essential component of the quality of care provided in the Center. The purpose of this document is to:~~

~~a. Delineate the role in and scope of infection prevention and control activities.~~

~~b. Define the infection control and prevention measures to be followed to prevent cross-infection among patients.~~

~~c. Provide procedures to be adhered to by the staff of the clinic for protection from illnesses/conditions related to working with and caring for patients admitted to the program.~~

~~B. **POLICY:**~~

~~1. A qualified patient will not be denied access to the services offered by the program *unless* the patient has an active infectious communicable airborne disease such as tuberculosis or has any other active communicable disease that cannot be safely managed by the clinic. This type of patient may be admitted to the program once he/she is medically cleared by a qualified physician.~~

~~2. All healthcare workers shall comply with the hospital's infection control policies and procedures.~~

~~3. The clinic shall follow infection control department policies and procedures related to compliance with State regulations for reporting of specified conditions.~~

~~C. **ACCOUNTABILITY:**~~

~~1. The clinical manager is responsible for implementing and monitoring compliance with all infection control policies and procedures.~~

~~2. The clinical manager is responsible for ensuring the appropriate infection control education/training is provided to all personnel.~~

~~3. The infection control policy is submitted to the Infection Control Committee as often as the hospital requires.~~

~~D. **PROCEDURE:**~~

~~1. Patient Considerations~~

~~a. Patients with a known or suspected infectious communicable airborne disease/condition (or any other condition that cannot be safely managed in the clinic) shall *not* be admitted to the program until medically cleared by a qualified physician.~~

~~b. Patients with known or suspected infection/condition that can be safely managed in the clinic shall be admitted to the program, and appropriate precautions shall be taken to prevent cross-infection. These include, but are not limited to, MRSA, VRE, and HIV.~~

~~c. Cultures are obtained from patients with open wounds/soft tissue infections or suspected bone infections for treatment purposes and to identify potential communicability.~~

d. At each clinic visit all patients will have affected extremity and hands cleansed with chlorhexidine gluconate cloth wipe prior to treatment unless allergy to product is noted.

2. Occupational/Employee Health
   a. All personnel shall comply with hospital policies related to the occupational health, safety, and well-being of healthcare workers as delineated in such policies as those found in the:
      i. Infection Control Manual and the Employee Health & Wellness Manual and include those related to:
         1) Employee health
         2) Hepatitis B vaccine program
         3) Post-blood exposure management
         4) Blood-borne pathogens exposure control plan
         5) Aerosol Transmissible Diseases and Tuberculosis management
3. Infection Transmission Reduction Methods: All staff members are expected to fully support the hospital's infection control efforts and to clearly understand the role they play in the infection control program. All clinic personnel shall comply with:
   a. Hospital transmission-based precautions such as Standard and Contact Precautions.
   b. The Blood-borne Pathogens Exposure Control Plan
   c. The hospital's hand hygiene policy
   d. The proper handling of biohazardous waste as defined in the Infection Control Manual.
   e. Aseptic sterile and clean technique
   f. Visitor and traffic control policies
4. Listed below are the minimum requirements recommended during controlled situations to protect the healthcare worker from potentially infectious agents. This list is not all-inclusive. If the situation indicates, increased infection control measures may be indicated, e.g., additional barrier protection in less controlled situations.

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Vital signs - TPR & BP	R				
Phlebotomy	R	R			
Handling specimens	R	R			
Routine dressing changes	R	R	S		
Dressing changes large amount draining	R	R	R	**	**
Handling medical waste	R	R	S		
Decontamination instruments	R	R	S	**	**
Cleaning equipment	R	R	S		
Applying pressure to control bleeding	R	R	S		
Assisting with procedures such as wound debridement	R	R	S	**	**
Wound irrigation	R	R	S	**	**
Suture/staple removal clean, dry wound	R	R			
Capillary blood glucose testing	R	R			
Cleaning work surfaces	R	R			
Cleaning up small blood spills	R	R			

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Cleaning large blood spills	R	R	R	**	**
Legend R = routinely S = If soiling likely ** = If splattering likely					

5. Decontamination and Sterilization
   a. Utilizing appropriate personal protective equipment (PPE), only trained personnel shall clean and decontaminate the clinic's surgical instruments and equipment.
   b. Decontaminated instruments shall be transported safely to Central Supply/Processing in a covered container.
   c. Central Supply shall decontaminate and sterilize all instruments used in the clinic.
   d. The hospital's "Event-Related Sterility" policy will be followed.
6. Housekeeping
   a. Routine environmental cleaning is performed by the designated housekeeping staff using hospital-approved germicidal products.
   b. Germicidal agents with "Hepatitis B" claim shall be used for cleaning blood or OPIM spills.
   c. Exam chairs are disinfected between patients by the clinical staff using approved germicidal wipes/solution. Linen may be placed on the chair for protection from large draining wounds.
   d. The clinical staff shall disinfect reusable items such as BP cuffs, stethoscopes, and electronic thermometers between each patient use.
   e. Work surfaces are cleaned/disinfected between each patient use and as needed by the clinic staff using the hospital approved germicide.
   f. The cleaning/decontamination of medical equipment is the responsibility of the clinic staff.
   g. Biohazardous waste is handled according to policy in the Infection Control Manual.
7. Surveillance Activities
   a. The clinic shall participate in the surveillance activity of the Infection Control Department, as requested by the Infection Control Committee.
   b. Any unusual microbial patterns or isolated findings shall be reported to the Infection Control Department/practitioner.
8. Infection Control Education/Training
   a. All personnel shall attend the infection control orientation program upon hire.
   b. All personnel shall complete the annual infection control module.
   c. Additional infection control inservice presentations and consultation shall be provided as needed.

E. **REFERENCES:**

1. Centers for Disease Control and Prevention (CDC), Guideline for Isolation Precautions in Hospitals, 2007
2. Centers for Disease Control and Prevention (CDC), Guideline for Infection Control in Health Care Personnel, 1998
3. OSHA Bloodborne Pathogens Standard, 1997
4. Title 17 California Code of Regulations, 2001
5. Philosophy IC. 2
6. Standard and Transmission Based Precautions IC. 5
7. Participation of Staff in the Infection Control Program IC.7
8. Hand Hygiene IC. 8
9. Cleaning and Disinfection IC. 9

~~10. Employee Health Services Policies~~

~~11.~~1. ~~Administrative Policy #401 Injury Prevention Program~~

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL MANUAL

SUBJECT: EBOLA PLAN ~~**POLICY NUMBER:**~~

ISSUE DATE: **NEW**
REVISION DATE(S):

Department Approval:	**06/17**
Infection Control Committee Approval:	**07/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To standardize the risk assessment, triage, transportation, and management of patients with possible/confirmed Ebola Virus Disease (EVD) throughout Tri-City Medical Center (TCMC) and its affiliated facilities.

B. **INTRODUCTION AND BACKGROUND:**

1. It is the mission of TCMC to take care of those in need, regardless of their illness. With that in mind, safety always has been and will continue to be the number one priority. TCMC is committed to providing a safe environment for everyone, including patients, visitors and staff in its facilities. The U.S. Centers for Disease Control and Prevention (CDC) recommends that all hospitals in the U.S. be prepared to care for patients who could have EVD.

C. **TCMC IS CONSIDERED A FRONTLINE HEALTHCARE FACILITY ACCORDING TO CDC, WHOSE ROLE IS TO:**

1. Rapidly identify and triage patients with relevant exposure history AND signs and symptoms compatible with EVD.
2. Immediately isolate any patient with relevant history and signs and symptoms of EVD and take appropriate steps to adequately don personal protective equipment (PPE) to protect staff triaging and caring for the patient.
3. Immediately notify hospital Infection Control, appropriate facility staff and local public health agency.
4. Frontline healthcare facilities, in accordance with the state's plan, should consider immediately transferring patients who have a higher probability of EVD or are more severely ill to an Ebola treatment center (University of California San Diego Medical Center; San Diego, California) that can provide Ebola testing and care for the higher risk patients until an EVD diagnosis is either confirmed or ruled out.

D. **ABOUT EBOLA:**

1. While Ebola is a dangerous virus that can be life-threatening, its spread can be contained.
   a. EVD is spread by contact with blood or any other body fluid from a person with symptoms of EVD infection. Infection is spread when infected body fluids come in contact with mucous membranes, breaks in the skin or by sharps injuries.
   b. EVD is not transmitted through the air unless there is exposure to body fluid droplets from an infected person (e.g., coughing, sneezing or spitting).
   c. EVD is not transmitted from persons who don't have symptoms of infection (see below for symptoms of EVD infection).

2. EVD usually starts with a sudden onset of fever along with symptoms, including chills, weakness, abdominal pain, joint muscle aches, headache, lack of appetite and body aches. Vomiting and diarrhea are common. In severe cases, internal and external bleeding may occur.
3. The illness begins an average of 8-10 days following exposure (although it could be from 2 to 21 days).
4. Some of the symptoms of EVD are similar to those of other infections that are common in West Africa, such as malaria and diarrheal illnesses.
5. There currently are no FDA-approved medications specific for treating Ebola virus infection. The main way we treat EVD is through supportive care. This means providing excellent medical and nursing care, including monitoring and replacing fluids and electrolytes, as well as transfusions as necessary. The goal is to provide this care to the patients until their bodies can control the virus.

E. **ASSUMPTIONS:**

1. Risk assessments will be done for patients entering our system through numerous routes, including:
   a. Emergency Department (ED)
   b. Labor and Delivery
   c. Walk in entrances as indicated by patient presentation
2. Procedures for risk assessments and screening at points of entry will include:
   a. Questioning about travel history within the past 21 days before illness onset, exposure risk, and history of febrile illness as provided below.
3. TCMC patients with suspect EVD will be triaged, isolated on site and transferred to the Ebola treatment center UCSD, under the direction of San Diego County Public Health. Single patients will remain in the ED room 26 for the duration of their hospitalization and necessary supplies and equipment will be provided in that location.
4. Obstetric patients over 20 weeks will be managed in ED room 26 with the support of the Labor and Delivery staff.
5. Patients will be transferred to University of California, San Diego Hospital in collaboration with the County of San Diego Public Health for definitive care.
6. General Incident Command Structure (HICS) will be activated during the period of time a patient with suspected EVD is within TCMC. The mission and direction will be provided by the Incident Commander with input from the Medical/Technical Specialists. The Incident Response Guide: Infectious Disease (HICS, 2014) will be utilized as a framework for general HEICS response.

F. **RISK ASSESSMENT:**

1. Because travel to high-risk areas is one of the risk factors for transmission, these guidelines address patients who are considered at high risk for EVD who meet travel criteria. In addition, exposure to a known EVD patient has also been included in the assessment. Upon initial arrival to one of the entry points into the system, patients will be screened for a positive travel history and symptoms consistent with EVD.
2. High-risk of EVD (Refer to CDC Checklist for Patients being Evauated for EVD in the U.S.)
   a. High-risk exposure (defined below) plus ANY symptoms suggestive of EVD (fever [subjective or > 38 degrees C, 100.4 degrees F] and/or other symptoms, including severe headache, muscle pain, vomiting, diarrhea, abdominal pain, bleeding). High-risk exposure is defined by the CDC as:
      i. Percutaneous (e.g., needle stick) or mucous membrane exposure to body fluids of confirmed or suspected EVD patient
      ii. Direct care of an EVD patient or exposure to body fluids from such a patient without appropriate personal protective equipment (PPE)
      iii. Processing body fluids of confirmed EVD patients without appropriate PPE or standard biosafety precautions
      iv. Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring

b. Low-risk exposure (defined below) plus high probability of infection based on clinical assessment.
   i. Low-risk exposure defined by the CDC as:
      1) Household contact with an EVD patient
      2) Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as:
         a) Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended PPE (i.e., standard, droplet and contact precautions)
         b) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended PPE
      3) NOTE: Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.

G. **DOCUMENTATION:**

1. Nursing documentation of EVD Risk Assessment will be documented in the Cerner Triage Form v2 for patients entering the ED. Patients arriving for Labor and Delivery care will have risk assessment documentation placed in the OB nursing intake assessment form in Cerner.
2. Initial Triage: (Refer to CDC Checklist for Patients being Evauated for EVD in the U.S.)
   a. The following actions will be taken for patients who demonstrate the following:
      i. Identify Exposure History (needs to meet one of the two below):
         1) a travel history to an affected country within the last 21 days
         2) contact with an individual with Ebola within the last 21 days
      ii. And one of the signs and symptoms of Ebola below:
         1) Fever: ≥100.4 F or 38.0 C or the following Ebola compatible symptoms:
            a) Headache
            b) Fatigue
            c) Weakness
            d) Muscle Pain
            e) Vomiting
            f) Diarrhea
            g) Abdominal Pain
            h) or Hemorrhage (bleeding gums, blood in urine, nose bleeds, coffee ground emesis or melena).
   b. If both i. and ii. are met (exposure history and signs and symptoms consistent with Ebola Virus Disease), the following measures should be implemented immediately in accordance with CDC recommendations.
   c. If only i. (the exposure/travel history) is met and not symptoms, continue with usual triage & notify public health for further guidance.
3. Initial Actions (if above is met):
   a. Mask patient immediately. Do not place in waiting room. Instruct patient to wait outside briefly in patio area away from other patients or visitors.
   b. Immediate triage staff don personal protective equipment (PPE), the minimum being a hooded Tychem suit, water resistant gown, double gloves, N95 mask*, goggles, face shield and knee high shoe covers.
      i. If patient is exhibiting bleeding, vomiting, diarrhea then a PAPR should be utilized.
         1) Additional full PPE will be donned by all direct care providers in the ante room adjacent to ED room 26 (See PPE Guidance Matrix by Job Positions and Job Checklists).
   c. Contact Security to assist with controlling the area. Security will also obtain the names of those are in the proximity of the patients.

d. Prior to placement of patient in room C26: room must be prepared to accept patient
   i. See job role (Job Checklists).
e. ED Charge to assign job roles. (Job Checklists)
f. Contact the ED charge RN and instruct them to unlock the exterior door to room 26.
   i. See ED Charge Nurse Job Descriptions for further initial actions (see Job Checklists).
g. Escort patient OUTSIDE to the exterior entrance to room 26.
h. Place "CONTACT, AIRBORNE" isolation and STOP signs on interior door. All dirty linens and supplies are to remain in the room with the patient.
i. Contact engineering to start monitoring the negative pressure room (C26) and to Contact ATI company to set up anteroom and Decon Room outside C26 (Diagram).
j. Don all recommended PPE for direct care provider prior to entering the room for patient care.
k. Post a designated assistant outside the room to monitor/assist PPE use and hand hygiene (see job description, Job Checklists)
l. Post a designated observer outside of room to monitor staff who enter/exit room. Take vital signs of staff before Donning and after Doffing of PPE (see job descriptions- Job Checklists and Observer Tracking Form).
m. Contact Administrative Supervisor, Infection Control, and Public Health (619-692-8499(Mon-Fri) or 858-565-5255 (after hours) as per posted advisement. Await direction from Public Health for ordering of labs, diagnostic studies, etc.
n. Contact EVS STAT for any contamination to public areas and to restrict access to any potentially contaminated areas.
o. Observer role: Document all staff who cared for patient and/or entered the room (see appendix for the form) Observer Tracking Form. Limit the amount of staff entering the room.

H. SPECIMEN MANAGEMENT FOR HIGH-RISK TESTING:

1. Laboratory guidelines for handling/testing specimens from suspected cases of Ebola virus disease:
   a. General Considerations:
      i. Initial testing of patients upon presentation shall be limited to the CDC-required PCR testing for confirmation of Ebola. All testing will be guided by the County of San Diego Public Health Epidemiology department (along with Infection Control and the Laboratory)
      ii. There will be **no** transport of specimens to the Laboratory.
      iii. Specimen processing should be performed in the patient's room or nearby in a contained testing area.
   b. Specimen Collection:
      i. In order to limit the number of TCMC employees involved in the patient's care and to limit exposure, an RN already inside the patient's room will draw 2 tubes of blood and place each tube in separate biohazard bags that another RN within the room is holding.
      ii. A minimum volume of 4 ml of whole blood preserved with EDTA or SPS (Sodium polyanethol sulfonate) in plastic vacutainer tubes should be drawn for EVD testing. Do not collect specimens in glass containers.
      iii. The specimen, enclosed in a small cold pack, will then be transported to the ante-room for pick-up by the San Diego County Public Health Microbiologist.
      iv. Immediately contact the San Diego County Public Health Services Epidemiology Program by phone at 619-692-8499 (Mon-Fri) or 858-565-5255 (after hours).
      v. San Diego County Public Health Services Epidemiology will assess the request, and will, if warranted, contact the San Diego County Public Health Services Laboratory.

vi. San Diego County Public Health Services Laboratory will send a specifically trained Public Health Microbiologist, with packaging and shipping materials, to the specially designated TCMC patient care containment area.
vii. The trained Public Health Microbiologist will prepare documents, prepare and package specimens, and arrange for shipment to the CDC and Los Angeles County Public Health laboratory for PCR testing.
viii. Fill up the attached Primary Specimen Contact List to record all personnel who come into contact with the specimen, including contact with primary specimen container.

2. Laboratory procedures for consideration while waiting for PCR results:
   a. NOTE: Unless critically needed, do not perform any additional laboratory testing. iSTAT should be ordered from the lab. If iSTAT is used, it will need to be kept in containment area for later cleaning with other supplies.
   b. Chemistry, Hematology:
      i. Blood gases, electrolytes, hemoglobin, hematocrit
      ii. Testing should be limited to iSTAT and should only be performed in the patient's room by the RN.
   c. Urinalysis:
      i. Available as a urine dipstick and performed in the patient's room.
   d. Malaria testing:
      i. Collect in a plastic lavender top (EDTA) vacutainer tube
      ii. Preparation of thin blood smears should be done in the patient's room. Wipe the outside of the lavender top tube (EDTA) with Super Sani Cloth disinfectant.
      iii. Remove stopper of lavender tube (EDTA) with Super Sani Cloth disinfectant wipes to prevent aerosol formation.
      iv. Prepare a thin blood film, fix in methanol for 30 minutes, and then place in dry heat at 95°C for 1 hour to inactivate the specimen.
      v. The smear can then be stained in the Hematology slide stainer.
      vi. WBC and platelet count can be estimated from the stained blood film.
   e. Blood Cultures:
      i. Perform only if required and minimize blood draws for blood cultures.
      ii. Once received in Microbiology, wipe the outside of the bottles with Super Sani Cloth. If the blood culture bottles are flagged as positive, unload the bottles from the instrument.
      iii. Wear the appropriate PPE (impermeable gown, double gloves, eye protection, N-95 mask, shoe covers).
      iv. Transfer the bottle to the biological safety hood and prepare slides for Gram stain examination and allow to dry.
      v. Fix the blood smears in methanol for 30 minutes, followed by dry heat at 95°C for 1 hour to inactivate the specimen. Perform testing of the gram stain QC slide in the same manner.
      vi. The smears can then be stained and read as usual.
3. Do not perform any plate subcultures on positive blood cultures until the results of PCR Ebola testing from the patient are available.

I. EVALUATING PATIENTS FOR EBOLA VIRUS AT L&D ENTRY

1. Initial Intake:
   a. DAYS: Secretary will have patients fill out the intake questionnaire at front desk, where (2) EBOLA specific questions have been added. If the patient answers "YES" to BOTH questions, the patient will be given a mask to wear and instructed to sit in wheel chair away from other patients. The charge nurse will be called and the patient immediately transported to Room #201 on 2S.
   b. NOCS: Before the patient is allowed access to the L&D Unit, the (2) EBOLA specific questions will be asked over the phone. If the patient answers "YES" to BOTH questions,

will NOT be given access to the unit. Staff will bring the patient out a mask to wear, wheelchair, and escort to Room #201 on 2S.

2. Initial PPE Precautions for staff transporting the patient:
   a. The staff member shall follow Standard, Contact and Droplet precautions and wear:
      i. White bunny suit
      ii. Gloves (2) pairs if desired (double donned)
      iii. Surgical Mask with face shield/ eye protection OR Surgical Mask and goggles(KITS have been made and are located on top of the File Cabinet in the Managers hallway)
      iv. Before removing the PPE, another staff member must be present to ensure correct removal practice.
3. Main Goals:
   a. To contain spread of the virus (masking patient) and transport patient to secure location for containment (Room 201 on 2S) Enter the BACK WAY EXIT or MOST direct way to the ROOM, need to deactivate the ALARM to do this. ~~(working to get door unlocked)~~
   b. Once patient is secure in 201, notify the Emergency Department (ED) Charge Nurse: ext. 3509 (anytime day or night) and also L&D Nursing Chain of Command, so staffing items can be discussed.
4. Ongoing Precautions:
   a. A more DETAILED, DOUBLED DONNED, PPE process will need to occur once the patient is moved to room 201 by the staff member expected to assess and care for the patient. The PPE Cart is located in the ED currently. ~~L&D also has a PPE cart We will get our own cart in the near future.~~ Staff SHOULD NOT re-enter the room without this more detailed level of PPE protection.
   b. A BUDDY System to both APPLY and REMOVE PPE, will be required. ~~(currently looking at staffing challenges related to this)~~
   c. All removed items from staff (PPE) and the patient's room (waste, etc.) will have specific disinfection needs and will be disposed of in an identified container) our perioperative aides will be getting this training.
   d. If patient is admitted and in labor, she will labor and deliver in room 201. Designated equipment (portable fetal monitor) and use of disposable items will be considered. (Items for delivery will be moved to her location) Although not ideal, LIMITED MOVEMENT of the infected person is what is BEST.
   e. Staff entering the room will be restricted to essential personnel ONLY (RN/Provider/ OB Tech, etc.) Items needed for care (supplies, meds, etc.) will be BROUGHT to the ROOM by an outside source
   f. A log of who enters the patient's room will be kept for any follow-up needs
   g. If delivery does occur, MOM and BABY may be separated and isolated from each other, Baby will remain in room next to mom, 200 and will have his/her own care team.

J. **EDUCATION:**
   a. System-wide education for PPE use will be provided to all staff in high risk patient care areas (ED, RT, EVS) as well as any staff who are interested. Education will include hands on practice in donning and doffing minimum required PPE, according to CDC recommendations. Advanced PPE, including PAPR use will be provided to direct care providers in high risk areas (ED, RT).
   b. Netlearning trainings are available on the doffing and donning of PPE.
      i. Education for Donning and Doffing of PPE for all staff is located on the TCMC Intranet>Departments>Clinical>Clinical References>Ebola Virus Disease References: Donning and Doffing in Ebola Virus Disease.
   c. Employee Health Services (see Employee Health Management EVD Protocol)
   d. Employee Health Services (EHS) is charged with establishing medical evaluation, surveillance procedures and ongoing review of the health status of all personnel in the event of a potential Ebola Virus Exposure. Employee Health Services will follow

guidance as directed by the County of San Diego Public Health Epidemiology, CDPH and CDC.

K. **FORM(S):**

1. Potential Exposure Contract List – Sample
2. Observer Tracking Form – Sample

L. **RELATED DOCUMENT(S):**

1. Employee Health Management EVD Protocol
2. Direct Health Care Provider Symptom Questionnaire (EVD)
3. PPE and Cleaning Supply List
4. PPE Guidance Matrix by Job Positions
5. Job Checklists
6. Room Diagram
7. PPE Guidance Matrix for EVD
8. Putting on PPE Properly for Ebola (N95)
9. Removal of PPE Properly for Ebola (N95)
10. Room Signage
11. CDC: Checklist for Patients Being Evaluated for EVD in the United States

Potential Exposure Contract List – Sample

Tri-City Medical Center

Potential Exposure Contact list

Date:

Name	Location in Hospital	Approximate Arrival Time	Address	Phone number

Security Officer Name: _____

Observer Tracking Form – Sample

Tri-City Medical Center

Observer Tracking Form: Health Care Workers Entering Patient Care Room

Health Care Worker Name	Employee ID	Vital Signs prior to Donning (B/P, T, P, R)				Time Entered Room	Time Exited Room	Vital Signs after Doffing (B/P, T, P, R)			
		B/P	T	P	R			B/P	T	P	R

Date: _____ **Observer Name:** _____

Employee Health Management EVD Protocol

Tri-City Medical Center

EVD Response Plan: Protocol for employees providing direct patient care (including lab personnel and anyone managing the waste stream)

A. To provide guidelines for employees who are providing direct patient care to a patient with Ebola Virus Disease. This includes lab personnel and anyone managing the waste stream.

B. **PROCEDURE**

1. All health care providers, including lab personnel and anyone managing the waste stream are **required** to measure their temperature and complete the symptom questionnaire twice daily.
2. Employees are required to report:
   a. Fever of 100 degrees F or equal or greater than 37.8 degrees C
   b. Symptoms of chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain, or lack of appetite.
   c. If symptomatic, **do not** leave the Unit; notify EHS, department manager/ designee and you will be evaluated in the Emergency Department.
3. Employees, who have provided care to a patient with Ebola, are **required** to complete the questionnaire and take their temperature twice a day, for **21 days** from the last shift worked and report to EHS if temperature or symptoms develop.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.

C. **COMPLIANCE**

1. Compliance with this policy is mandatory. Employees who do not comply with this requirement may be subject to disciplinary actions.

Direct Health Care Provider Symptom Questionnaire (EVD)

Tri-City Medical Center

Direct Health Care Provider Symptom Questionnaire (EVD)

Direct Health Care Provider (including Lab Personnel and Anyone Managing the Waste Stream) Symptom Questionnaire (EVD)

Name_____

Employee ID #_____

Date_____

Time _____

Cell phone number (best contact #) _____

1.	Temperature:_____	degrees C/F		If yes, onset and duration
2.	Nausea/Vomiting:	N_____	Y_____	_____
3.	Diarrhea:	N_____	Y_____	_____
4.	Headache:	N_____	Y_____	_____
5.	Joint or Muscle Aches, or both	N_____	Y_____	_____
6.	Stomach Pain:	N_____	Y_____	_____
7.	Lack of Appetite:	N_____	Y_____	_____
8.	Weakness:	N_____	Y_____	_____

1. All health care providers providing direct patient care (including lab personnel and anyone managing the waste stream) are **required** to complete this form at the beginning and at the end of their shift.
2. If you have a fever of ≥ 37.8 degrees C, 100 degrees F, or any of the symptoms listed above, please call Employee Health Services prior to leaving the Unit.
3. Complete an Employee Injury/Illness Form.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.
5. Any health care provider (including lab and anyone managing the waste stream) are required to monitor their temperature twice daily and monitor for any symptoms (listed above) on days not worked on the Unit. Report these symptoms immediately to Occupational Injury Management. You are required to report any fever of ≥ 37.8 degrees C, 100 degrees F or any of the following symptoms (chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain or lack of appetite) for 21 days from the last shift worked on the Unit.

Signature: _____

PPE and Cleaning Supply List

Tri-City Medical Center

High Level PPE Direct Caregiver	Step Down PPE Indirect Care	Cleaning Supplies
Item Description	Item Description	Item Description
TYCHEM SUIT - LG	TYCHEM HOODED SUIT – LG	DISINFECTING DETERGENT 4X 1GAL
TYCHEM SUIT - XL	TYCHEM HOODED SUIT - XL	SANI-CLOTH WIPES -PURPLE TOP
TYCHEM SUIT - 2XL	TYCHEM HOODED SUIT – 2XL	SANI-CLOTH XLG 8X14 PURPLE TOP
LEVEL 4 SURGICAL GOWN - LG	N95 MASK – SM, MED, LG	BLEACH WIPES
KNEE HIGH SURGICAL BOOTS - LG	LEVEL 4 SURGICAL GOWN - LG	ABSORBENT 21GR
PLASTIC APRON	KNEE HIGH SURGICAL BOOTS - LG	
PLASTIC SAFETY GOGGLES	PLASTIC APRON	
FACE SHIELD	GLOVE NITRILE 6" - SM, MED, LG	
TYVEK SHROUDED PAPR HOOD	GLOVE NITRILE 8" – SM, MED, LG	
COVER BOOT – LG	FACE SHIELD	
GLOVE NITRILE 6" - SM, MED, LG	PLASTIC SAFETY GOGGLES	
GLOVE NITRILE 8" – SM, MED, LG	SURGICAL HEAD COVER	
DUCT TAPE		
BELT MOUNTED PAPR W CARTRIDGE (OBTAIN FROM SPD)		

PPE Guidance Matrix by Job Positions

Tri-City Medical Center

Role	Observer 1	Observer 2	In Room Observer	Anteroom Assistant	Decon Assistant	Direct Caregiver	EVS
Description of role	Posted outside room to view actions in the room through window. Redirects caregiver when needed to protect from contamination. Provide aide if needed. Link for communication outside room.	Posted outside to direct Donning and Doffing - Reads step by step the donning or doffing process and observes to make certain correctly completed. Observes for any signs of contamination during doffing.	Optional: depends on how sick patient is and how much care is required	Hands on assistance with doffing	Hands on Assistance with doffing	Anyone working inside the patient room	Cleaning outside patient room. (Cleaning inside room, handling linens or trash from inside the room is considered Direct care.
Level of PPE required	Tychem suit Knee high surgical boots Readily available if needed for assistance in room: PAPR with Cartridge Shrouded PAPR Hood Level 4 Surg. Gown Plastic Apron Cover boot 2 pr long nitrile gloves 1 pr. reg nitrile gloves. Duct tape	No PPE necessary	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	No PPE necessary	Same level of PPE as person assisting with doffing. (N95 or PAPR) Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	Correct size N95 mask. (If unable to be fit test N95, must wear PAPR) Tychem suit Level 4 Surg. gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape

Job Checklists

Tri-City Medical Center

A. Job Descriptions Overview:
   1. Observer #1
   2. Observer #2
      a. Please Note: There are two observer positions:
         i. One posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window
         ii. the other posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
      b. In Room Observer (Optional Role)
      c. Assistants
         i. Ante Room Assistant
         ii. Decon Room Assistant
   3. Charge Nurse

Job Checklists

Tri-City Medical Center

Observer #1:

A. Location: posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window (Stationed at all times)

B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation

C. Perform the following activities:
   1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
   2. Limit anyone entering and exiting room
   3. If anyone tries to enter, direct them to the entrance outside C26 Ambulance Bay. (see Diagram in Rom Diagram).
   4. Do not allow visitors (unless approved by Public Health).
   5. Look through window outside of room C26 during patient care activities: Observe practice of worker within room to ensure that worker does not contaminate self (ie. Accidently remove PPE, compromise PPE, etc).
   6. Provide immediate corrective action if the worker does not follow recommended activities.
   7. Should know the exposure management plan in the event of the unintentional break in the procedure
   8. Helps to coordinate patient care rotation

Job Checklists

Tri-City Medical Center

Observer #2:

A. Location: Posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
B. Role: Observe and read aloud each step of the Donning and Doffing of the Worker entering/exiting the patient room. Ensure adherence to the donning and doffing process. Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation
C. Perform the following activities:
    1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
    2. Limit anyone entering and exiting room
    3. Document and record anyone entering and exiting room with corresponding time. (see Observer Tracking Form).
    4. Do not allow visitors (unless approved by Public Health).
    5. Obtain vital signs of worker prior to donning PPE.
    6. Read aloud each step of the donning and doffing procedure. Refer to PPE Guidance Matrix for EVD for each step.
    7. Provide immediate corrective action if the worker does not follow recommended step
    8. Should know the exposure management plan in the event of the unintentional break in the procedure
    9. Ensure the following after worker leave decon area. Ensure worker has at least a ½ break before resuming activities and rehydrates.

Job Checklists

Tri-City Medical Center

In Room Observer (Optional Role):

A. Location: posted in the patient care room

B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The In Room Observers primary role is not to perform patient care activities but to conduct observation (But may assist with patient care activities as needed).

C. Perform the following activities:
   1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
   2. Do not allow visitors (unless approved by Public Health).
   3. Observe practice of worker within room to ensure that worker does not contaminate self (ie. accidently remove PPE, compromise PPE, etc).
   4. Assist with patient care activities as needed.
   5. Provide immediate corrective action if the worker does not follow recommended activities.
   6. Should know the exposure management plan in the event of the unintentional break in the procedure
   7. Role will transition into primary patient care worker and be replaced by a new In room observer.

Job Checklists

Tri-City Medical Center

Assistants:

A. Ante Room Assistant
   1. Role: Assist the "Clean" worker in the Ante Room to don the PPE.
   2. Perform the following:
      a. Wear appropriate PPE. PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
      b. Assists the "Clean" Worker in donning the PPE under the guidance of the observer
      c. Confirm visually that all PPE is serviceable
      d. Confirm the integrity of the ensemble with no skin or hair visible

B. Decon Room Assistant
   1. Role: Assist the "Dirty" worker in Decon in removing the PPE.
   2. Perform the following:
      a. Wears the same level of PPE as the worker (caring for the patient). PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
      b. Assists the "Dirty" Worker in removing the PPE under the guidance of the observer
      c. Periodically clean the decon area and decon area floors when visibly soiled using EPA approved disinfectant: bleach

Job Checklists

Tri-City Medical Center

Charge Nurse

A. Role: Oversee the management & coordination of the patient care.
B. Perform or assign the following initial steps:
    1. Contact Security
    2. Contact Administrative supervisor (who should contact Infection control)
    3. Contact Public Health (619-692-8499)
    4. Contact Engineering: to start monitoring room and they will call the company to set up decon room containment.
    5. Prepare the Room (C26)*
        a. Cover equipment in room with C-arm
        b. Place commode with red bags in the room
    6. Get the PPE cart from Disaster cage (basement)
C. Perform or assign the following continuing steps:
    1. Oversee additional PPE supply needs

Diagram

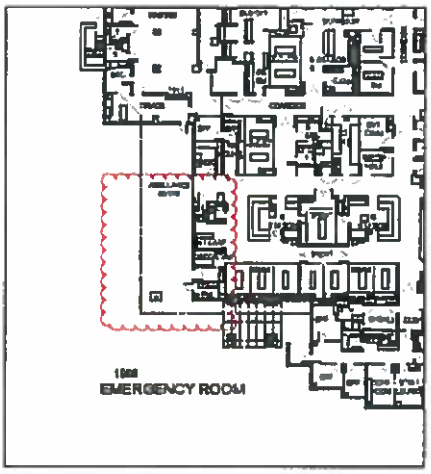
Tri-City Medical Center

A. **C 26(Negative Pressure Room):** Patient Care room
B. **C25 (Inside of ED):** Cordon off area. This is controlled area. Do not enter room from this side. This is where Observer #1 observes practice through window.
C. **Outside of C26 (Ambulance Bay area)**: Doffing & Decon area- containment set up by ATI.

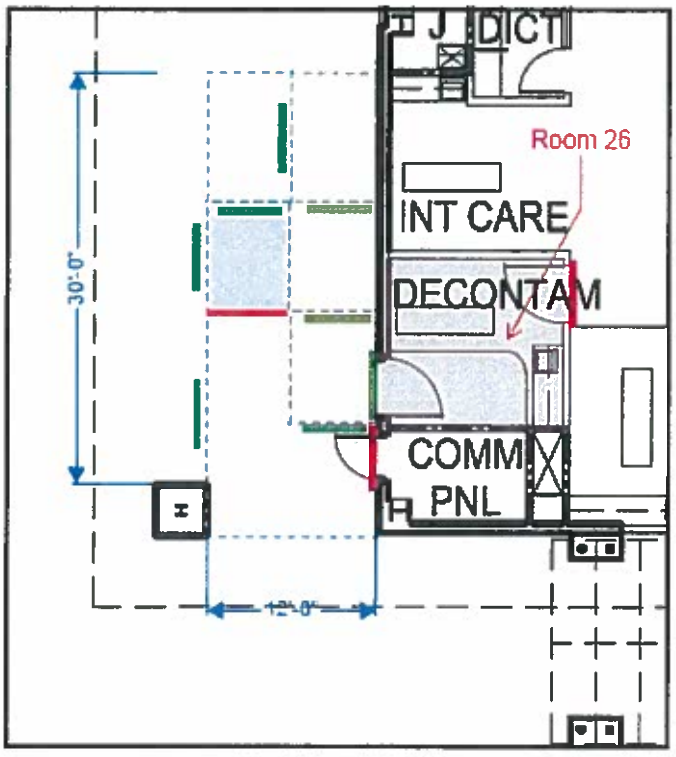
Tri-City Medical Center
Infectious Diseases
Barrier Layout







BARRIER LAYOUT



PPE Guidance Matrix for EVD

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Direct Care Giver –PAPR)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O Long nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvek jumpsuit (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Put on PAPR hood
- O Attach PAPR and secure around waist.
- O Blue surgical gown over the jumpsuit and inside layer of PAPR hood. Tie.
- O Put outer layer of hood down over shoulders.
- O Long Nitrile gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Indirect Care Giver –N95 mask)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O 12" nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvekjumpsuit with hood (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Blue surgical gown over the jumpsuit. Tie.
- O 12" Nitra-gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Bouffant cap if needed to contain hair
- O Proper size N95 mask
- O Goggles
- O Put hood on & zip the jumpsuit the rest of the way
- O Face shield over the hood and tape (with tab) to hood. (No exposed skin or hair)
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

Putting on PPE properly for Ebola (N95)

Tri-City Medical Center

***Apply under the guidance of a trained observer**
*Change into **hospital scrubs** – remove person clothing/jewelry/shoes.

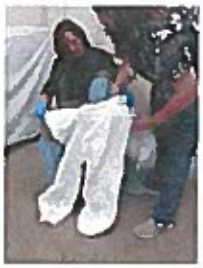
1. **Inspect** all PPE

2. **Hand Hygiene**

3. Put on first set of gloves (12"ntirile)

4. Put blue surgical booties on over scrub pants.

5. Put on the Jumpsuit with hood over blue surgical booties and gloves.



Zip the jumpsuit up to the chin

6. Tape the gloves to the jumpsuit. Leave at tab so it's easy to pull off

****Direct Patient Caregivers proceed to step 17. Omit steps 7-16.******

7. Put blue level four surgical gown on over the jumpsuit and tie in back


8. Put on 2nd set 12" nitrile gloves over surgical gown. Tape at top of gloves.



(Leave tap on tape for easy removal.)

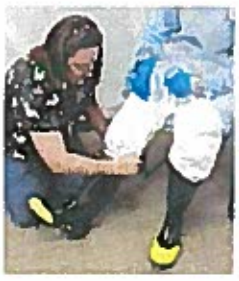
9. Bouffant cap to keep hair out of eyes if needed.

10. Put on proper size N95 mask.

11. Put on Goggles.

12. Put hood on and zip the suit all the way up

14. Put black boots on over the jumpsuit and tape to the suit at the top of the boot.



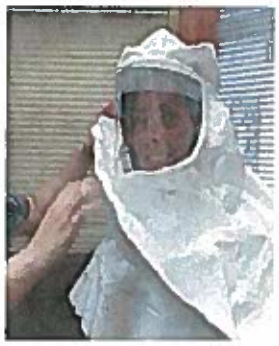

15. Put on regular set of gloves (no tape)

16. Apron

Ready to assist.

****Direct Patient Care Providers: After completing steps 1-6, continue here.**

17. Put on PAPR hood



18. Attach PAPR.

Secure around waist.

19. Put blue level four surgical gown on over the jumpsuit, PAPR and inside layer of hood, leaving outside layer exposed. Tie in back.

20. Pull outer layer of hood down over shoulders.

21. Put on 2nd set 12" nitrile gloves over gown. Tape at top of gloves.

Leave tap on tape for easy removal.

12. Put black boots on over the jumpsuit and tape to the suit at the top of the boot.

13. Put on regular set of gloves (no tape)

14. Apron

Removal of PPE properly for Ebola (N95)

Tri-City Medical Center

Removal of PPE properly for Ebola (N95)
**Remove under supervision of a trained observer
**Assistant to perform hand hygiene

1. **Inspect** for visible contamination – use bleach wipes to remove
2. **Hand hygiene** with gloves on using Dispatch (bleach)
3. Remove **apron.**
4. **Hand hygiene** with gloves on using Dispatch (bleach)
5. Remove third layer of **gloves**
6. Dispatch again (wait for it to dry)
7. **Un-tape second set** of gloves
8. Remove **surgical gown and second set of gloves** together – roll from inside out**
9. Assistant **un-tape boots & remove boots** (while Dispatch is drying)**
10. **Disinfect** with Dispatch again (wait for it to dry)
11. **Inspect** PPE
12. **Un-tape** first set of gloves
13. **Disinfect** gloves
14. **Un-tape face shield**
15. Remove **face shield** – grabbing from rear strap and pull over head**
16. **Disinfect** gloves with dispatch
17. **Unzip** jumpsuit
18. **Remove hood and jumpsuit together****
19. **Disinfect** gloves with dispatch
20. Remove **blue booties****
21. **Dispatch** again (wait for it to dry)
22. Remove **goggles**
23. Remove **mask**
24. Remove **bouffant cap**
25. Dispatch again (wait for it to dry)
26. Remove **last set of gloves**
27. Hand Hygiene
28. Leave PPE removal area
29. Shower.

Tri-City Medical Center

Removal of PPE properly for Ebola (N95)
**Remove under supervision of a trained observer
**Assistant to perform hand hygiene

1. Inspect all PPE for any visible soiling

If any present, clean with Dispatch wipes

2. Hand hygiene with Dispatch

3. Remove outside pair of gloves.

4. Hand hygiene with Dispatch

5. Assistant untie apron in back & cut neck strap. Remove apron.**

6. Hand hygiene with Dispatch
7. Remove tape from glove/gown

8. Assistant unties gown. Remove gown and outside set of gloves**

9. Assistant un-tapes & removes boots

10. Hand Hygiene with dispatch

11. **Inspect next layer of PPE for visible soiling.**

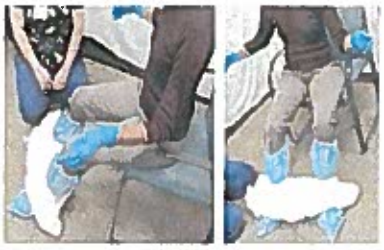
12. Remove tape from gloves/suit

13. Assistant removes tape and shield- back to front**

15. Unzip jumpsuit. Remove rolling down inside to out.

14. Hand Hygiene with Dispatch

16. Sit back on chair in cool zone.



17. Remove jumpsuit & surgical booties. Place feet in cool zone.

18. Hand hygiene. Remove goggles.

20. Remove mask and bouffant cap

21. Remove last pair of gloves.

22. Hand Hygiene

23. Shower

Tri-City Medical Center

Removal of PPE properly for Ebola (PAPR)
**Remove under supervision of a trained observer
**Assistant to perform hand hygiene

1. **Inspect** for visible contamination – use bleach wipes to remove
2. **Hand hygiene** with gloves on using Dispatch (bleach)
3. Remove third layer of **gloves**
4. Dispatch again (wait for it to dry)
5. **Un-tape second set** of gloves
6. Remove **surgical gown and second set of gloves** together – roll from inside out**
7. **Disinfect** with Dispatch again (wait for it to dry)
8. Assistant **un-tape boots & remove boots** (while Dispatch is drying)**
9. **Disinfect** with Dispatch again (wait for it to dry)
10. **Inspect** PPE
11. **Untape** first set of gloves
12. **Disinfect** gloves
13. Remove **PAPR**
14. **Disinfect** gloves with dispatch
15. **Unzip** jumpsuit
16. **Remove hood and jumpsuit together****
17. **Disinfect** gloves with dispatch
18. Remove **blue booties****
19. **Dispatch** again (wait for it to dry)
20. Remove **bouffant cap**
21. Dispatch again (wait for it to dry)**
22. Remove **last set of gloves**
23. **Hand Hygiene**
24. Leave PPE removal area
25. **Shower**.

Tri-City Medical Center

Removal of PPE properly for Ebola (PAPR)

**Remove under supervision of a trained observer

**Assistant to perform hand hygiene

1. Inspect the PPE to assess for visible contamination, cuts, or tears before starting removal process.

Disinfect any potentially contaminated PPE with Dispatch (must be allowed dry to be effective.)

2. Hand hygiene with Dispatch

Allow to dry completely before next actions

3. Remove outside pair of gloves.

4. Hand Hygiene with Dispatch

5. Assistant untie apron in back and cut neck strap. Remove apron rolling inside out.**
(Note: Assistant would be in full PPE gear)

6. Hand hygiene with Dispatch and allow to d

7. Remove tape from glove/gown

Take your time. Sudden jerking motions will throw contaminates into the air.

8. Assistant untles gown. Remove gown rolling inside over the outside

Include outside set of gloves**

9. Assistant un-tapes & removes boots**

10. Hand Hygiene with dispatch

11. Inspect next layer of PPE for visible soiling.

12. Remove tape holding gloves to the suit

13. Assistant removes PAPR

14. Place PAPR in designated area for cleaning**

15. Hand Hygiene with Dispatch

16. Assistant to roll back shoulder covering of hood up - outside in. **

Leaning forward, remove the back to front

17. Hand Hygiene with dispatch

18. Inspect PPE for visible soiling.

19. Unzip jumpsuit.

20. Remove rolling down inside to out.

21. Assistant removes jumpsuit and surgical booties being careful that feet dc not touch the floor of hot zone.** Place feet in cool zone.

22 Clean gloves with Dispatch

23. Remove last pair of gloves.

1st glove is removed touching only the outside of the glove. Be careful not to touch any skin

2nd glove is removed touching only the inside of the glove.

Slide one or two fingers inside Carefully avoiding contact with the outside of the glove. Pull off.

24. Hand Hygiene

25. Inspect one more time for contamination.

You may now leave the doffing area, shower and change into your own clothes.

Room Signage

PPE Storage and Donning Area

Room Signage

Patient Room

(Keep door Closed)

Room Signage

PPE Removal Area

CDC: Checklist for Patients Being Evaluated for EVD in the United States

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Assess the patient for a fever (subjective or ≥100.4°F [≥38.0°C])
- ❑ Determine if the patient has symptoms compatible with EVD (such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage)
- ❑ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset

Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present

See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at [illegible]

Upon initial assessment

- ❑ Isolate patient in a single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital infection control program at [illegible]
- ❑ Report to the health department at [illegible]

Conduct a risk assessment for:

High-risk exposures

- ❑ Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluid from an EVD patient
- ❑ Direct skin contact with blood or body fluids from an EVD patient
- ❑ Processing laboratory specimens from an EVD patient without appropriate PPE
- ❑ Direct contact with a deceased person who died of EVD without appropriate PPE

Low-risk exposures

- ❑ Household members or other EVD patient contacts who had brief, direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel or laboratory workers who have cared for EVD patients without appropriate PPE

Use of personal protective equipment (PPE)

- ❑ Use a buddy system to ensure that PPE is put on and removed safely

Before entering patient room, wear:

- ❑ Gown (fluid resistant or impermeable)
- ❑ Facemask
- ❑ Eye protection (goggles or face shield)
- ❑ Gloves

If likely to be exposed to blood or body fluids, additional PPE may include but isn't limited to:

- ❑ Double gloving
- ❑ Disposable shoe covers
- ❑ Leg coverings

Upon exiting patient room

- ❑ PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials
- ❑ Discard disposable PPE
- ❑ Re-useable PPE should be cleaned and disinfected per the manufacturer's reprocessing instructions
- ❑ Hand hygiene should be performed immediately after removal of PPE

During aerosol-generating procedures

- ❑ Limit number of personnel present
- ❑ Conduct in an airborne infection isolation room
- ❑ Don PPE as described above except use a NIOSH-certified, fit-tested N95 filtering or elastomeric air-purifying respirator, or other alternative (e.g., PAPR) instead of a facemask

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment if possible
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnosis and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (details in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses**

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing***
- ❑ Consider test for, and treat (when appropriate) other possible infectious causes of illness (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete
- ❑ Evaluate for evidence of bleeding and assess hemodynamic and coagulation parameters
- ❑ Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
- ❑ Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

* See [illegible] for a current list of West African countries with widespread Ebola transmission. [illegible] country has widespread Ebola transmission.

** See [illegible] for information on environmental infection control for Ebola virus.

*** See interim guidance for Specimen Collection, Laboratory Testing and Submission for Persons Under Investigation for Ebola Virus Disease in the United States at [illegible]

ISSUE DATE: 10/07

SUBJECT: Mold Abatement

STANDARD NUMBER: IC. 13.3

REVISED DATE(S): 07/14, 06/20

~~Infection Control~~ Department Approval:	**~~07/14~~06/17**
Infection Control Committee Approval:	**~~07/14~~07/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/14~~07/17**
Professional Affairs Committee Approval:	**~~08/14~~08/17**
Board of Directors Approval:	**08/14**

A. **INTRODUCTION:**

1. Molds and fungi can be found anywhere inside or outside throughout the year. About 1000 species of mold can be found in the United States with more than 100,000 known species worldwide. Outdoors, molds play an important role in nature by breaking down organic matter such as toppled trees, fallen leaves, and dead animals. We would not have food and medicines, like cheese and penicillin, without mold. When excessive moisture or water accumulates indoors, mold growth often will occur, particularly if the moisture problem remains uncorrected. While it is impossible to eliminate all molds and mold spores, controlling moisture can control indoor mold growth. **Moisture control is the key to mold control. When water leaks or spills occur indoors - act promptly. Any initial water infiltration should be stopped and cleaned promptly. A prompt response (within 24-48 hours) and thorough clean- up, drying, and/or removal of water-damaged materials will prevent or limit mold growth.**
2. Delayed or insufficient maintenance may contribute to moisture problems in buildings. Molds may cause localized skin or mucosal infections but, in general, do not cause systemic infections in humans, except for persons with impaired immunity, AIDS, uncontrolled diabetes, or those taking immune suppressive drugs.

B. **PURPOSE:**

1. The purpose of mold remediation is to correct the moisture problem and to remove moldy and contaminated materials to prevent human exposure and further damage to building materials and furnishings. Porous materials that are wet and have mold growing on them may have to be discarded because molds can infiltrate porous substances and grow on or fill in empty spaces or crevices.

C. **PROCEDURE:**

~~1. Responsibility~~

1. Infection Preventionist and Environment of Care Officer will:
   a. Provide consultation during water damage remediation and mold abatement.
   b. Inspect abatement areas for compliance with recommended practices.
   c. Review indication for environmental cultures or volumetric air sampling.
2. Engineering staff will:
   a. Participate in training process for mold remediation activities and construction barrier containment.
   b. Follow remediation precautions as outlined in this plan.
   c. Notify Infection Preventionist and Safety Officer about water intrusion and remediation.
   d. Follow procedure for containment found in ~~IC 13.2 Construction Policy Matrix.~~**Infection Control Construction Permit**

e. Coordinate the remediation of the mold by trained staff,
f. Wear the appropriate PPE during remediation.
g. Assess the extent of mold contamination for appropriate remediation activity level.

3. Mold Remediation/Cleanup Methods
   a. **A variety of cleanup methods are available for remediating damage to building materials and furnishings caused by moisture control problems and mold growth. The specific method or group of methods used will depend on the type of material affected.** ~~For mold remediation Level IV barrier precautions are required. See Construction Policy 13.2 Matrix and permit to determine appropriate job class and precautions. Water damaged areas should be dried within 48-72 hours of water exposure. It is recommended that dehumidifiers be used for this purpose because fans can cause aerosolization of mold spores.~~ **Water damaged areas should be dried within 48-72 hours of water exposure. It is recommended that dehumidifiers be used for this purpose because fans can cause aerosolization of mold spores. Some methods that may be used include the following:**
   ~~a.~~**b.** Wet Vacuum - can be used to remove water from floors, carpets, and hard surfaces where water has accumulated. They should not be used to vacuum porous materials, such as gypsum board. Wet vacuums should be used only on wet materials, as spores may be exhausted into the indoor environment if insufficient liquid is present. The tanks, hoses, and attachments of these vacuums should be thoroughly cleaned and dried after use since mold and mold spores may adhere to equipment surfaces.
   ~~b.~~**c.** Damp Wipe - Mold can be removed from nonporous surfaces by wiping or scrubbing with a hospital approved disinfectant. It is important to dry these surfaces quickly and thoroughly to discourage further mold growth.
   ~~c.~~**d.** HEPA Vacuum - HEPA (High-Efficiency Particulate Air) vacuums are used for final cleanup of remediation areas after materials have been thoroughly dried and contaminated materials removed. HEPA vacuums also are used for cleanup of dust that may have settled on surfaces outside the remediation area. Care is taken to assure that the filter is properly seated in the vacuum so that all the air passes through the filter. When changing the vacuum filter, wear N-95 respirators, appropriate personal protective clothing, gloves, and eye protection to prevent exposure to any captured mold and other contaminants. The filter and contents of the HEPA vacuum must be disposed of in impermeable bags or containers in such a way as to prevent release of the debris.
   ~~d.~~**e.** Disposal of Damaged Materials - Building materials and furnishings contaminated with mold growth that are not salvageable should be placed in sealed impermeable bags or closed containers while in the remediation area. These materials can usually be discarded as ordinary construction waste. Large items with heavy mold growth are covered with polyethylene sheeting and sealed with duct tape before being removed from the remediation area.
   ~~e.~~**f.** Use of Biocides - The use of a biocide, such as chlorine bleach, is indicated when immuno-compromised individuals are present. A dilution of 500 ppm is recommended for this purpose (dilution to attain this concentration is 1 part bleach to 100 parts water). Containers shall be labeled appropriately and discarded after use. **When you use biocides as a disinfectant or fungicide, always ventilate the area well and apply appropriate PPE, including respirators.**
   ~~f.~~**g.** Never mix chlorine bleach solution with other cleaning solutions or detergents that contain ammonia because this ~~may~~ produces highly toxic vapors and create a hazard to workers.

4. Mold Remediation **Guidelines** ~~Procedure~~
   a. Level I: Small Isolated Areas (10 sq. ft or less) - e.g., ceiling tiles, small areas on walls.
      ~~b.~~**i.** Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.
      ~~c.~~**ii.** Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.

~~d.~~iii. N-95 disposable respirators are used. Gloves and eye protection are worn.
~~e.~~iv. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.
~~f.~~v. The work area and egress area are cleaned with a damp cloth or mop and a hospital approved disinfectant.
~~g.~~vi. vAll areas are left dry and visibly free from contamination and debris.

~~h.~~b. Level II: Mid-Sized Isolated Areas (10-30 sq. ft.) – e.g., individual wallboard panels.
i. Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.
~~j.~~ii. Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.
~~k.~~iii. N-95 disposable respirators are used. Gloves and eye protection are worn.
~~l.~~iv. Surfaces in the work area that could become contaminated are covered with a secured plastic sheet(s) before remediation to contain dust/debris and prevent further contamination.
~~m.~~v. Dust suppression methods, such as misting (not soaking) surfaces prior to remediation, are used.
~~n.~~vi. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.
~~o.~~vii. The work area and egress areas are HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.
~~p.~~viii. All areas are left dry and visibly free from contamination and debris.

~~2.~~c. Level III: Large Isolated Areas (30 –100 square feet) – e.g., several wallboard panels.
~~a.~~i. The following procedures may be implemented depending upon the severity of the contamination:
1) Install Infection Control Containment. Containment level to be determined by the infection control officer and engineering supervisor.
~~i.~~2) Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.
~~ii.~~3) N-95 disposable respirators are used. Gloves and eye protection are worn.
~~iii.~~4) Surfaces in the work area and areas directly adjacent that could become contaminated should be covered with a secured plastic sheet(s) before remediation to contain dust/ debris and prevent further contamination.
~~iv.~~5) Seal ventilation ducts/grills in the work area and areas directly adjacent with plastic sheeting.
~~v.~~6) Dust suppression methods, such as misting (not soaking) surfaces prior to mediation, are used.
~~vi.~~7) Contaminated materials that cannot be cleaned are removed from the building in sealed impermeable plastic bags. These materials may be disposed of as ordinary waste.
~~vii.~~8) The work area and surrounding areas should be HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.
~~viii.~~9) All areas should be left dry and visibly free from contamination and debris.
~~ix.~~10) Note: If abatement procedures are expected to generate a lot of dust (e.g., abrasive cleaning of contaminated surfaces, demolition of plaster walls) or the visible concentration of the mold is heavy (blanket coverage as opposed to patchy), it is recommended that the remediation procedures for Level IV be followed.

~~3.~~d. Level IV: Extensive Contamination (greater than 100 contiguous square feet in an area).

~~a.~~i. Industrial hygienists or other environmental health and safety professionals with experience performing microbial investigations and/or mold remediation should be consulted prior to remediation activities to provide oversight for the project. The following procedures may be implemented depending upon the severity of the contamination:

1) Personnel trained in the handling of hazardous materials and equipped with:
   a) Full face piece respirators with HEPA cartridges, disposable protective clothing covering entire body including both head and shoes and gloves.
2) Containment of the affected area: Complete isolation of work area from occupied spaces using plastic sheeting and sealed with duct tape (including ventilation ducts/grills, fixtures, and other openings). The use of exhaust fan with HEPA filter to generate negative pressurization. Airlocks and decontamination room.
3) Removal of infants, persons having undergone recent surgery, immune-suppressed people, or people with chronic lung disease ie: asthma, hypersensitivity pneumonitis and severe allergies is recommended from surrounding work areas. All others may not need to be moved if contaminant practices effectively prevented mold from migrating from affected area.
4) Contaminated materials that cannot be cleaned should be removed from the building in sealed impermeable plastic bags. The outside of the bags should be cleaned with a damp cloth and a detergent solution or HEPA vacuumed in the decontamination chamber prior to their transport to uncontaminated areas of the building. These materials may be disposed of as ordinary waste.
5) The contained area and decontamination room should be HEPA vacuumed and cleaned with a damp cloth or mopped with a detergent solution and be visibly clean prior to the removal of isolation barriers.

~~4.~~5. Personal Protective Equipment (PPE)

~~b.~~a. Gloves are used to protect the skin from contact with mold and disinfecting agents. **Long gloves that extend to the middle of the forearm are recommended.**

~~c.~~b. Eye Protection:
To protect your eyes, use properly fitted goggles or a full face piece respirator. Goggles must be designed to prevent the entry of dust and small particles. Safety glasses or goggles with open vent holes are not appropriate in mold remediation.

~~d.~~c. Respiratory Protection - N-95 disposable respirators are available for use during Level I through Level III remediation procedures. It is recommended that during Level IV remediation procedures utilize PAPR units.

~~e.~~d. Protective Clothing

~~f.~~e. Disposable PPE should be discarded after it is used. They should be placed into impermeable bags, and usually can be discarded as ordinary construction waste.

~~5.~~6. Sampling for Mold - Air sampling is not a necessary part of a routine assessment because decisions about appropriate remediation strategies often can be made on the basis of a visual inspection. The Medical Director of Infection Prevention and Control will be consulted when air sampling is considered.

~~a.~~7. Moisture Meters - Moisture meters measure/monitor moisture levels in building materials, and may be helpful for measuring the moisture content in a variety of building materials following water damage. Moisture content $\leq$ 20% as determined by moisture meter readings is considered to be acceptable.

D. **REFERENCES**:

1. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities,

2003.

2. U.S. Department of Labor Occupational Safety and Health Administration, A ~~B~~brief Guide to Mold in the Workplace (SHIB 03-10-10) **updated August 13, 2011.**

Tri-City Health Care District
Oceanside, California

Infection Control Policy ~~Manual~~

SUBJECT: **Prion Diseases: Transmissible Spongiform Encephalopathies (TSE) such as: Creutzfeldt-Jakob disease (CJD) and Variant (vCJD), Gerstmann-Sträussler-Scheinker Syndrome (GSS), Kuru, Fatal Insomnia, or Bovine Spongiform Encephalopathy (BSE or Mad Cow disease)**

ISSUE DATE: 01/03
REVISION DATE(S): 01/09, 02/12

Department Approval:	~~03/16~~06/17
Infection Control Committee Approval:	~~03/16~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~07/17
Professional Affairs Committee Approval:	~~02/17~~08/17
Board of Directors Approval:	02/17

A. **INTRODUCTION:**

1. Prion diseases, or transmissible spongiform encephalopathies (TSE's) are a family of rare progressive neurodegenerative disorders that affect both humans and animals. They are distinguished by long incubation periods, characteristic spongiform changes associated with neuronal loss, and a failure to induce inflammatory response. The causative agents of TSE's are believed to be prions. The term "prions" refers to abnormal, pathogenic agents that are transmissible and are able to induce abnormal folding of specific normal cellular proteins called prion proteins that are found most abundantly in the brain. This abnormal folding of the prion proteins leads to progressive degenerative brain and nervous system damage. Prion diseases are usually rapid progressive and always fatal. Examples of Human Prion Diseases: Creutzfeldt-Jacob Disease (CJD), Variant Creutzfeldt-Jakob Disease (vCJD), Gerstmann-Straussler-Scheinher Syndrome, Fatal Familial Insomnia, and Kuru. Examples of Animal Prion Diseases: Bovine Spongiform Encephalopathy (BSE or Mad Cow Disease), Chronic Wasting Disease, and Scrapie.
2. Prion diseases are not known to spread by contact from person to person. In the healthcare setting, risk of transmission to patients has been associated with direct contact with infectious tissues (See B.7. Tissue Infectivity). Contaminated surgical equipment or implantation of electrodes deep in the brain can also transmit infectious prions from one patient to another. Transmission has occurred during invasive medical interventions (two confirmed and four unconfirmed cases) after contaminated medical equipment was not properly cleaned before use on another person.
3. The prions that cause TSE's exhibit an unusual resistance to conventional chemical and physical decontamination methods. The infectious agents that transmit prion diseases are resistant to inactivation by heat and chemicals, and therefore require special biosafety precautions. Incineration is the preferred method for all instruments exposed to high infectivity tissues.
4. Prion diseases are transmissible by inoculation or ingestion of infected tissues. A new variant CJD has been linked to eating contaminated beef, elk or deer meat.
5. Symptoms include an insidious onset of confusion, progressive dementia, variable ataxia, seizures, visual or sensory deficits, and rapid mental deterioration in patients' aged 16+, most frequently between 40 and 70 years old. Incubation period ranges from 15 months to more than 30 years, usually fatal within 1 year after diagnosis.
6. The most common form, sporadic Creutzfeldt-Jakob disease (CJD), has a worldwide death rate of about 1 case per million people each year.

B. **PATIENT CARE:**

1. Normal social and patient contact, and non-invasive procedures with TSE patients do not present a risk to healthcare workers, relatives, other patients or visitors.
2. Standard precautions should be used for all known or suspected cases.
3. It is very important that patients who are known or suspected to have prion disease be identified before any surgical procedure involving tissues that may be infectious.
4. Patients with TSEs must not donate organs, tissues, or blood components.
5. TSE is not known to be transmitted from mother to child during pregnancy or childbirth.
6. To prevent the transmission, it is important to consider: (1) the probability that an individual has or will develop TSE, (2) the level of infectivity in tissues or fluids, and (3) the nature or route of the exposure. Risk assessment and prevention of exposure through the use of personal protective equipment and disposable equipment are the best means to reduce any risk of transmission in the healthcare setting [Assignment of different organs and tissues to categories of high and low infectivity is chiefly based upon the frequency with which infectivity has been detectable, rather than upon quantitative assays of the level of infectivity, for which data are incomplete.]
7. Tissue infectivity:

a.	Highly infective tissues	Brain, spinal cord **and&** eye
b.	Low infective tissues	Cerebral spinal fluid, lung, liver, kidney, spleen/lymph nodes, and placenta
c.	Not infective	Heart, skeletal muscle, peripheral nerve, adipose tissue, gingival tissue, intestine, adrenal gland, thyroid, prostate, testis) or in blood, bodily secretions or excretions (urine, feces, saliva, mucous, semen, milk, tears, sweat, serous exudates).

8. Route of exposure:

a.	Very serious risk	CNS exposures (i.e. inoculation of the eye or CNS)
b.	Greater potential risk	Transcutaneous exposures: cut or puncture by a contaminated sharp instrument or contact with the mucus membrane of the eye
c.	Negligible risk	Cutaneous exposure of intact skin or mucous membranes, except those of the eye

C. **DIAGNOSTIC AND SURGICAL PROCEDURES**

1. All non-emergent brain biopsy procedures and neurosurgical and neuroophthalmology procedures are screened by the schedulers in Surgery Services or Interventional Radiology (See Appendix A). If the brain biopsy is for any reason other than tumor, or if TSE is suspected, notify the departments listed on the screening tool so that planning can be made for instrument handling, storage, cleaning and decontamination or disposal.
   a. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details. Clinical Laboratory stores 1 Molar sodium hydroxide.
   b. All known cases and cases that meet the case definition of suspect Transmissible Spongiform Encephalopathies will be performed with disposable instruments whenever possible.
   c. Procedures that are normally carried out at the bedside (e.g. lumbar puncture) may be performed at the bedside. Use a chux at the site to contain a potential spill of infective material.
   d. Alert the laboratory and clearly label all specimens. Place specimens in formalin as usual.

2. Dental Procedures: general infection control practices recommended by national dental associations are sufficient when treating TSE patients during procedures not involving neurovascular tissue. The following are precautions for major dental work:
   a. Use single-use items and equipment e.g. needles and anesthetic cartridges.
   b. Re-usable dental broaches and burrs that may have become contaminated with neurovascular tissue should be destroyed after use by incineration or decontaminated by a method listed on Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details.
   c. Schedule procedures involving neurovascular tissue at end of day to permit more extensive cleaning and decontamination.
3. If reusable instrumentation must be used keep instruments and other devices moist between the time of exposure to infectious materials and subsequent decontamination and cleaning. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7, 8, and 9 for details.
   a. Remove bio-burden from reusable instruments while wearing a face shield or goggles and surgical mask and double glove. Instruments are then placed in a flash pan for processing as close as possible to the room where the procedure was performed. Autoclave for 18 minutes at 134°C.
   b. If the procedure was performed in another department (for example a brain biopsy in the CT Scan) call Sterile Processing Department for assistance with autoclaving.
   c. After autoclaving place instruments in a robust, leak-proof container labeled "Incinerate Only". This box will be placed and remain in a designated locked area.
      i. If the laboratory result is negative, all items can be returned to the decontamination area and reprocesses as normal.
      ii. If the laboratory result confirms a Transmissible Spongiform Encephalopathy, the instruments will be sent out for incineration.
4. See unit specific policies for safety in the Clinical Laboratory.
5. Occupational exposure
   a. There have been no confirmed cases of occupational transmission of TSE to humans. Report any occupational exposure to blood, body fluids, or other potentially infectious materials to your supervisor and go to Emergency Room for assistance.

D. RELATED DOCUMENT(S):

~~D.~~**1. Controlling TSE Agent Transmission in the Hospital**
~~1.~~**2.** Employee Health **& Wellness:**~~Services Policies: AP&P #401~~ Injury **Illness** Prevention Program
~~2.~~**3.** Infection Control **Policy** ~~Manual~~**:** Standard and Transmission Based Precautions
4. Infection Control **Policy** ~~Manual~~: Bloodborne Exposure Control Plan
~~3.~~**5. Instrument Handling Algorithm**
6. ~~Tri-City Medical Center~~ Laboratory **Microbiology Policy:**~~Procedure: The Handling of~~ Tissues **Handling Protocol**~~of Patients with Transmissble Spongiform Encephalopathies (TSE) including Creutzfeld-Jakob Disease~~
~~4.~~**7. Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool**

E. REFERENCE(S):

1. Brown, P., Wolff, A., Gajdusek, D.C. (1990) A simple and effective method for inactivating virus infectivity in formalin-fixed tissue samples from patients with CJD. Neurology, 40: 887-890
2. Karasin, M. (2014, October). Special Needs Populations: Perioperative Care of the Patient with Creutzfeldt-Jakob Disease. Vol 100, No 4.
3. Kavanagh, B. (2014) Creutzfeldt-Jakob disease and other Prion Diseases. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 73:1-14.

4. Rutula, W., and Weber, D. (2010, February). SHEA Guideline: Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments. *Infection Control and Hospital Epidemiology*, Vol 31, No.2, 107-117.
5. Steelman, V.M. (1994) Creutzfeld-Jakob Disease: recommendations for infection control. American Journal of Infection Control, 22(5): 312-318.
6. www.who.int/emc WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies. (1999)

Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

This information is required when scheduling any patient for non-emergent craniotomy or brain biopsy to identify potential Creutzfeldt-Jakob Disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstemenn-Straussler-Scheinder Syndrome (GSS), Kuru, or Fatal Insomnia

	Circle One	
1. Does the patient present with symptoms of TSE (rapidly progressive dementia, cerebella symptoms, spasticity or hyper-reflexia, EEG with periodic sharp-wave complexes, rapid cerebral atrophy on CT scan)?	Yes	No
2. Does the patient have a family history of CJD or CJD-like fatal illness?	Yes	No
3. Is the patient being scheduled for craniotomy or brain biopsy when diagnosis is unknown or uncertain (no specific lesion identified by imaging procedures)?	Yes	No
4. Is the biopsy for the diagnosis of dementia or encephalitis?	Yes	No

Patient Name_____ Today's Date_____

Surgeon providing the screening information_____

Office personnel providing the screening information_____

Print name of scheduler taking the Information_____

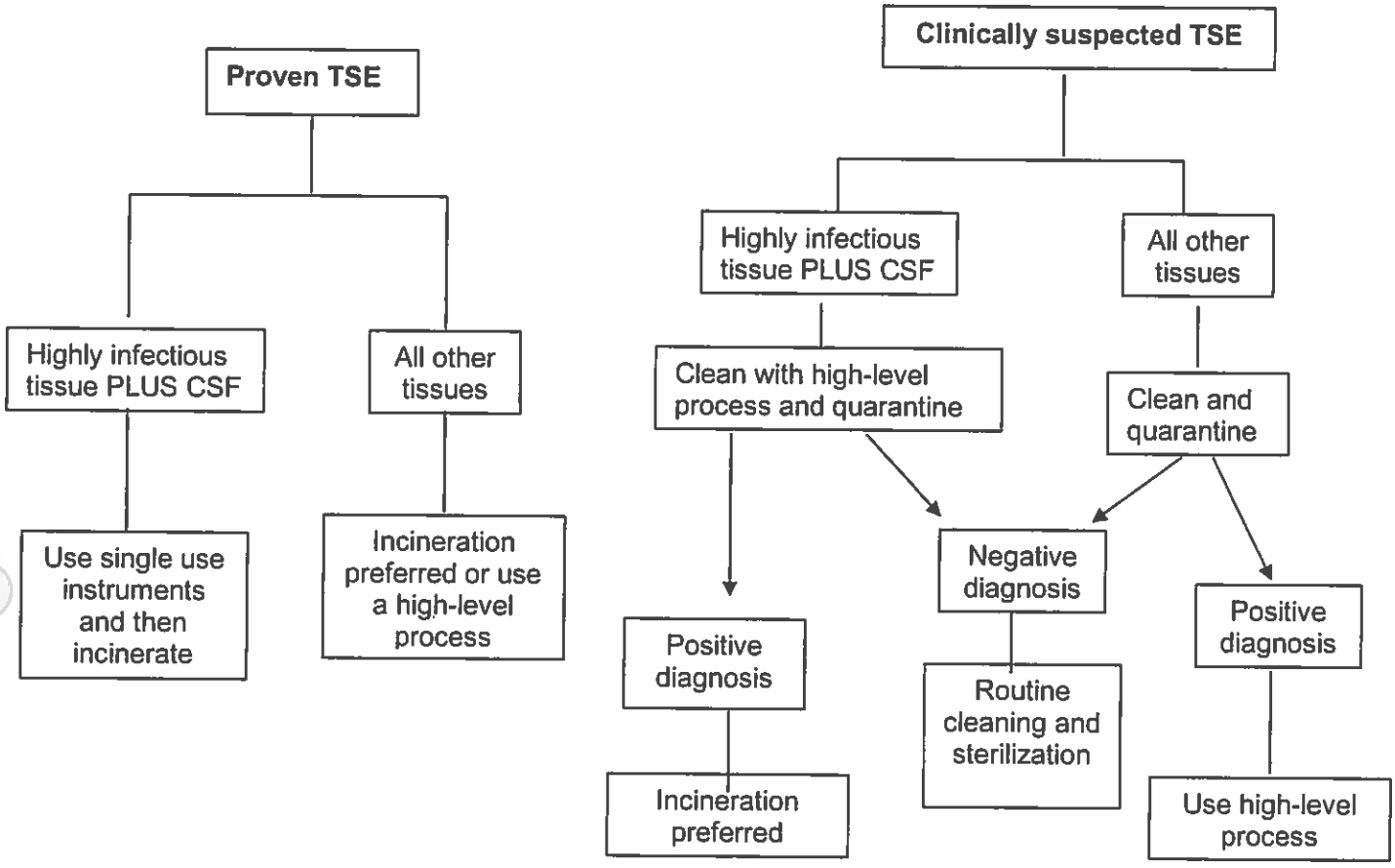
A "No" answer may be scheduled as usual.

A "Yes" answer to one of these questions means the patient meets the case definition of suspect Transmissible Spongiform Encephalopathies. Call the following services below to report and reference the policy in the Infection Control Manual, Transmissible Spongiform Encephalopathies.

Service	Phone Number	Message left	Spoke with (name of person) and Comments
Neuro-Speciality Coordinator	5400		
Environmental Services	7295		
SPD Ops Manager	7338		
Histology Supervisor	7914		
Infection Control	7410 or 5696		
Pharmacy	3012		

Instrument Handling Algorithm

Decontamination and disposition of instruments and equipment used with confirmed or suspected Transmissible spongiform encephalopathies (TSEs) patients.



Controlling TSE Agent Transmission in the Hospital

Diagnosis	Procedures	Method and product/devices		Comments
Sporadic CJD; suspected TSE; at risk for CJD asymptomatic; (hormone recipient, dura mater transplant, familial CJD in a first degree relative).	1. Noninvasive procedures 2. Care after death, no postmortem performed 3. Employee sharps injury	1. Use standard cleaning, regular laundering, and routine waste handling. ~~2. Embalming is acceptable.~~ ~~3.~~2. Gently encourage site to bleed, wash with warm soapy water, rinse, and cover with a waterproof bandage.		1. There is no epidemiological evidence that normal contact presents a risk to health care providers. Procedures involving high-risk tissue or fluid, e.g., brain, spinal cord, pituitary, dura mater, retina, and cornea, require use of disposal aprons/gowns, gloves and single-use instruments/equipment. See next section. 2. Refer to special handling of tissue and special handling of the body after pathology procedures and postmortem. 3. Document all incidents. Maintain all files in the Employee Health dept.
Diagnosis	**Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)**	**Other nondisposable equipment**		
Known TSE	• Where possible, avoid performing OR procedure. • If procedure must take place, book case at the end of the day. • The surgeon is to alert Surgery or Interventional Radiology when scheduling procedures. Schedulers are to notify the departments listed on the Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool. • Use dedicated sterile equipment or	• Cover nondisposable power equipment that must be used with plastic drapes. • Avoid touching surfaces with gloves, which have been in contact with brain, spinal cord and adjacent	Steps, OR Room: 1. Use damp cloth/sponge, superficial cleaning method 2 N NaOH undiluted for surfaces in the OR. 2. At end of case, place cleaning cloths in an "Incinerate Only" box. 3. Chemical disinfection - 2 N NaOH undiluted, disassembled equipment, completely	• Consult with Sterile Processing Department (SPD) for supply and use of equipment nearing end-of-life use. (NaOH is highly corrosive). • Cases booked at the end of the day allow for surface decontamination of "touch surfaces" at end of the case with noxious agents (2 N NaOH undiluted for one hour and rinsed with water, non-

	equipment nearing "end-of-life use" where possible. • Use disposable OR packs, gowns, drapes. • Use nonelectrical (mechanical) hand saws/drills. • Incinerate disposable supplies when procedure is complete. Suction wastewater and treat container with Premicide prior to placing in "Incinerate Only" box. 1. During procedure, use a damp cloth OR sponge-superficial wiping method to keep items clear of debris. Avoid excess handling of instruments. 2. At the end of the procedure, place all disposables in an "Incinerate Only" box and call the waste management vendor for disposal. Do not put any instruments from this case in contact with reusable containers.	tissue. If in doubt, change gloves. • Keep the least amount of equipment in the room. • Completely isolate/drape anesthetic/respiratory equipment near the patient's head to prevent accidental splatter or contamination of the equipment.	submerged, or continuously wet for 60 min. Rinse in water and wipe dry. 4. Confine and contain all effluent for incineration. Treat with Premicide to solidify waste for ease of handling 5. Manual clean instruments in OR area while wearing full face shield or mask and goggles. 6. Steam autoclave reusable items for 18 min. at 134 C; use an open container in a prevaccum sterilizer. 6. Place in an "Incinerate Only" box and transport to SPD for quarantine in the in a designated locked area.	critical patient care items and surfaces). • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent. • Tissue dried on instruments, which have not been inactivated first by NaOH, may have a protective effect on the TSE agent and render the autoclave process ineffective. Keep instruments moist until decontamination occurs.
Diagnosis	**Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)**	**Other procedures, equipment, potential risk**		**Comments**
Suspected TSE	Follow steps as above. SPD 1. Quarantine autoclaved reusable equipment until the diagnosis is finalized. • If confirmed positive, incinerate equipment. • If negative, follow regular cleaning in a washer	Follow steps as above.		See comments above.

	disinfector, then routine sterilization.		
At risk for TSE asymptomatic (hormone recipient, dura mater, corneal transplant, familial CJD in a first-degree relative.	• Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period). Use disposable instruments wherever possible and follow steps as above.	Follow standard cleaning and sterilization.	• Regular cleaning and disinfection procedures with a hospital grade disinfectant in a basin (contact time according to label recommendation). • the incubation period for TSE is long. • Asmptomatic patients have very low infectivity. • Upgraded neurosurgical procedure equipment sterilization cycles will provide a margin of safety in the very rare event a TSE diagnosed case is found.
Diagnosis	**Lumbar puncture/biopsies**	**Specimen handling**	**Comments**
Known TSE **Suspected TSE**	• Notify Infection Control • Only trained staff aware of TSE hazards should perform these procedures. • Perform procedures in an OR environment whenever possible. • Use disposable, single-use equipment where possible. • Incinerate packs, gowns, barrier drapes after use. • Where possible, avoid performing the OR procedure.	• It is prudent to refer to a specialist neuropathology lab center for brain and tissue biopsy material. • Containment is level 3 for central nervous system (CNS) samples. See department specific P&P. • Other clinical specimens are handled as per standard routine infection control precautions. • Tissue may still be infective if fixed in formaldehyde and then c steam sterilized. • Other clinical specimens are handled as per standard routine infection control precautions. Other clinical specimens are handled as per standard routine infection control precautions.	• Routine disinfection for all non-contaminated surfaces. • Cases booked at the end of the day allow for decontamination of brain tissue contaminated surfaces with a solution of 2 N NaOH undiluted for one hour and rinsed with water, non critical patient care items and surfaces. Pay close attention to technique to avoid contamination and decrease the need for additional use of NaOH. • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent.

At risk for TSE asymptomatic	• If diagnosis is delayed (long incubation period) use disposable instruments wherever possible or use the NaOH decontamination process (see above procedure for suspected TSE). • Regular cleaning and sterilization		

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~MANUAL~~

SUBJECT: Standard and Transmission-Based Precautions

ISSUE DATE: 11/99
REVISION DATE(S): 10/05, 01/11, 09/15, 01/17

~~Infection Control~~ Department Approval:	**~~10/16~~07/17**
Infection Control Committee Approval:	**~~10/16~~07/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/17~~07/17**
Professional Affairs Committee Approval:	**~~01/17~~08/17**
Board of Directors Approval:	**01/17**

A. **PURPOSE:**

1. The Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of PPE prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. For immunocompromised patients see Patient Care Services: ~~(PCS)~~ Neutropenic Precautions **Policy.**
   a. Use Standard Precautions, with emphasis on hand hygiene.
   b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
   c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be ordered for the patient.
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and gown based upon anticipated contact with infectious materials.
   c. Physicians should be aware of their current vaccination status regarding (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.
3. The role of nurses and other direct care providers is to:
   a. Assure that isolation orders are entered and proper isolation signage is posted outside of the patients' room.
   b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance. Direct care

providers need to evaluate their interaction with the patient and use barriers such as masks, eyewear, and gown based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.

d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.

e. The nurse and or caregiver is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the Off Unit Transfer/Assessment: Type of Isolation/Precautions in the electronic medical record (EMR)

4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.

5. All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center.

6. Specimen Labeling
   a. Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients' diagnosis. Standard precautions need to be utilized while handling all specimens. (In 1990, the Clinical Laboratory established formal policies requiring that all specimens be handled as if potentially infectious. To place "blood and body fluid precautions" on specimen conveys the notion to others to treat this particular specimen with caution, but other specimen without the labeling need not be handled as carefully. If needed, it is permissible to note the patient's diagnosis on laboratory requests, pathology requests, radiology request, etc. Please note that it is illegal in the state of California to note a person's HIV status on requests).

7. Handling of soiled linen from patients' rooms
   a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.

8. Dishware and eating utensils
   a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.

9. Disposal of waste from patients' rooms
   a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.

10. All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:
    a. Obtain a red "biohazardous" plastic bag from the soiled utility room.
    b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.
    c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.
    d. All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.

11. Wound Dressings
    a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids, gauze or cotton balls used in fingerstick glucose testing,
    b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucus membranes and non-intact skin.
    a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
    a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
    b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
        i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
    c. Gloves
        i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
        ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
        iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
        iv. Decontaminate hands immediately after removing gloves.
    d. Masks, Eye/Face Shields:
        i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Appendix: Standard Precautions: Personal Precautions Equipment Table)
        ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
    e. Gown
        i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
        i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
        ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene

after glove removal

4. Patient Care Equipment
   a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.
   b. Ensure that reusable equipment is properly cleaned and disinfected before it is used for the care of another patient.
   c. Single use items should be discarded.
5. Environmental Control
   a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.
6. Safe injection practices – see **Patient Care Services:** Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
   a. Use aseptic technique to avoid contamination of sterile injection equipment.
   b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
   c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

D. **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
   a. Types of Transmission-based Precautions:
      i. Airborne Precautions
      ii. Droplet Precautions
      iii. Contact Precautions
   ~~iii.~~**b. See Type and Duration of Precautions - Disease Specific (FKA Short Sheet).**
   ~~b.~~**c.** Communicate and notify receiving department/services if patient requires Transmission-based Precautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
   a. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.
   d. Mask patients during transport.
4. Contact Precautions

a. In addition to Standard Precautions, use Contact Precautions for specified patients known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients environment such as MRSA and VRE. (See Infection Control Policy: Management of Patients with MDRO's)
b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control staff is advised when there are questions about patient placement.
c. Gloves
    i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails) Don gloves upon entry into the room or cubicle.
d. Gowns
    i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle.
    ii. Remove gown and gloves and observe hand hygiene before leaving the patient-care environment
e. Dedicate the use of non-critical equipment to a single patient, when possible
f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant
g. Patient transport
    i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

E. **RELATED DOCUMENT(S):**

1. **Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions**
2. **Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats**
~~1.~~3. Infection Control Policy: ATD: Tuberculosis Control Plan
4. Infection Control Policy: Blood borne Pathogen Exposure Control Plan
~~2.~~5. **Infection Control Policy: Ebola Plan**
~~3.~~6. **Patient Care Services Policy:** Medication Administration ~~Policy~~
~~4.~~7. **Patient Care Services Policy:** Neutropenic Precautions
8. **Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings**
9. **Type and Duration of Precautions - Disease Specific (FKA Short Sheet)**

F. **REFERENCE(S):**

1. **Centers for Disease Control and Prevention (2017). CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html**
~~5.~~2. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
~~6.~~3. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection

control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.

~~7.~~4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

Type and Duration of Precautions - Disease Specific (FKA Short Sheet)

A. **CONTACT PRECAUTIONS:**

1. For illnesses easily passed by direct contact with the patient or equipment. Private room if available. Cohort with others with same organisms. Do not place with fresh post-op or patients with invasive tubes. HCW wear gloves in the room and add a gown if clothes might touch objects or the patient. Use a mask is to protect your face from sprays or splashes.

B. **DROPLET PRECAUTIONS:**

1. For illnesses passed in large droplets (wet drop to wet mucus membrane contact). Private room if available. Cohort with others with same organisms. HCW wear a mask when closer than 3 ft. to the patient. Surgical masks for visitors going closer than 3 ft. to the patient and for patients outside the isolation rooms.

C. **AIRBORNE PRECAUTIONS:**

1. For illnesses passed in the air. Place in a negative pressure room (C26, 143, 243, 443, 287, 387, 487, 200, 201, 301, 312 & 326) Keep the door closed at all times. HCW wear N95 respirators in the patient's room. Surgical masks for visitors going into the isolation room and for patients outside the isolation rooms.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness (with wound lesions, until	No dressing or containment of drainage; until drainage stops or can be contained by dressing

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
		wounds stop draining)	
Abscess Draining, minor or limited	Standard		Dressing covers and contains drainage
Acquired human immunodeficiency syndrome (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Actinomycosis	Standard		Not transmitted from person to person
Adenovirus infection (see agent-specific guidance under gastroenteritis, conjunctivitis, pneumonia)			
Amebiasis	Standard		Person to person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046].
Anthrax	Standard		Infected patients do not generally pose a transmission risk.
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard		Not transmitted from person to person
Anthrax Environmental: aerosolizable spore-containing powder or other substance		Until environment completely decontaminated	Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm513 5a3.htm)) Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against spores [983]. Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND
Antibiotic-associated colitis (see *Clostridium difficile*)			
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally [530, 1047]. Install screens in windows and doors in endemic areas.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
• Nile Virus) and viral fevers (dengue, yellow fever, Colorado tick fever)			Use DEET-containing mosquito repellants and clothing to cover extremities.
Ascariasis	Standard		Not transmitted from person to person
Aspergillosis	Standard		Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard		Not transmitted from person to person
Botulism	Standard		Not transmitted from person to person
Bronchiolitis (see respiratory infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050].
Campylobacter gastroenteritis (see gastroenteritis)			
Candidiasis, all forms including mucocutaneous	Standard		
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person
Cellulitis	Standard		
Chancroid (soft chancre) (*H. ducreyi*)	Standard		Transmitted sexually from person to person
Chickenpox (see >varicella)			
Chlamydia trachomatis Conjunctivitis	Standard		
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard		
Chlamydia trachomatis Pneumonia (infants ≤3 mos. of age)	Standard		
Chlamydia pneumoniae	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Contact Precautions if there is copious uncontained drainage
Closed-cavity infection No drain or closed drainage system in place	Standard		
Clostridium botulinum	Standard		Not transmitted from person to person
Clostridium difficile (see gastroenteritis, *C. difficile*)	Contact + Standard	Duration of illness	

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Clostridium perfringens Food poisoning	Standard		Not transmitted from person to person
Clostridium perfringens Gas gangrene	Standard		Transmission from person to person rare; one outbreak in a surgical setting reported [1053]. Use Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054].
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans [1054, 1055].
Colorado tick fever	Standard		Not transmitted from person to person
Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly neg. after 3 mos. of age
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial *Chlamydia*	Standard		
Conjunctivitis Acute bacterial Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 814, 1058, 1059 461, 1060].
Corona virus associated with SARS (SARS-CoV) (see severe acute respiratory syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures [1061]
Croup (see respiratory infections in infants and young children)			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant [1062, 1063]
Cryptosporidiosis (see gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person
Cytomegalovirus infection, including in neonates and immunosuppressed patients	Standard		No additional precautions for pregnant HCWs
Decubitus ulcer (see Pressure ulcer)			
Dengue fever	Standard		Not transmitted from person to person
Diarrhea, acute-infective etiology suspected (see gastroenteritis)			
Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Ebola virus (see viral hemorrhagic fevers)			⚠ Ebola Virus Disease for Healthcare Workers [2014]: Update: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person
Echovirus (see enteroviral infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
Enterococcus species (see multidrug- resistant organisms if epidemiologically significant or vancomycin resistant)			
Enterocolitis, *C. difficile* (see *C. difficile*, gastroenteritis)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks
Epiglottitis, due to *Haemophilus influenzae* type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
Escherichia coli gastroenteritis (see gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person
Food poisoning C. *perfringens* or *welchii*	Standard		Not transmitted from person to person
Food poisoning Staphylococcal	Standard		Not transmitted from person to person
Furunculosis, staphylococcal	Standard		Contact if drainage not controlled. Follow institutional policies if MRSA
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person
Gastroenteritis	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below
Gastroenteritis Adenovirus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Campylobacter* species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Cholera (*Vibrio cholerae*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *C. difficile*	Contact + Standard	Duration of illness	Discontinue antibiotics if appropriate. Do not share electronic thermometers [853], 854; ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983].
Gastroenteritis *Cryptosporidium species*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *E. coli* Enteropathogenic O157:H7 and other shiga toxin- producing strains	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *E. coli* Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis	Standard		Use Contact Precautions for diapered or

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Giardia lamblia			incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Noroviruses	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances [142, 147 148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]). Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks.
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis *Salmonella* species (including *S. typhi*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Shigella* species (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Vibrio parahaemolyticus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Viral (if not covered elsewhere)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis *Yersinia enterocolitica*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
German measles (see rubella; see congenital rubella)			
Giardiasis (see gastroenteritis)			
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barre' syndrome	Standard		Not an infectious condition
Haemophilus influenzae (see disease- specific recommendations)			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Hand, foot, and mouth disease (see enteroviral infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person
Helicobacter pylori	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine post-exposure as recommended [1065]
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of patients in hemodialysis centers 778
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of patients in hemodialysis centers [778]
Hepatitis, viral Type D (seen only with hepatitis B)	Standard		
Hepatitis, viral Type E	Standard		Use Contact Precautions for diapered or incontinent individuals for the duration of illness [1068]
Hepatitis, viral Type G	Standard		
Herpangina (see enteroviral infection)			
Hookworm	Standard		
Herpes simplex (*Herpesvirus hominis*) Encephalitis	Standard		
Herpes simplex (Herpesvirus hominis) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	
Herpes simplex (Herpesvirus hominis) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (Herpesvirus hominis) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours. of age negative after 48 hours incubation [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator; for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles)	Standard	Duration of illness (with	Susceptible HCWs should not provide direct patient care when other immune caregivers

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Localized in patient with intact immune system with lesions that can be contained/covered		wound lesions, until wounds stop draining)	are available.
Histoplasmosis	Standard		Not transmitted from person to person
Human immunodeficiency virus (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.
Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal Influenza)	-		See Prevention Strategies for Seasonal Influenza in Healthcare Settings (https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm) for current seasonal influenza guidance.
Influenza Avian (e.g., H5N1, H7, H9 strains)	-		See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection- control.htm), accessed May 2016.] for current avian Influenza guidance.
Influenza Pandemic Influenza (also a human Influenza virus)	Droplet		See [This link is no longer active: http://www.pandemicflu.gov. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection- control.htm), accessed May 2016.] for current pandemic Influenza guidance.
Kawasaki syndrome	Standard		Not an infectious condition
Lassa fever (see viral hemorrhagic fevers)	-		
Legionnaires' disease	Standard		Not transmitted from person to person
Leprosy	Standard		
Leptospirosis	Standard		Not transmitted from person to person
Lice Head (pediculosis)	Contact + Standard	Until 24 hours after initiation of effective therapy	See [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm.Similar information may be found at CDC's Parasites -

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Body	Standard		Transmitted person to person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm. Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Pubic	Standard		Transmitted person to person through sexual contact. See CDC's [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm. Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Listeriosis (listeria monocytogenes)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported [1072, 1073 1074, 1075]
Lyme disease	Standard		Not transmitted from person to person
Lymphocytic choriomeningitis	Standard		Not transmitted from person to person
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during patient care 1076-1079. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Marburg virus disease (see viral hemorrhagic fevers)	-		
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness (with wound lesions, until wounds stop draining) in immune compromised	⚠ Measles Update [November 2011]: Updated recommendations can be found at Immunization of Healthcare Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf). Susceptible HCWs should not enter room if immune care providers are available; no recommendation for face protection for immune HCW; no recommendation for type of face protection for susceptible HCWs, i.e., mask or respirator [1027, 1028]. For exposed susceptibles, post-exposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.
Melioidosis, all forms	Standard		Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Meningitis Aseptic (nonbacterial or viral; also see enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis *Haemophilus Influenzae*, type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Meningitis *Listeria monocytogenes* (See Listeriosis)	Standard		
Meningitis *Neisseria meningitidis* (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease below.
Meningitis *Streptococcus pneumoniae*	Standard		
Meningitis *M. tuberculosis*	Standard		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne; For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see tuberculosis below) [42]
Meningitis Other diagnosed bacterial	Standard		
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks [15, 17].
Molluscum contagiosum	Standard		
Monkeypox	Airborne + Contact + Standard	Airborne-Until monkeypox confirmed and smallpox excluded Contact-Until lesions crusted	See CDC's Monkeypox website (https://www.cdc.gov/poxvirus/monkeypox/) [Current version of this document may differ from original.] for most current recommendations. Transmission in hospital settings unlikely [269]. Pre- and post-exposure smallpox vaccine recommended for exposed HCWs
Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant *S. pneumoniae*)	Contact + Standard		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug- Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infectioncontrol/guidelines

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			/mdro/) [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 9 days	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. Note: (Recent assessment of outbreaks in healthy 18- 24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk patient populations remain to be clarified.)
Mycobacteria, nontuberculosis (atypical)			Not transmitted person-to-person
Mycobacteria, nontuberculosis (atypical) Pulmonary	Standard		
Mycobacteria, nontuberculosis (atypical) Wound	Standard		
Mycoplasma pneumonia	Droplet + Standard	Duration of Illness	
Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporally [1080-1083].
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person
Norovirus (see gastroenteritis)			
Norwalk agent Gastroenteritis (see gastroenteritis)			
Orf	Standard		
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients [1009, 1010]. Reliability of antigentesting to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard		Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (Lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet + Standard	Until 5 days	Single patient room preferred. Cohorting an option. Post-exposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine in adults under development.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			⚠ Tdap Vaccine Recommendations [2011] Update: Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations (www.cdc.gov/vaccines/hcp/acip-recs/vacc- specific/tdap-td.html).
Pinworm infection (Enterobiasis)	Standard		
Plague (*Yersinia pestis*) Bubonic	Standard		
Plague (*Yersinia pestis*) Pneumonic	Droplet + Standard	Until 48 hours	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus [931]
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia *B. cepacia* in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline [20]
Pneumonia *B. cepacia* in patients without CF (see multidrug-resistant organisms)			
Pneumonia *Chlamydia*	Standard		
Pneumonia Fungal	Standard		
Pneumonia *Haemophilus influenzae*, type b Adults	Standard		
Pneumonia *Haemophilus influenzae*, type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Pneumonia *Legionella spp.*	Standard		
Pneumonia Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease above
Pneumonia Multidrug-resistant bacterial (see multidrug-resistant organisms)			
Pneumonia *Mycoplasma* (primary typical Pneumonia)	Droplet	Duration of illness	
Pneumonia Pneumococcal pneumonia	Standard		Use Droplet Precautions if evidence of transmission within a patient care unit or facility [196-198, 1087]

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Pneumonia *Pneumocystis jiroveci* (*Pneumocystis carinii*)	Standard		Avoid placement in the same room with an immunocompromised patient.
Pneumonia *Staphylococcus aureus*	Standard		For MRSA, see MDROs
Pneumonia Streptococcus, group A Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See streptococcal disease (group A streptococcus) below Contact precautions if skin lesions present
Pneumonia *Streptococcus*, group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present
Pneumonia Varicella-zoster (See Varicella- Zoster)			
Pneumonia Viral Adults	Standard		
Pneumonia Viral Infants and young children (see respiratory infectious disease, acute, or specific viral agent)			
Poliomyelitis	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Pressure ulcer (decubitus ulcer, pressure sore) infected Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	If no dressing or containment of drainage; until drainage stops or can be contained by dressing
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (*Chlamydia psittaci*)	Standard		Not transmitted from person to person
Q fever	Standard		
Rabies	Standard		Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (*Streptobacillus moniliformis* disease, *Spirillum*	Standard		Not transmitted from person to person

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
minus disease)			
Relapsing fever	Standard		Not transmitted from person to person
Resistant bacterial infection or colonization (see multidrug-resistant organisms)			
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Also see syndromes or conditions listed in Table 2
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding [928]). Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard		Not an infectious condition
Rheumatic fever	Standard		Not an infectious condition
Rhinovirus	Droplet + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Ritter's disease (staphylococcal scalded skin syndrome)	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see gastroenteritis)			
Rubella (German measles) (also see congenital rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			women who are not immune should not care for these patients [17, 33]. Administer vaccine within three days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post-exposure vaccine.
Rubeola (see measles)			
Salmonellosis (see gastroenteritis)			
Scabies	Contact	Until 24	
Scalded skin syndrome, staphylococcal	Contact	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below)
Schistosomiasis (bilharziasis)	Standard		
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining) plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; D if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol- generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars. Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/index.html), accessed May 2016.])
Shigellosis (see gastroenteritis)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard		
Spirillum minor disease (rat-bite fever)	Standard		Not transmitted from person to person
Staphylococcal disease (*S aureus*) Skin, wound, or burn Major	Contact	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately
Staphylococcal disease (*S aureus*) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Staphylococcal disease (*S aureus*) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Staphylococcal disease (*S aureus*) Multidrug-resistant (see multidrug-resistant organisms)			
Staphylococcal disease (*S aureus*) Pneumonia	Standard		
Staphylococcal disease (*S aureus*) Scalded skin syndrome	Contact	Duration of illness (with wound lesions, until wounds stop draining)	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (*S aureus*) Toxic shock syndrome	Standard		
Streptobacillus moniliformis disease (rat-bite fever)	Standard		Not transmitted from person to person
Streptococcal disease (group A streptococcus) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	No dressing or dressing does not contain drainage adequately
Streptococcal disease (group A streptococcus) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Streptococcal disease (group A streptococcus) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A streptococcus) Pharyngitis in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Pneumonia	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Scarlet fever in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Serious invasive disease	Droplet	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098] Contact Precautions for draining wound as above; follow rec. for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group B streptococcus), neonatal	Standard		
Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
multidrug-resistant organisms)			
Strongyloidiasis	Standard		
Syphilis Latent (tertiary) and seropositivity without lesions	Standard		
Syphilis Skin and mucous membrane, including congenital, primary, secondary	Standard		
Tapeworm disease *Hymenolepis nana*	Standard		Not transmitted from person to person
Tapeworm disease *Taenia solium* (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A streptococcus is a likely etiology
Trachoma, acute	Standard		
Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (*M. tuberculosis*) Extrapulmonary, draining lesion	Airborne + Contact + Standard		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are three consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (*M. tuberculosis*) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out [42]
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, confirmed	Airborne		Discontinue precautions only when patient on effective therapy is improving clinically and has three consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005 (https://www.cdc.gov/mmwr/preview/mmwrhtml/r

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			r5417a 1.htm?s_cid=rr5417a1_e)) [12].
Tuberculosis (*M. tuberculosis*) Pulmonary or laryngeal disease, suspected	Airborne		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome or 2. the results of three sputum smears for AFB are negative. Each of the three sputum specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen
Tuberculosis (*M. tuberculosis*) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person
Tularemia Pulmonary	Standard		Not transmitted from person to person
Typhoid (*Salmonella typhi*) fever (see gastroenteritis)			
Typhus *Rickettsia prowazekii* (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact
Typhus *Rickettsia typhi*	Standard		Not transmitted from person to person
Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact		For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) PostVaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., *S. aureus*, group A beta hemolytic streptococcus)	Standard + Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection, i.e., surgical mask or respirator for susceptible HCWs. In immunocompromised host with varicella Pneumonia, prolong duration of precautions for duration of illness. Post-exposure prophylaxis: provide post-exposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5days before delivery or within 48 hours after delivery) provide VZIG, when available, within 96 hours; if unavailable, use IVIG, Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received VZIG, regardless of postexposure vaccination. [1036].
Variola (see smallpox)			
Vibrio parahaemolyticus (see gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Standard + Droplet + Contact	Duration of illness (with wound lesions, until wounds stop draining)	⚠ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			Single-patient room preferred. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid- resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3 for Ebola as a bioterrorism agent.
Viral respiratory diseases (not covered elsewhere) Adults	Standard		
Viral respiratory diseases (not covered elsewhere) Infants and young children (see respiratory infectious disease, acute)			
Whooping cough (see pertussis)			
Wound infections Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately
Wound infections Minor or limited	Standard		Dressing covers and contains drainage adequately
Yersinia enterocolitica Gastroenteritis (see gastroenteritis)			
Zoster (varicella-zoster) (see herpes zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person

Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Diarrhea	Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Contact Precautions (pediatrics and adult)
Meningitis	Meningitis	*Neisseria meningitidis*	Droplet Precautions for first 24 hours of antimicrobial therapy; mask and face protection for intubation
Meningitis	Meningitis	Enteroviruses	Contact Precautions for infants and children
Meningitis	Meningitis	*M. tuberculosis*	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general)	*Neisseria meningitides*	Droplet Precautions for first 24 hours of antimicrobial therapy
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general) - If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed. ⚠ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).
Rash or Exanthems, Generalized, Etiology Unknown	Vesicular	Varicella-zoster, *herpes simplex*, variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions; Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Rash or Exanthems, Generalized, Etiology Unknown	Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne Precautions
Respiratory Infections	Cough/fever/upper lobe pulmonary infiltrate in an HIV- negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	*M. tuberculosis*, Respiratory viruses, *S. pneumoniae*, *S. aureus* (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung	*M. tuberculosis*, Respiratory	Airborne Precautions plus Contact Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
	location in an HIV-infected patient or a patient at high risk for HIV infection	viruses, *S. pneumoniae, S. aureus* (MSSA or MRSA)	Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	*M. tuberculosis,* severe acute respiratory syndrome virus (SARS- CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory Infections	Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, *Human metapneumovirus*	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection	Abscess or draining wound that cannot be covered	*Staphylococcus aureus* (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

⚠ Format Change [February 2017]: The format of this section was changed to improve readability and accessibility. The content is unchanged.

* Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.
† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g.neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.
‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.
§ These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella spp,* hepatitis A virus, noroviruses, rotavirus, *C. difficile.*

Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats

Table 3A. Anthrax

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode Cutaneous and inhalation disease have occurred in past bioterrorist incidents	Cutaneous (contact with spores); Respiratory Tract: (inhalation of spores); Gastrointestinal Tract (ingestion of spores - rare) Comment: Spores can be inhaled into the lower respiratory tract. The infectious dose of *B. anthracis* in humans by any route is not precisely known. In primates, the LD50 (i.e., the dose required to kill 50% of animals) for an aerosol challenge with *B. anthracis* is estimated to be 8,000–50,000 spores; the infectious dose may be as low as 1-3 spores
Incubation Period	Cutaneous: 1 to12 days; Respiratory Tract: Usually 1 to 7 days but up to 43 days reported; Gastrointestinal Tract: 15-72 hours
Clinical Features	Cutaneous: Painless, reddish papule, which develops a central vesicle or bulla in 1-2 days; over next 3-7 days lesion becomes pustular, and then necrotic, with black eschar; extensive surrounding edema. Respiratory Tract: initial flu-like illness for 1-3 days with headache, fever, malaise, cough; by day 4 severe dyspnea and shock, and is usually fatal (85%- 90% if untreated; meningitis in 50% of Respiratory Tract cases. Gastrointestinal Tract: if intestinal form, necrotic, ulcerated edematous lesions develop in intestines with fever, nausea and vomiting, progression to hematemesis and bloody diarrhea; 25-60% fatal
Diagnosis	Cutaneous: Swabs of lesion (under eschar) for immunohistochemistry, polymerase chain reaction and culture; punch biopsy for immunohistochemistry, polymerase chain reaction and culture; vesicular fluid aspirate for Gram stain and culture; blood culture if systemic symptoms; acute and convalescent sera for ELISA serology Respiratory Tract: Chest X-ray or CT scan demonstrating wide mediastinal widening and/or pleural effusion, hilar abnormalities; blood for culture and polymerase chain reaction; pleural effusion for culture, polymerase chain reaction and immunohistochemistry; cerebrospinal fluid if meningeal signs present for immunohistochemistry, polymerase chain reaction and culture; acute and convalescent sera for ELISA serology; pleural and/or bronchial biopsies immunohistochemistry. Gastrointestinal Tract: blood and ascites fluid, stool samples, rectal swabs, and swabs of oropharyngeal lesions if present for culture, polymerase chain reaction and immunohistochemistry.
Infectivity	Cutaneous: Person-to-person transmission from contact with lesion of untreated patient possible, but extremely rare. Respiratory Tract and Gastrointestinal Tract: Person-to-person transmission does not occur. Aerosolized powder, environmental exposures: Highly infectious if aerosolized
Recommended Precautions	Cutaneous: Standard Precautions; Contact Precautions if uncontained copious drainage. Respiratory Tract and Gastrointestinal Tract: Standard Precautions. Aerosolized powder, environmental exposures: Respirator (N95 mask or Powered Air Purifying Respirators), protective clothing; decontamination of persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm)). Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against spores [Weber DJ JAMA 2003; 289:1274]). Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-

Characteristics	Infection Control Considerations
	exposure vaccine under IND

Table 3B. Botulism

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Gastrointestinal Tract: Ingestion of toxin-containing food, Respiratory Tract: Inhalation of toxin containing aerosol cause disease. Comment: Toxin ingested or potentially delivered by aerosol in bioterrorist incidents. LD50 (lethal dose for 50% of experimental animals) for type A is 0.001 µg/ml/kg.
Incubation Period	1-5 days.
Clinical Features	Ptosis, generalized weakness, dizziness, dry mouth and throat, blurred vision, diplopia, dysarthria, dysphonia, and dysphagia followed by symmetrical descending paralysis and respiratory failure.
Diagnosis	Clinical diagnosis; identification of toxin in stool, serology unless toxin-containing material available for toxin neutralization bioassays.
Infectivity	Not transmitted from person to person. Exposure to toxin necessary for disease.
Recommended Precautions	Standard Precautions.

Table 3C. Ebola Hemorrhagic Fever

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	As a rule infection develops after exposure of mucous membranes or respiratory tract, or through broken skin or percutaneous injury.
Incubation Period	2-19 days, usually 5-10 days
Clinical Features	Febrile illnesses with malaise, myalgias, headache, vomiting and diarrhea that are rapidly complicated by hypotension, shock, and hemorrhagic features. Massive hemorrhage in < 50% pts.
Diagnosis	Etiologic diagnosis can be made using respiratory tract-polymerase chain reaction, serologic detection of antibody and antigen, pathologic assessment with immunohistochemistry and viral culture with EM confirmation of morphology,
Infectivity	Person-to-person transmission primarily occurs through unprotected contact with blood and body fluids; percutaneous injuries (e.g., needlestick) associated with a high rate of transmission; transmission in healthcare settings has been reported but is prevented by use of barrier precautions.
Recommended Precautions	Hemorrhagic fever specific barrier precautions: If disease is believed to be related to intentional release of a bioweapon, epidemiology of transmission is unpredictable pending observation of disease transmission. Until the nature of the pathogen is understood and its transmission pattern confirmed, Standard, Contact and Airborne Precautions should be used. Once the pathogen is characterized, if the epidemiology of transmission is consistent with natural disease, Droplet Precautions can be substituted for Airborne Precautions. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid- resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. In settings where AIIRs are unavailable or the large numbers of patients cannot be accommodated by existing AIIRs, observe Droplet Precautions (plus Standard Precautions and Contact Precautions) and segregate patients from those not suspected of VHF infection. Limit blooddraws to those essential to care. See text for discussion and Appendix A for recommendations for naturally occurring VHFs.

Plague

Pneumonic plague is not as contagious as is often thought. Historical accounts and contemporary

evidence indicate that persons with plague usually transmit the infection only when the disease is in the end stage. These persons cough copious amounts of bloody sputum that contains many plague bacteria. Patients in the early stage of primary pneumonic plague (approximately the first 20–24 h) apparently pose little risk [1, 2]. Antibiotic medication rapidly clears the sputum of plague bacilli, so that a patient generally is not infective within hours after initiation of effective antibiotic treatment [3]. This means that in modern times many patients will never reach a stage where they pose a significant risk to others. Even in the end stage of disease, transmission only occurs after close contact. Simple protective measures, such as wearing masks, good hygiene, and avoiding close contact, have been effective to interrupt transmission during many pneumonic plague outbreaks [2]. In the United States, the last known cases of person to person transmission of pneumonic plague occurred in 1925 [2].

Table 3D. Plague

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of respiratory droplets. Comment: Pneumonic plague most likely to occur if used as a biological weapon, but some cases of bubonic and primary septicemia may also occur. Infective dose 100 to 500 bacteria
Incubation Period	1 to 6, usually 2 to 3 days.
Clinical Features	Pneumonic: fever, chills, headache, cough, dyspnea, rapid progression of weakness, and in a later stage hemoptysis, circulatory collapse, and bleeding diathesis
Diagnosis	Presumptive diagnosis from Gram stain or Wayson stain of sputum, blood, or lymph node aspirate; definitive diagnosis from cultures of same material, or paired acute/convalescent serology.
Infectivity	Person-to-person transmission occurs via respiratory droplets risk of transmission is low during first 20-24 hours of illness and requires close contact. Respiratory secretions probably are not infectious within a few hours after initiation of appropriate therapy.
Recommended Precautions	Standard Precautions, Droplet Precautions until patients have received 48 hours of appropriate therapy. Chemoprophylaxis: Consider antibiotic prophylaxis for HCWs with close contact exposure.

1. Wu L-T. A treatise on pneumonic plague. Geneva: League of Nations, 1926. III. Health.
2. Kool JL. Risk of person to person transmission of pneumonic plague. Clinical Infectious Diseases, 2005; 40 (8): 1166-1172
3. Butler TC. Plague and other Yersinia infections. In: Greenough WB, ed. Current topics in infectious disease. New York: Plenum Medical Book Company, 1983.

Table 3E. Smallpox

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract Inhalation of droplet or, rarely, aerosols; and skin lesions (contact with virus). Comment: If used as a biological weapon, natural disease, which has not occurred since 1977, will likely result.
Incubation Period	7 to 19 days (mean 12 days)
Clinical Features	Fever, malaise, backache, headache, and often vomiting for 2-3 days; then generalized papular or maculopapular rash (more on face and extremities), which becomes vesicular (on day 4 or 5) and then pustular; lesions all in same stage.
Diagnosis	Electron microscopy of vesicular fluid or culture of vesicular fluid by WHO approved laboratory (CDC); detection by polymerase chain reaction available only in select LRN labs, CDC and USAMRID
Infectivity	Secondary attack rates up to 50% in unvaccinated persons; infected persons may transmit disease from time rash appears until all lesions have crusted over (about 3 weeks); greatest infectivity during first 10 days of rash.
Recommended Precautions	Combined use of Standard, Contact, and Airborne Precautions until all scabs have separated (3-4 weeks). Transmission by the airborne route is a rare event; Airborne Precautions is recommended when possible, but in the event of mass exposures, barrier precautions and containment within a designated area are most important.

Characteristics	Infection Control Considerations
	204, 212 Only immune HCWs to care for pts; post-exposure vaccine within 4 days. Vaccinia: HCWs cover vaccination site with gauze and semi-permeable dressing until scab separates (≥21 days). Observe hand hygiene. Adverse events with virus-containing lesions: Standard plus Contact Precautions until all lesions crusted. Vaccinia adverse events with lesions containing infectious virus include inadvertent autoinoculation, ocular lesions (blepharitis, conjunctivitis), generalized vaccinia, progressive vaccinia, eczema vaccinatum; bacterial superinfection also requires addition of contact precautions if exudates cannot be contained. [216, 217]

Table 3F. Tularemia

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of aerosolized bacteria. Gastrointestinal Tract: Ingestion of food or drink contaminated with aerosolized bacteria. Comment: Pneumonic or typhoidal disease likely to occur after bioterrorist event using aerosol delivery. Infective dose 10-50 bacteria
Incubation Period	2 to 10 days, usually 3 to 5 days
Clinical Features	Pneumonic: malaise, cough, sputum production, dyspnea; Typhoidal: fever, prostration, weight loss and frequently an associated pneumonia.
Diagnosis	Diagnosis usually made with serology on acute and convalescent serum specimens; bacterium can be detected by polymerase chain reaction (LRN) or isolated from blood and other body fluids on cysteine-enriched media or mouse inoculation.
Infectivity	Person-to-person spread is rare. Laboratory workers who encounter/handle cultures of this organism are at high risk for disease if exposed.
Recommended Precautions	Standard Precautions

Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings

Component	Recommendations
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE) Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Personal protective equipment (PPE) Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Personal protective equipment (PPE) Mask, eye protection (goggles), face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

(See Sections II.D.-II.J. and III.A.1)

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

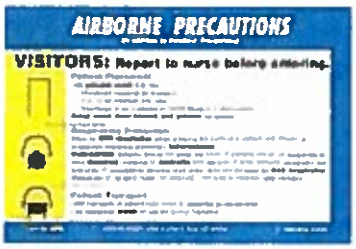
DELETE: Incorporated into Infection Control: Standard and Transmission-Based Precautions Policy

SUBJECT: Disease Index: Type and Duration of Precautions for Selected Infections and Conditions
STANDARD NUMBER: IC. 5.1

ISSUE DATE: 03/01
REVISION DATE(S): 01/11

Department Approval:	**06/17**
Infection Control Committee Approval:	**~~01/11~~07/17**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

~~**Airborne Precautions:** for illnesses passed in the air. **Place in a negative pressure room (143, 243, 443, 287, 387, 487, or 200) Keep the door closed at all times.** HCW wear N95 respirators in the patient's room. Surgical masks for visitors going into the isolation room and for patients outside the isolation rooms.~~



~~**Droplet Precautions:** for illnesses passed in large droplets (wet drop to wet mucus membrane contact). **Private room if available. Cohort with others with same organisms.** HCW wear a mask when closer than 3 ft. to the patient. Surgical masks for visitors going closer than 3 ft. to the patient and for patients outside the isolation rooms.~~

~~**Contact Precautions:** for illnesses easily passed by direct contact with the patient or equipment. **Private room if available. Cohort with others with same organisms. Do not place with fresh post-op or patients with invasive tubes.** HCW wear gloves in the room and add a gown if clothes might touch objects or the patient. Use a mask is to protect your face from sprays or splashes.~~

TYPE AND DURATION OF PRECAUTIONS RECOMMENDED FOR SELECTED INFECTIONS AND CONDITIONS

Infection/Condition	Type	Duration	Precautions/Comments
Abscess			-
- Draining, major	C	DI	No dressing or containment of drainage; until drainage stops or can be contained by dressing
- Draining, minor or limited	S		Dressing covers and contains drainage
Acquired human immunodeficiency syndrome (HIV)	S		Post-exposure chemoprophylaxis for some blood exposures
Actinomycosis	S		Not transmitted from person to person
Adenovirus infection (see agent specific guidance under gastroenteritis, conjuctivitis, pneumonia)			-
Amebiasis	S		Person to person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported. Use care when handling diapered infants and mentally challenged persons.
Anthrax	S		Infected patients do not generally pose a transmission risk.
- Cutaneous	S		Transmission through non intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol based antiseptics since alcohol does not have sporicidal activity.
- Pulmonary	S		Not transmitted from person to person
- Environmental: unknown aerosolizable spore containing powder or other substance		DE	Until decontamination of environment complete. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm) Hand hygiene: Handwashing for 30 60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against

				spores 983. **Post-exposure prophylaxis following environmental exposure:** 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND
Antibiotic-associated colitis (see Clostridium difficile)				-
Arthropod-borne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and viral fevers (dengue, yellow fever, Colorado tick fever)	S			Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally. Install screens in windows and doors in endemic areas Use DEET-containing mosquito repellants and clothing to cover extremities
Ascariasis	S			Not transmitted from person to person
Aspergillosis	S			Contact Precautions and Airborne Precautions if massive soft tissue infection with copious drainage and repeated irrigations required.
Avian influenza (see influenza, avian below)				-
Babesiosis	S			Not transmitted from person to person except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	S			Not transmitted from person to person
Botulism	S			Not transmitted from person to person
Bronchiolitis (see respiratory infections in infants and young children)	C	DI		Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	S			Not transmitted from person to person except rarely via banked spermatozoa and sexual contact. Provide antimicrobial prophylaxis following laboratory exposure.
Campylobacter gastroenteritis (see gastroenteritis)				-
Candidiasis, all forms including mucocutaneous	S			-
Cat-scratch fever (benign inoculation lymphoreticulosis)	S			Not transmitted from person to person
Cellulitis	S			-
Chancroid (soft chancre) (H. ducreyi)	S			Transmitted sexually from person to person

Chickenpox (see varicella)			-
Chlamydia trachomatis			-
- Conjunctivitis	S		-
- Genital (lymphogranuloma venereum)	S		-
- Pneumonia (infants < 3 mos. of age))	S		-
Chlamydia pneumoniae	S		Outbreaks in institutionalized populations reported, rarely
Cholera (see gastroenteritis)			-
Closed-cavity infection			-
- Open drain in place; limited or minor drainage	S		Contact Precautions if there is copious uncontained drainage
- No drain or closed drainage system in place	S		-
Clostridium			-
- C. botulinum	S		Not transmitted from person to person
- C. difficile (see Gastroenteritis, C. difficile)	C	DI	-
- C. perfringens			-
- Food poisoning	S		Not transmitted from person to person
- Gas gangrene	S		Transmission from person to person rare; one outbreak in a surgical setting reported. Use Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever)			-
- Draining lesions	S		Not transmitted from person to person except under extraordinary circumstances because the infectious arthroconidial form of *Coccidioides immitis* is not produced in humans.
- Pneumonia	S		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of Coccidioides

				immitis is not produced in humans,.
Colorado tick fever		S		Not transmitted from person to person
Congenital rubella		C	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly neg. after 3 mos. of age
Conjunctivitis				-
-	Acute bacterial	S		-
-	Chlamydia	S		-
-	Gonococcal	S		-
-	Acute viral (acute hemorrhagic)	C	DI	Adenovirus most common; enterovirus, Coxsackie virus A also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings.
Corona virus associated with SARS (SARS-CoV) (see severe acute respiratory syndrome)				-
Coxsackie virus disease (see enteroviral infection)				-
Creutzfeldt-Jakob disease CJD, vCJD		S		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures
Croup (see respiratory infections in infants and young children)				-
Crimean-Congo Fever (see Viral Hemorrhagic Fever)		S		-
Cryptococcosis		S		Not transmitted from person to person, except rarely via tissue and corneal transplant
Cryptosporidiosis (see gastroenteritis)			-	-

Cysticercosis	S	-	Not transmitted from person to person
Cytomegalovirus infection, including in neonates and immunosuppressed patients	S	-	No additional precautions for pregnant HCWs
Decubitus ulcer (see Pressure ulcer)			-
Dengue fever			-
Diarrhea, acute infective etiology suspected (see gastroenteritis)			-
Diphtheria			-
- Cutaneous	C	CN	Until 2 cultures taken 24 hrs. apart negative
- Pharyngeal	D	CN	Until 2 cultures taken 24 hrs. apart negative
Ebola virus (see viral hemorrhagic fevers)			-
Echinococcosis (hydatidosis)	S		-
Echovirus (see enteroviral infection)			-
Encephalitis or encephalomyelitis (see specific etiologic agents)			-
Endometritis (endomyometritis)	S		-
Enterobiasis (pinworm disease, oxyuriasis)	S		-
Enterococcus species (see multidrug-resistant organisms if			-
epidemiologically significant or vancomycin-resistant)			-
Enterocolitis, C. difficile (see C. difficile, gastroenteritis)			-
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	S		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks
Epiglottitis, due to Haemophilus influenzae type b	D	U 24 hrs	See specific disease agents for epiglottitis due to other etiologies)
Epstein-Barr virus infection, including infectious mononucleosis	S		-
Erythema infectiosum (also see Parvovirus B19)			-

Escherichia coli gastroenteritis (see gastroenteritis)			-
Food poisoning			-
- Botulism	S		Not transmitted from person to person
- C. perfringens or welchii	S		Not transmitted from person to person
- Staphylococcal	S		Not transmitted from person to person
Furunculosis, staphylococcal	S		Contact if drainage not controlled. Follow institutional policies if MRSA
- Infants and young children	C	DI	-
Gangrene (gas gangrene)	S		Not transmitted from person to person
Gastroenteritis	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below
- Adenovirus	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
- Campylobacter species	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
- Cholera (Vibrio cholerae)	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
- C. difficile	C	DI	Discontinue antibiotics if appropriate. Do not share electronic thermometers,; ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs.
Cryptosporidium species	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
E. coli			-

-	~~Enteropathogenic O157:H7 and other shiga toxin-producing Strains~~	~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~
-	~~Other species~~	~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~
~~Giardia lamblia~~		~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~
~~Noroviruses~~		~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances,; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled. Hypochlorite solutions may be required when there is continued transmission. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks.~~
~~Rotavirus~~		~~C~~	~~DI~~ ~~Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly,.~~
-	~~Salmonella species (including S. typhi)~~	~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~
-	~~Shigella species (Bacillary dysentery)~~	~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~
-	~~Vibrio parahaemolyticus~~	~~S~~	~~Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks~~

-	Viral (if not covered elsewhere)	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
-	Yersinia enterocolitica	S		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
German measles (see rubella; see congenital rubella)				-
Giardiasis (see gastroenteritis)				-
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)		S		-
Gonorrhea		S		-
Granuloma inguinale (Donovanosis, granuloma venereum)		S		-
Guillain-Barré' syndrome		S		Not an infectious condition
Haemophilus influenzae (see disease-specific recommendations)				-
Hand, foot, and mouth disease (see enteroviral infection)				-
Hansen's Disease (see Leprosy)				-
Hantavirus pulmonary syndrome		S		Not transmitted from person to person
Helicobacter pylori		S		-
Hepatitis, viral				-
-	Type A	S		Provide hepatitis A vaccine post-exposure as recommended
-	Diapered or incontinent patients	C		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms.
-	Type B-HBsAg positive; acute or chronic	S		See specific recommendations for care of patients in hemodialysis centers
-	Type C and other unspecified non-A, non-B	S		See specific recommendations for care of patients in hemodialysis centers

-	Type D (seen only with hepatitis B)	S		-
-	Type E	S		Use Contact Precautions for diapered or incontinent individuals for the duration of illness
-	Type G	S		-
Herpangina (see enteroviral infection)				-
Hookworm		S		-
Herpes simplex (Herpesvirus hominis)				-
-	Encephalitis	S		-
-	Mucocutaneous, disseminated or primary, severe	C	Until lesions dry and crusted	-
-	Mucocutaneous, recurrent (skin, oral, genital)	S	-	-
-	Neonatal	C	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hrs until infant surface cultures obtained at 24-36 hrs. of age negative after 48 hrs incubation,
Herpes zoster (varicella zoster) (shingles)				-
-	Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	A, C	DI	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator, for susceptible HCWs.
-	Localized in patient with intact immune system with lesions that can be contained/covered	S	DI	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis		S	-	Not transmitted from person to person
Human immunodeficiency virus (HIV)		S	-	Post-exposure chemoprophylaxis for some blood exposures.
Human metapneumovirus		C	DI	HAI reported, but route of transmission not established. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions..

Impetigo	C	U 24 hrs	-
Infectious mononucleosis	S	-	-
Influenza	-	-	-
- Human (seasonal influenza)	D	5 days except DI in immuno compromised persons	Single patient room when available or cohort; avoid placement with high-risk patients; mask patient when transported out of room; chemoprophylaxis/vaccine to control/prevent outbreaks. Use gown and gloves according to Standard Precautions may be especially important in pediatric settings. Duration of precautions for immunocompromised patients cannot be defined; prolonged duration of viral shedding (i.e. for several weeks) has been observed; implications for transmission are unknown.
- Avian (e.g., H5N1, H7, H9 strains))	-	-	See www.cdc.gov/flu/avian/professional/infect-control.htm for current avian influenza guidance.
- Pandemic influenza (also a human influenza virus)	D	5 days from onset of symptoms	See http://www.pandemicflu.gov? for current pandemic influenza guidance.
Kawasaki syndrome	S	-	Not an infectious condition
Lassa fever (see viral hemorrhagic fevers)	-	-	-
Legionnaires' disease	S	-	Not transmitted from person to person
Leprosy	S	-	-
Leptospirosis	S	-	Not transmitted from person to person
Lice	-	-	See http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm
- Head (pediculosis)	C	U 24 hrs	-
- Body	S	-	Transmitted person to person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance above
- Pubic	S	-	Transmitted person to person through sexual contact
Listeriosis (listeria monocytogenes)	S	-	Person-to-person transmission rare; cross-transmission in neonatal settings reported

Lyme disease	S	-	Not transmitted from person to person
Lymphocytic choriomeningitis	S	-	Not transmitted from person to person
Lymphogranuloma venereum	S	-	-
Malaria	S	-	Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during patient care . Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities
Marburg virus disease (see viral hemorrhagic fevers)		-	-
Measles (rubeola)	A	4 days after onset of rash; DI in immune compromised	Susceptible HCWs should not enter room if immune care providers are available; no recommendation for face protection for immune HCW; no recommendation for type of face protection for susceptible HCWs, i.e., mask or respirator,. For exposed susceptibles, post-exposure vaccine within 72 hrs. or immune globulin within 6 days when available. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post-exposure vaccine.
Melioidosis, all forms	S	-	Not transmitted from person to person
Meningitis	-	-	-
- Aseptic (nonbacterial or viral; also see enteroviral infections)	S		Contact for infants and young children
- Bacterial, gram-negative enteric, in neonates	S		-
- Fungal	S		-
- Haemophilus influenzae, type b known or suspected	D	U 24 hrs	-
- Listeria monocytogenes (See Listeriosis)	S		-
- Neisseria meningitidis (meningococcal) known or suspected	D	U 24 hrs	See meningococcal disease below
- Streptococcus pneumoniae	S		-

-	M. tuberculosis	S		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne Precautions; For children, airborne precautions until active tuberculosis ruled out in visiting family members (see tuberculosis below)
-	Other diagnosed bacterial	S		-
Meningococcal disease: sepsis, pneumonia, meningitis		D	U 24 hrs	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks.
Molluscum contagiosum		S		-
Monkeypox		A, C	A Until monkeypox confirmed and smallpox excluded C Until lesions crusted	Use See www.cdc.gov/ncidod/monkeypox for most current recommendations. Transmission in hospital settings unlikely. Pre- and post-exposure smallpox vaccine recommended for exposed HCWs
Mucormycosis		S		-
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant S. pneumoniae)		S/C		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)		D	U 9 days	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. Note: (Recent assessment of outbreaks in healthy 18-24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk patient populations remain to be clarified.)
Mycobacteria, nontuberculosis (atypical)				Not transmitted person-to-person

- Pulmonary	S		-
- Wound	S		-
Mycoplasma pneumonia	D	DI	-
Necrotizing enterocolitis	S		Contact Precautions when cases clustered temporally.
Nocardiosis, draining lesions, or other presentations	S	-	Not transmitted person-to-person
Norovirus (see gastroenteritis)	-	-	-
Norwalk-agent gastroenteritis (see gastroenteritis)	-	-	-
Orf	S	-	-
Parainfluenza virus infection, respiratory in infants and young children		DI	Viral shedding may be prolonged in immunosuppressed patients. Reliability of antigentesting to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	D	-	Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred.
Pediculosis (lice)	C	U 24 hrs after treatment	-
Pertussis (whooping cough)	D	U 5 days	Single patient room preferred. Cohorting an option. Post-exposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions. Recommendations for Tdap vaccine in adults under development.
Pinworm infection (Enterobiasis)	S	-	-
Plague (Yersinia pestis)		-	-
- Bubonic	S		-
- Pneumonic	D	U 48 hrs	Antimicrobial prophylaxis for exposed HCW.
Pneumonia		-	-
- Adenovirus	D, C	DI	Outbreaks in pediatric and institutional settings

				reported. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus
-	Bacterial not listed elsewhere (including gram-negative bacterial)	S		-
-	B. cepacia in patients with CF, including respiratory tract colonization	C	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline
-	B. cepacia in patients without CF(see Multidrug-resistant organisms)			-
-	Chlamydia	S		-
-	Fungal	S		-
-	Haemophilus influenzae, type b			-
-	Adults	S		-
-	Infants and children	D	U 24 hrs	-
-	Legionella spp.	S		-
-	Meningococcal	D	U 24 hrs	See meningococcal disease above
-	Multidrug-resistant bacterial (see multidrug-resistant organisms)			-
-	Mycoplasma (primary atypical pneumonia)	D	DI	-
-	Pneumococcal pneumonia	S		Use Droplet Precautions if evidence of transmission within a patient care unit or facility
-	Pneumocystis jiroveci (Pneumocystis carinii)	S		Avoid placement in the same room with an immunocompromised patient.
-	Staphylococcus aureus	S	-	For MRSA, see MDROs
-	Streptococcus, group A	-	-	-
-	Adults	D	U 24 hrs	See streptococcal disease (group A streptococcus) below Contact precautions if skin lesions present
-	Infants and young children	D	U 24 hrs	Contact Precautions if skin lesions present

- Varicella-zoster (See Varicella-Zoster)			-
- Viral			-
- Adults	S		-
- Infants and young children (see respiratory infectious disease, acute, or specific viral agent)			-
Poliomyelitis	C	DI	-
Pressure ulcer (decubitus ulcer, pressure sore) infected	-	-	-
- Major	C	DI	If no dressing or containment of drainage; until drainage stops or can be contained by dressing
- Minor or limited	S		If dressing covers and contains drainage
Prion disease (See Creutzfeld-Jacob Disease)			-
Psittacosis (ornithosis) (Chlamydia psittaci)	S	-	Not transmitted from person to person
Q fever	S	-	-
Rabies	S	-	Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis.
Rat-bite fever (Streptobacillus moniliformis disease, Spirillum minus disease)	S	-	Not transmitted from person to person
Relapsing fever	S	-	Not transmitted from person to person
Resistant bacterial infection or colonization (see multidrug-resistant organisms)	-	-	-
Respiratory infectious disease, acute (if not covered elsewhere)	-	-	-
- Adults	S		-
- Infants and young children	C	DI	Also see syndromes or conditions listed in Table 2
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	C	DI	Wear mask according to Standard Precautions. In immunocompromised patients, extend the duration of

			Contact Precautions due to prolonged shedding). Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	S	-	Not an infectious condition
Rheumatic fever	S	-	Not an infectious condition
Rhinovirus	D	DI	Droplet most important route of transmission. Outbreaks have occurred in NICUs and LTCFs. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants).
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne typhus fever)	S	-	Not transmitted from person to person except through transfusion, rarely
Rickettsialpox (vesicular rickettsiosis)	S	-	Not transmitted from person to person
Ringworm (dermatophytosis, dermatomycosis, tinea)	S	-	Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU, rehabilitation hospital. Use Contact Precautions for outbreak.
Ritter's disease (staphylococcal scalded skin syndrome)	C	DI	See staphylococcal disease, scalded skin syndrome below
Rocky Mountain spotted fever	S	-	-
Roseola infantum (exanthem subitum; caused by HHV 6)	S	-	-
Rotavirus infection (see gastroenteritis)	-	-	-
Rubella (German measles) (also see congenital rubella)	D	U 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients. Administer vaccine within three days of exposure to non pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post exposure vaccine.
Rubeola (see measles)	-	-	-

Salmonellosis (see gastroenteritis)	-	-	-
Scabies	C	U 24	-
Scalded skin syndrome, staphylococcal	C	DI	See staphylococcal disease, scalded skin syndrome below)
Schistosomiasis (bilharziasis)	S	-	-
Severe acute respiratory syndrome (SARS)	A, D,C	DI plus 10 days after resolution or fever, provided respiratory symptoms are absent or improving	Airborne Precautions preferred; D if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets.Vigilant environmental disinfection (see www.cdc.gov/ncidod/sars)
Shigellosis (see gastroenteritis)	-	-	-
Smallpox (variola; see vaccinia for management of vaccinated persons)	A, C	DI	Until all scabs have crusted and separated (3-4 weeks). Non vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective.
Sporotrichosis	S		-
Spirillum minor disease (rat-bite fever)	S		Not transmitted from person to person
Staphylococcal disease (S aureus)			-
- Skin, wound, or burn			-
- Major	C	DI	No dressing or dressing does not contain drainage adequately
- Minor or limited	S		Dressing covers and contains drainage adequately
- Enterocolitis	S		Use Contact Precautions for diapered or incontinent children for duration of illness
- Multidrug resistant (see multidrug resistant organisms)			-
- Pneumonia	S		-
- Scalded skin syndrome	C	DI	Consider healthcare personnel as potential source of

				nursery, NICU outbreak.
-	Toxic shock syndrome	S		-
Streptobacillus moniliformis disease (rat-bite fever)		S		Not transmitted from person to person
Streptococcal disease (group A streptococcus)		-	-	-
-	Skin, wound, or burn			-
-	Major	C, D	U 24 hrs	No dressing or dressing does not contain drainage adequately
-	Minor or limited	S		Dressing covers and contains drainage adequately
-	Endometritis (puerperal sepsis)	S		-
-	Pharyngitis in infants and young children	D	U 24 hrs	-
-	Pneumonia	D	U 24 hrs	-
-	Scarlet fever in infants and young children	D	U 24 hrs	-
-	Serious invasive disease	D	U 24 hrs	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel Contact Precautions for draining wound as above; follow rec. for antimicrobial prophylaxis in selected conditions.
Streptococcal disease (group B streptococcus), neonatal		S	-	-
Streptococcal disease (not group A or B) unless covered elsewhere				-
-	Multidrug-resistant (see multidrug-resistant organisms)	-	-	-
Strongyloidiasis		S		-
Syphilis				-
-	Latent (tertiary) and seropositivity without lesions	S	-	-
-	Skin and mucous membrane, including congenital, primary, Secondary	S	-	-
Tapeworm disease				-
-	Hymenolepis nana	S	-	Not transmitted from person to person

-	Taenia solium (pork)	S	-	-
-	Other	S	-	-
Tetanus		S		Not transmitted from person to person
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)		S		Rare episodes of person-to-person transmission
Toxoplasmosis		S		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare
Toxic shock syndrome (staphylococcal disease, streptococcal disease)		S		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A streptococcus is a likely etiology
Trachoma, acute		S		-
Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)				-
Trench mouth (Vincent's angina)		S		-
Trichinosis		S		-
Trichomoniasis		S		-
Trichuriasis (whipworm disease)		S		-
Tuberculosis (M. tuberculosis)				-
-	Extrapulmonary, draining lesion)	A, C		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are three consecutive negative cultures of continued drainage. Examine for evidence of active pulmonary tuberculosis.
-	Extrapulmonary, no draining lesion, meningitis	S		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne Precautions until active pulmonary tuberculosis in visiting family members ruled out
-	Pulmonary or laryngeal disease, confirmed	A		Discontinue precautions only when patient on effective therapy is improving clinically and has three consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-

				17 www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e)
-	Pulmonary or laryngeal disease, suspected	A		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1) there is another diagnosis that explains the clinical syndrome or 2) the results of three sputum smears for AFB are negative. Each of the three sputum specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen
-	Skin-test positive with no evidence of current active disease	S		-
Tularemia				-
-	Draining lesion	S		Not transmitted from person to person
-	Pulmonary	S		Not transmitted from person to person
Typhoid (Salmonella typhi) fever (see gastroenteritis)				-
Typhus				-
-	*Rickettsia prowazekii* (Epidemic or Louse-borne typhus)	S		Transmitted from person to person through close personal or clothing contact
-	*Rickettsia typhi*	S		Not transmitted from person to person
Urinary tract infection (including pyelonephritis), with or without urinary cathete		S		-
Vaccinia (vaccination site, adverse events following vaccination) *				Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
-	Vaccination site care (including autoinoculated areas)	S		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes.
-	Eczema vaccinatum	C	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
-	Fetal vaccinia	C		

-	Generalized vaccinia	C		
-	Progressive vaccinia	C		-
-	Postvaccinia encephalitis	S		-
-	Blepharitis or conjunctivitis	S/C		Use Contact Precautions if there is copious drainage
-	Iritis or keratitis	S		-
-	Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	S		Not an infectious condition
-	Secondary bacterial infection (e.g., S. aureus, group A beta hemolytic streptococcus	S/C		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage
Varicella Zoster		A, C	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator for susceptible HCWs. In immunocompromised host with varicella pneumonia, prolong duration of precautions for duration of illness. Post-exposure prophylaxis: provide post-exposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5days before delivery or within 48 hrs after delivery) provide VZIG, when available, within 96 hours; if unavailable, use IVIG. Use Airborne Precautions for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received VZIG, regardless of postexposure vaccination..
Variola (see smallpox)		-	-	-
Vibrio parahaemolyticus (see gastroenteritis)		-	-	-
Vincent's angina (trench mouth)		S	-	-
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses		S, D, C	DI	Single-patient room preferred. Emphasize: 1) use of sharps safety devices and safe work practices, 2) hand hygiene; 3) barrier protection against blood and body

			fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4) appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected Also see Table 3 for Ebola as a bioterrorism agent
Viral respiratory diseases (not covered elsewhere)	-	-	-
- Adults	S	-	
- Infants and young children (see respiratory infectious disease, acute)			-
Whooping cough (see pertussis)	-	-	-
Wound infections	-	-	-
- Major	C	DI	No dressing or dressing does not contain drainage adequately
- Minor or limited	S	-	Dressing covers and contains drainage adequately
Yersinia enterocolitica gastroenteritis (see gastroenteritis)	-	-	-
Zoster (varicella-zoster) (see herpes zoster)	-	-	-
Zygomycosis (phycomycosis, mucormycosis)	S	-	Not transmitted person-to-person

1 Type of Precautions: A, Airborne Precautions; C, Contact; D, Droplet; S, Standard; when A, C, and D are specified, also use S.
† Duration of precautions: CN, until off antimicrobial treatment and culture-negative; DI, duration of illness (with wound lesions, DI means until wounds stop draining); DE, until environment completely decontaminated; U, until time specified in hours (hrs) after initiation of effective therapy; Unknown: criteria for establishing eradication of pathogen has not been determined

Reference: http://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html

Table 2. Clinical Syndromes Or Conditions Warranting Empiric Transmission-Based Precautions In Addition To Standard Precautions Pending Confirmation Of Diagnosis*

Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always includes Standard Precautions)
Diarrhea		
Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Contact Precautions (pediatrics and adult)
Meningitis	*Neisseria meningitidis*	Droplet Precautions for first 24 hrs of antimicrobial therapy; mask and face protection for intubation
	Enteroviruses	Contact Precautions for infants and children
	M. tuberculosis	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash Or Exanthems, Generalized, Etiology Unknown		
Petechial/ecchymotic with fever (general)	*Neisseria meningitidos*	Droplet Precautions for first 24 hrs of antimicrobial therapy
If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed
Vesicular	Varicella-zoster, herpes simplex, variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions;
	Vaccinia virus	Contact Precautions only if herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne Precautions
Respiratory Infections		
Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	*M. tuberculosis*, Respiratory viruses, S. pneumoniae, S. aureus (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at	*M. tuberculosis*, Respiratory viruses, S.	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure

high risk for HIV infection	pneumoniae, S. aureus (MSSA or MRSA)	performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV-negative individual
Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	*M. tuberculosis*, severe acute respiratory syndrome virus (SARS-CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, Human metapneumovirus	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection		
Abscess or draining wound that cannot be covered	*Staphylococcus aureus* (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

* Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.
† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g.neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.
‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.
§ These pathogens include enterohemorrhagic Escherichia coli O157:H7, Shigella spp, hepatitis A virus, noroviruses, rotavirus, *C. difficile*.

Table 4. Recommendations For Application Of Standard Precautions For The Care Of All Patients In All Healthcare Settings

COMPONENT	RECOMMENDATIONS
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE)	-
Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Gown	During procedures and patient care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Mask, eye protection (goggles), face shield*	During procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand manipulate used needles; if recapping is required, use a one handed scoop technique only; use safety features when available; place used sharps in puncture resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

* * During aerosol generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols (e.g., SARS), wear a fit tested N95 or higher respirator in addition to gloves, gown,and face/eye protection.

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Cardiology
Standardized Procedures

Approvals

Cardiology Division (Signature):	_____
Medicine Department (Signature):	_____
Interdisciplinary Practice Committee (Date):	July 14, 2017
Medical Executive Committee (Date):	July 24, 2017
Professional Affairs Committee (Date):	August 10, 2017
Board of Directors (Date):	_____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Cardiology NP will:
   a. Assume responsibility for the *Cardiac* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Cardiology division Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Cardiology division Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve health care and patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for the Cardiology Division are as follows:

i. CARD ACS, CP, CAD
ii. CARD CHF Beta Blockers and Calcium Channel Blockers
iii. CARD Cath Lab PTCA Stent
iv. CARD Cath Lab Post Procedure
v. CARD Cath Lab Pre Procedure
vi. CARD Elective Cardioversion Post
vii. CARD Elective Cardioversion Pre
viii. CARD Heart Failure
ix. CARD Integrilin
x. CARD Post Cath Lab Teach (subphase)
xi. CARD Transesophageal Echocardiogram PRE
xii. CARD Pericardiocentesis

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of cardiology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
    1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
    1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
    2. Acute exacerbation of a patient's situation;
    3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
    4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
    5. Upon request of the patient, another clinician or Supervisor.
    6. Upon request of the NP.
    7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. ACLS in accordance with the specialty requirement.
    6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Cardiology and the NP Cardiovascular Health Institute Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 04/05	**SUBJECT:** Credentialing Standards for Vertebral Augmentation
REVISION DATE(S): 05/11	**POLICY NUMBER:** 8710-534

Department Approval:	06/17
Credentials Committee Approval:	~~04/11~~06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/11~~07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	05/11

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in vertebral augmentation procedures:
   a. Didactic education in the diagnosis and treatment of patients with spine fractures and or deformity of the spine resulting from osteoporosis or tumors;
   b. Training in the technical aspects of the performance of vertebral augmentation;
   c. Proctoring;
   d. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. The applicant must be either an MD or DO.
   b. The applicant must have completed an ACGME/AOA-accredited residency program and possess board certification or board eligibility in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology and one of the following:
      i. Fellowship Training in Spine Surgery or Interventional Radiology or;
      ii. Current Competence* in spine surgery or interventional spine procedures (*provide documentation of ten (10) cases in past two years, without significant complications)
   c. The applicant must be trained in fluoroscopy and have a valid Fluoroscopy Supervisor and Operator permit.
   d. The applicant must have completed training in vertebral augmentation. Evidence of this training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.
2. Proctoring Criteria:
   a. Five (5) cases performed during the first ~~twelve (12) months after granting of the privilege(s)~~**two year appointment** will be proctored by a member of the TCMC Medical Staff with unsupervised vertebral augmentation privileges.
3. Reappointment Criteria:
   a. Five (5) vertebral augmentation procedures annually performed during the reappointment cycle (10 cases total) with acceptable success and complication rates (Refer to **Possible Complications for Vertebral Augmentation**~~Appendix I~~).

C. **REFERENCE(S):**

1. Clinical Privilege White Paper: Procedure 201, Balloon Kyphoplasty;
2. Clinical Privilege White Paper: Procedure 30, Percutaneous Vertebroplasty
3. Palomar Hospital Privileging Criteria for Percutaneous Vertebroplasty and/or Balloon Assisted Vertebroplasty (Kyphoplasty)

D. **RELATED DOCUMENT(S):** ~~**APPENDIX:**~~

1. Possible Complications for Vertebral Augmentation

~~**Approvals:**~~
~~**Imaging Division Approval: 04/11**~~
~~**Credentials Committee: 04/11**~~
~~**Medical Executive Committee Approval: 05/11**~~
~~**Board of Directors Approval: 03/08, 10/09, 05/11**~~

~~Appendix 1~~

Possible Complications for Vertebral Augmentation:

1. Clinical Complications:
   a. Death (0%)
   b. Permanent (duration > 30 days) neurological deficit (other than radicular pain):
      1) Osteoporosis (0%)
      2) Neoplasm (5%)
   c. Transient (duration < 30 days) neurological deficit (other than radicular pain) or radicular pain syndrome (either permanent or transient):
      1) Osteoporosis (5%)
      2) Neoplasm (10%)
   d. Symptomatic pulmonary cement embolus (0%)
   e. Symptomatic epidural venous cement embolus (5%)
   f. Infection (0%)
   g. Fracture of rib or vertebrae (5%)
   h. Significant hemorrhage or vascular injury (0%)
   i. Allergic or idiosyncratic reaction (1%)

2. Technical/Procedural Complications:
   a. Failure to obtain proper informed consent (0%)
   b. Cement embolus to pulmonary vasculature without clinical sequela and estimated volume > 0.25 ml (5%)
   c. Cement embolus to epidural veins without clinical sequela and producing > 10% spinal canal compromise or estimated volume > 0.25 ml (10%)

Tri-City Health Care District
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 03/08	**SUBJECT:** Focused Professional Practice Evaluation / Proctoring
REVISION DATE(S): 06/08, 02/10, 04/10, 05/10	**POLICY NUMBER:** 8710 - 542

Department Approval:	06/17
Credentials Committee Approval:	~~05/10~~06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/10~~07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	05/10

A. **PURPOSE:**

1. To ensure members of the Medical Staff can carry out the privileges they request in a competent, safe manner.

B. **DEFINITION(S):**

1. Proctoring: The observation of a physician's practice over a sufficient period of time to judge his or her competence to perform the procedures(s) in question, and then, if required, assists in developing an educational program to bring the practice up to acceptable standards. This may include a specialist with recognized expertise to work with a physician on-site. The expert may work interactively on designated procedures to assist, critique, and educate in identified areas of deficiency.
2. Prospective: Whereby the proctor previews the care to be administered to a patient.
3. Concurrent: Whereby the proctor observes clinical care being administered in real time.
4. Retrospective: Whereby the proctor reviews the care given to the patient after it has been administered.
5. Competence: Refers to a person's ability to perform a particular activity to a prescribed standard or a desirable outcome. There are particular qualities on which competency is based, including knowledge (education/training), traits, skills, and abilities.
6. Knowledge: Involves understanding certain facts and procedures. This is evidenced by completion of educational and training requirements. On-the-job experience – including feedback from peers, in-service training, and continuing education – enhances knowledge.
7. Traits: Characteristics that predispose a person to behave or respond in a certain way (e.g., self-control, self-confidence, the ability to take criticism, and the ability to get along with others).
8. Skill: The capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply that knowledge. Skills can be gained by hands-on training using anatomic models or real patients or through role-play exercises. For instance, a surgeon learning to use a laser may use animal tissue in hands-on training rather than a human subject.
9. Abilities: The attributes that a person has acquired through previous experience. Because abilities are gained or developed over time, they are more easily retained than knowledge and skills. They also include the abilities with which a person is born.
10. Focused Professional Practice Evaluation: As defined in Medical Staff Policy #509, Professional Practice Evaluation.

C. **GENERAL PROVISIONS:**

1. Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of proctoring in accordance with the applicable departmental proctoring requirements. Such

proctoring will generally include a period of Level I proctoring in accordance with the Bylaws and Rules and Regulations, unless additional circumstances appear to warrant a higher level of proctoring. Each appointee or a recipient of new clinical privileges shall be assigned a department where performance of an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chairman of the department, or the chairman's designee, during the period of proctoring specified in the department's Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that departments chairman or his designee. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

a. a report signed by the chairman of the department/division to which the member is assigned describing the type and number of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department/division, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the privilege to which the appointment was made; or

b. a report signed by the chairman of the other department(s)/division(s) in which appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

c. For practitioners who do not have sufficient activity at the hospital to meet proctoring requirements, as determined and under the direction by either the department/division Chairman, 50% of required cases from another Joint Commission accredited facility may be used to fulfill proctoring requirements in accordance with departmental/division proctoring policies.

2. A Focused Professional Practice Evaluation shall be used in at least the following situations:

a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation / proctoring in accordance with the Bylaws and the Rules and Regulations of the department/division in which the applicant or member will be exercising those privileges.

b. In special instances, focused professional practice evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area.

c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused professional practice evaluation may be imposed.

d. As otherwise defined in the Bylaws or Medical Staff Policy #509.

e. Nothing in the foregoing precludes the use of other proctoring tools, as deemed warranted by the circumstances.

D. **PROCTORING:**

1. Overview of Proctoring Levels:

a. Level I: Proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges or infrequently used existing privileges in accordance with the Bylaws and the Rules and Regulations.

b. Level II: Proctoring is appropriate in situations where a practitioner's competency or performance is called into question, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to

providing services, but is permitted to proceed without the proctor if one is not available). (Focused Professional Evaluation)

c. Level III: Proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided in Bylaws, Article VII, Hearings and Appellate Reviews.

2. Overview of Proctoring Procedures:
   a. Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
   b. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
   c. In the event that the new applicant has privileges at a Joint Commission accredited hospital where members of Tri-City Medical Center's Medical Staff are familiar with the member to be proctored, and familiar with that Joint Commission accredited hospital's peer review standards, privileges and proctoring information from that Joint Commission accredited hospital may, at the discretion of the department or division chair, be acceptable to satisfy a portion of the focused professional practice evaluation / proctoring required.
3. Proctor: Scope of Responsibility:
   a. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the department/division, the Medical Executive Committee and the Governing Board. Selection of appropriate proctor(s) is defined within each respective Department/Division Rules and Regulations.
   b. When additional privileges are added after completion of initial proctoring, proctoring volumes shall be determined by the Department/Division Chairperson on a privilege-by-privilege basis.
   c. The intervention of a proctor shall be governed by the following guidelines:
      i. A medical staff member who is serving as a proctor does not act as a supervisor of the practitioner he or she is observing. His or her role is to observe and record the performance of the practitioner being proctored, and report his or her evaluation to the department/division chair.
      ii. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner being proctored.
      iii. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor acting in good faith should be deemed a Good Samaritan within the "Good Samaritan" laws of the State of California.
4. Completion of Proctoring:
   a. The practitioner shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:
      i. A report signed by the department/division chair describing the types and numbers of cases observed and the evaluation of the practitioner's performance, a statement that the practitioner appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the medical staff category to which the appointment was made; and if applicable,
      ii. A report signed by the Chair of such other department(s) in which the practitioner may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the practitioner's performance and a statement

that the practitioner has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments/divisions.

b. For such situations where the practitioner has satisfactorily completed proctoring requirements after the Medical Executive Committee has convened, the Department/Division Chairperson has the discretion to release the practitioner from further proctoring and the file will be furnished to the next MEC meeting.

5. Effect of Failure to Complete Proctoring:
   a. Failure to Complete Necessary Volume
   Any practitioner undergoing Level I proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules and Regulations shall be deemed to have voluntary withdrawn his or her request for the relevant privileges, and he or she shall not be afforded the procedural rights provided in the Bylaws, Article VII, Hearings and Appellate Reviews. However, the department/division has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in the Bylaws, Article VII, Hearings and Appellate Reviews.
   Level II – Volumes for this level must be completed in accordance with the recommendations from the department/division Chair/Chief. (Initiation of a focused review as defined by Medical Staff policy #509)
   b. Failure to Satisfactorily Complete Proctoring
   If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, at the discretion of the department/division Chair/Chief, proctoring may be extended until competency can be ascertained.
   c. Effect on Advancement
   The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Bylaws, Article V, Section 5.3-2 or 5.3-3, if proctoring is not completed thereafter within a reasonable timeframe.

E. **PROCEDURE:**

1. Upon Board approval of a Medical Staff member's privileges, the following shall occur:
   a. Record privileges in the credentialing database.
   b. Create a proctoring file for all privileges requiring proctoring (as indicated by the departmental Rules and Regulations).
   c. Mail proctoring letter explaining proctoring requirements, applicable proctoring forms, and current privileges to Medical Staff member.
   d. Load practitioner's proctoring requirements into the credentialing database.
2. Completed proctoring forms may be submitted to the Medical Staff Office via the locked Proctoring box located on the Surgery unit (must be checked at least weekly). The Medical Staff Office maintains the key to the locked box.
3. Upon receipt of completed proctoring forms, the Credentialing Specialist shall
   a. review the form for completeness and relevancy to the practitioner's privileges currently on a "Proctoring" status.
4. Log proctored cases into the credentialing database.
5. Print a proctoring report from the database to initiate proctoring release process for completed requirements of applicable privileges.
6. To release a practitioner from proctoring status:
   a. Ensure the correct number of completed proctoring forms are assembled in the appropriate practitioner's proctoring file.
   b. Generate the following forms for review and approval by the Department/Division, Credentials Committee, Medical Executive Committee, and the Board of Directors:
      i. Proctoring Evaluation Approval Form

ii. Proctoring Approval Flowsheet

7. Upon Board approval of releasing a practitioner from proctoring, the Credentialing Specialist shall:
   a. Update the practitioner's privileges in the credentialing database.
   b. Send a letter to the practitioner indicating the privileges that have been released from proctoring and a copy of their updated privileges.
   c. Upon releasing a practitioner 100% from proctoring, the contents of the proctoring file are placed in the practitioner's credential file under the proctoring section (behind the privilege section).

F. **REFERENCE(S):**
1. Joint Commission ~~2010~~ **2016** Medical Staff Standards
2. Title XXII

~~**Approvals:**~~
~~**Credentials Committee Approval: 05/10**~~
~~**Medical Executive Committee Approval: 05/10**~~
~~**Board of Directors Approval: 06/08; 02/10; 04/10, 5/10**~~

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Hospitalist
Standardized Procedures

Approvals

Medicine Department (Signature): _____

Interdisciplinary Practice Committee (Date): June 27, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Hospitalist NP will:
2. Assume responsibility for the *Hospitalist* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   a. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
3. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
4. Order medications as included in the Medicine Department Cerner Power Plans.
   a. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
   b. The NP orders the medication and documents the information into the chart and in the clinical notes.
   c. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and

place the order via telephone order communication type for supervising physician co- signature.

5. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
6. Obtain medical histories and perform overall health assessment for any presenting problem.
7. Order and interpret specific laboratory studies for the patient as included in the Hospitalist Power Plans.
8. Provide or ensure case management and coordination of treatment.
9. Make referrals to outpatient primary care practitioners or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
10. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
11. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
12. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
13. Formulate recommendations to improve mental health care and patient outcomes.
14. Provide patient health education related to medications and health issues.
15. The PowerPlans for the Hospitalist are as follows:
    - ADMIT Standard Mediciations
    - AM Labs General
    - ANES CVS PostOp
    - Admission to ICU ACS, CP, CAD Multi Phase
    - Admission to ICU CHF Multi Phase
    - Admission to ICU DKA Multi Phase
    - Admission to ICU Gastrointestinal Multiphase
    - Admission to ICU General Multiphase
    - Admission to ICU Hemorrhagic Stroke
    - Admission to ICU Ischemic Stroke Multi Phase
    - Admission to ICU Pulmonary Multi Phase
    - Admission to ICU Sepsis (Severe) Multi Phase
    - Admission to ICU Therapeutic Hypothermia Post Arrest MP
    - Admission to ICU tPA/Ischemic Stroke Multi Phase
    - Admission to MS Ischemic Stroke Multi Phase
    - Admission to MedSurg Gi Multi Phase
    - Admission to MedSurg General Multi Phase
    - Admission to MedSurg Pulmonary Multiphase
    - Admission to Telemetry ACS, CP, CAD Multi Phase
    - Admission to Telemetry CHF Multi Phase
    - Admission to Telemetry Gastrointestinal Multiphase
    - Admission to Telemetry General Multi Phase
    - Admission to Telemetry Pulmonary Multi Phase
    - Alcohol (Ethylene & Methanol) Toxicity Peds
    - Alcohol (Ethylene & Methanol) Toxicity Adult
    - Alcohol and Benzodiazepine Detoxification SubPhase (Decision to Admit)
    - Discharge Patient
    - KEO Feed Tub Insertion
    - Palliative Care
    - Stool Studies SubPhase
    - Sub Phase Admit to OPOBS/Extended Recovery

- Sub Phase ED Core Measure AMI
- Sub Phase ICU
- Sub Phase Telemetry
- Sub Plan Medically Monitored Transfer
- Sub Plan Telemetry Transfer
- SubPhase ACS, CP, CAD (Decision to Admit)
- SubPhase ACS, CP, CAD (Floor)
- SubPhase Admit Standard Medications (Decision to Admit)
- SubPhase COPD/Asthma (Decision to Admit)
- SubPhase DKA (Decision to Admit)
- SubPhase DKA (Floor Orders)
- SubPhase GI Bleed (Decision to Admit)
- SubPhase Heart Failure (Decision to Admit)
- SubPhase Heart Failure (Floor)
- SubPhase Pancreatitis (Decision to Admit)
- SubPhase Pneumonia (CAP)ICU Decision to Admit)
- SubPhase Pneumonia (CAP) NON-ICU (Decision to Admit)
- SubPhase Pneumonia (HAP) Admission (Decision to Admit)
- SubPhase Severe Sepsis (Decision to Admit)
- SubPhase Stroke – Hemorrhagic (Decision to Admit ICU)
- SubPhase Stroke – Hemorrhagic (Decision to Admit Non ICU)
- SubPhase Stroke – Hemorrhagic (Floor Orders)
- SubPhase Stroke – Ischemic (Decision to Admit)
- SubPhase Stroke – Ischemic (Floor)
- SubPhase Stroke – tPA Ischemic ICU (Decision to Admit)
- SubPhase Stroke – tPA Ischemic Stroke NON ICU (Decision to Admit)
- Subphase Admit Standard Medications (Floor)
- Subphase COPD/Asthma (Floor)
- Subphase Electrolyte Replacement (Decision to Admit)
- Subphase Severe Sepsis (Floor)
- Transfer to IC DKA Diabetic Ketoacidosis
- Transfer to Intensive Care (ICU)
- Transfer to Lower Level of Care – Adult
- Transfer to Medical Surgical Care
- Transfer to Telemetry Care
- Tub Feeding – ICU
- VTE (Venous Thromboembolism) Prophylaxis
- VTE (Venous Thromboembolism) Treatment
- VTE Prophylaxis and Treatment
- VTE Prophylaxis and Treatment Other (Floor Orders)
- Percutaneous Gastrostomy (Requesting) Tube Placement
- Discharge to Interfaculty (Adult)
- Enteral Feedings
- Severe Sepsis
- Subphase Severe Sepsis (Floor)
- AM Labs General
- ICU Enteral Feeding
- KEO Feed Tube Insertion

III. **MANAGEMENT OF CONTROLLED SUBSTANCES**

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
    a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Medicine.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by an MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
    1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
    1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
    2. Acute exacerbation of a patient's situation;
    3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
    4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
    5. Upon request of the patient, another clinician or Supervisor.
    6. Upon request of the NP.
    7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. BLS or ACLS in accordance with the specialty requirement.
    ~~6. CNOR Certification, if assisting in surgery.~~

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform

appropriate personnel.

2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

A. As determined by the NP – Hospitalist Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neonatal
Standardized Procedures

Approvals

Neonatology Division (Signature):	_____
Pediatrics Department (Signature):	_____
Interdisciplinary Practice Committee (Date):	July 14, 2017
Medical Executive Committee (Date):	July 24, 2017
Professional Affairs Committee (Date):	August 10, 2017
Board of Directors (Date):	_____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Neonatal NP will:
   a. Assume responsibility for the *Neonatal* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Neonatal Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Neonatal Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for NICU are as follows:

i. NICU Acyclovir
ii. NICU Admission _1
iii. NICU Amphotericin Liposomal
iv. NICU Caffeine Citrate Initiation
v. NICU Diflucan
vi. NICU Decadron DART
vii. NICU Feeding
viii. NICU Flagyl
ix. NICU Follow Up Labs
x. NICU Gentamicin
xi. NICU IV Fluids/PICC Line Insertion
xii. NICU Meropenem
xiii. NICU Neonatal Abstinence Syndrome
xiv. NICU PICC Line Insertion
xv. NICU Phenobarbital
xvi. NICU Pre Eye Exam Medication Orders
xvii. NICU Respiratory
xviii. NICU Sepsis Work Up
xix. NICU Treatment for HIV Exposure
xx. NICU Vaccines
xxi. NICU Vancomycin
xxii. NICU CSF Labs
xxiii. SP NICU Newborn Medications – Nursing

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Division of Neonatology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

1. Additional Supervision occurs as described below under "Quality Improvement."

F. Supervisor notification and consultation is obtained under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:

1. Master's degree in Nursing from an accredited college or university; AND
2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:

1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
2. Currently certified by the State of California as a Nurse Practitioner;
3. Possession of a California State-issued medication Furnishing Number;
4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
5. BLS or ~~ACLS~~ **NRP** in accordance with the specialty requirement.
6. ~~CNOR Certification if assisting in surgery.~~

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Neonatal Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – OB/GYN
Standardized Procedures

Approvals

OB/GYN Department (Signature): _____

Interdisciplinary Practice Committee (Date): July 14, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The OB/GYN NP will:
   a. Assume responsibility for the *OB/GYN* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the OB/GYN Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the OB/GYN Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for OB are as follows:

i. OB Admit to L&D C-Section
ii. OB Admit to Postpartum C Section
iii. OB GYN Pre Operative Hold
iv. OB GYN Pre Operative Education
v. OB Pre-Op Teach Labs
vi. OB Tubal Ligation Pre/Intra Orders
vii. Discharge Women's
viii. OB 2016 L&D C-Section
ix. OB 2016 Postpartum C Section
x. OB 2016 Postpartum Vaginal Delivery
xi. OB 2016 Tubal Ligation Pre/Intra Orders

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of OB/GYN.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
    1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
    1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
    2. Acute exacerbation of a patient's situation;
    3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
    4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
    5. Upon request of the patient, another clinician or Supervisor.
    6. Upon request of the NP.
    7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. **NRP,** BLS or ACLS in accordance with the specialty requirement.
    6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – OB/GYN Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Oncology
Standardized Procedures

Approvals

Oncology Division (Signature): _____

Medicine Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 11, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Oncology NP will:
   a. Assume responsibility for the *Oncology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
   d. Obtain medical histories and perform overall health assessment for any presenting problem.
   e. Provide or ensure case management and coordination of treatment.

f. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
g. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
h. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
i. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
j. Formulate recommendations to improve patient outcomes.
k. Provide patient health education related to medications health issues.

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Division of Oncology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. **QUALIFICATIONS - EDUCATION AND LICENSING**

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. **QUALITY IMPROVEMENT**

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Oncology Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Orthopedic & Spine Institute
Standardized Procedures

Approvals

Orthopedic Division (Signature): _____

Surgery Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 11, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Orthopedic & Spinal Institute NP will:
   a. Assume responsibility for the *Orthopedic & Spinal Institute* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Orthopedic division Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Orthopedic division Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for the Orthopedic Division are as follows:

i. ORTHO Cervical Spinal Fusion Post Op Multi Phase
ii. ORTHO Hip Fracture Post Operative Multi Phase
iii. ORTHO Lumbar Spinal Fusion Post Op Multi Phase
iv. ORTHO Post Operative
v. ORTHO Pre Operative
vi. ORTHO Radiographs Lower Extremity
vii. ORTHO Radiographs Upper Extremity
viii. ORTHO Spine PostOp
ix. ORTHO Spine PreOp

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power

Plans approved by the treating or supervising physician and the division of orthopedic surgery.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
    1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
    1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
    2. Acute exacerbation of a patient's situation;
    3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
    4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
    5. Upon request of the patient, another clinician or Supervisor.
    6. Upon request of the NP.
    7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. BLS or ACLS in accordance with the specialty requirement.
    6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Orthopaedic & Spine Institute Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Pediatrics
Standardized Procedures

Approvals

Pediatrics Department (Signature): _____

Interdisciplinary Practice Committee (Date): July 14, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Pediatric NP will:
   a. Assume responsibility for the *Pediatric* patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Pediatric Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Pediatric Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for Pediatric are as follows:

i. Discharge Newborn

ii. PED Admission to Peds

iii. PED Hyperbilirubinemia

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Pediatrics.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
    1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
    1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
    2. Acute exacerbation of a patient's situation;
    3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
    4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
    5. Upon request of the patient, another clinician or Supervisor.
    6. Upon request of the NP.
    7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Pediatric, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. BLS~~, ACLS~~ or NRP in accordance with the specialty requirement.
    ~~6. CNOR Certification if assisting in surgery.~~

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
    5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.
B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
    1. Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

A. As determined by the NP – Pediatrics Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Psychiatry Division
Standardized Procedures

Approvals

Psychiatry Division (Signature): _____

Medicine Department (Signature): _____

Interdisciplinary Practice Committee (Date): April 11, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): August 10, 2017

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City **Healthcare District**~~Medical Center~~ (TC**HD**~~MC~~) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

1. The NP may function within any locations operated through ~~Tri-City Medical Center (~~TC**HD**~~MC)~~ designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in ~~TCMC~~**TCHD** locations.

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Psychiatry Division NP will:
   a. Assume responsibility for the *Psychiatry* care of patients, under written standardized procedures and under the supervision of the ~~TCMC~~**TCHD** medical staff member (physician) as outlined in the ~~TCMC~~**TCHD** Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the ~~TCMC~~**TCHD** medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Psychiatry division Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Psychiatry division Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve mental health care and patient outcomes.

m. Provide patient health education related to medications, psychiatric conditions and health issues.

n. The PowerPlans for the Psychiatry Division are as follows:

i. 5150 Order/Sub Phase
ii. Alcohol and Benzodiazepine Detoxification SubPhase (Decision to Admit)
iii. BHU Admission
iv. BHU Alcohol and Benzodiazepine Detoxification
v. BHU Anxiety
vi. BHU Bipolar-Mania
vii. BHU Clozapine Titration
viii. BHU Depression
ix. BHU Emergency Medications
x. BHU Invega Sustenna
xi. BHU Nicotine Smoking Cessation Plan
xii. BHU Opiate Detox
xiii. BHU Psychosis
xiv. BHU Standard Admission Medications
xv. BHU Suboxone Taper Off
xvi. Discharge BHU (NEW)
xvii. Discharge BHU Patient

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of Psychiatry.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified ~~TCMC~~**TCHD** physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
   1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   2. Acute exacerbation of a patient's situation;
   3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   4. Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   5. Upon request of the patient, another clinician or Supervisor.
   6. Upon request of the NP.
   7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **Practice Prerogatives**

A. As determined by the NP – Psychiatry Division Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at ~~TCMC~~**TCHD** that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and ~~TCMC~~**TCHD**.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date
~~Sponsoring~~**Supervising** Physician Signature	Date

Tri-City Medical Center
Oceanside, California

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: DEVELOPMENTAL SUPPORTIVE CARE IN THE NICU

ISSUE DATE: 09/07
REVISION DATE(S): 04/09, 06/11, 08/12, ~~05/17~~

Department Approval:	**05/17**
Perinatal Collaborative Practice:	**07/17**
Division of Neonatology Approval:	**07/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **POLICY:**

1. Developmental care is an approach to modify the NICU environment so as to minimize the stress experienced by the infant in the NICU. Growth and development of the preterm **infant** may be enhanced by consistently providing the infant and their family developmentally supportive care. Additionally, developmental outcomes will be improved as a result of stabilization of the preterm **infant's** ~~'s~~ unique physiologic and behavioral functioning.

B. **PROCEDURE:**

1. Minimal Handling **and Individualization of Care** ~~(Refer to Guidelines for Care of the Extremely Low Birth Weight Infant and Very Low Birth Weight Infant).~~
   ~~a. Care should be patient centered, not caregiver centered.~~
   ~~b.~~**a.** Handling should be slow and based on the infant's cues. Sudden changes in movement should be avoided.
   ~~c.~~**b.** Promote sleep by clustering care. Time care around wake cycles as much as possible, allowing for blocks of two to three hours of uninterrupted sleep. **Instruct Parents on protective sleep and cluster care.**
   ~~d.~~**c.** Hands on care should be coordinated with the needs of the interdisciplinary team (MD, **AHP,** RCP, OT/PT, Lab, etc.).
   ~~e.~~**d.** Monitor the patient during all routine and medical care procedures for stress responses. Stress may be minimized through containment or swaddling, non-nutritive suck on a pacifier, use of oral sucrose solution **during painful or invasive procedures** and allocation of rest periods. **Some critical infants may not tolerate prolonged care times, adjust care accordingly.**
   e. Parents should be encouraged to provide gentle touch and containment by cupping head and buttocks**/legs** rather than stroking.
2. Noise Stimuli
   ~~a. Noise levels should not exceed 50 dB. Transient sounds should not exceed 70 dB.~~
   ~~b.~~**a.** Staff will respond to all equipment alarms quickly. Anticipate alarms and temporarily silence them before they sound during care interventions known to trigger alarms.
   b. Staff will utilize appropriate sound levels, teach, and encourage sound compliance of visitors and staff.
   c. Minimize noise from equipment.~~,~~ ~~including~~ **Cclosinge** isolette doors **slowly/softly and** ~~,~~ ~~placing~~**avoid placing** items on top of **the** isolette. ~~and staff conversations.~~

~~d. Gentle musical stimulation is appropriate for >34 weeks adjusted gestational age for a maximum of 15 minutes at a time during quiet alert stages of arousal. Tape recordings of parents' voices may enhance parent-infant bonding.~~

d. Instruct parents on appropriate vocal and sound communication with their infant.

~~e. Use earmuffs as indicated on ventilated patients.~~

3.~~4.~~ Visual/Light Stimuli:

a. Avoid direct light on patient care spaces except for **during** procedures. **During procedures, p**~~P~~**rotect eyes from bright lights.**

b. Individualize light exposure through the use of isolette covers~~, etc~~. Avoid abrupt increase in light.

~~c.~~ **Critically ill** ~~Warming lights used during bath times should be directed from back of patient, not from the side or front of patient.~~

~~d.~~**c.** **p**~~P~~**atients and those** <31 weeks ~~or who are critically ill~~ will benefit from continuous shielding from ambient lighting.

~~e.~~**d.** Patients >31 weeks may benefit from non-direct cycled lighting by folding open the isolette covers during the daytime hours.

~~f.~~**e.** Periods of dimmed light levels while maintaining safe levels for accurate clinical observation should be provided during nighttime cycles for all patients.

~~g.~~**f.** Provide adequate eye protection for patients receiving phototherapy.

~~h.~~**g.** **P**~~P~~**rovide the patient with visual stimuli that has a distinctive facial pattern by** ~~,~~**place picturesd** on the isolette or crib wall in line with patient's line of vision when awake.

~~i.~~**h.** ~~Avoid placing too many items in the patient's isolette or crib.~~ Remove visual stimuli **if**~~when~~ patient **begins to** show signs of disorganization.

5. Olfactory Stimuli:

a. **Staff are to** A~~a~~void ~~personal~~ use of scented soaps, lotions and ~~perfumes~~**fragrances**.

i. Encourage Parents to avoid use of scented soaps, lotions, fragrances during NICU visits.

~~i.~~**ii. Educate Parents to the risks of NICU infant exposure to second hand smoke.**

b. Open ~~alcohol,~~ betadine and other skin prep pads away from the isolette to reduce patient exposure to noxious odors.

c. Remove ~~alcohol,~~ betadine and other skin prep pads from isolette immediately after use.

d. Encourage the parents to provide a soft small blanket/cloth that the mother or father have held close to their body to place near or under patient.

6. Oral Stimuli:

a. Provide oral care for intubated and/or NPO patients during hands-on care**, prior to suctioning** or at minimum every **three to** ~~four~~ **six** hours **with touch times**.

b. Provide oral stimulation when appropriate to promote non-nutritive sucking for patients ~~>30 weeks~~ using ~~size~~ **an** appropriate**ly sized** pacifier.

c. Minimize **orally aversive** procedures**,** ~~that may promote oral aversion~~ such as unnecessary oral suctioning or repeated insertion of oral/nasal gastric tube.

7. Tactile/Vestibular Stimuli:

a. Introduce one stimulus at a time (visual, tactile, verbal). Observe the patient's physiological response while assessing for changes in baseline color, respiratory rate, heart rate, blood pressure, and oxygen saturations.

b. Allow the patient to set the pace for care giving. When the patient begins to show signs of disorganization, withdraw stimulus, provide hands-on containment and allow recovery time before continuing care.

8. Positioning

a. Developmentally supportive care giving is aimed at minimizing energy expenditure while promoting a balance between flexion and extension in **every**~~any~~ patient.

b. Provide age-appropriate care based on current gestational age and determine the appropriate position for the neonate based on the following:~~,~~

i. **The goal is to model behaviors that have been shown to decrease the incidence of SIDS to enhance parental compliance with these recommendations post-discharge.**
ii. **Stable term neonate and premature neonate greater than 32 weeks' GA position supine.**
iii. ~~**The goal is to model behaviors that have been shown to decrease the incidence of SIDS to enhance compliance with these recommendations post-discharge.**~~**The infant's head should be shifted/turned with cares to decrease plagiocephaly.**
~~i.~~iv. **Preterm neonates 23 to 32 weeks' gestational age (GA) are to be positioned to sustain ~~ing supine with~~ head in midline position for the first 72 hours of life. Infant's position may be rotated with cares; however, midline head position will ~~should/ must~~ be maintained. No p~~P~~rone positioning.**
v. **Critically ill term neonates and preterm neonates greater than 32 weeks' GA ideally are positioned side-lying or prone, transitioning to supine as they stabilize.**
vi. **For the patient <34 weeks, positioning aids are necessary to support physiological flexion and orientation towards midline.** ~~Prone and lateral positioning has been shown to improve oxygenation as well as a stable heart rate and respirations. Tuck knees under buttocks, pushing the pelvis upward, forcing the patient's weight onto the head and shoulder, and thus decreasing random movement in the patient.~~
~~ii. Lateral positioning facilitates mid-line orientation and promotes physiological flexion.~~
~~iii.~~vii. Supine positioning ~~favors extension, increases or~~ facilitates random movement, startling and awakening from sleep.~~Therefore, for the patient <34 weeks, positioning aids are necessary to support physiological flexion and orientation towards midline.~~

c. Shoulders should be rounded with a curved back to avoid hyperextension of the trunk.~~The younger the patient, the more help assuming this positioning will be needed.~~ When in the prone position, a **small body positioner** ~~gel cushion~~ can be used to raise the trunk.~~ and let the arms be placed by the side~~
~~b.~~**d.** **The neck should not be extended nor hyperextended.**~~**.**~~
~~c.~~**e.** Patient's hands should be near the mouth, with elbows flexed.
~~d.~~**f.** The hips and legs should be flexed and midline **with** knees and ankles ~~should be~~ together.
~~e. No frog leg positioning.~~
~~f. The neck should not be extended or hyper extended.~~
g. Avoid pressure around the patient's medial aspects of the knees and elbows that promote external rotation and extension based posture. Provide appropriate boundaries to maintain desired ~~flexion~~ **flexion**~~positioning~~.
h. ~~Gel cushions~~**Soft head positioners** may be used for patients less than 34 weeks and/or with severe respiratory compromise **or injury** that would limit head positioning.
~~i.~~ ~~Gel cushions~~**Soft head positioners** ~~are not for home use and need to be discontinued when transitioned to an open crib and/or when the patient reaches 36 weeks unless a positioning program has been established to address head shape abnormalities.~~
i. ~~As appropriate, swaddle the patient or provide hands on containment during stressful procedures.~~ Swaddle the patient with shoulders tucked midline and hands free for self-consoling, grasping and hand to face and mouth behaviors.
j. **As appropriate, swaddle the patient or provide hands on containment, and sucrose (if ordered,) during stressful procedures.**
~~k. All ventilated patients will be developmentally appropriately positioned, utilizing nesting/boundary techniques.~~
k. Oscillator Positioning **and** Care:

i. **Respiratory Care Practitioner (RCP) should be present to assist with airway maintenance. Do not disconnect from oscillator.**

~~i. Position at least once every shift in supine, side-lying, prone or as condition allows.~~

~~ii. Position change is a 2-3 person procedure.~~

~~iii. When HFOV is first initiated, position should be supine and developmentally supported. Do not reposition for the first 24 hours.~~

~~iv.~~ii. ~~Second day (next 24 hours),~~The patient can be repositioned every 4-6 hours, as needed **and as toleratesd.**

iii. ~~without disconnecting from oscillator.~~ This can be accomplished by using ~~rolls~~**positioners or blanket rolls** to support side lying and rolling the patient from a side to prone position. **If unstable, it is also an option to shift position slightly utilizing the soft body positioner to relieve pressure areas.**

~~v. Use of gel cushions under the head or torso is contraindicated during high frequency ventilation~~

~~vi. After 48 hours, patient may be disconnected from oscillator for 5-10 second intervals to reposition every 4-6 hours as conditions permit.~~

~~vii.~~iv. Position the patient so that ~~an uphill orientation of the circuit from the ventilator to the patient occurs to ensure that~~ **circuit** moisture drains from the patient to the ventilator.

~~viii.~~v. Implement position changes to promote ~~pulmonary toilet,~~ skin integrity, developmentally appropriate care, and to minimize torticollis as follows:

1) Turn body from head to toe, rotating along horizontal axis, allowing the head to be turned to the opposite shoulder.
2) Roll patient from prone to supine or supine to prone, which permits the head to be turned toward the opposite shoulder.
3) Assess and document patient's tolerance to position change to include:
   a) **V**~~v~~ital signs
   b) ETT cm mark at lip
   c) **B**~~b~~reath sounds
   d) ~~vibration/~~**Chest wiggle**/chest movement
4) ~~Back to Sleep~~**Safe sleep** and Tummy Time

l. **Safe sleep guidelines will be followed on all** ~~P~~patients ~~will be transitioned "back to sleep"~~ when transferred to an open crib.~~, at approximately 35 weeks.~~

i. At 35 weeks, flatten the **head of** bed unless ~~there is evidence~~ **otherwise ordered by physician/AHP due to evidence** of reflux.

~~i.~~ii. ~~At 36 weeks, r~~Remove all positioning devices **unless suggested by OT/PT, AND ordered by the Physician/AHP.**

~~ii. .At 37 weeks, position the patient supine only in preparation for home "back to sleep."~~

iii. Term patients, **who are** in open cribs upon admission, should be swaddled **or in a sleep sack** and supine.

iv. Demonstrate and encourage parents to practice ~~prone positioning~~ tummy time **during** ~~during~~ visits when patient is awake and active.

~~B. Instruct parents of danger of having patients sleep in the parents' bed with them.~~

~~i.~~v. Patient's beds should be free of all soft objects, i.e., stuffed animals.

~~C.~~B. REFERENCE(S) ~~LIST~~:

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8. Martucci, M. (2004). Considerations in Planning a Newborn Developmental Care Program in a Community Hospital Setting. *Advances in Neonatal Care*, 4(2), 59-69.
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11. Symington, A. & Pinelli, J. Developmental care for promoting development and preventing morbidity in preterm infants. *Cochrone Review* (2006).
12. Vandenberg, K. (2007). Individualized developmental care for high-risk newborns in the NICU: A practice guideline. *Early Human Development* 83(7) 433-42.

~~D. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Abbreviations

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 05/06, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

~~**Note: Please refer also to the list of approved and unapproved abbreviations in the TCMC Administrative Policy and Procedure manual**~~

A. **PURPOSE:**
1. To define the list of abbreviations applicable to ~~OPBHS~~**Outpatient Behavioral Health**.

B. **POLICY:**
1. When documenting in the patient medical record, clinical staff may use the following Program and the hospital approved abbreviations.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical Staff.

D. **RELATED DOCUMENT(S):**
1. **Outpatient Behavioral Health Abbreviation List**
2. **Patient Care Services Policy: Abbreviations, Use Of**

E. **EXTERNAL LINK(S):**
1. **Neil-Davis Medical Abbreviation - MedAbbrev.com**

Outpatient Behavioral Health Abbreviation List

	Approved List
ψ	Psychiatric
- with a circle	Negative
+ with a circle	Positive
~~1:1~~	~~Individual Psychotherapy~~
~~AH~~	~~Auditory Hallucinations~~
~~AA~~	~~Alcoholics Anonymous~~
~~ADHD~~	~~Attention Deficit Hyperactivity Disorder~~
~~ADL~~	~~Activities of Daily Living~~
~~AEB~~	~~As evidenced by~~
~~AMA~~	~~Against Medical Advice~~
B & C	Board and Care
~~APS~~	~~Adult Protective Services~~
BHOS	Behavioral Health Outpatient Services
~~BPD~~	~~Borderline Personality Disorder~~
~~BH~~	~~Behavioral Health~~
~~Bx~~	~~Behavior~~
~~C~~	~~With~~
~~CBT~~	~~Cognitive Behavior Therapy~~
~~C.D.~~	~~Chemical Dependency~~
~~C/O~~	~~Complaining Of~~
CC	Clinical Coordinator
CLC	Community Liaison Coordinator
Clt	Client
CM	Clinical Manager
~~DBT~~	~~Dialectical Behavior Therapy~~
~~D/C~~	~~Discharge~~
~~DC~~	~~Discontinue~~
~~d/o~~	~~Disorder~~
DR	Dual Recovery
~~DX~~	~~Diagnosis~~
~~ECT~~	~~Electroconvulsive Therapy~~
EFR	Early Full Remission
EPR	Early Partial Remission
F with a circle around it	Father
~~FOO~~	~~Family of Origin~~
~~GAD~~	~~Generalized Anxiety Disorder~~
~~GERD~~	~~Gastroesophgeal Reflux Disease~~
~~GAF~~	~~Global Assessment of Functioning~~
~~GRP~~	~~Group~~
~~HI~~	~~Homicidal Ideation~~
~~H/O~~	~~History Of~~
~~Hx~~	~~History~~
~~IBS~~	~~Irritable Bowel Syndrome~~
~~ID~~	~~Identify or Identified~~
~~IDDM~~	~~Insulin Dependent Diabetes Mellitus~~
~~IOP or OP~~	~~(Intensive) Outpatient Program~~
~~IOR~~	~~Ideas of Reference~~
ITP	Initial Treatment Plan
~~LCSW~~	~~Licensed Clinical Social Worker~~

~~LOS~~	~~Length of Stay~~
~~LTG~~	~~Long Term Goal~~
M with a circle around it	Mother
~~MAOI~~	~~Monoamine Oxidase Inhibitors~~
~~MDD~~	~~Major Depressive Disorder~~
~~Med. (s)~~	~~Medication (s)~~
MFT or MFTI	Marriage and Family Therapist (Intern)
~~Mgmt~~	~~Management~~
~~MSE~~	~~Mental Status Exam~~
~~MTP~~	~~Master Treatment Plan~~
~~NIDDM~~	~~Non-Insulin Dependent Diabetes Mellitus~~
~~NOS~~	~~Not Otherwise Specified~~
~~NTE~~	~~Not To Exceed~~
~~OCD~~	~~Obsessive Compulsive Disorder~~
~~OD~~	~~Overdose~~
PI	Paranoid Ideation
~~Pt~~	~~Patient~~
~~PRN~~	~~As Needed~~
~~Re~~	~~Regarding~~
RI	Resulting In
~~RN~~	~~Registered Nurse~~
~~R/O~~	~~Rule Out~~
RCF	Residential Care Facility
~~RX~~	~~Prescription~~
~~S~~	~~Without~~
~~SA~~	~~Suicide Attempt~~
~~SAD~~	~~Schizoaffective Disorder~~
~~SI~~	~~Suicidal Ideation~~
~~SNF~~	~~Skilled Nursing Facility~~
SFR	Sustained Full Remission
~~S/P~~	~~Status Post~~
SPR	Sustained Partial Remission
~~STG~~	~~Short Term Goal~~
~~Sx~~	~~Symptoms~~
~~t/c~~	~~To consider~~
~~TCMC~~	~~Tri-City Medical Center~~
~~TDD~~	~~Total Daily Dose~~
Th	Therapist
TPR	Treatment Plan Review
~~Tx~~	~~Treatment~~
~~VH~~	~~Visual Hallucinations~~
~~W/~~	~~With~~
~~WNL~~	~~Within Normal Limits~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Admission and Eligibility Criteria

ISSUE DATE: 08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13

Department Approval:	~~4/16~~ 12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE**

1. To define the clinical criteria which determine eligibility for admission to the Behavioral Health Outpatient Services.

B. **POLICY**

1. Persons may be admitted to the Behavioral Health Outpatient Services if they meet specific clinical criteria related to diagnosis, type of impairment and severity of impairment. The specific criteria are listed below. Generally, the criteria require the presence of a serious mental illness, significant functional impairment and a course of illness which, absent the proposed treatment, would likely result in psychiatric hospitalization.
2. Exclusion criteria generally relate to conditions in which the level of clinical risk warrants inpatient hospitalization, situations in which treatment could be reasonably provided at a less intensive level of care or there is an unstable non-psychiatric medical condition which cannot be appropriately managed in an outpatient setting.

C. **PRIMARY DIAGNOSTIC CATEGORIES**

1. Serious Mental Illness-Diagnostic Criteria:
   a. Schizophrenia and Other Psychotic Disorders
   b. Anxiety Disorders
   c. Mood Disorders
   d. Somatoform Disorders
   e. Eating Disorders
   f. Personality Disorders
   g. Other Diagnostic Categories that significantly impair functioning and are authorized for treatment at IOP level of care.

D. **ADMISSION ELIGIBILITY CRITERIA:**

1. Current exacerbation of symptoms of Axis I diagnosis
2. Functional impairment resulting in difficulty performing ADL's
3. Treatment at lower level of care has been unsuccessful
4. Severity of the current symptoms is such that success resulting from a lower level of care is doubtful
5. Reasonable expectation that symptoms, behaviors and functional levels can be stabilized or improved
6. Risk to self, others, or property is present but is such that patient can be managed with the structure and support of the program

7. Despite the degree of impairment present, patient has sufficient intact functioning to benefit from an active treatment program (e.g. any cognitive deficit or other diagnosis indicating organicity will not preclude the patient from successful treatment.)
8. An adequate support system outside the program exists or patient is capable of creating such a support network
9. Recently discharged from an inpatient psychiatric hospitalization and requires this level of care to assist in reintegration into the community
10. Patient is capable of regularly attending program per treatment planning schedule

E. CONTINUED STAY ELIGIBILITY

1. Persistence of Axis I symptomatology
2. Persistence of impairment in social, familial, residential, or vocational functioning.
3. Persistent inability to perform ADL's
4. Continues to be reasonable expectation that patient will improve or be stabilized within a reasonable time frame
5. Patient is participating in program
6. Patient is capable of attending program (including groups) per treatment plan
7. Patient is showing capacity to benefit

F. EXCLUSIONARY CRITERIA

1. Deterioration in functioning represents a situational crisis, unrelated to the psychiatric condition
2. Patient is actively and seriously suicidal
3. Patient is actively and seriously homicidal **or poses a threat of harm to others.**
4. Patient is medically unstable
5. Patient has dissocial personality disorder or strong dissocial personality traits
6. Patient unable to follow ground rules (e.g. verbally/physically abusive to others)
7. Symptoms are transient and self-limiting
8. Patient requires inpatient level of care due to severity of psychiatric conditions
9. Current symptoms and impairment can be adequately managed at lower level of care
10. No reasonable expectation that condition can be stabilized or improved
11. Multiple absenteeism (from groups or program) and/or non-participation in program interfere with patient's ability to benefit from program
12. Substance abuse interferes with ability to benefit from Program
13. Program physicians unwilling to treat patient due to treatment non-adherence

G. DISCHARGE CRITERIA

1. Symptoms/Impairments have decreased to a level indicating patient no longer requires treatment for their illness
2. Symptoms/impairments have been stabilized or **p~~P~~**atient is back to baseline
3. Patient is in need of or ready for a more intensive or less restrictive level of care
4. Patient is not able to benefit from the program
5. There is no reasonable expectation for improvement
6. Patient has achieved their established program goals and would not benefit from additional treatment goals
7. Patient is a danger to self or others and cannot be effectively or safely managed within the program needing a higher level of care
8. Patient does not have the capacity to benefit from program
9. Patient is not participating and/or not attending per treatment plan
10. Patient has achieved maximum benefit from this level of care
11. Patient presents a threat (physical or verbal) to the safety of the milieu

H. REFERENCE(S):

~~12.~~1. **Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Admission Assessment

ISSUE DATE: 08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE**

1. To identify the guidelines for the Psychiatric Admission Assessment.

B. **PROCEDURE**

1. Who may perform/responsible: Attending Psychiatrist
~~1.~~**2.** The Psychiatric Admission Assessment (or update of recent workup done within the last 90 days) must be completed by the attending physician within five program days (seven calendar days) from date of admission **to the Intensive Outpatient Program and within 24 hours of admission to the Partial Hospitalization Program**. The Assessment should be filed in the chart and becomes a permanent part of the medical record.
~~2.~~**3.** If the patient has been discharged from an in-patient psychiatric setting fourteen (14) days prior to admission to **Outpatient Behavioral Health Services** (OPBHS), then the Discharge Summary from that hospitalization may be copied and placed in the patient's medical record in lieu of the Psychiatric Admission Assessment, with an update by the attending Program physician. Though preferable, it is not mandatory that the assessment be completed at the actual location of the Program.
~~3.~~**4.** An update to a recent work up or discharge summary should include the following:
   a. Reason for re-referral: information referencing recent hospitalization
   b. Current mental status
   c. Current Diagnosis, Axes I through V
   d. Plan of treatment including number of days per week of attendance, goals and medications
   e. Discharge plan
~~4.~~**5.** The physician reviews and signs the dictated assessment for content and thoroughness.
~~5.~~**6.** The physician informs the primary therapist of any additional significant information so that the therapist has information from the admission assessment to develop a thorough Master Treatment Plan.
~~6.~~**7.** The physician should have the following information available to aid in the completion of the Psychiatric Admission Assessment:
   a. **Community Liaison Coordinator** (CLC) Referral and Screening Report
   b. **Attempts will be made to obtain** ~~C~~collateral including prior Program admission, treatment, and discharge information; last psychiatric inpatient hospital admission notes, history and physical, discharge summaries, medication sheet, and relevant treatment notes~~; referral packet from case managers including current medication sheet,~~ current psychosocial summary, face sheet, etc.
   c. The CLC or **Registered Nurse** (RN) provides a brief presentation of the patient to the

treatment team prior to admission.

~~7.~~**8.** It is critical that prior level of functioning and recent acute change in mental status be documented in the assessment in order to demonstrate current need for OPBHS. It is important that the physician be specific with regard to treatment plan recommendations so that physician driven treatment is evidenced.

9. If the patient is a re-admission, the above guidelines for the Psychiatric Admission Assessment should be followed. A copy of the prior assessment or discharge summary and the update should be filed in the patient's chart in the assessment section.

C. REFERENCE(S):

~~8.~~**1. California Hospital Association (2017). *California Hospital Consent Manual.* Sacramento, CA: California Hospital Association.**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Attendance/Leaving Program Without Notifying Staff

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/05, 06/07, 06/10, 04/13

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Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To define staff response to attendance issues and patients leaving Outpatient Behavioral Health Services without permission.~~

~~B. POLICY~~

~~1. Patients are expected to be responsible for being on time and to attend as scheduled. Patients are requested to notify staff in advance if they are to be absent for any portion of the day or the entire day. The staff should be aware of who is expected to be in each group but have no right to detain a patient if he/she insists on leaving.~~

~~C. PROCEDURE~~

~~1. Who may perform/responsible: OPBHS clinical and administrative staff~~

~~a. Patients who are unable to attend program as scheduled are responsible for calling in prior to 8:30 a.m. to report their absence. If a patient is absent and does not call in, the patient's therapist or back up is responsible for calling within the first hour of the no show to check on the patient's well being and to encourage attendance.~~

~~b. Patients are required to sign in when they arrive.~~

~~c. Patients are responsible for notifying the group leader if they must be absent during part of a group. Otherwise, patients are expected to attend the full group session.~~

~~d. Patients who do not adhere to attendance guidelines will be discussed in treatment team. A treatment intervention will be developed to assess current clinical needs of the patient, address the attendance issue, re-engage the patient, and encourage regular participation in program.~~

~~e. When a patient becomes unaccounted for, the staff will conduct a search of the program area and advise the Operations Manager.~~

~~f. If the patient cannot be found and has been agitated or showing signs of decompensation, contact the physician, family, board and care manager and case manager, if appropriate, to notify them of the patient's absence.~~

~~g.~~a. ~~The clinical staff will discuss with the physician the need to notify the police, will document the absence in the chart and include any circumstances that contributed to the patient's behavior and disappearance. The staff will document the physician's recommendations and the contacts that were made. If necessary, the police may be contacted.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Clinical Assessment

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional special assessments which are completed, as necessary, by physician's/**Allied Health Professional's (AHP)** order.

B. **POLICY**

1. All patients admitted to the program will routinely have an Admission Psychiatric Assessment, and a Biopsychosocial Assessment, which includes a Nursing Assessment and psychosocial assessment.

C. **PROCEDURES**

1. Who may perform/responsible: Physicians, Therapy, and Nursing Staff
2. Intensive Outpatient Program Services:
   a. All core assessments will be completed by appropriately licensed and qualified personnel using Tri-City **Healthcare District (TCHD)**~~Medical Center~~ approved medical records forms.
   b. Though the Psychosocial and Nursing Assessments are routine and part of the core assessments, they should be checked as ordered on the Physician Admission Order. All assessments will include findings and treatment recommendations, which will take into consideration patient strengths. Prior assessments that are less than six months old may be updated and placed in the medical record.
   c. All dual diagnosis patients receive a substance abuse assessment.
   d. All new patients will undergo a suicide assessment at intake and as needed during their treatment.
   e. If the patient is a re-admission and the prior assessments are less than six months old, an update can be written and attached to the original assessment and placed in the medical record.
   f. A general health statement by the attending psychiatrist or patient's medical doctor must be made on admission. If the patient has been hospitalized within the last 30 days for any reason, an effort must be made to obtain a copy of the H & P and any other pertinent data.
   g. If there are any special assessments needed for diagnostic purposes, they are to be indicated on the Physician Admission Order.
   h. If qualified personnel are not available on staff, then arrangements will be made for the special assessments to be completed by appropriately qualified independent practitioners.

D. **BIOPSYCHOSOCIAL ASSESSMENT AND ADMIT NOTE: OVERVIEW**

1. PART A:
   a. Part A of the Biopsychosocial Assessment is the Nursing Assessment and it is completed within 24 hours of admission by the Program **Registered Nurse** (RN). It should speak to medical necessity for admission and provide information to be considered in the development of the Initial and the Master Treatment Plan. In addition, it should address medical concerns and ~~Axis III~~ **medical** diagnoses to be followed regularly.
   b. Part A of the Biopsychosocial Assessment shall contain patient identification and diagnosis and the following:
      i. Physical Data
      ii. Allergies and Sensitivities
      iii. Current Medications and Compliance
      iv. Nutritional Screening and History with a subsequent referral index for dietitian referral potential
      v. Functional Assessment
      vi. Sensory/Communication assessment
      vii. Surgical history
      viii. Medical Problems/History and Falls Risk Assessment
      ix. Contagious Diseases/exposure
      x. Pain Screening and subsequent Assessment with potential for reassessment
      xi. Suicidal and Homicidal Assessment: **If at risk, safety goals will be initialed.**
      xii. Summary of Impressions to include recommendations for f/u for any Axis III diagnosis
      ~~a.~~**xiii.** Fall Risk Assessment: **If fall risk is indicated, then Fall Risk goals will be initiated along with treatment interventions**

2. PART B:
   a. Part B of the Biopsychosocial Assessment is the Psychosocial Assessment and can be used as a rapport building opportunity between the Therapist and the patient. It is recommended, however, that it be conducted after the patient has had a few days to acclimate to the program but within one week of admission. It is also preferable that some rapport building occur between the Therapist and the patient prior to the assessment as the level of trust and the level of self-disclosure may be greater.
   b. This assessment should also be used as a springboard for exploring with the patient specific treatment plan problems and goals. This discussion should provide the patient with a thorough understanding of how a treatment plan is developed and revised and the role of the patient as an active participant in the treatment planning process. It may be useful during this discussion to share with the patient the impressions and recommendations of team members based on other assessments (e.g., the Psychiatric Admission Assessment; Part A of the Biopsychosocial Assessment) as you and the patient begin exploring potential treatment plan problems and goal areas. In doing so, the patient can perhaps better understand the connection between the assessment process and the treatment plan. Include in this discussion how the identified strengths of the patient will be incorporated into the treatment plan and reinforce patient active participation in the process.
   c. Part B of the Biopsychosocial shall contain the following:
      i. Source of information
      ii. Family relationships and current living arrangements
      iii. Brief psychiatric history
      iv. Developmental and family of origin history
      v. Ethnicity and Sexuality
      vi. Spirituality
      vii. Substance Use History
      viii. Adult social history
      ix. Education / Learning ability

x. Employment / Vocational data
xi. Legal history
xii. Financial resources / Community support needs
xiii. Military Service history
xiv. Risk factors / Violent behavior / Abuse history
xv. Additional observations and/or Special needs

3. An admission note should also be included in the chart. This provides an introduction of the patient to the various team members in the narrative form. It should emphasize the reason for referral, recent change in mental status, and symptomatology. All of these support medical necessity for admission and help paint a clear picture for why the patient is being admitted to the program.
4. When a patient is a re-admission to the program and has had a full Behavioral Health Outpatient Services Biopsychosocial Assessment completed within the past 6 months, the Therapist has the option of simply updating Part B of the assessment. To do this, one needs to review the prior Biopsychosocial Assessment and, using an individual note, include any updated information. A copy of the prior Biopsychosocial Assessment and the new update page should be filed in the section of the chart for assessments. If the prior Biopsychosocial Assessment is more than 6 months old, a new Biopsychosocial Assessment must be completed for the re-admission.

E. **ADMISSION NOTE OUTLINE**

1. Admission **to include:**
   - ~~1.~~**a.** Note: to be completed on day of admission~~ to include:~~
   - ~~a.~~**b.** Demographics (age, race, sex, who accompanied)
   - ~~b.~~**c.** Brief rationale for present admission to the program: Include observable psychiatric symptomatology and functional impairment.
   - ~~c.~~**d.** Remarkable observations of mood, affect, behavior
   - ~~d.~~**e.** Suicidal / homicidal / assaultive ideation or gestures upon presentation
   - ~~e.~~**f.** Patient Orientation to therapeutic milieu, schedule, staff, ~~&~~**and** Program (per **Outpatient Behavioral Health:** ~~Program~~ Orientation **of New Patients Policy**~~protocol~~).

F. **RELATED DOCUMENT(S):**

~~f.~~1. **Outpatient Behavioral Health Policy: Orientation of New Patients**

G. **REFERENCE(S):**

1. **California Hospital Association (2017). *California Hospital Consent Manual.* Sacramento, CA: California Hospital Association.**
~~g.~~2. **Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Community Meetings

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To identify the forum for patients to discuss milieu issues, Outpatient Behavioral Health Services concerns and make announcements.~~

~~B. POLICY~~

~~1. Patients are to be given the opportunity to increase their involvement in the therapeutic milieu and to discuss their issues and concerns in a scheduled Community Meeting.~~

~~C. PROCEDURE~~

~~1. Who may perform/responsible: OPBHS Staff~~

~~a. The community meeting is held daily at the beginning of each treatment day.~~
~~b. The meeting can be held for the entire community or in smaller groups.~~
~~c. The leader of the meeting is a staff member and patient leader.~~
~~d. All patients and designated staff attend.~~
~~e. New patients are introduced to the "community."~~
~~f. The meeting provides a forum for discussion of issues and encourages interaction between patients and peers as well as staff.~~
~~g. Patients are given every opportunity to participate in the meeting.~~
~~h. Community tasks are assigned on a voluntary basis.~~
~~i. Patients are recognized for progress or Program completion.~~
~~j. The staff's role is to help patients develop mutual trust, to help patients develop problem-solving skills and to assist patients in maintaining a therapeutic milieu.~~
~~k. Emergency meetings may be called for specific reasons, such as, disturbances in the program, unusual incidents or substance abuse.~~
~~l.a. Staff will review all pertinent information in staff meetings and morning review meetings to insure maintenance of the therapeutic milieu and appropriate communication of information.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Community Outings

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/05, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To specify limited parameters where community outings may be appropriate.~~

~~B. POLICY~~

~~1. Community outings (i.e., transporting of patients off of the program premises for a leisure, recreational or other activity) are prohibited. However, recognizing that at times it may be clinically appropriate to break up continuous treatment to assist patients to learn skills related to community integration, certain limited exceptions are permissible as indicated below.~~

~~C. PROCEDURE~~

~~1. Who may perform/responsible: OPBHS Staff~~

~~2. Community outings are permissible only on a limited basis if all of the following criteria are met:~~

~~a. Community outings are not a billable service and must not be billed for under any circumstances.~~

~~b. Patients are accompanied and supervised by staff during the community outing at all times.~~

~~c. The community outing has recognized therapeutic value and is not designed to influence or induce an individual to receive services, or to continue to receive services.~~

~~d. The community outing is within close physical proximity to the Program site, i.e., within walking distance and not otherwise requiring transportation, unless for a clinically acceptable and therapeutic activity that is beneficial to the patient's functional status. Examples include a walk in the park or an organized mental health activity in the community that may require limited transportation.~~

~~e. The community outing is free of charge to the public, regardless of whether any charitable donation exists and can include for example, a walk in the park, attending a twelve step meeting, a NAMI function, or other community mental health activities.~~

~~f. The entire patient population is allowed the opportunity to attend any and all scheduled, community outings. Discrimination based upon patient disability, program level, or any other classification is prohibited.~~

~~g. The community outing does not interfere with regular treatment programming or schedules.~~

~~h.~~a. ~~The community outing is approved and scheduled by the Operations Manager / designee.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Contraband

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:`	

A. **PURPOSE:**

1. To maintain patient and staff safety within **Outpatient** Behavioral Health ~~Outpatient~~ Services **(OPBHS).**

B. **POLICY:**

1. Contraband items are not allowed in program. Contraband is defined as items that can be injurious to self or others. Contraband includes weapons or potential weapons, illegal drugs and alcohol. Medications that are not needed during program hours are also considered contraband.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS staff

~~1.~~**2.** Contraband brought to the ~~Behavioral Health Outpatient Services~~**OPBHS** will be removed from patient access and stored in a secure area. These items may be returned at the end of the day and the patient escorted out of the building. Contraband will be returned only if the Program Administrator feels that possession of the contraband item will not pose a threat to the patient or others. Items that are illegal to possess, such as illegal drugs and firearms, will be securely stored until their appropriate disposition is determined. The Operations Manager will notify the Director of Behavioral Health.

~~2.~~**3.** Patients who bring contraband to the **OPBHS**~~Behavioral Health Outpatient Services~~ will be given one warning not to bring the item(s) back. Repeated violations of the contraband policy will result in suspension from the Program until the patient meets with his/her Therapist and the Operations Manager. At that time, the patient's noncompliance will be discussed as a treatment issue. A treatment contract will be written and the patient may be rescheduled if he/she agrees to stop bringing contraband to **OPBHS**~~Behavioral Health Outpatient Services~~.

~~3.~~**4.** Continued violations of the contraband policy may result in the patient's discharge from **OPBHS**~~Outpatient Behavioral Health Services~~.

~~4.~~**5.** If the patient refuses to relinquish the contraband, he/she shall be told to leave the premises and the attending physician shall be notified.

6. The incident should be documented on a Quality Review Report, and as applicable, in the patient's record along with the action taken.

D. **RELATED DOCUMENT(S):**

~~5.~~**1. Security Policy: Seized Evidence or Contraband 231**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Daily Progress Notes

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE**

1. To provide guidelines for the documentation of patient progress in the **Outpatient Behavioral Health Services (OPBHS)** Program.

B. **POLICY**

1. The Program is required by the fiscal intermediary to document progress for each intervention provided. The treatment plan problems ~~should~~ **can** be identified within each note. Each intervention should be identified in terms of the focus, modality and the format ~~; the targeted problem that the intervention addresses;~~ and the facilitator / therapist name and credentials. Specific goals for each intervention, as well as symptoms, behaviors and/or responses should be documented
2. Individual Therapy, a Family Session,~~,~~ and Crisis Intervention should also be documented as it occurs. Specific treatment, outcomes, and goals of the session should be documented in narrative form as an Interdisciplinary Progress Note.

C. **PROCEDURE**

1. Who may perform/responsible: Clinical Staff and Physicians

~~1.~~**2.** Per Service Notes:

a. The note must clearly show how the various groups the patient is attending are focused on treating his/her specific psychiatric problems. The documentation must illustrate how the treatment relates to the problems stated in the treatment plan, what kind of improvement is shown and what still needs to be improved. Progress notes must reflect active treatment.

b. When charting, refer to observable ~~symptometology~~**symptomatology**, staff interventions and response/progress noted.

c. Physicians should document patient progress toward treatment goals, need for continued treatment and discharge readiness.

~~2.~~**3.** Charting Basics:

a. Use black ink **in the absence of an electronic form.**~~.~~

b. Date and sign all documentation.

c. Write legibly.

d. Clinical staff must document daily on groups attended and patient progress/participation in the groups.

e. Special notes (i.e., nursing notes) are identified as such.

f. Charting needs to be descriptive, not interpretative. When documenting, include observed behaviors and patient statements.

g. Document all treatment rendered to the patient and the patient's response. Any quotations used are to be brief and relevant to the patient's problems.
h. Make chronological entries of the patient's clinical course - late entries ~~are permitted but will~~**must** be identified as such.
i. All entries in the MR are completed by the writer.
j. On paper forms, errors must be indicated by using one line through the incorrect documentation, write "error" over the line, and initial the error. Never use white-out.

D. REFERENCE(S):

1. California Hospital Association (2017). California Hospital Consent Manual. Sacramento, CA: California Hospital Association.
~~j.~~2. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Destructive or Potentially Violent Behavior**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE**

1. To protect the safety of patients, staff, and visitors.

B. **POLICY**

1. All destructive and/or potentially violent behavior will be dealt with immediately to prevent any harm to patients, staff and visitors.

C. **PROCEDURE**

1. Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) Staff
2. ~~1.~~ To maintain safety, any signs of escalation, increased psychiatric symptoms, or increased agitation needs to be addressed immediately and if possible identified in the morning patient review meeting.
3. ~~2.~~ Staff is to contact 911 using the black emergency phone if there are any signs of danger, and risk to patients and staff members.
4. ~~3.~~ Staff is to attempt to remove the agitated patient away from other patients by calmly walking him/her away from other patients and toward a safe area where the patient and the therapist can escape easily.
5. ~~4.~~ If the patient refuses to leave group, staff is to instruct other patients to leave the group room.
6. ~~5.~~ Staff member is to request help from other available staff by sending a patient for assistance or using the whistle/**walkie-talkie** to alert staff of danger.
7. ~~6.~~ The use of the whistle/**walkie-talkie** is a last resort to obtain help and only after failed attempts to de-escalate the patient or remove him/her from the group. Premature use of the whistle can further escalate an agitated or angry patient.
8. ~~7.~~ Staff, along with the operations manager or clinical coordinator will gather all information regarding the threatening behavior and assess the patient's mental status.
9. ~~8.~~ Implement the most appropriate response, which may be a time out, verbal de-escalation techniques, suspension, 911 call, or inpatient hospitalization.
10. ~~9.~~ If inpatient admission is required, follow the procedure outlined in the ~~"~~**Patient Care Services:** Admission ~~to an Inpatient~~ Psychiatric **Patients**~~Unit"~~ Policy and contact the program psychiatrist.
11. ~~10.~~ Physical restraint is not used as a clinical intervention. If a patient becomes violent 911 must be called immediately and the patient must be allowed to escape.
12. ~~11.~~ To help de-escalate the agitated or angry patient, staff is to calmly communicate the intent to help the patient, convey empathy, and attempt to remove the patient from group or milieu.
13. ~~12.~~ Staff must take safety precautions by sitting close to an exit, ensuring that they have an escape, and not placing self at risk by meeting with an agitated patient alone, walking in front of a patient that is agitated, or blocking the patient from escape.

~~13.~~**14.** The Operations Manager or designee will meet with all staff and patients involved to process the incident and address safety concerns. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.

~~14.~~**15.** Staff is to complete the on-line Quality Review forms, when necessary, and report any safety issues or violent behavior to the CNE and Risk Management department.

~~15.~~**16.** Staff is to document the incident and staff response in the patient's medical record.

~~16.~~**17.** Staff will discuss the incident in the treatment team meeting with the physician to determine the best course of action and to assess whether the patient is appropriate in the intensive outpatient program.

~~17.~~**18.** Patients that are unable to control anger and pose a risk to other patients or staff are not appropriate for Outpatient Level of Care and must be referred to a more appropriate setting.

D. RELATED DOCUMENT(S):

1. **Behavioral Health Services Policy: Management of Aggressive and Assaultive Behavior**
~~D.~~**2. Patient Care Services Policy: Admission Psychiatric Patients**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Disaster Plan**

ISSUE DATE: **08/96**
REVISION DATE(S): 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To insure efficient Outpatient Behavioral Health Services **(OPBHS)** disaster procedures and to maintain adequate availability of personnel in the event of disaster.

B. **INTRODUCTION:**

1. Due to the varying types and magnitudes of emergency events, Tri-City **Health Care District (TCHD)**~~Medical Center~~ has adopted the command structure of Hospital Incident Command Systems (HICS) the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the ~~TCMC~~ **Environment of Care:** Safety ~~and Disaster~~ Plan **Policy**~~Manual located in the Operations Manager's office on the Tri-City Medical Center Intranet~~.

C. **NOTIFICATION:**

1. ~~Outpatient Behavioral Health Services~~ **OPBHS** will be notified of the main house Disaster Plan activation by telephone**, cell phone, and/or email**.

D. **DISASTER PLAN PROCEDURES:**

1. Operations Manager Responsibilities:
   a. The Operations Manager will take direction from the Director of Behavioral Health **and Safety Officer** who has assessed the nature and extent of the disaster. In the event of the absence of the Operations Manager the Clinical Coordinator will assume the leadership role.
   b. The Operations Manager will complete the Personnel Inventory Form or make a list of all available staff and be prepared to send it to the HICS center at the main house, should it be requested.
      ~~b.~~**i.** Note: Personnel Inventory Forms are found in the Safety and Disaster Manual ~~located. in the Operations Manager's office.~~ The Incident Command Center is located in the French Rooms.
   c. The Operations Manager will assemble all available staff to inform them of disaster procedures and standby to report to disaster priority areas at the main house in the event OPBHS staff is needed in the main House (after all OPBHS patients have been safely transported to their residences).
   d. The Operations Manager will designate one Administrative staff to contact all non present staff of the disaster and prepare for call-in procedures should they be required.
   e. The Operations Manager will contact the Patient Transport Express and the Dispatcher if he/she is not present in the building to alert him/her to ready the vans for early departure from Program if the disaster allows for patients to be transported.

f. The Operations Manager will relay as much information as possible to the Incident Command Center.

2. **Registered Nurse** (RN) Responsibilities:
   a. RN's will notify the residential care providers of the disaster procedures and inform them that their residents will be leaving Program early.
   b. RN's will call Program physicians to inform them of the disaster procedures, and to obtain orders.
3. Therapist Responsibilities:
   a. The Therapists will assemble the patients in the Community Room to inform them of the disaster procedures and to organize them for departure from Program if they can exit safely.
   b. The Therapists will begin calling family members, Case Managers and Conservators to inform them of Program Closure for the day and the possibility of continued Program closure until the disaster has cleared.
   c. Therapists will attend to the medical records to insure that they are in proper order and the documentation is current before securing them in the Chart Room.
   d. In the event patients cannot be safely exited from the Program and delivered to their residences by hospital vans, they will be contained within the building until notified of safe departure. Appropriate de-escalation techniques will be utilized to allay panic.
4. Dispatcher and Drivers:
   a. The Dispatcher will contact Patient Transport Express supervisor to collaborate with the PTE Supervisor about the needs of the vans throughout the hospital.
   b. The Dispatcher will contact all available drivers to alert them for the possibility of reporting for duty.
   c. The Dispatcher will assemble the drivers on site and distribute the route sheets appropriately.
   d. The Drivers will safely transport patients to their residences as per the route sheets and return to base at the hospital.
5. Administrative and Support Staff:
   a. The Administrative and Support Staff will take direction from the Operations Manager who has assessed the need within the building.
   b. Administrative and Support staff will respond to phone calls and direct callers appropriately.
   c. The Administrative and Support staff will assist the Therapists and Drivers in boarding the patients on the vans.

E. **RELATED DOCUMENT(S):**
1. **Emergency Operations Procedure: Emergency Operations Plan**
2. **Environment of Care Policy: Safety Plan**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Discharge Planning and Discharge**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE**

1. To define the discharge process as an integral part of treatment.

B. **POLICY**

1. Discharge planning will be an organized, coordinated process, with interdisciplinary treatment team, patient, physician and family/significant other input. The process identifies the patient's needs before and after discharge, delineates plans to meet these needs and engages the patient and family members in the process of plan implementation. Discharge planning will begin on admission.
2. Discharge criteria are tied to the long-term goals and will be established during the development of the Master Treatment Plan (MTP). At each treatment plan Update, the discharge criteria will be reviewed and modified as necessary, depending upon the rate of progress (or lack of progress) in treatment. A rationale for each change will be documented.
3. If a patient does not respond favorably to the Program or does not seem to be benefiting from the prescribed course of treatment, the issue is taken to the treatment team meeting to determine appropriateness of the treatment and identify possible changes in treatment plan or possible alternative referrals. However, lack of progress in treatment does not automatically imply the necessity for discharge. Treatment goals need to be re-evaluated and every effort must be put forth to insure that identified problems and target dates are appropriate and reasonable, prior to considering discharge.
4. Circumstances warranting discharge may include:
    a. Attainment of treatment goals, including a significant reduction in symptoms and functional impairment.
    b. Continued abusive and/or aggressive behavior after clinical/behavioral interventions fail.
    c. Repeated substance abuse, after treatment interventions have been tried, to a point that substance abuse substantially interferes with the team's ability to address the primary Axis I diagnosis and patient does not appear to work towards harm reduction or abstinence as a goal.
    d. Repeated non-compliance with treatment or program rules.
    e. Discharge to inpatient due to:
        i. suicide attempt or high risk of suicide;
        ii. serious injury;
        iii. accidental injury;
        iv. acute exacerbation of symptoms;
        v. danger to others.
5. Patient refusal to continue in treatment.
    When patient refuses to continue in treatment, follow-up efforts will be made by the

Therapist;

6. The patient will be discussed at the treatment team meeting and interventions planned in an effort to re-engage patient;
   Patients may be administratively discharged if they do not attend the Program on a regular basis and have failed to respond to repeated attempts to re-engage; and Program physician may discharge the patient due to lack of follow through with treatment recommendations.
7. All anticipated discharges from the Program will be discussed with the physician and significant others involved in the patient's care, before a discharge decision is made.
8. The focus of discharge planning is to assist patients in achieving and maintaining their goals. This will be provided on a group/individual basis and will be related to the treatment plan. Assessing the potential of each individual, evaluating his/her progress in overcoming deficits, and counseling the patient to develop expectations for him/herself will be an on-going part of treatment. Planning for a smooth transition from the Program will also be an ongoing part of treatment.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical Staff

~~1.~~**2.** Patient progress toward goals and appropriateness for discharge will be discussed in treatment team meetings and the discharge plan will also be reviewed at the treatment team meeting.

~~2.~~**3.** A plan of transition will be developed, which includes contacting the appropriate referral agency, establishing a time-line for discharge from the program, actively involving the patient in the planning and a subsequent decrease in treatment days.

~~3.~~**4.** The plan of transition will be developed to limit the potential for separation related stress and/or increased symptomatology. The plan will be discussed with, and agreed upon by the patient.

~~4.~~**5.** When the transition is complete, with the approval of the treating psychiatrist, patient, and the treatment team, the patient will be discharged from the Program.

~~5.~~**6.** When discharging a patient:

a. Complete the discharge checklist on the day of discharge
b. Complete the Aftercare plan, to include the discharge medications, discharge instructions, and follow up care. In the case of an unanticipated discharge, mail the patient and caregiver a copy of this Aftercare plan.
c. Audit the chart and check for:
   i. all pages labeled/identified with name of patient, date of birth, date of admission, attending physician and Medical Record number;
   ii. all progress notes completed, dated and signed;
   iii. all orders noted and signed;
   iv. physician progress notes and treatment plan reviews are current
d. The complete discharge summary must be written and signed within ~~10 working days of discharge.~~**3 days by ~~M~~dthe physician/Allied Health Professional (AHP) on their next scheduled day.**

~~6.~~**7.** The medical record may be retained on site for up to ten days.

~~7.~~**8.** The discharge audit form is completed by the therapist within ~~ten~~ **five** days of discharge. The chart will then be sent to Medical Records to be scanned.

D. **REFERENCE(S):**

~~8.~~**1. California Hospital Association (2017). *California Hospital Consent Manual.* Sacramento, CA: California Hospital Association.**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Utilize Administrative Policy: 513 Disclosure of Protected Health Information (PHI)

SUBJECT: Disclosure of Information Over The Telephone

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To insure confidentiality of the patient's treatment and define the procedures for maintaining confidentiality.~~

~~B. POLICY~~

~~1. It is the policy of the Outpatient Behavioral Health Services to prohibit dissemination of patient information over the telephone, except to those individuals identified and specified by consent of the patient.~~

~~C. PROCEDURE~~

~~Who may perform/responsible:all OPBHS staff.~~

~~1. Patients may specify persons able to receive information.~~

~~2. If consent is given, information will be limited to statements regarding the patient's progress in the Outpatient Behavioral Health Services.~~

~~3. Without a consent, inquiring callers will be told that information is not given over the telephone, such a statement may be phrased as follows:~~

~~"Patient confidentiality prevents my being able to confirm a person's presence here or give out any information."~~

~~4. Treatment related information can be given to treatment providers in situations, including handoff, treatment coordination, or arranging for psychiatric hospitalizations.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Dress Code for Patients

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE~~

~~1. To define the dress code for patients attending Outpatient Behavioral Health Services~~

~~B. POLICY~~

~~1. While attending Program, all patients must be appropriately dressed.~~

~~C. PROCEDURE~~

~~1. Patients will be given the following general guidelines.~~

~~a. All clothing should be appropriate and clean. No tube tops, short shorts, bare back dresses or tank tops are to be worn. No bare torsos for men or women;~~

~~b. Hair should be clean and well groomed. Personal hygiene should be maintained.~~

~~c. Footwear should be well fitting; shoes and socks/stockings or sandals may be worn. No bare feet or excessively high heels that could reduce mobility or stability and result in increased risk of injury.~~

~~2. Problems with personal hygiene and inappropriate dress will be dealt with as a treatment issue by the treatment team and may result in being asked to go home to change clothing or attend to hygiene.~~

~~3.~~1. ~~Patients with a history of incontinence will be asked to bring an extra pair of clothing in case of an emergency.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Family Involvement

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE**
1. To identify the role of the family in the patient's treatment.

B. **POLICY**
1. When appropriate, the patient's family and or significant others will be involved in the patient's treatment.

C. **PROCEDURE**
1. Who may perform/responsible: Clinical staff
2. At the time of screening, the **Community Liaison Coordinator** (CLC) will discuss the opportunity for family participation in treatment with the potential patient and the family when appropriate.
3. With the patient's consent, family members will be encouraged to participate in the treatment process ~~by attending treatment planning sessions or participaing~~**by participating** in family therapy sessions as ordered by the attending physician.
4. With the patient's consent, the family will also be involved in the discharge planning process.
5. A Release of Information must be signed by the patient before any interaction is initiated with the family or significant other, or before any information is provided to them.

D. **RELATED DOCUMENT(S):**
~~5.~~1. **Patient Care Services Policy: Patient and Family Education**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Involuntary Patient Detention**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To protect the patient's health and safety when the patient is a danger to self, danger to others and/or gravely disabled

B. **POLICY:**

1. When a patient displays behavior that indicates s/he is a danger to himself/herself or others, gravely disabled as a result of a mental disorder ~~, from inebriation, or the use of narcotics or dangerous drugs,~~ he/she may be placed on a 5150.

C. **PROCEDURE**

1. Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) clinical staff.
~~1.~~2. When a patient presents as a danger to self, danger to others or gravely disabled, the staff must follow **OBHS**~~Behavioral Health Outpatient Services~~ policies (see **Outpatient Behavioral Health:** Suicide Assessment, Psychiatric Emergencies, and Destructive or~~and~~ Potentially Violent Behavior policies).
~~2.~~3. Staff has the legal obligation to contact authorized personnel for psychiatric evaluation of patient for involuntary detention per physician recommendation.
~~3.~~4. Those staff authorized to initiate a 5150 can complete the necessary paperwork with the attending physician's approval. **See Patient Care Services: Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient Policy.**
~~4.~~5. Staff is to assist in patient disposition as requested by the authorized person(s). If the patient is uncooperative or the situation is particularly lethal, police assistance may be called for.

~~5.~~D. **RELATED DOCUMENT(S):**

~~6. Behavioral Health Services: Involuntary Hold Patients~~
~~7.~~1. **Outpatient Behavioral Health Policy: Suicide Assessment**
2. **Outpatient Behavioral Health Policy: Psychiatric Emergencies**
3. **Outpatient Behavioral Health Policy: Destructive or Potentially Violent Behavior**
~~8.~~4. **Patient Care Services Policy: Hold 72 Hours, Evaluation and Treatment of the Involuntary Patient**

E. **REFERENCE(S):**

1. **County of San Diego Health and Human Services Agency (2014). Training Packet for Involuntary Detainment Under Welfare and Institutions Code 5150.**
~~9.~~2. **Involuntary Treatment, Cal. S. 5150 – 5349.5, Chapter 2 (Cal. Stat. 1967).**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Laboratory Services

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide laboratory services for patients attending the **Outpatient** Behavioral Health ~~Outpatient~~ **Services (OPBHS)**~~Program~~.

B. **POLICY:**

1. ~~Outpatient Behavioral Health Services~~**OPBHS** provides patients access to Tri-City **Healthcare District (TCHD)** ~~Medical Center~~ laboratory services as ordered by the attending physician/**Allied Health Professional (AHP)** or medical consultant.

C. **PROCEDURES:**

1. Who may perform/responsible: **Registered Nurse** (R.N.) and Laboratory Staff
~~1.~~**2.** The R.N. notes the ~~M.D.~~**physician/AHP** order for laboratory services and completes the appropriate lab requisition form indicating that results are either to be faxed or printed at the program.
~~2.~~**3.** The R.N. refers to the **physician/AHP**~~MD~~ order and hospital lab for any special provisions or preparations (i.e. fasting; hold a.m. prescription) and instructs patients prior to lab work.
~~3.~~**4.** The R.N. arranges with the patient the date and time of laboratory procedures.
~~4.~~**5.** The R.N. provides the phlebotomist with the completed laboratory requisition forms and assists in identifying the patients scheduled for laboratory procedures.
~~5.~~**6.** Same sex staff should supervise collection from patients of specimens for drug and alcohol urine screenings.
~~6.~~**7.** The R.N. is responsible for correctly labeling the urine specimen and arranging for safe transport to the laboratory.
~~7.~~**8.** All staff handling urine specimens **are to** utilize Infection Control: ~~procedures and Universal~~ **Standard and Transmission-Based** Precautions.
~~8.~~**9.** The **physician/AHP**~~MD~~ signs lab results and the labs are filed in the lab section of the medical record.
~~9.~~**10.** In the event of a critical lab value, the RN contacts the **physician/AHP**~~MD~~ immediately, and proceeds with **physician/AHP**~~MD~~ orders.

D. **RELATED DOCUMENT(S):**

~~10.~~**1. Infection Control Policy: Standard and Transmission-Based Precautions**

E. **REFERENCE(S):**

~~11.~~**1. Joint Commission Safety Manual**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Medical Emergencies**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define appropriate methods of handling emergency medical situations.

B. **POLICY:**
1. Medical emergencies are managed by **Outpatient Behavioral Health Services (OPBHS)**~~a program~~ **Registered Nurse** (R.N.). All clinical staff assisting in medical emergencies is required to maintain current **Basic Life Support (BLS)** Certification.

C. **PROCEDURE:**
1. Who may perform/responsible: Nursing Staff
~~1.~~**2.** For minor injuries (i.e., superficial cuts and bruises), the patient will be evaluated by the R.N. on duty. First aid treatment is provided by the R.N. The patient is referred to his/her primary care physician for follow-up, as necessary.
~~2.~~**3.** For acute medical conditions requiring immediate attention, the R.N. will arrange for the most appropriate type of transportation for the patient, to the nearest Emergency Department.
~~3.~~**4.** In cases of severe suicide attempts or medical emergency, the R.N. will initiate life saving procedures (i.e., CPR, direct pressure, etc.) and have a staff member immediately dial 911.
~~4.~~**5.** Any first aid or other medical services provided to the patient must be documented by the R.N. in the patient's medical record.

D. **RELATED DOCUMENT(S):**
~~5.~~**1.** **Outpatient Infusion Center Policy: Medical Emergencies**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Medically Excused Absences

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE:**~~

~~1. To define the process for excusing medically ill patients from Program.~~

~~B. **POLICY:**~~

~~1. The R.N. will screen and evaluate the symptoms of patients who request to leave the program for medical reasons.~~

~~C. **PROCEDURE:**~~

~~Who may perform/responsible: R.N.~~

~~1. Patients who complain of medical problems will be evaluated by the R.N upon arrival to the Program. If there is any question of medical instability during transport, the driver will call a Program RN immediately to determine what action should be taken.~~

~~2. Patients who request to leave program for medical reasons will be seen by the R.N. for evaluation of symptoms.~~

~~3. The R.N. will observe the patient and discuss his/her signs and symptoms. The R.N. (or designated and trained staff) will take the patient's vital signs if needed and document in the medication record. and record them on the vital signs log.~~

~~4. The R.N. will evaluate the patient and based on the findings will:~~

~~5. Send the patient home from program if they have an elevated temperature or other valid medical complaint that makes it inappropriate for the patient to remain at the facility. When appropriate, the R.N. should call the patient or care provider to follow up on his/her status and to provide further recommendations as needed.~~

~~6. Provide the patient with the appropriate medical referral as indicated after consultation with the attending physician.~~

~~7. In cases of Medical Emergencies the nurse will send the patient to the Emergency Department or call 911 (depending on the severity of the emergency) and will notify the attending physician of the situation.~~

~~8. When a patient requests to leave the program for medical reasons on a consistent basis and no apparent medical reason can be found, the patient should be discussed at treatment team meetings to evaluate appropriateness of OPBHS level of care. The team will then provide special treatment interventions to encourage the patient to remain in treatment, or to provide appropriate referrals in the community.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Medicare Additional Development Document Request

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE:**~~

~~1. To ensure proper and timely preparation and tracking of Additional Development Requests which is critical in assuring reimbursement for services and limiting the amount of time revenue is suspended from payment.~~

~~B. **PROCEDURE:**~~

~~Who may perform/responsible: OPBHS Operations Manager or designee and Tri-City Medical Center Business Office.~~

~~1. Notification of ADR:~~

~~a. The Operations Manager is responsible for overseeing and monitoring the process by which **notified of any** Additional Development Requests (ADR) are obtained from the Fiscal Intermediary (FI) on the DDE system located on site.~~

~~b. The Patient Accounting office should access**will check** the DDE system a minimum of twice per week to receive notification of the ADR's and/or Denial of payment of suspended claims.**for any ADRs, Denials, or suspended claims.**~~

~~2. Tracking Systems:~~

~~a. The Operations Manager or designee is responsible for developing systems for tracking ADR's and Denials.~~

~~b. Upon receipt of an ADR(s) entry will be made in the tracking system logs. These logs are to be updated on a regular basis and will be sent to the Billing Office at Tri-City Medical Center upon request.~~

~~3. ADR Chart Preparation:~~

~~a. The FI will allow**usually allows** the Tri-City Medical Center at least 30 days to submit an ADR. If the FI does not receive the requested documentation by the date indicated on the ADR, payment is automatically denied without right to appeal.~~

~~b. Review the ADR carefully for the specific requested items and dates of service (DOS) in question. It is critical that every item requested by the FI in an ADR is sent, or a letter of explanation for anything omitted~~

~~c. Make two (2) copies ADR, UB92, and itemized billing statements. One set is retained on site in the event of a Denial and the other is attached to the copied chart that is sent to the FI.~~

~~d. Copy the medical record using the ADR/Denial Checklist as a guide. Section dividers should be utilized to assist the reviewer in identifying the requested documentation. All copies should be clear and legible.~~

~~e. After the chart is copied and collated, it should be reviewed two (2) times by designated Outpatient Behavioral Health staff for completion.~~

~~f. All ADR's should be mailed directly to the FI via certified mail and a return receipt requested.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Non-~~compliance~~-Adherence with Program Rules

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE:**~~

~~1. To maintain a therapeutic treatment milieu within Outpatient Behavioral Health Services.~~

~~B. **POLICY:**~~

~~1. Habitual or repeated noncompliance **non-adherence** with Program rules is viewed as a treatment issue that requires assessment and intervention.~~

~~2. Noncompliance **Non-adherence** may be a behavioral cue signifying the need for further assessment of the appropriateness of the current treatment or the addition of new therapeutic interventions.~~

~~C. **PROCEDURE:**~~

~~1. Who may perform/responsible: OPBHS Staff~~

~~2. Information will be collected regarding the noncompliant **non-adherent** behavior in various ways: observation of the patient, gathering information from other sources such as family/ significant others, conferring with other program staff and reviewing attendance sheets.~~

~~3. When there is a problem with habitual or repeated noncompliance**non-adherence**, the Therapist will meet with the patient in an effort to assess the nature and possible reasons for the problem. The rules will be restated to the patient at that time.~~

~~4. If the problem remains unresolved, the Therapist will bring the problem to the treatment team for problem solving. The patient may be asked to attend this meeting. A therapeutic behavioral contract will be written with patient input and added to the treatment plan.~~

~~5. If all of the above steps have been followed and noncompliance **non-adherence** continues, the attending psychiatrist and the treatment team, after consultation, may decide to discharge the patient from the Program.~~

~~6. If the patient is referred for re-admission to the Program, a contract, specifying treatment adherence and expectations regarding participation, should be signed prior to readmission.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Organizational Structure**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define lines of responsibility for clinical supervision and administrative supervision.

B. **POLICY:**

1. **Outpatient Behavioral Health Services** (OPBHS) staff operate using the guidelines of the organizational structure, and obtain both clinical and administrative supervision.

C. **PROCEDURES:**

1. Who may perform/responsible: Tri-City **Healthcare District (TCHD)**~~Medical Center~~ Administrative Staff, Medical Directors, Operations Manager and Director of Behavioral Health or designee.

~~1.~~**2.** Clinical Supervision:

a. All patients must be admitted by a psychiatrist who has the responsibility for supervising and periodically evaluating all treatment services provided to the patient under his/her care. The attending physician/**Allied Health Professional (AHP)** must also provide supervision and direction to any therapist involved in the client's treatment. The ~~Program~~**OPBHS** Medical Director(s) has responsibility for overseeing and ensuring the quality of care provided to the patients. The Medical Director(s) reports administratively to the Operations Manager. The Medical Director(s) reports in all matters of a clinical nature to the ~~Tri-City Medical Center~~**TCHD** Psychiatric Committee.

~~2.~~**3.** Administrative Supervision:

a. The Operations Manager provides administrative supervision of all ~~Outpatient Behavioral Health~~**OPBHS** staff and has administrative responsibility for all aspects of the ~~Program~~**OPBHS**. The Operations Manager reports to the Director of Behavioral Health or CNE.

~~3.~~**4.** Site Management:

a. Administrative and financial operation of the ~~Program~~**OPBHS** is the responsibility of ~~Tri-City Medical Center~~**TCHD**. The Operations Manager has responsibility for day to day operation of the site including staff recruitment and supervision, clinical services, nursing services, environmental maintenance, quality improvement and utilization review activities. Also included is monitoring of staff and physician documentation compliance and monitoring of compliance to all ~~Tri-City Medical Center~~**TCHD** rules, policies and procedures.

b. The Medical Director(s) has responsibility for overseeing the quality of medical care provided at the ~~Program~~**OPBHSs**. The Medical Director(s) must be a Board Certified or Board Eligible Psychiatrist and be a member in good standing of the ~~Tri-City Medical Center~~**TCHD** medical staff and a member of the appropriate ~~Tri-City Medical~~

~~Center~~**TCHD** medical committee. The Medical Director(s) attends weekly treatment planning meetings, clinical problem solving meetings and is available to the Operations Manager and staff to consult on ~~difficult~~ cases, physician issues and clinical programming. The Operations Manager **and Registered Nurses (R.N.s)** provide~~s~~ initial orientation and training of all Medical Director(s). The training includes:

i. responsibilities and duties of the Medical Director(s);
ii. documentation requirements;
iii. policies and procedures; and
iv. clinical program guidelines.

~~4.~~**5.** Quality Improvement and Utilization Review:

a. The Operations Manager has responsibility for monitoring and reporting Quality Improvement and UR issues to **TCHD**~~Tri-City Medical Center~~ Director of Behavioral Health and other medical staff committees. This includes an analysis of trends and a plan of correction when needed. Reports provide statistical analysis and trending of results across programs and recommend changes in programming, policies and procedures based upon an analysis of the results.

~~5.~~**6.** Personnel:

a. Clinical and administrative personnel at OPBHS are ~~Tri-City Medical Center~~**TCHD** employees. All employees must satisfy the personnel requirements set forth by ~~Tri-City Medical Center~~**TCHD** (which may include) a pre-employment physical with a PPD test or chest x-ray. The operations Manager or designee provides an orientation for all new employees. Staff development is provided on a regular basis to all staff. The Operations Manager is responsible for overseeing compliance with:

i. TCHD~~MC~~ policies;
ii. The Joint Commission, Medicare, or appropriate standards, and staff development requirements (i.e., ~~Tri-City Medical Center~~**TCHD** orientation, **Basic Life Support**, ~~infection control,~~ fire/disaster training, etc.);
iii. state and federal employee regulations; and
iv. periodic and annual performance evaluations.

~~6.~~**7.** Community Development and Liaison **(CLC):**

a. The CLC is responsible for screening each potential patient to determine clinical appropriateness for admission. The CLC also has responsibility for establishing and maintaining relationships with community agencies, residential care facilities, public and private mental health providers, advocacy groups and others involved in the treatment of the mental health patients in the community. The maintenance of these relationships is critical in providing a continuum of care for patients with psychiatric disabilities. Additionally, the CLC is responsible for developing community education programs for both professionals and non-professionals involved with patients.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Utilize Patient Care Services: Patient Complaints and Grievances Policy

SUBJECT: Patient Complaints

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To identify the procedure the patient is to follow for registering a complaint.~~

~~B. **POLICY**~~

~~1. Patient complaints, whether written or verbal, are never ignored. Complaints are evaluated and feedback is given to the patient.~~

~~C. **PROCEDURE**~~

~~Who may perform/responsible: Operations Manager, Director of Behavioral Health or designee~~

~~1. The patient complaint procedure is explained at orientation and reviewed as needed.~~
~~2. Patients are informed of their right to submit a grievance without fear of being subjected to discrimination or retaliation, or interruption of treatment.~~
~~3. During orientation the patient is given a copy of the complaints protocol, to include the phone numbers of the Clinical Coordinator, Operations Manager, Director, Patient Advocacy, and the Joint Commission.~~
~~4. To lodge a complaint, the patient tells the complaint to a staff member or Program Administrator.~~
~~5. The staff member reports the complaint to the Operations Manager.~~
~~6. When appropriate, the patient may discuss the complaint at the community meeting. Feedback must still be given to the patient.~~
~~7. The complaint is evaluated and the patient receives feedback on any action taken or not taken. If the patient does not think the issue is resolved, the patient has the right to call the Patient Rights Advocate or patient representative. A quality review report is completed whenever a complaint is not resolved.~~
~~8. The Operations Manager/designee evaluates the complaint and, if necessary, informs the Tri-City Medical Center Director of Behavioral Health, or CNE..~~
~~9. If the complaint concerns quality of care, safety or patients' rights, the Operations Manager must inform the Director of Behavioral Health and develop a plan of action to correct the situation. Results of follow-up corrective action will be reported to the appropriate Tri-City Medical Center committees and through a quality review report.~~
~~10.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Physician Admission Order

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To clarify what is necessary for admission to Outpatient Behavioral Health Services **(OPBHS)**.

B. **POLICY:**
1. Admission to the ~~Program~~ **OPBHS** must be upon the order of a program physician~~/Allied Health Professional (AHP)~~.

C. **PROCEDURE:**
1. Who may perform/responsible: TC**HD**~~MC~~ credentialed physicians~~/AHPs~~.
~~1.~~**2.** A Physician Admission Order must be received on the day the patient is admitted to the ~~Program~~**OPBHS**.
~~2.~~**3.** The patient may be admitted with a telephone order but must be seen by the physician~~/AHP~~ within seven days of admission to ~~Program.~~**Intensive Outpatient and within 24 hours of admission to Partial Hospitalization Program.**
~~3.~~**4.** All assessments, ~~Program~~ **OPBHS** interventions (group therapy, individual and family therapies) must be ordered by a program physician~~/AHP~~.
~~4.~~**5.** On admission, the physician~~/AHP~~ orders the duration of treatment, based on medical need.
~~5.~~**6.** Admission to ~~Outpatient Behavioral Health~~**OPBHS** requires a general health statement by the admitting physician, indicating medical stability.

D. **REFERENCE(S):**
~~6.~~**1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Unit

DELETE – Covered in Patient Care Services: Physician/Provider Orders Policy

SUBJECT: Physician and Nurse Practitioner Orders

ISSUE DATE: 08/96
REVIEW DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/15
REVISION DATE(S):

Department Approval Date(s):	~~11/15~~01/16
Division of Psychiatry Approval Date(s):	06/17
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	07/17
Professional Affairs Committee Approval Date(s):	08/17
Board of Directors Approval Date(s):	

~~A. **PURPOSE:**~~

~~1. To communicate to the staff, the patient's comprehensive treatment, such as, medication changes**medication changes**, treatment frequency changes, etc.~~

~~B. **POLICY:**~~

~~1. Physician/**Nurse Practitioner (NP)** orders are required for all patient treatments and procedures.~~

~~C. **PROCEDURE:**~~

~~1. Who May Perform/Responsible: Physician/**NP** and R.N.~~

~~a. All medical orders meet the following criteria:~~

~~i. Date, Time; and are legible and clear.~~

~~ii. The RN notifies the physician/**NP** if patient unable to comply with the medical order.~~

~~iii. Telephone orders may be obtained from the physician/**NP** by RNs, within their scope of practice.~~

~~iv. Telephone orders must be signed by MD/**NP** within 48 hours.~~

~~v. Telephone orders include the following:~~

~~1) Date;~~

~~2) Time;~~

~~3) The order as stated by physician/**NP**~~

~~4) Name of the physician/**NP** and signature and title of person taking the order;~~

~~5) A flag labeled "Signature Needed" placed at the right side of the page; and~~

~~6) Telephone orders are verified by reading the order back to the physician/**NP** at the time the order is taken.~~

~~vi. All medication orders shall include the date, time, name of the drug, the dosage, frequency and route of administration. PRN medications include the indications for the medication.~~

~~b. Processing of Preprinted Admission Orders:~~

~~i. A preprinted Admission order sheet is used at the time of admission.~~

~~A. The physician/**NP** dates, times and signs the preprinted orders. If the physician/**NP** is ordering any services not listed on the preprinted order, he/she will write this order on an order sheet.~~

~~c. Nurses Responsibility:~~

~~i. The RN notes all orders with the date, time, and signature, including telephone orders.~~

~~ii. Ensures that Telephone orders are signed by the M.D/**NP**. within 48 hours.~~

~~iii. Ensures that the physician has checked all the appropriate interventions and assessments.~~

~~iv. Does not alter the physician **NP**'s order or add any additional information to the order, after the physician/**NP** signs it.~~

~~v.~~i. ~~Notifies the physician/**NP** regarding any concerns with the MD orders, for clarification, or additional direction to carry out~~ the order.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: ~~Plan for Professional Services and Staff Composition~~**Scope of Services**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the specific plan and staff qualifications necessary to provide treatment in the intensive outpatient and partial hospitalization Program (PHP). Intensive Outpatient Treatment is a level of care that provides treatment for individuals with psychiatric illness who continue to require structured treatment but of lesser intensity than is offered in Inpatient Behavioral Health Treatment. Partial hospitalization is a level of care that is more intensive than IOP, provided for patients exhibiting severe and disabling symptoms.

B. **POLICY:**

1. In providing treatment in the Intensive Outpatient Treatment and partial hospitalization programs, the goal of the Behavioral Health Outpatient Services is to provide psychiatric treatment to individuals with psychiatric illness as defined in the current DSM of the American Psychiatric Association, in a less restrictive setting than an inpatient unit. The benefits of this type of care include: lessening the disruption of social, family and community ties; encouraging the patient to test new skills in a more natural environment than a hospital setting; providing a treatment milieu that fosters independence and self reliance; soliciting feedback from the home environment thereby involving the patient's family or care providers in the treatment process and providing cost-saving benefits through a shortening of the inpatient stay or preventing the need for full hospitalization.

C. **SERVICES OFFERED:**

1. The Program philosophy of care is based on the belief that individuals with psychiatric symptoms can achieve recovery, maintain stability, and reach their maximum rehabilitation potential through the provision of quality, goal oriented treatment. Outpatient Behavioral Health Services **(OPBHS)** provides a highly structured treatment environment that is predicated on personal responsibility, individual dignity and respect for self-determination. Individuals served in OPBHS attend groups and activities based on an individualized assessment of their needs. Each patient is encouraged to participate with the staff and physician in planning their treatment, setting realistic, obtainable goals and assessing their progress in the Program.
2. The ~~Outpatient Behavioral Health Services~~**OPBHS** utilizes a blend of psychosocial rehabilitation and the medical model of treatment to help individuals achieve recovery. The Program is continually evaluated, utilizing feedback from physicians, staff, and patients; and evidenced-based information. The Program is responsive to the needs of the patients and the community standard of practice.
3. A highly trained and motivated staff is the key to maintaining a quality clinical Program. Staff development is promoted through a comprehensive orientation Program, ongoing in-service education and continuing educational opportunities. The philosophy revolves around the patient,

his/her unique needs and assisting the patient to cope more effectively with psychiatric symptoms and life stressors. Assessment of a person's needs is based on past history and present level of functioning. Every area is assessed including physical, psychological, social, spiritual and environmental, so that a treatment plan is designed specific to each patient's needs. Through individual and group experiences in the OPBHS, progress will be assessed and the treatment interventions modified, as needed, to accomplish the goals defined by the patient and the treatment team. The ~~Outpatient Behavioral Health Services~~**OPBHS** are designed to provide a series of successful experiences, allowing the patient to utilize skills learned, that result in enhanced symptom management and personal empowerment.

D. **CLINICAL PROGRAM:**

1. The clinical Program is based on the ~~principals~~ **principles** of recovery, crisis stabilization, psychiatric rehabilitation and relapse prevention. Programming includes group psychotherapy and individual psychotherapy, focusing on recovery, life management skill building, symptom management, functional skills development, relapse prevention and developing/utilizing a community based support system. Dual Recovery groups are also provided for patients with Co-Occurring Mental Health and Substance Use Disorders.

E. **POPULATION SERVED:**

1. The ~~Outpatient Behavioral Health Services~~**OPBHS** treats persons from the age of 18 and up who have a DSM psychiatric disorder with a primary Axis I diagnosis of Schizophrenia, or other psychotic disorders, Anxiety Disorders, Mood Disorders, ~~,~~ Somatoform Disorders, Eating Disorders, Personality Disorders, and other Diagnostic Categories that significantly impact functioning.

F. **ACCESSING SERVICES:**

1. A person may enter the ~~Outpatient Behavioral Health Services~~**OPBHS** in several ways:
2. Referral by a discharge planner as a follow-up to inpatient treatment;
3. Self-referral in coordination with a treating physician/**Allied Health Professional (AHP)** (If the patient is not currently in treatment with a psychiatrist, one will be assigned from the medical staff);
4. Community referral from a family member, board and care manager, conservator, social worker, or therapist.
5. Physician referral (The primary psychiatrist is encouraged to follow the patient while in treatment and a co-treatment option may be available).

G. **HOURS OF OPERATION:**

1. The ~~Outpatient Behavioral Health Services~~**OPBHS** will provide three to four hours of clinical programming a day, Monday through Friday, except major holidays. Patients in IOP **usually** receive no more than ~~eleven~~ **twelve (12)** units of service per week. Patients in the PHP can receive more services, up to four per day, five days per week. **Some exceptions can be granted for brief periods if the level of symptoms increase, and the insurance care manager approves.**

H. **SCREENING:**

1. When an individual is referred for treatment in the ~~Outpatient Behavioral Health Services~~**OPBHS**, an appointment is set for an initial screening. This is performed by the Community Liaison Coordinator (CLC), but may be done by another health care professional on the staff. The purpose of the initial screening is to determine if the patient meets the clinical admission criteria for OPBHS (Admission & Eligibility Criteria policy). If the results of the initial screening indicate that the patient is not appropriate for this level of care, the referral source is contacted and an appropriate referral is made.

I. **ASSESSMENT AND EVALUATION:**

1. Upon admission to the ~~Outpatient Behavioral Health Services~~**OPBHS**, an initial psychiatric

assessment, nursing assessment, psychosocial assessment, suicide **risk** assessment, and if indicated, a substance abuse assessment will be completed. When a person is evaluated for treatment, the following information is obtained:

a. Past psychiatric history;
b. Current psychiatric/medical diagnosis and any medications being prescribed;
c. Current symptoms;
d. Risk for suicide;
e. Risk for Falls;
f. Substance abuse history;
g. Identification of patient's strengths; and
h. Any special considerations.

J. **METHOD OF SERVICE DELIVERY:**

1. Clinical needs, once identified, will be addressed in group and on an individual basis. Structured psycho-educational and process groups will utilize appropriate materials to enhance learning and address specific issues related to symptom management and functional living skills. The focus is on recovery, medication management, symptom management, community living skills, crisis management, managing relationships, personal care management, substance abuse recovery and other topics as needed.

K. **THERAPEUTIC PROGRAM:**

1. All services provided are appropriate for the treatment of the patient's identified problems. OPBHS will assist in the improvement of the patient's functional level and reduce the risk for exacerbation of symptoms, relapse on drugs or alcohol and hospitalization. Programming is individualized so that patients may initially attend two to five days per week as needed. As the patient improves, it is anticipated that he/she will move to a lower level of care. This will assist in maintaining stability and preventing psychiatric decompensation.

L. **TREATMENT PLANNING AND REVIEW OF GOALS AND OBJECTIVES:**

1. The treatment planning process involves the establishment of Master Treatment Plan within seven days of admission to the ~~Outpatient Behavioral Health Services~~**OPBHS**. This individualized treatment plan is written based on the patient's identified symptoms, goals, and wishes, and in collaboration with the patient. The plan is written by the Therapist assigned to the patient, and is initiated under the direction of the admitting psychiatrist. Within seven days of treatment, a Master Treatment Plan (MTP) is completed by the Treatment Team, under the direction of the attending physician and/or Medical Director. After the completion of the MTP, the next treatment plan review will occur monthly for IOP or **bi**-weekly for PHP. The plan is also reviewed if the patient goes into crisis, or if their condition changes, so that treatment provided in the Program accommodates newly identified needs.

M. **DISCHARGE PROCESS:**

1. The patient's discharge needs are identified on admission to the ~~Outpatient Behavioral Health Services~~**OPBHS**. As the patient's needs become more defined, programming and discharge planning for the patient will be modified to meet those needs. As part of the discharge planning process, the Therapist will follow-up with the referral source and those in the community providing support, as well as the patient, to assure a smooth transition back into the community and/or a transition to a lower level of care.

N. **ORGANIZATIONAL RELATIONSHIPS:**

1. The ~~Outpatient Behavioral Health Services~~**OPBHS** staff is accountable to the Operations Manager. Each interdisciplinary treatment team member has input into the Program planning process. Staff meetings are held ~~bi-~~monthly or as necessary to address problems as they relate to patient care.
2. The Operations Manager/designee has the authority to make operational decisions on a day to day basis. The Operations Manager is supervised by the Director of Behavioral Health or **Chief**

Nurse Executive (CNE).

O. **EMERGENCY SERVICES:**

1. If a crisis or emergency psychiatric situation should occur at the site, immediate contact will be made by staff to de-escalate the situation. If attempts by staff at verbal de-escalation fail, emergency procedures will be initiated (see Psychiatric Emergencies). If a medical emergency occurs, it will be evaluated by the **Registered Nurse** (RN) and 911 will be called, if necessary (see **Outpatient Behavioral Health:** Medical Emergencies **Policy**).

P. **AFTERCARE AND POST-DISCHARGE:**

1. Post discharge planning will be provided by the patient's Therapist in an effort to provide continuity of care. The Clinical Coordinator and ~~Community Liaison Coordinator~~**CLC** will maintain and make available to staff, a current list of community resources. An Aftercare group, facilitated by a program therapist, will be offered one time per week as a free follow-up support service.

Q. **STAFFING QUALIFICATIONS AND PATTERNS:**

1. The ~~Outpatient Behavioral Health Services~~**OPBHS** will provide clinical services delivered by qualified health care professionals to adequately assess and address the identified clinical needs of patients. These services are augmented by administrative and support staff necessary to maintaining a comprehensive and responsive treatment program. Professional staff meets all federal and state requirements for licensing, registration or certification. Clinical staff providing services are Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT), Psychologists, and **Master of Social Work** (MSW) and MFT interns who are supervised on site by licensed practitioners. There will be availability of professional nursing services to meet the needs of those patients requiring such services. Nursing services are provided by Registered Nurses who provide, supervise and evaluate nursing care.
2. Each therapist working a forty (40) hour week will be responsible for managing an average total of sixteen to twenty patient cases (on their caseload) and facilitating ten groups per week.
3. When appropriate qualified professional staff members are not available or are not needed on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

R. **RELATED DOCUMENT(S):**

1. **Outpatient Behavioral Health Policy: Medical Emergencies**

S. **REFERENCE(S):**

1. **Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**
2. ~~4.~~ **Joint Commission Safety Provision of Care 2017**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Positive Reinforcement Techniques

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To provide parameters for use of positive reinforcement techniques in the attainment of patient treatment goals.~~

~~B. **POLICY**~~

~~1. Only clinically acceptable, positive reinforcement techniques are to be utilized, if at all, in the treatment of a patient. Such techniques must be incorporated into the written treatment plan and approved by the patient's attending physician, and must not fall into any of the exclusion categories listed below.~~

~~C. **EXCLUSIONS**~~

~~1. Any incentive that is likely to influence or induce an individual to receive services, or to continue to receive services, or to improve attendance (including, but not limited to, money, gifts, cigarettes, or points) is strictly prohibited.~~

~~2. As a general guideline, immaterial items of nominal value (e.g., $10.00 and under) which would not likely influence or induce an individual to receive services and that also have some therapeutic value (such as, sobriety birthdays, birthday cakes or recognition certificates) would be allowed.~~

~~3. There shall be no attendance awards (or attendance based awards) such as, certificates or award ceremonies, which "reward" a patient for perfect attendance.~~

~~4. Token Economies and bonus stores, whether run by staff or patients, as a rule, are strictly prohibited. Only under particular patient circumstances and based upon an individual's treatment plan (and appropriate physician order), might it be approved, provided, that it would not likely influence or induce an individual to receive services, or to continue to receive services.~~

~~5. Exceptions may be made for the December holiday celebration; gifts not exceeding $20 in value may be given to patients. Staff must assure that all patients receive holiday gifts of equal value.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Psychiatric Emergencies

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the appropriate methods of handling emergency psychiatric situations.

B. **POLICY:**

1. Psychiatric emergencies should be handled by the most qualified person(s) available. Patient and staff safety are of prime concern.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical and Nursing Staff.

~~1.~~**2.** For minor psychiatric problems (i.e., agitation, oppositional behavior and verbal abuse of others), attempts should be made to isolate the patient from others in the milieu, reduce stimulation (i.e., noise, traffic), and prevent any further escalation of the behavior. Depending on how receptive the patient is to staff intervention, he/she may be permitted to rejoin the group, be instructed to take a "time out" or be excused from the ~~Program~~ **Outpatient Behavioral Health Services (OPBHS)** for the remainder of the day. The **Registered Nurse** (R.N.) may contact the physician/**Allied Health Professional (AHP)** to evaluate the need for a PRN medication.

~~2.~~**3.** There's a psychiatric emergency box that contains **emergency** medications, such as Cogentin, and Haldol.

~~3.~~**4.** For major psychiatric emergencies (e.g., suicide attempt or violence), the safety and welfare of the patient and the group are the primary concerns. Proceed by dialing 911, request the type(s) of assistance needed (e.g., ambulance, police), and remove all other patients from the area. In all cases, the patient's primary and attending psychiatrist (if not the same) are notified and consulted in a timely manner.

~~4.~~**5.** Physical restraint is not used as a clinical intervention. If a patient becomes violent, 911 must be called immediately.

~~5.~~**6.** For both major and minor psychiatric emergencies, the Clinical Coordinator, program R.N., or designated clinical staff member, must assess the need for inpatient hospitalization. This assessment must be made in consultation with the patient's attending psychiatrist. If the attending psychiatrist cannot be reached, the Program Medical Director should be notified and consulted. If the decision is made to admit the patient for inpatient hospitalization, the following procedures are followed:

a. The Clinical Coordinator, R.N. or Therapist discusses the need for inpatient hospitalization with the patient. The patient's family, residential care provider, case manager, and/or primary physician are also notified. If the patient agrees to voluntary admission, the staff makes transportation arrangements and the patient is transported to the inpatient unit. Relevant information from the chart (psychiatric evaluation, assessments, treatment plan, medication list, etc.) will be sent to the inpatient facility to

ensure coordination of treatment.

b. If the physician recommends a direct admission to the **Behavioral Health Unit** (BHU), the physician or designated staff must contact the physician on-call **or the Psychiatric Liaison** to make the recommendation and conduct hand-off communication

c. The Community Liaison Coordinator or Therapist maintains contact with the inpatient treatment team during hospitalization, to ensure continuity of care and a smooth transition back to the ~~Program~~ **OPBHS** after discharge from the inpatient unit.

d. When a patient **that is suicidal or homicidal, or gravely disabled,** ~~-~~ will not voluntarily accept admission to the inpatient unit, the involuntary detention procedure may be initiated by a physician or 5150 certified clinical staff under the direction of a physician.

~~6.~~**7.** Psychiatric emergencies that occur after program hours will be directed to call the 911, **Tri-City Healthcare District** TCHD~~MC~~ in-patient unit or a psychiatric Crisis hotline.

~~7.~~**8.** If the psychiatric emergency results in the patient's independently leaving the program during normal treatment hours, the clinical staff notifies the primary and/or attending physician, patient's family, residential care provider, case manager and anyone else actively involved in the patient's care. Police should be notified, if appropriate, and in all cases when the patient may be a danger to self or others, **or gravely disabled.** ~~-~~

9. All interventions and the results of the interventions must be documented in the patient's medical record by the R~~.~~N~~.~~ or clinician who managed the psychiatric emergency.

D. **RELATED DOCUMENT(S):**

1. **Behavioral Health Services Policy: Involuntary Hold Patients**

E. **REFERENCE(S):**

~~8.~~**1.** **Involuntary Treatment, Cal. S. 5150 – 5349.5, Chapter 2 (Cal. Stat. 1967).**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Referral and Admission Screening**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the referral and admission screening process.

B. **POLICY:**
1. Referrals for outpatient services are accepted from professional sources, through self-referral, from family members or from residential care providers. It is the responsibility of the Community Liaison Coordinator **(CLC)** (or his/her designated backup) to determine eligibility for service. All individuals that are in need of service should be evaluated as quickly as possible.
2. Whenever it is determined that a person, who is referred, is not eligible for services, it is the responsibility of the ~~Community Liaison Coordinator~~**CLC** to assure that an appropriate referral for alternative service(s) is made.
3. All persons accepted into the Program must meet admission criteria (see **Outpatient Behavioral Health:** Admission **&** /Eligibility Criteria Policy).

C. **PROCEDURE:**
1. Who may perform/responsible: ~~Community Liaison Coordinator~~**CLC** or designee
~~1.~~**2.** At the point of initial referral contact, the ~~Community Liaison Coordinator (~~CLC~~)~~ makes an initial determination of eligibility and legal status (if on conservatorship, the CLC obtains the conservator's consent to treat by the first day of admission to program). The CLC, along with the prospective patient, establishes a suitable time and location for admission screening. Screening may take place in an inpatient setting, at the patient's home, the program site, or other convenient location.
~~2.~~**3.** If the patient is referred by a non-psychiatrist, the CLC, after obtaining a release of information, contacts the psychiatrist currently working with the patient to determine if he/she agrees with the recommendation for treatment. The CLC inquiries about whether the community psychiatrist will continue to follow patient during treatment or if a program psychiatrist will follow the patient.
~~3.~~**4.** The CLC conducts a ~~face-to-face~~ screening and completes the "Referral and Screening Report" to establish eligibility and appropriateness for admission, to identify any special issues or concerns and to gather all essential background information. The CLC obtains a "Authorization for Release of Information" which can be used to obtain copies of clinical records from previous treatment providers ~~(see Release of Information Policy)~~.
~~4.~~**5.** The CLC will meet with the Operations Manager, Clinical Coordinator, RN or designees to triage the potential admissions ~~and~~ **or** to coordinate the admission process for any new patients.
~~5.~~**6.** The clinical staff will be briefed on all new admissions in the daily morning meeting. Briefing should include the patient's history and presenting problems.
~~6.~~**7.** The CLC will contact referral sources and the patient to advise them of specific admission activities, day and time. The CLC is responsible for assuring that arrangements for physician

coverage have been finalized.

~~7.~~**8.** In the case of a program re-admission, if the patient has been discharged from the program for more than 30 days, the CLC ~~will follow procedures outlined in A, B, C, D and E and~~ will complete the Re-Assessment Screening Form. In the event that a patient is discharged from the program for a period less than 30 days and is referred back to the Program, a new CLC assessment may not be necessary. The physician's Admission assessment, Psychosocial Assessment, and Nursing Assessment will suffice.

D. **CLC REFERRAL AND SCREENING REPORT: OVERVIEW:**

1. This report is used by the ~~Community Liaison Coordinator~~**CLC** for the purpose of evaluating clinical eligibility for admission to the Program. It is an important component to the admission process and should be thoroughly completed. This report is a document included in the medical record (in the admission section), and it should be filled out completely. The medical director and attending physicians should use this report as part of their orientation to any potential admission prior to completion of the Psychiatric Admission Assessment. The final decision whether to admit the patient to program is the psychiatrist's.
2. The report should support medical necessity for this level of intensity of treatment by documented evidence which identifies: recent inpatient hospitalizations; failed efforts to ameliorate symptoms through outpatient services/lower level of care; recent change in acuity of psychiatric ~~symptometology~~**symptomatology**; a description of decrease in functioning level; and, ~~of course,~~ evidence that the individual meets the diagnostic inclusion criteria and criteria related to type and severity of impairment.
3. The first page of this report is used primarily for billing purposes, transportation, and Therapist orchestration of services. Diagnosis, history of illness and psychiatric treatment, current symptomology, current risk factors, and the clinical admission criteria and summary of impressions are detailed in the screening report.

E. **FORM(S):**

1. **Authorization for Release of Information**
~~4.~~**2.** **Referral and Screening Report**

F. **RELATED DOCUMENT(S):**

1. **Outpatient Behavioral Health Policy: Admission & Eligibility Criteria**
~~5.~~**2.** ~~Outpatient Behavioral Health: Release of Information Policy~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Utilize Administrative Policy: 515 Use and Disclosure of Protected Health Information: Records

SUBJECT: Release of Information

ISSUE DATE: 08/96
REVISION DATE(S): 08/00, 07/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. PURPOSE:~~

~~1. To identify what circumstances necessitate a consent for release of information and to identify how a patient consents to the release of information.~~

~~B. POLICY:~~

~~1. A separate and individual Consent for Release of Information will be used to obtain copies of clinical records from any of the patient's previous treatment providers. A Consent for Release of Information will also be used with each significant individual involved in continuity of care with whom staff members have verbal contact. Although obtaining records is not the goal in this instance, consent for the purpose of open communication regarding different aspects of the patients care is necessary.~~

~~C. PROCEDURE:~~

~~1. Who may perform/responsible: OPBHS clinical or administrative staff~~
~~2. The patient will be told what information will be requested and to whom it will be released. The patient will be given an opportunity to discuss the release of information. The decision to consent must be voluntary.~~
~~3. The patient is informed that they have the right to revoke the release with a written request.~~
~~4. If the patient is under conservatorship, the signature of the conservator will be obtained for the purpose of the Consent to Treat.~~
~~5. The patient will be told that provision of treatment is not based on the consent to release information unless the physician states it is necessary for treatment.~~
~~6. The patient will be asked to read the authorization form and asked if there are questions. The staff member will respond to any questions.~~
~~7. On each form, the specific record(s) to be released will be indicated and the specific purpose of the disclosure will also be provided.~~
~~8. The patient will be asked to sign the form and date it indicating the release's expiration date.~~
~~9. A witness will sign name, date and indicate title.~~
~~10.~~1. ~~The signed form(s) will be placed in the Legal section of the patient's medical record.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Role of the Therapist

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To delineate the responsibilities of the Therapist in the ~~Programs~~**Outpatient Behavioral Health Services (OPBHS).**

B. **POLICY:**
1. **A therapist is defined as a qualified mental health clinician authorized by the state to provide services, such as a psychologist, licensed clinical social worker, marriage family therapist, licensed professional clinical counselor, or license eligible therapists with California Board of Behavioral health registration.**
~~1.~~**2.** On admission, all patients are assigned a Therapist. The Therapist acts as the primary ~~Program~~**OPBHS** treatment coordinator for the patient, coordinating all treatment services provided to the patient, under the direction of the attending physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical staff
2. Responsibilities of the Therapist:
   ~~1.~~**a.** Care Coordination:
      ~~a.~~**i.** Develops therapeutic relationship with individual patients in caseload. Schedules regular 1:1 interaction to review patient goals and progress;
      ~~b.~~**ii.** For each patient in caseload, the therapist has regular documented contacts with others involved in the patients care (i.e., physician, family members, residential care providers, case managers, conservators, etc.). Acts as liaison, as necessary, for information regarding treatment issues, changes in treatment plan, discharge plan, etc. These contacts may be both by phone and in person;
      ~~c.~~**iii.** Monitors patient attendance at treatment program, following up in a timely manner when attendance problems develop;
      ~~d.~~**iv.** Gathers information, initiates and implements behavioral contracts as needed;
      ~~e.~~**v.** Assists in obtaining insurance authorizations and counseling patient on funding issues, as needed;
      ~~f.~~**vi.** Coordinates with attending physician all treatment plan changes, reviews patient progress and discharge plan; and
      ~~g.~~**vii.** Maintains patient satisfaction with the treatment program.
   ~~2.~~**b.** Treatment and Documentation:
      ~~a.~~**i.** Facilitates group treatment modalities within scope of practice, as assigned by the Operations Manager, using approved curriculum and standard group facilitation techniques.
      ~~b.~~**ii.** Conducts initial assessment of new patients within caseload and develops the

treatment plan with patient and team collaboration. Develops master treatment plans in a timely manner as prescribed by ~~program~~**OPBHS** policies and procedures, using data from all assessments and with approval from treatment team.

~~c.~~**iii.** Reviews and updates treatment plans for patients within caseload, as defined in the ~~program~~**OPBHS** policies and procedures.

~~d.~~**iv.** Utilizes treatment planning meetings to review problems, progress and discharge plans for all patients on caseload.

~~e.~~**v.** Documents progress on a daily basis for all patients in groups facilitated by a Therapist. Progress notes are accurate; refer to problems identified on the treatment plan, and address group focus and patient response as related to treatment goals. ~~Notes are written legibly.~~**All documentation must be legible.**

~~f.~~**vi.** Documents each incident or unusual occurrence at the time it happens.

~~g.~~**vii.** Monitors medical records, for all patients within caseload, to insure completeness and accuracy. Notifies Operations Manager of any deficiencies and develops a plan of correction.

~~h.~~**viii.** Completes discharge summaries for all patients on caseload as prescribed by ~~program~~**OPBHS** policies and procedures.

~~3.~~**c.** Other Duties:

~~a.~~**i.** Participates in public relations and educational activities as assigned by the Operations Manager.

~~b.~~**ii.** Assists in the evaluation of patients referred for admission to ~~program~~**OPBHS**, as requested by Operations Manager.

D. REFERENCE(S):

1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Smoke Free Environment

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish a smoke free environment.

B. **POLICY:**
1. It is the responsibility of the ~~Program~~ **Outpatient Behavioral Health Services (OPBHS)** to establish and maintain an optimally healthy and safe environment for its patients, employees, medical staff and visitors. Therefore, smoking is prohibited in all areas within the ~~Program~~**OPBHS**.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff and patients
~~1.~~**2.** TCMC is a non-smoking facility.
~~2.~~**3.** All employees are expected to respect and assist in enforcing this policy. Failure to maintain a smoke free environment is a violation of various local and state ordinances.
~~3.~~**4.** Outside area of OPBHS is not a TCMC property and patients may choose to smoke outside the building.
~~4.~~**5.** Patients are encouraged to not smoke in the front of the building.
~~5.~~**6.** Staff will provide patients with information and referrals for smoking cessation.
~~Conspicuous "No Smoking" signs may be placed in areas where smoking is prohibited.~~

D. **RELATED DOCUMENT(S):**
~~6.~~**1. Administrative Policy: 205 Smoke-Free Environment**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Standards for Clinical and Professional Practice**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide mandatory standards for Clinical and Professional Practice in Outpatient Behavioral Health **Services (OPBHS)**~~Program~~.

B. **POLICY:**

1. All staff members must act in a professional and appropriate manner at all times at the ~~Program~~**OPBHS** and must treat patients of the ~~Program~~**OPBHS**, as well as each other, with respect and consideration. Accordingly, there are specific, clinically accepted and approved operating standards and principles that all staff members must follow, including, but not limited to, the following specific areas:
2. Community Outings and Diversional/Enrichment Activities:
   ~~1.~~**a.** Certain diversional and enrichment activities can assist patients in developing tools to better understand and identify the natural support and opportunities available in the community after discharge from the ~~program~~**OPBHS**. However, community outings and diversional or enrichment activities are <u>not</u> a billable service and must <u>not</u> be billed for ~~(See, Positive Reinforcement Techniques Policy)~~. Most times, outings are properly classed as an enrichment or a diversional activity. Recognizing that at times it may be sensible and clinically appropriate to break up continuous treatment with diversional activities, however, the rule is simple—enrichment or diversional activities can occur, but must not be billed.
3. Token Economies, "Bonus" Stores, and Attendance Awards:
   ~~2.~~**a.** Token economies and bonus stores, whether run by staff or patients, as a rule, are not allowed. Only under particular patient circumstances and based upon an individual patient's treatment plan (and appropriate physician order), might it be approved. Further, any incentive that is likely to influence or induce an individual to receive services, or to continue to receive services, is strictly prohibited. There shall be no attendance awards such as, certificates or award ceremonies, which "reward" a patient for perfect attendance.
4. Bribes and Contingencies:
   ~~3.~~**a.** It is unacceptable for any staff member to bribe a patient in any way to improve attendance or participation in programming or for any other reason. It is equally unacceptable for any staff member to withhold from a patient any of the patient's personal possessions or any item to which the patient is entitled in order to improve the patient's attendance or participation in programming.
5. Recording of Services Provided:
   ~~4.~~**a.** Groups are to be scheduled for a minimum of 45 minutes. To be credited for having provided a group therapy service to a patient, that patient must have participated in the group for a reasonable amount of time. The service is considered billable only if the

patient has participated based on level of ~~symptometology~~**symptomatology**. These sessions must begin and end on time. There must be absolute integrity and accuracy in the recording of such services.

6. Group Size:
   ~~5.~~**a.** Staffing standards allow for reasonably sized therapy groups. A range of between 8 and 10 patients per group is optimal for the type of group work being conducted.
7. Use of Stigmatizing Language/Gestures:
   a. It is clear that language not only reflects the nature of thinking, but it also shapes the quality of thinking and actions. It is with conviction that a ~~program~~**OPBHS** culture is created in which the language that staff use is congruent with the view that consumers of ~~program~~**OPBHS** services are whole, adult people. Programs are designed to instill hope and support recovery.
   ~~6.~~**b.** Accordingly, it is inappropriate for any staff member to use stigmatizing, or otherwise offensive, language or gestures in the treatment of patients at the ~~Program~~**OPBHS**.
8. Professional Boundaries:
   a. All staff members are required to maintain professional boundaries with patients at all times. It is in the best interest of the patient for staff members to avoid a personal relationship of any kind with patients or any family members or significant others of a current patient who participated in the patient's treatment. No staff member shall socialize or fraternize, by phone, social media, in-person or otherwise, at any time with any patients of the ~~Program~~**OPBHS**, or any family member or significant others of patients who participated in the patient's treatment.
   ~~7.~~**b.** If there's an existing relationship between a staff member and a patient/family member prior to the patient beginning treatment, the staff member must maintain professional boundaries and not engage in any discussions regarding the patient outside of the ~~program~~**OPBHS**. In addition, the staff member must convey to the treatment team the nature of the existing relationship so that adequate precautions are taken to protect patient's confidentiality.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS Staff
~~1.~~**2.** All clinical and administrative staff members must abide by the above standards in the planning or provision of services or in the operation of the ~~Program~~**OPBHS**. Any practice that conflicts with the above standards is prohibited and could result in disciplinary action, up to and including, termination.
~~2.~~**3.** If an individual case arises where a patient's physician**/Allied Health Professional (AHP)** and treatment team believe a patient would clinically benefit from a particular incentive or specific behavioral contract (which appears to be contradictory to the above), the Operations Manager must obtain approval from the Director of Behavioral Health.
~~3.~~**4.** Any staff member who becomes aware of a suspected compliance issue with respect to the above standards and requirements must report it immediately to his/her Supervisor, or Tri-City **Healthcare District** ~~Medical Center~~**(TCHD)** Values Line.

~~B. RELATED DOCUMENT(S):~~
~~1. Outpatient Behavioral Health: Community Outings Policy~~
~~2. Outpatient Behavioral Health: Positive Reinforcement Techniques Policy~~

D. **REFERENCE(S):**
~~4.~~**1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Summary of Care List

ISSUE DATE: 02/06
REVISION DATE(S): 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **PURPOSE:**

1. To insure that a complete and current Summary of Care List is included in the patient's medical record that will be available and readily accessible to all staff and caregivers.

B. **POLICY:**

1. The Outpatient Behavioral Health **Services (OPBHS)** Summary of Care list will include the five required elements:
   - **a.** ~~(1)~~ patient name, ~~(2)~~
   - **b.** diagnosis, ~~(3)~~
   - **c.** current medications (including initial order date, change order dates, d/c date, dose, frequency, dates reordered), ~~(4)~~
   - **d.** allergies, ~~and (5)~~
   - **e.** relevant, past operative/invasive procedures.
   - ~~1.~~**f.** Additionally, for the purposes of this department, it will include the name of the attending psychiatrist, patient phone number, co-treating psychiatrist (if applicable), the patient's pharmacy and pharmacy phone number.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS nursing staff
2. ~~1.~~ A Summary of Care/Medication List will be completed by a Program **Registered Nurse** (RN) upon patient admission to OPBHS.
3. ~~2.~~ The Summary of Care List will be inserted as the cover document in the Medication section (red tab) of the medical record **or in the electronic record**.
4. ~~3.~~ The Program RN will revise and keep current the List as necessary to include changes in medications, diagnosis, or other relevant data.
5. Upon discharge from the Program ~~the List will be archived with the medical record.~~**a copy of medications list is given to the patient.**

D. **FORM(S):**

1. ~~4.~~ **Summary Care List**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Policy is a department guideline and not a regulatory requirement.

SUBJECT: Telephone Use by Patients

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

~~A. **PURPOSE:**~~
~~1. To define patient use of the telephone.~~

~~B. **POLICY:**~~
~~1. A telephone will be provided for patient use at Outpatient Behavioral Health Program.~~

~~C. **PROCEDURE:**~~
~~Who may perform/responsible: OPBHS Staff~~
~~1. Personal calls: **Patients are encouraged to make calls** should be made outside of program hours. Business calls may be made during break time or during program hours with permission of staff.~~
~~2. Use of the telephone may be an adjunct to the patient's individual treatment plan (e.g., learning to manage anxiety related to use of the telephone, calling to secure needed assistance or community based resources, etc.) and may be supervised by staff.~~
~~3. Patients with cell phones will be asked to turn them off during groups and community meetings, and to use phones only during breaks. Patients with cameras on their cell phones are informed that no picture taking is allowed in program.~~
~~4. Misuse or abuse of telephone privileges will be discussed as a treatment issue. This discussion and any action taken should be documented in the patient's record.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Treatment Planning**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

~~1.~~A. **PURPOSE**

1. To establish the requirements for inter-disciplinary treatment and develop appropriate plan for treatment.

~~2.~~B. **POLICY**

1. A patient's treatment in the ~~Program~~ **Outpatient Behavioral Health Services (OPBHS)** will be guided by a written, individualized, inter-disciplinary, physician approved plan of treatment that abides by all regulatory guidelines. Pursuant to written clinical assessments (see **Outpatient Behavioral Health:** Clinical Assessments Policy), a master treatment plan (MTP) will be established within seven days of admission. This MTP is reviewed and, as clinically indicated, revised during the course of the patient's participation in ~~Program~~**OPBHS**. It will be developed around medically authorized short-term and long-term treatment goals. These goals will be aimed at enabling the patient to recover and function appropriately at a less intensive level of care in the shortest amount of time possible and will reflect individualized discharge criteria. There is a high value placed upon patient participation in treatment planning and, accordingly, the MTP that is established will reflect a blend of both clinical judgment and patient preference. ~~Axis I through IV~~**Psychiatric** Diagnoses will be listed on the MTP in accordance with Medicare guidelines. Treatment Plan Reviews will be completed each calendar month thereafter and will incorporate feedback and recommendations provided during treatment planning and review meetings. **Partial hospitalization patients will have treatment reviews every two weeks~~,~~.**
2. While the content of the treatment plan is ultimately a medical/clinical responsibility, it is the responsibility of the Operations Manager/designee to manage the treatment planning process and to assure that an up-to-date treatment plan is established and maintained for every patient in the ~~program~~**OPBHS** throughout the course of his/her treatment.

~~3.~~C. **PROCEDURE**

1. Who may perform/responsible: OPBHS Clinical Staff
~~1.~~**2.** The assigned Therapist and the patient meet to begin developing the treatment plan. On the first day of treatment, the problem title is identified by the patient and the therapist. Within the first week of admission, a more comprehensive **Master** Treatment Plan (MTP) will be developed with input from the clinical team, including the physician, during the treatment team process. The MTP includes:
   ~~1.~~**a.** At least one individual problem title and goal plan that reflects the ~~Axis I~~**psychiatric** diagnosis, medical necessity for this level of treatment, a list of patient strengths, discharge criteria, and the recommendations of the physician. If the patient also has ~~an Axis I~~**a** diagnosis related to substance ~~abuse or dependence~~**use**, a second problem title

and goal plan may be completed as well.

~~2.~~**b.** Each individual problem title and goal plan ~~page~~ should include a minimum of one short-term goal that directly correlates with the problem title and ~~Axis I~~ diagnosis.

~~3.~~**c.** If the patient carries ~~an Axis III~~**a medical/physical** diagnosis that is treated by an outside physician and has the potential for being addressed in ~~program~~**OPBHS** (i.e. diabetes), a separate problem title may be opened and indicated as "active" or "monitored". This determination should be a collaborative effort between clinical and nursing staff.

~~1.~~**3.** The ~~Master Treatment Plan~~**MTP** is presented in treatment team for approval by the seventh calendar day following admission to ~~Program~~**OPBHS**. Patients in the Dual Recovery Treatment Track will have two active problems with two goals for each problem. Patient preferences are considered when developing treatment goals. The patient must always be involved in the treatment planning process.

a. The MTP is developed based on information obtained from a variety of sources. These include past history; current assessments or screenings conducted by the Community Liaison Coordinator, physician**/Allied Health Professional (AHP)**, nurse, and therapist; and information provided by the patient and caregivers. Consistent with the "physician driven treatment" model, the patient's diagnosis is determined by the physician**/AHP** and the treatment plan must be approved by the physician**/AHP**.

~~2.~~**4.** Treatment interventions should be completed and include groups the patient will be attending, number of days per week they will be attending, and individual therapy interventions. Any changes in the interventions and frequency of treatment must be ordered by the physician**/AHP**.

~~3.~~**5.** All core clinical assessments and any other assessments ordered on admission will be completed before MTP presentation, within seven calendar days of admission. However if the patient does not attend prior to treatment team presentation, **or is too anxious to complete the assessment,** staff must make an effort to complete all assessments as soon as possible. The Therapist meets with the patient to conduct assessments, explain the treatment planning process and to determine his/her preferences concerning possible short and long-term goals and treatment interventions. Discharge planning and discharge criteria will also be discussed as part of the assessment process.

~~4.~~**6.** A ~~Treatment Planning~~**MTP** meeting is conducted by the Operations Manager, Clinical Coordinator, or designee, no later than the 7th calendar day following admission for patients in the ~~Outpatient Behavioral Health Program~~**OPBHS**. All staff who have completed assessments will either be present at the meeting or will have submitted written recommendations to the designated Therapist. The Therapist leads an oral case presentation to summarize the reasons for referral to the ~~Program~~**OPBHS**, present a concise clinical formulation and to identify/recommend problems, goals and treatment interventions. The presentation is based on:

~~1.~~**a.** The initial CLC Referral and Screening Report;

~~2.~~**b.** The physician's admission orders;

~~3.~~**c.** All core and special clinical assessments (Physician Admission Assessment, Nursing Assessment, Fall Risk Assessment Biopsychosocial Assessment, Substance Abuse Assessment, and Suicide Risk Assessment);

~~4.~~**d.** The patient's stated treatment preferences;

~~5.~~**e.** Problem Title and Short Term Goals that are measurable, specific and descriptive of the patient's behavior and what they will do, followed by a baseline statement to use as a benchmark for measurement.

~~6.~~**f.** Clinical impressions of the patient's initial response to treatment; and

~~7.~~**g.** Other available clinical history/collateral information

~~5.~~**7.** The presentation of the patient is to include:

~~1.~~**a.** Physical description;

~~2.~~**b.** Diagnosis ~~(Axis I – Axis V)~~;

~~3.~~**c.** Brief history of psychiatric illness;

~~4.~~**d.** Current medications;

~~5.~~**e.** Previous psychiatric hospitalizations (total number and most current);

~~6.~~**f.** Specifically what triggered this admission, including any psychosocial stressors;
~~7.~~**g.** Summary of recommendations from clinical assessments; and
~~8.~~**h.** Problem title and goals.
~~b.~~**i.** The treatment team is responsible for finalizing a MTP for each patient. The MTP is to be completed by the therapist and is reviewed in treatment team and approved by the ~~program~~**OPBHS** psychiatrist.

~~6.~~**8.** Patients' active participation in treatment planning is vital. The Therapist meets with the patient to review the ~~Master Treatment Plan~~**MTP** and obtain the patient's ~~signature~~**approval**.

~~7.~~**9.** Routinely, at the prescribed treatment plan review intervals, the Therapist meets with the patient to assess his/her perspective on treatment progress and to review goal status, making goal and treatment modifications as necessary.

~~8.~~**10.** A review of each patient's treatment plan is conducted monthly **for intensive outpatient and bi-weekly for partial hospitalization patients** (depending on FI guidelines) at which time the Therapist once again leads a case presentation. This presentation will be preceded by the Therapist's review of all progress notes since the last ~~Treatment Planning~~**MTP** meeting. The purpose of the presentation is to summarize progress and to determine the need for any changes to identified problems, goals, treatment interventions or discharge criteria.

~~9.~~**11.** The Therapist completes any agreed upon treatment plan revisions and obtains ~~signature~~ approval from the patient~~, treating psychiatrist, and other treatment team members~~ **and the treatment ~~.~~team.**

~~10.~~**12.** To promote successful completion of treatment goals and positive outcomes, the patient's primary therapist will maintain contacts with patient's family members and outside providers as warranted. In addition, the therapist or the ~~program~~**OPBHS** Service Coordinator may assist patient with coordinating any outside services needed.

D. RELATED DOCUMENT(S):

1. **CLC Referral and Screening Report**
~~11.~~**2. Outpatient Behavioral Health Policy: Clinical Assessment**

E. REFERENCE(S):

~~12.~~**1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)**

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~— OCEANSIDE POLICY MANUAL~~

ISSUE DATE: 032/13 **SUBJECT: MEDICAL EMERGENCIES**

REVISION DATE:

Department Approval Date(s):	**06/16**
Division of Oncology Approval Date(s):	**03/17**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**~~03/13~~06/17**
Professional Affairs Committee Approval Date(s):	**~~03/13~~08/17**
Board of Directors Approval Date(s):	**03/13**

A. **PURPOSE:**

1. Sudden and unexpected medical events may occur at any time. To minimize adverse/detrimental affects to the patient, prompt/immediate response form a competent and qualified staff is required. This policy outlines the process by which the clinic remains current to respond effectively to medical emergencies.

B. **POLICY:**

1. The provision for emergent care in the **Outpatient Infusion Center** (Center) will remain current through the appropriate certification and practice of its staff members.
2. All clinical staff will maintain current **Cardiopulmonary Resuscitation** (CPR) certification and be compete in:
   a. Identifying emergency situations
   b. The proper notification/communication process
   c. Palpating pulses
   d. Maintaining an adequate airway
   e. The use of oxygen therapy
   f. Performing adequate chest compression\
3. Response to an emergency by the clinical staff will be limited to CPR.
4. Basic emergency response equipment will be readily available in the clinic at all times and in good working order.
5. Emergency equipment will be checked, per hospital policy, and replaced as necessary.

C. **PROCEDURE:**

1. Once a valid emergency situation has been identified:~~, other clinic at all times~~
   a. The support staff (or any available staff member) will dial 911.
   b. Basic CPR will be administered until the advanced emergency team has arrived.
   c. The support staff, with the assistance and direction from the clinical staff, will be responsible for coordinating the patient/visitor traffic flow, as well as the advanced emergency responder traffic.
   d. The support staff will also maintain order in the clinic and be available for questions from patient's/families, etc. while adhering to all applicable privacy and confidentiality policies and regulations.
   e. The **Registered Nurse** (RN)~~/ANM~~ will coordinate the clinic's emergency response activity and remain with the patient at all times.
   f. The RN~~/ANM~~ or designee will notify family/friends/caregiver of the emergency and provide a private waiting area. If family member or patient representative is not present, every effort to contact the appropriate party.

2. The nurse manger, program director, or medical director will conduct mock emergency scenarios periodically to assess staff readiness.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

SUBJECT: Community Out-Reach Groups ~~APHASIA GROUP~~
POLICY NUMBER: 800

ISSUE DATE: 04/95
REVISION DATE(S): 09/97, 01/00, 01/03, 01/06, 01/09, 05/12

Department Approval:	09/15
Department of Medicine Approval:	06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	08/17
Board of Directors Approval:	

A. **POLICY:**~~PURPOSE~~
   1. ~~To promote communication~~**Community Out-Reach Groups are provided** in a social/group setting to emphasize ~~return~~**sustaining or returning** to the highest level of functioning within the individual's home and in the community.

B. **PROCEDURE:**
~~C. POLICY~~
   1. **Requests for Service:**
      a. Participants will be self-referred or referred by a healthcare professional to attend group treatment, per ~~attached *Candidacy Guidelines*.~~**the following guidelines, the patient should display the following:**
         i. ~~PROCEDURE~~**Appropriate level of motivation to participate and benefit from group treatment.**
      b. **Appropriate comprehension necessary to understand simple directions and be able to attend for one hour.**
      c. **Have a realistic expectation of group therapy goals.**
   2. **Hours ~~O~~of Service**
      a. **One session weekly for one hour, subject to change due to community needs.**
   3. **Responsibilities**
      a. Group therapy will involve utilization of multi-modal ~~communicative skills including verbal, written, gestural, and pictorial modes. Topics~~**communication skills. Groups** and group goals will be selected pertinent to participants' wants and needs. ~~Topics~~
      ~~1.~~b. **Groups** may include, but will not be limited to:
         i. **Aphasia Group** ~~Development of effective~~
            1) **This group is for individuals who have difficulty with speech and/or language skills and whose personal therapy may have been completed or discharge from therapy is forthcoming. This is language therapy in a group setting, emphasizing** social communication skills~~ with a variety of communication partners~~ **solving communication problems within the community and promoting multimodal communication skills.**
         ii. **Parkinson's Group**
            1) **This exercise program is designs to improve the quality of life for those with Parkinson's disease. The purpose is to help ~~restore~~maintain maximum function. The Class begins with a warm-**

up, followed by upper extremity, lower extremity and trunk strengthening, then a fun activity to increase coordination, balance or mobility. The session ends with a cool-=down activity. Participants are also given written exercises to perform at home and are encouraged to ask questions relating to their disease process.

iii. Stroke Exercise Group

~~ii.~~1) This group is geared toward clients who have been discharged from therapy services and are looking for a continued exercise program for maintenance, learning new techniques, friendships, or just getting out. We begin with a stretching warm-up, upper extremity exercises, lower extremity exercises, balance activities and then a few fun activities.

~~a. Discussion of world events and issues~~

~~b. Identification of emotional aspect of communication breakdowns, and providing opportunities for participants to convey encouragement and support to each other~~

~~c. Problem-, solving communication problems within the community and promoting multimodal communication skills.~~

~~d. Methods of facilitating multi-modal communication skills~~

~~e. Strategies for remaining physically and mentally fit following a stroke or other neurological disorders~~

CANDIDACY FOR PARTICIPATION IN THE APHASIA GROUP

PATIENT SELECTION GUIDELINES

1. **PATIENT MOTIVATION:**

   The participant should display an appropriate level of motivation to participate and benefit from group treatment.

2. **ALERT MENTAL STATUS:**

   The participant should be sufficiently alert to understand simple directions and be able to attend for one hour.

3. **INDIVIDUAL THERAPY:**

   The participant may have participated in previous therapy or be involved in individual therapy currently. Individuals who have not participated in previous therapy may also be candidates.

4. **COMMUNICATIVE DISORDER:**

   The participant will exhibit minimum to severe aphasia or apraxia of speech and be able to follow simple instruction. Communication may be verbal or non-verbal to convey basic needs.

5. **EXPECTATIONS:**

   The participant will have a realistic expectation of group therapy goals.

6. **COMMITMENT:**

   The participant will be prepared to commit to attending group regularly.

Tri-City Medical Center
Oceanside, California

TELEMETRY ~~UNIT POLICY MANUAL~~

ISSUE DATE: NEW	**SUBJECT: Skin and Wound Team, Rounds**
REVISION DATE:	**POLICY NUMBER: 6150- 119**
Department Approval:	**07/15**
Division of Cardiology Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**08/17**
Board of Directors Approval:	

A. PURPOSE:

1. Decrease the risk of skin impairment presented by the development of stage II or III pressure ulcers (PU) to zero for patients admitted or transferred to the Telemetry Unit by establishing:
   a. Registered Nurse (RNs) Skin and Wound Champions
   b. Weekly unit skin and wound rounds
2. To identify the process for performing weekly skins and wound rounds.

B. DEFINITION(S):

1. RN Skin and Wound Champions – Telemetry RNs identified as skin and wound experts and mentors for the unit
2. Telemetry Skin and Wound Team – RN Skin and Wound Champions, Advanced Care Technicians (ACT), and Lift Team Technicians (LTT) assigned to the rounding unit, when available
3. Skin and Wounds Rounds – Weekly skin assessment of patients ~~between 1-2pm~~**scheduled** by RN Skin and Wound Champions based on the criteria listed in this policy

C. POLICY:

1. Skin and Wound rounds:
   a. Occur weekly ~~on Wednesdays from 1-2pm~~**for 1-2 hours** based on patients' location on Telemetry or the RN Skin and Wound Champion's discretion.
   b. Initiated by a RN Skin and Wound Champion with the participation of the following staff when available:
      i. ACT assigned to the unit
      ii. LTT assigned to the unit
      iii. Primary RN or Relief RN
      iv. PRN Nurse
2. Criteria for identifying patients that may be assessed during Skin and Wound rounds
   a. Braden score of 18 or below
   b. Upon the request of the Primary RN, one patient per RN
   c. Patients hospitalized greater than two days and non-ambulatory
   d. Post-operative patient not ambulating
   ~~d.~~**e. New admissions or transfers**
3. RN Skin and Wound champions will:
   a. Update primary RNs on the skin interventions provided
   b. Educate primary RNs, if required, on the following:
      i. Basic skin assessment and documentation requirements
      ii. Preventative skin interventions
      iii. Proper patient positioning
      iv. Obtaining photographs of skin and wound abnormalities

D. PROCEDURE:

1. Print and review the daily census to identify patients
   a. Rounds may be limited to one unit or patients on multiple units on Telemetry
2. Obtain permission from primary RN assigned to patients to perform a skin assessment
3. Verify with primary RN skin interventions that are in place
4. Assess patients' skin as outlined in the Standards of Patient Care. Notify the primary RN or Relief RN immediately at the patient's bedside when the following are identified:
   ~~a. Deep Tissue Injury not identified by primary RN~~
   ~~b. PUs stage II or higher without preventative or treatment interventions implemented~~
   ~~c. Skin abnormalities identified on a patient admitted or transferred to unit during rounds~~
5. Document assessment findings and interventions initiated in the Electronic Health Record (EHR)
6. Update the primary RN

E. RELATED DOCUMENT(S):

~~7.~~1. **Patient Care Services Policy: Skin and Wound Care**

F. REFERENCE(S):

~~8.~~1. **National Pressure Ulcer Advisory Panel (NPUAP). (2016). National pressure ulcer advisory panel (npuap) announces a change in terminology from pressure to pressure injury and updates the stages of pressure injury: Reference Tool. Retrieved from http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/**

Governance & Legislative Committee
(No meeting held in August, 2017)

Audit, Compliance & Ethics Committee (No meeting held in August, 2017)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

July 27, 2017 – 1:30 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on July 27, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Absent was Chairman Dagostino

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Financial Officer
Norma Braun, Chief Human Resource Officer
Scott Livingstone, Interim Chief Compliance Officer
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1 The Board Vice Chairman, Director Kellett called the meeting to order at 1:30 p.m. in Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2 Approval of Agenda

It was moved by Director Schallock to add an additional matter to Existing Litigation, Medical Acquisitions Company vs. TCHD and TCHD vs. Medical Acquisitions Company. Director Grass seconded the motion. The motion passed (5-1-0-1) with Director Reno opposed and Director Dagostino absent.

It was moved by Director Nygaard to add an additional matter to Existing Litigation, San Diego County Office of Education, et al. vs. The County of San Diego, et al. Director Schallock seconded the motion. The motion passed (5-0-1-1) with Director Reno abstaining and Director Dagostino absent.

3 Public Comments – Announcement

Vice Chairman Kellett read the Public Comments section listed on the July 27, 2017 Regular Board of Directors Meeting Agenda.

4 Oral Announcement of Items to be discussed during Closed Session.

Vice Chairman Kellett deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the July 24, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; two (4) matters of Potential Litigation; two Reports Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding three (3) matters of Existing Litigation; and Approval of Closed Session Minutes.

5 Motion to go into Closed Session

It was moved by Director Grass and seconded by Director Nygaard to go into closed session at 1:35 p.m. The motion passed (6-0-1) with Director Dagostino absent.

6 The Board adjourned to Closed Session at 1:35 p.m.

8 At 3:30 p.m. in Assembly Rooms 2 and 3, Vice Chairman Kellett announced that the Board was back in Open Session.

The following Board members were present:

Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Scott Livingstone, Interim Chief Compliance Officer
Greg Moser, General Legal Counsel
Adriana Ochoa, General Legal Counsel
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9 Vice Chairman Kellett reported no action was taken in open session.

10 Director Reno led the Pledge of Allegiance.

11 Vice Chairman Kellett read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12 Community Update

There was no Community Update.

13 Report from TCHD Auxiliary, Mary Gleisberg, President

Ms. Gleisberg, TCHD Auxiliary President reported she has been the new President of the Auxiliary since July 1st and it has been a fairly smooth transition.

Ms. Gleisberg reported that over the past year (July 1, 2016 – June 30, 2017) the Auxilians have volunteered over 68,000 hours. She stated the Auxilians are a wonderful dedicated group of volunteers who are here everyday rain or shine and love their work. Ms. Gleisberg expressed her appreciation for allowing the Auxilians to serve this community.

Ms. Gleisberg reported the Auxiliary installed a new Board on June 24, 2017 at their Installation Luncheon in which three new Board members joined the Auxiliary Board. She stated these individuals are all experienced Auxilians that have had very successful careers and will be a wonderful addition to their Board.

Ms. Gleisberg expressed her appreciation to Vice Chairman Kellett who attended the Auxiliary's monthly board meeting yesterday.

Ms. Gleisberg reported the Auxiliary Board presented the hospital with a check recently for $70,000. She stated the Gift Shop is the Auxiliary's only source of income that enables them to donate to the hospital and she encouraged everyone to shop there.

Ms. Gleisberg reported on Friday, August 4th at 10:00 a.m. there will be a presentation of checks from the proceeds of the *Tails on the Trails Charity Dog Walk* near the hospital entrance. This year checks will be presented to the Oceanside and Carlsbad K9 Units. Ms. Gleisberg stated it takes a great deal of money to raise, train, feed and care for those dogs and they do a wonderful job in the community. Ms. Gleisberg stated a check will also be presented to The Tender Loving Canines Assistance Dog Program. She explained this program trains dogs for our autistic children and wounded warriors. She invited members of the Board and C-Suite to attend the presentation of checks.

Ms. Gleisberg reported proceeds from the *Tails on the Trails Charity Dog Walk* also supports our JV Scholarship Program and the Auxiliary has given the Program $1,000.

In addition, a $1,000 check will be presented to the Special Needs Foundation for Companion Animals which does a lot of research on cancer of our canines.

Lastly, Ms. Gleisberg extended a big thank you to Ms. Sharon Schultz, CNE who supported our JV volunteers this summer. She stated at the June 23rd JV Volunteer Workshop the highlight was when Ms. Schultz Nurse Managers welcomed the

students, affirmed how important they were to the hospital and acknowledged their desire to learn more about all the aspects of healthcare. Ms. Gleisberg stated the attendees went away feeling very special and were invited to contact Sharon and the Nurse Managers and come to do a tour.

Vice Chairman Kellett stated 68,000 volunteer hours is really astounding. He stated it is not only the hours but the warm, tender and welcoming attitude that the volunteers bring to the hospital.

No action was taken.

14 Report from Chief Executive Officer

Mr. Steve Dietlin, CEO welcomed Mary Gleisberg, incoming Auxiliary President. He expressed his appreciation to the Auxilians for their countless hours of service and everything the Auxilians do for the hospital as well as the entire community. Mr. Dietlin stated our Auxilians really do make Tri-City unique.

Mr. Dietlin welcomed Dr. Victor Souza, incoming Chief of Staff. Mr. Dietlin expressed his appreciation to Dr. Souza for reaching out and continuing the efforts of the Medical Staff to realign with the Board and with Administration and the entire hospital. He stated working together we can really make things happen.

Mr. Dietlin reported the first North County Heart Walk is scheduled for September 30th at the Oceanside Pier. He stated we are collaborating with the American Heart Association and encouraged everyone to sign up for the event. Mr. Dietlin stated this is a great opportunity to get out there and educate the community about the wonderful care right here at Tri-City.

Mr. Dietlin reported we recently held our public RFQ (Request for Qualifications) meeting regarding future campus development. He stated we are very excited about moving forward with our campus development plan and seeing some actual construction activity happening right here on the campus.

In closing, Mr. Dietlin shared a touching note from a Fallbrook resident who chose Tri-City for their care and was extremely grateful.

No action was taken.

15 Report from Acting Chief Financial Officer

Mr. Rivas reported there is no financial presentation today as June is our fiscal year-end and we keep the books open longer to prepare for our year-end audit.

Mr. Rivas presented a brief update on the audit process. He stated at this month's Audit, Compliance & Ethics Committee meeting, Moss Adams presented their Audit Entrance report in which they introduced new audit partner, Ms. Stacey Stelzeride. He explained the change in audit partner was due to the departure of Mr. John Blakey midway through the audit. Mr. Rivas stated during the Audit Entrance Report, Ms. Stelzeride reviewed the audit process which begins with review of our internal controls. The strength of our internal controls determines the scope of the audit. Materiality was also discussed. During the report Ms. Stelzeride pointed out that we have a large amount of revenue and expense, however depending on the end user

that would determine what they decide is materiality. Mr. Rivas stated the significant items the auditors will focus on this year are going to include the patient revenue, Accounts Receivable and our cost report settlements which is the annual report we do with Medicare. In addition, they will review the status of our Medical Office Building, our HUD refinancing and study our self- insurance liabilities. Mr. Rivas reported Moss Adams conducted a pre-audit in May and will start field work on August 7th. Mr. Rivas stated we hope to report results of the audit to the Audit Committee in September and bring forward for acceptance by the Board in September as well.

Vice Chairman Kellett stated he is glad to hear the audit is once again on schedule.

No action was taken.

16 New Business

a. Consideration to approve Resolution No. 788, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing a Conflict of Interest Policy Covering Design-Build Projects

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve Resolution No, 788, A Resolution of the Tri-City Healthcare District Board of Directors Establishing a Conflict of Interest Policy Covering Design-Build Project. Director Reno seconded the motion.

Director Schallock requested clarification on Addendum 2 B in reference to the conflicts of interest and the mention of employees. Mr. Moser stated this policy is required by the Design-Build statute if you are going to use the design build process. He explained that typically the people who design are separate from the people who build however here it is a combined team so this policy is designed to apply to only the people that propose to build our design build project. Mr. Moser further explained that typically contractors are not subject to our Conflict of Interest Code or Public Reform Act because they are not employees or Officers however the legislature wants to ensure that there were no conflicts within the group of individuals that are brought together under a design build contract.

Director Reno requested clarification on the statement "a resolution of conflict of interest issues is the sole discretion of the Board". Mr. Moser stated if a contractor comes up with a conflict the Board has the authority to waive it and decide it is still in the best interest of the District to move forward with the contract.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

17 a) Old Business

a) Consideration to approve Resolution No. 787, A Resolution of Application for Proposed Annexation of LAFCO-Recommended Unserved Areas (South Carlsbad and Vista)

Ms. Adriana Ochoa reported Resolution No. 787 is brought forward today at the request of the Board at the June regular meeting. She stated the Resolution as drafted proposed to annex the South Carlsbad and Shadowridge areas previously discussed. LAFCO has indicated the Resolution would adequately serve the purpose, however they are requesting that we annex two additional areas (A & D of the map). Area "D" is a small northeastern portion of Oceanside (approximately 2730 acres). This particular area would be detached from Fallbrook Health Care District and annexed to Tri-City. LAFCO has also asked that the Board consider detaching from Tri-City area "A" on the map which is Camp Pendleton. She explained the reason we are annexing in Shadowridge and South Carlsbad is because the Principle Act which is the Healthcare District Law states that municipal corporations or territories like cities shouldn't be divided so in essence they are trying to make the District boundaries coterminous with the city boundaries. Ms. Ochoa stated under this methodology Tri-City would be expected to include Oceanside, Vista and Carlsbad in their entirety within our jurisdiction and no more and no less. That is the basis of the annexation for B & C. LAFCO is basically asking us to add these territories as clean-up items and detach area "A", annex area "D" and also asking us to take action on area "E" which is the 58 acres in Tri-City to be annexed to Palomar which would put San Marcos completely in Palomar's district.

Director Reno requested clarification on the Camp Pendleton area. Ms. Ochoa explained LAFCO has requested that we detach that area and it would become an unserved area and just be in the federal lands. Mr. Livingstone clarified that detaching the Camp Pendleton area really does not change the delivery of healthcare. This applies more to redistricting and voters. He explained we will lose zero votes from area "A" because the voters who are residents of area "A" are military residents of a federal reserve. Their place of residence is their permanent home. Ms. Ochoa stated Tri-City does not have any offices or primary care clinics in the Camp Pendleton area because those types of clinics are limited to the District's physical boundaries so we would not lose anything in terms of voters; it is simply a "clean-up item".

Ms. Ochoa recommended that the Board approve Resolution 787 subject to the additions of these areas requested by LAFCO. She explained that LAFCO has the power to modify any resolution that comes their way and may do so with or without the Board's approval.

Director Grass questioned if there is any negative or financial impact on the District if we detach as recommended by LAFCO. It was Ms. Ochoa's opinion that there would likely not be a negative or financial impact on Tri-City. Ms. Ochoa noted that LAFCO has offered to waive all fees for their requests which are in areas "A" and "D" and "E" and have also volunteered to do the legwork for preparing the legal descriptions and the plat maps for those areas.

Mr. Moser stated theoretically there may be one potential negative impact related to recruitment calculation area. Director Reno stated she would be voting no on the Resolution because it would have an impact on the ED physicians. Mr. Moser

clarified that the detachment would not have any impact on those physicians and it also would not have any impact on taxes that are collected.

Director Reno questioned if physicians can still come from Camp Pendleton and work in our Emergency Department like have in the past. Dr. Souza stated he does not see any reason why an Emergency Department physician could not work here.

Ms. Ochoa reiterated that areas "A" and "E" on the map are the only two detachments. The rest are annexations which and the District would be absorbing those voters. With respect to area "D", estimates for projected voter population were run and it was fairly small, between 2 and 3,000.

Director Nygaard stated in her opinion the process will move along more quickly with LAFCO if the Board agrees to LAFCO's proposed detachments and annexation. Ms. Ochoa agreed. Director Kellett agreed with Director Nygaard and Ms. Ochoa and entertained a motion to include the addendum.

It was moved by Director Nygaard that the Tri-City Hospital District Board of Directors approve Resolution No. 787, A Resolution of Application for Proposed Annexation of LAFCO-Recommended Unserved Areas (South Carlsbad and Vista) subject to the three additions proposed by LAFCO. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass, Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**Dagostino**

17 b) Update on CVRA Districting Consultant

General Counsel Ms. Adrianna Ochoa stated we have retained a consultant, Doug Johnson of National Demographics Corporation to get us moving in terms of the redistricting process. She explained the District is required to have two public hearings before we start to begin drawing maps. Ms. Ochoa proposed the first of the two public hearings be held at the next board meeting to coincide with the Board's regular board meeting to avoid having to call a Special Meeting and the second public hearing on September 28th to coincide with the Board's regular September board meeting. Ms. Ochoa stated that this timeline meets the requirements that the two hearings be held within 30 days of each other. Following the two public hearings, National Demographics will begin drawing two parallel maps, one with the current District boundaries and one with the modified District boundaries. Ms. Ochoa explained that once the maps are drawn there will be discussion with the Board about the sequence of elections so the maps that are drawn will reflect the seven Districts with numbers. Ms. Ochoa noted proposed maps will be posted at least seven days prior to the third public hearing which is slated for October and the fourth hearing within 45 days of the October meeting. The final public hearing will be held to adopt the final maps.

No action taken.

18. Chief of Staff

a. Consideration of July 2017 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on July 24, 2017.

It was moved by Director Schallock to approve the July 2017 Credentialing Actions and Reappointments involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee at their meeting on July 24, 2017. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

b. Consideration of Privilege Cards

1) NP – Cardiology
2) PA – Cardiology
3) NP – OBGYN
4) NP – Pediatrics
5) NP – Interventional Radiology
6) NP - Neonatal

It was moved by Director Mitchell to approve the Allied Health Privilege Cards presented for approval including the NP – Cardiology, PA – Cardiology, NP – OBGYN, NP – Pediatrics, NP – Interventional Radiology and NP – Neonatal, as recommended by the Medical Executive Committee at their meeting on July 24, 2017. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

19 Consent Calendar

It was moved by Director Nygaard to approve the Consent Calendar. Director Schallock seconded the motion.

It was moved by Director Reno to pull items 19 (1) D. 6) Approval of an agreement with Dr. Henry Showah to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 through June 30, 2019; 19(1) D. 8) Approval of the formation of

an Institute for Clinical Excellence, LLC; TCMC membership in and purchase of membership units, and approval of a co-management agreement with the LLC for a term of 34 months, beginning September 1, 2017 through June 30, 2020, for an annual cost of $750,000 and a total cost for the term of $2,125,000; and 19 (2) Minutes – Regular Board of Directors Meeting – June 29, 2017 and Special Board of Directors Meeting – June 22, 2017. Director Nygaard seconded the motion.

It was moved by Director Schallock to pull items 9(1) E. 2) d) Handling of Pharmaceutical Waste, Expired Medications and 19 (1) E. 10 b) Visitors in the OR Policy. Director Reno seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

20. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 19 (1) D. 6) Approval of an agreement with Dr. Henry Showah to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 through June 30, 2019 questioned why there was not any monetary reimbursement for Dr. Showah. Director Kellett explained Dr. Showah is simply joining the existing call panel and will be reimbursed according to the terms of the existing call panel.

It was moved by Director Nygaard to approve an agreement with Dr. Henry Showah to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 through June 30, 2019.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

Director Reno who pulled item 19(1) D. 8) Approval of the formation of an Institute for Clinical Excellence, LLC; TCMC membership in and purchase of membership units, and approval of a co-management agreement with the LLC for a term of 34 months, beginning September 1, 2017 through June 30, 2020, for an annual cost of $750,000 and a total cost for the term of $2,125,000 questioned why the agenda item was not presented to the full Board. Director Reno stated it appeared the report was presented by Moss Adams. Director Nygaard clarified that the report by Moss Adams was the Audit Entrance report presented to the Audit, Compliance & Ethics Committee and is a different agenda item. Vice Chairman Kellett invited Mr. Jeremy Raimo to discuss the Institute for Clinical Effectiveness agenda item that was pulled.

Mr. Raimo acknowledged Mr. Scott Livingstone's efforts around the Institute for Clinical Effectiveness. He explained that this is a collaboration of surgeons, hospitalists, Emergency Department physicians and Anesthesia to look at the continuum of care where patients access services. Through the Institute, the whole objective is to have the different participants in the Institute provide guidance around topics that, in the absence of the Institute, would be very difficult for us to tackle. Mr. Raimo stated this may include readmission rates for certain areas of specialties, ED throughput and Antibiotic Stewardship, to name a few. He commented that there are really no limits to this Institute's boundaries in impacting patient care and trying to drive better outcomes.

It was moved by Director Nygaard to approve the formation of an Institute for Clinical Excellence, LLC; TCMC membership in and purchase of membership units, and approval of a co-management agreement with the LLC for a term of 34 months, beginning September 1, 2017 through June 30, 2020, for an annual cost of $750,000 and a total cost for the term of $2,125,000. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

Director Schallock commented that both Dr. Worman and Dr. Johnson have been involved in the development of the Institute and have been the champions at the table since day one.

Director Nygaard commented that Mr. Raimo provided the Finance, Operations & Planning Committee with an excellent report on the Institute and it is going to drive better practices in our hospital.

Dr. Souza stated the Institute will not only bring a lot of data which is very important but will also aid in decreasing costs in many areas of the hospital.

Director Grass commented that she would appreciate it if staff would share this kind of data whenever it's available.

Director Schallock who pulled item 19(1) E. 2) d) Handling of Pharmaceutical Waste, Expired Medications questioned why EVS was picking up and storing the containers rather than the Pharmacy.

Mr. Kevin McQueen explained that the State of California is very stringent about how we get rid of certain waste products and a new container has been added to our current waste management program which handles controlled substance waste. He stated the container is filled with a liquid that dissolves and breaks down the medication. It includes a neutralizer so that the medication is no longer functional and a chemical that if ingested will result in profuse vomiting. He noted that once the controlled substance is put in the container it is no longer considered hazardous waste but rather waste. The filled contained is then picked up by EVS and hauled away by a contracted provider to comply with California standards. Mr. McQueen stated it is truly a protective way to dispose of controlled substances.

Director Reno questioned if this process is also used for outdated medications. Mr. McQueen stated outdated medications go through a reverse recycling program through the Pharmacy. He explained any outdated medications or any medications that we do not use go back to the pharmacy and they have a reverse distributor that they use. The new container is just for wasting small amounts of left over medications.

Director Mitchell questioned if EVS handles chemo waste. Mr. McQueen stated the yellow container shown on the poster is used for chemo waste. He stated there are so many different containers used for different purposes which are explained in detail on the poster. Mr. McQueen emphasized that EVS only handles the sealed containers and they are also trained to handle spills.

Director Reno suggested this information be made available to the public. Mr. McQueen stated this process is for hospital waste and the public brings their unused outdated medications to the Sheriff's Department except when we have the annual pick-up. Director Schallock stated the Board of Pharmacy is currently attempting to enact rules wherein medications could be taken to pharmacies or other centralized locations which are more convenient, however it is still in the Board of Pharmacy regulation process.

It was moved by Director Schallock to approve item 19 (1) E. 2) d) Handling of Pharmaceutical Waste, Expired Medications Policy. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

Director Schallock who pulled item 19 (1) E. 10 b) Visitors in the OR Policy requested clarification on whether sales representatives are allowed in the OR and if so how their presence is controlled.

Ms. Mary Diamond, Director of Surgical Services stated sales representatives are allowed under our Business Visitor and Vendors Policy. She explained that their access is controlled through Reptrax which is an automated system we have that assures that all credentials and requirements are in place before providing a badge. OR Staff will not allow individuals in the OR without the appropriate badge. Ms. Diamond confirmed all individuals present in the OR are documented in the Medical Record.

It was moved by Director Schallock to approve item 19 (1) E. 10 b) Visitors in the OR Policy. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

Director Reno who pulled item 19 (2) Minutes – Regular Board of Directors Meeting – June 29, 2017 and Special Board of Directors Meeting – June 22, 2017 stated she would be voting no.

It was moved by Director Nygaard to approve the minutes of the June 29, 2017 Regular Board of Directors meeting and the minutes of the June 22, 2017 Special Board of Directors Meeting as presented. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Grass Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Dagostino**

21 Reports (Discussion by exception only)

22 Legislative Update - None

23 Comments by members of the Public

There were no comments by members of the public.

24 Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

25 Board Communications

Director Reno commented on a letter she received that cautioned Medical Staff to be aware of unethical and illegal practices in the workplace. Board members stated they too received the letter and it has been brought to the attention of the appropriate staff.

Director Reno stated we are very fortunate that we have two wonderful organizations the Auxiliary and the Foundation that donate countless hours and provide monetary support for so many of our projects.

Director Nygaard reported she received a number of letters from the CHAC Grant recipients whom had many positive things to say about Tri-City. She stated the recipients were extremely grateful.

Director Grass did not have any comments.

Director Mitchell did not have any comments.

Director Schallock did not have any comments.

26 Report from Vice Chairperson

Vice Chairman Kellett expressed his appreciation to the Auxilians for their contributions day in and day out.

32 **It was moved by Director Grass to adjourn the meeting. Director Mitchell seconded the motion. The motion passed (6-0-1) with Director Dagostino absent.**

Hearing no further business, Vice Chairman Kellett adjourned the meeting at 4:33 p.m.

James J Dagostino, DPT
Chairman

ATTEST:

Laura E. Mitchell, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

August 1, 2017 – 6:00 o'clock p.m.
Assembly Room 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 6:00 p.m. on August 1, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard (via teleconference)
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Interim Chief Compliance Officer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 6:00 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Schallock seconded the motion. The motion passed by a roll call vote (7-0) with Director Nygaard voting by teleconference.

   Chairman Dagostino stated in order to be efficient with individual's time the agenda will be reordered to reflect open session immediately following the first closed session item.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of items listed on the August 1, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report on Trade Secrets with a disclosure date of August 1, 2017 and Conference with Legal Counsel regarding one matter of Existing Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Mitchell to go into Closed Session. The motion passed by a roll call vote (7-0) with Director Nygaard voting via teleconference.

Chairman Dagostino adjourned the meeting to Closed Session at 6:02 p.m.

7. The Board returned to Open Session at 6:18 p.m. with all Board Members present and Director Nygaard present via teleconference.

8. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

10. Open Session

1) Consideration to approve the UCSD Cardiothoracic Surgery Professional Services Agreement

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the UCSD Cardiothoracic Surgery Professional Services Agreement as presented including up to $1.2 million and other costs as agreed to in the contract. Director Nygaard seconded the motion.

The roll call vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

11. The Board returned to Closed Session to conduct unfinished business **at 6:20 p.m.**

12. The Board returned to Open Session at 7:17 p.m. with all Directors present with the exception of Director Reno and Director Nygaard participating via teleconference.

13. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action was taken in Closed Session.

14. There being no further business, Chairman Dagostino adjourned the meeting at 7:17 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

Trustee.

RENEWAL INVOICE

Health Forum
P.O. Box 92567
Chicago IL 60675-2567

INVOICE #46646
DATE: July 7, 2017

TO: TERI DONNELLAN
EXEC ASST
TRI-CITY MEDICAL CENTER
ADMIN
4002 VISTA WAY
OCEANSIDE CA 92056-4506

Make Check Payable & Remit To:
Health Forum
P.O. Box 92567
Chicago IL 60675-2567

INVOICE #	PURCHASE ORDER	EFFORT #	EXPIRE	TERM
46646		RNEG1	NOV/DEC 17	10 / YR

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Stakeholder Experience

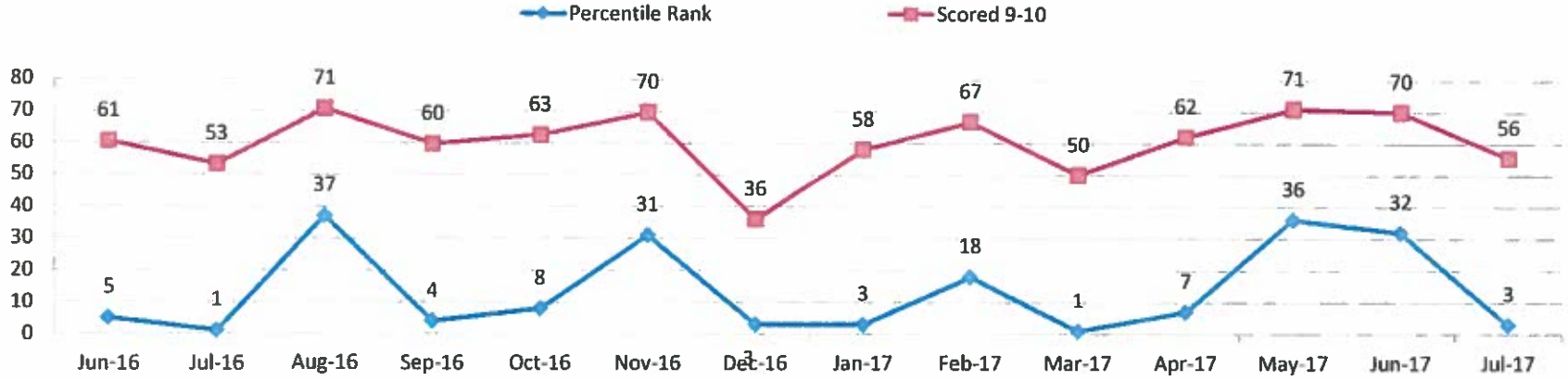
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

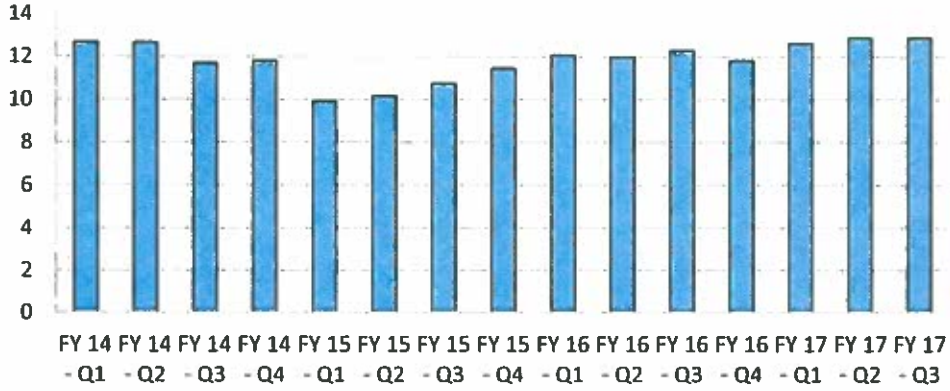
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

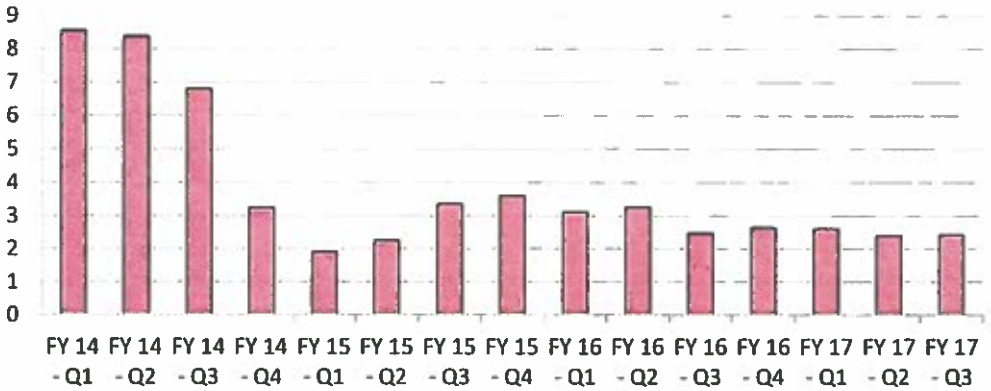
Overall Rating of Hospital (0-10)



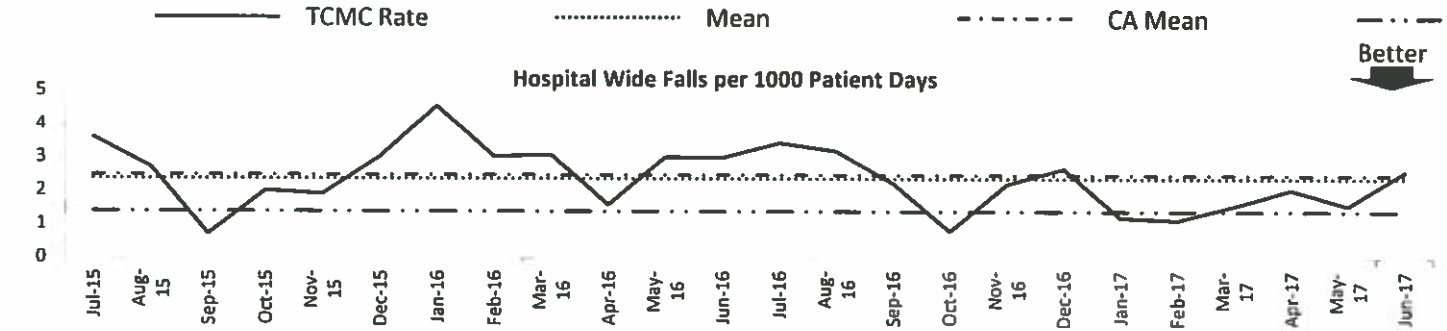
Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

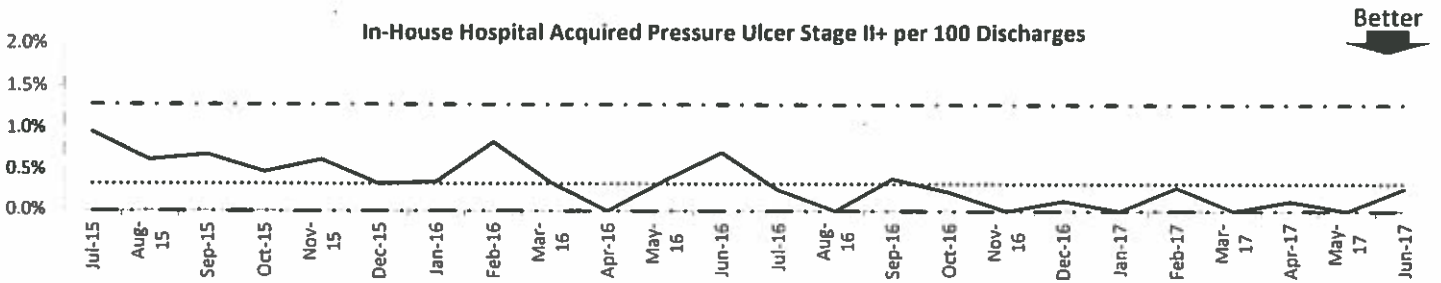


Current Trending Measures

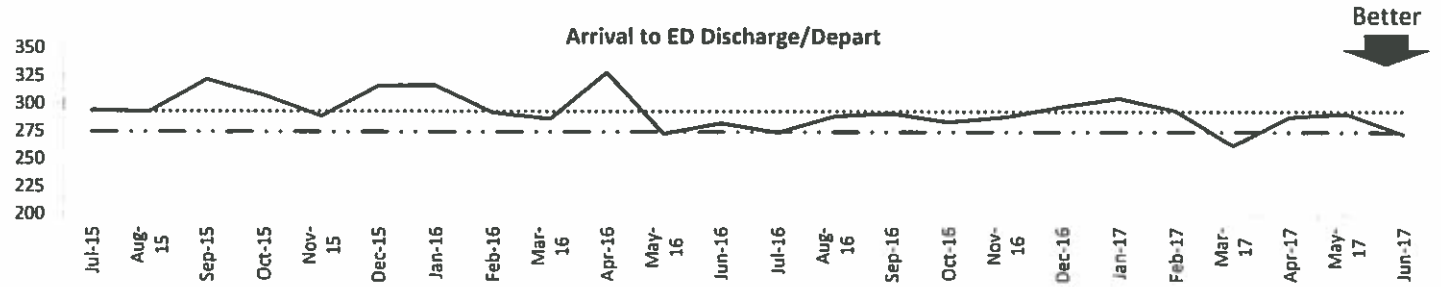


Action Plan

Continued progress due to:
- Assisted Toileting Process
- Redesign of Fall Risk ID
- Pt/Family/RN Partnering Safety Plan
- New Tele Sitter Program
- Redesign of the Post Fall Huddle
- Implement housewide Falls Audit
- Challenges: Pts don't call: Pts occ left unattended in BR.



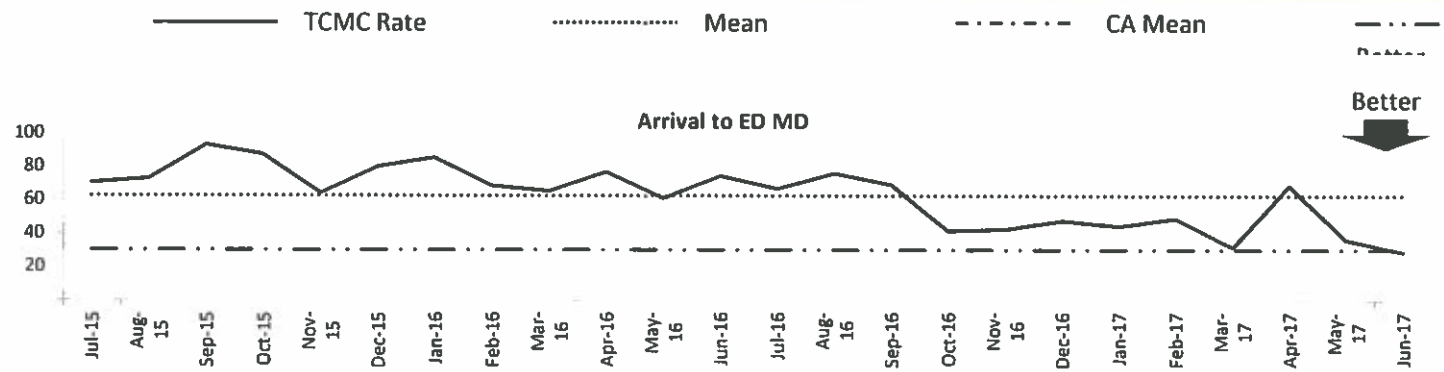
Action Plan



Action Plan

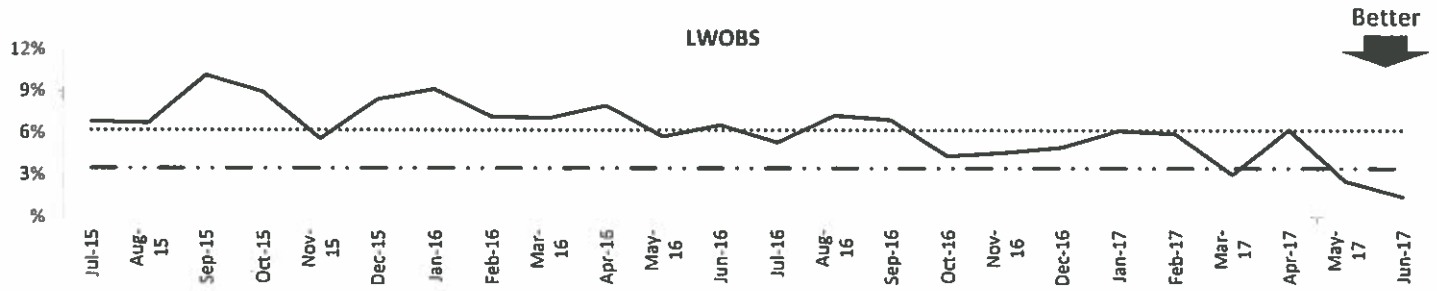
- ED Triage remodel est. completion in Dec 2017.
- Hospitality Suite up and running
- Added admit nurse to improve hand off; reduce delays in adm process.
- ACS RNs added daily 12n-12 mn

Current Trending Measures



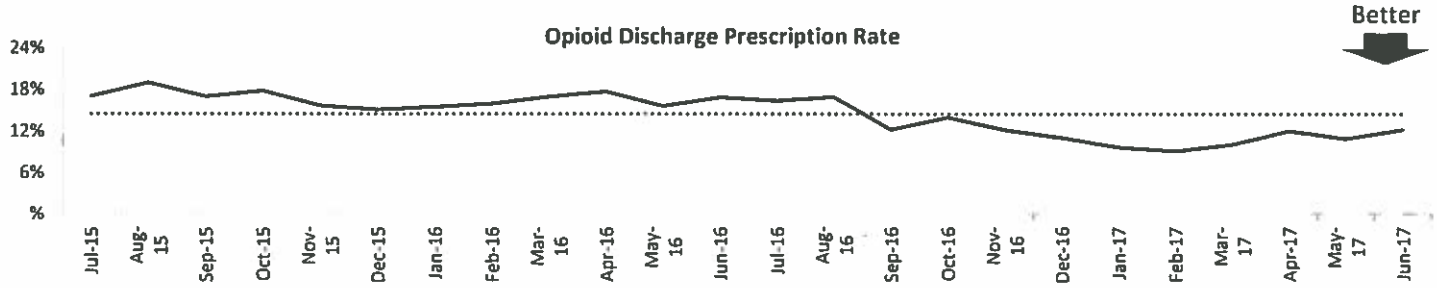
Action Plan

MDs and PAs expanded hours in Triage. MD hours 10am-12mn
Earlier treatment and test orders. Improved pt flow and Pt Satisfaction along with significantly decr Left Without Being Seen numbers.
Expanded treatments, meds and Ivs added to triage area to assist in pt. early discharge



Action Plan

As above.



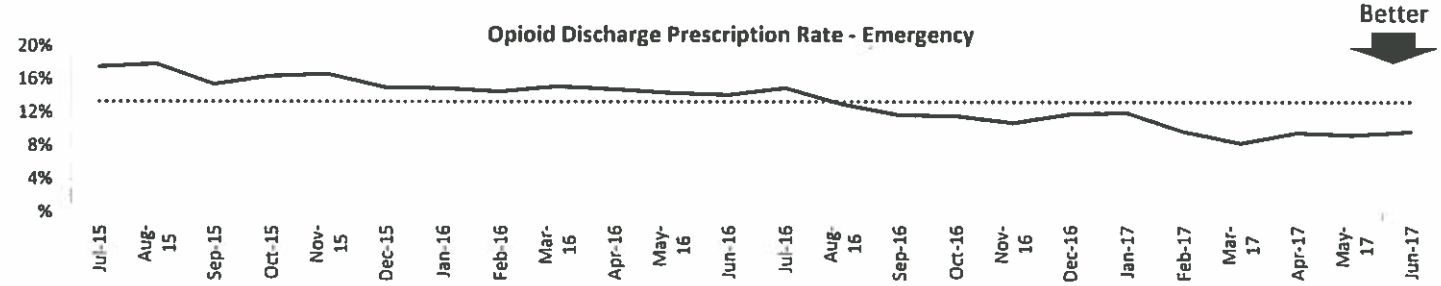
Action Plan

- 3rd Quarter report accepted by Livanta
- Met with hospitalist regarding power plans for pain
- Opioid education will be added to the patient handbook
- Opioid fact pamphlet being made for patients/family members

Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target

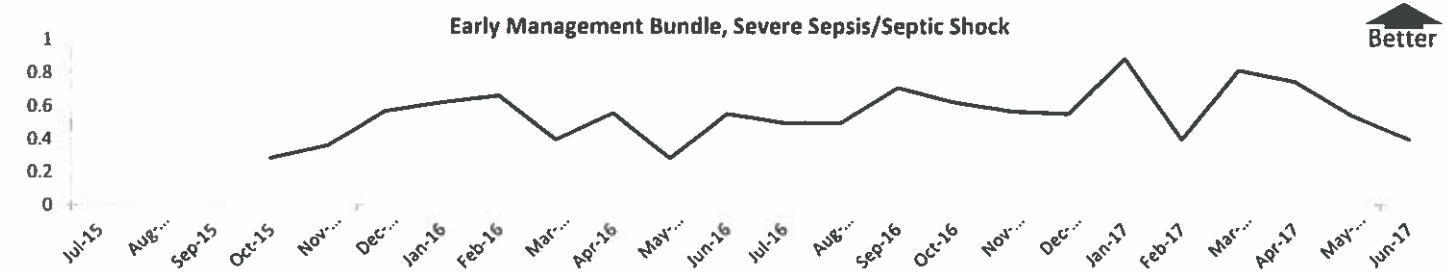
Opioid Discharge Prescription Rate - Emergency



Action Plan

-Housewide discharge instructions to include opioid safe disposal information · Education to physicians on how to implement the CURES link in the tool bar for increased compliance

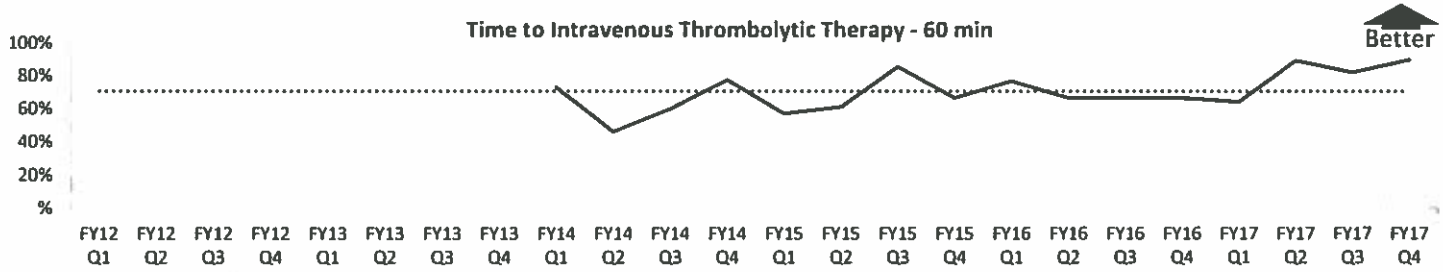
Early Management Bundle, Severe Sepsis/Septic Shock



Action Plan

Back slide to 58% in last quarter.
-National pass rate about 46%
-Improving Code Sepsis process in ED
-Developing post admission Sepsis alert process with RRT.

Time to Intravenous Thrombolytic Therapy - 60 min

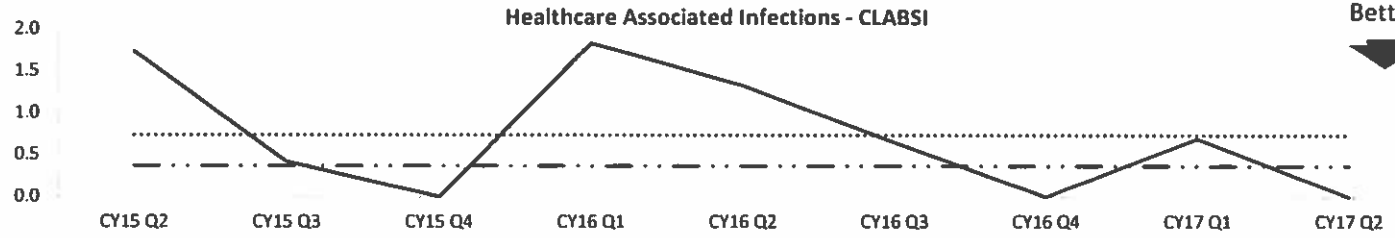


Action Plan

Results continue to improve.
Built drop dow in Cerner for MD's to provide a valid medical reason for a delay.
This will remove case from denominator.

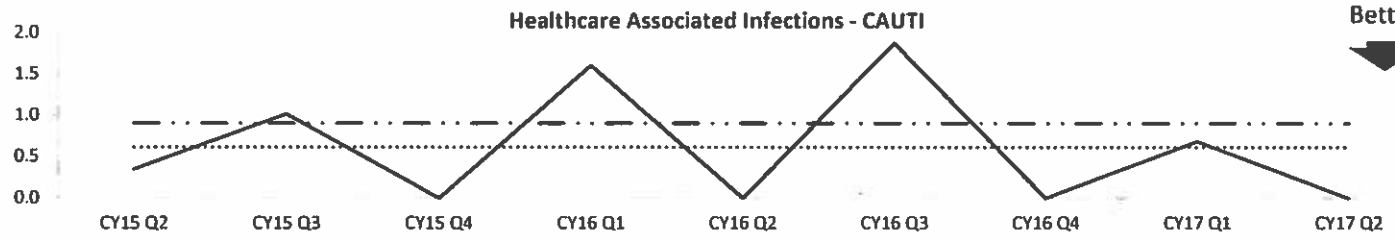
Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target



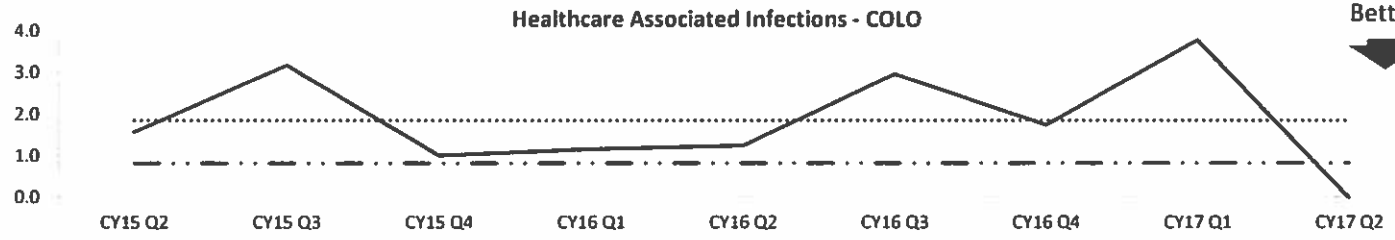
Action Plan

- Ongoing educ to improve compliance with central line bundle. i.e. daily CHG baths, high touch areas cleaned daily, and pt educ doc in Cerner.



Action Plan

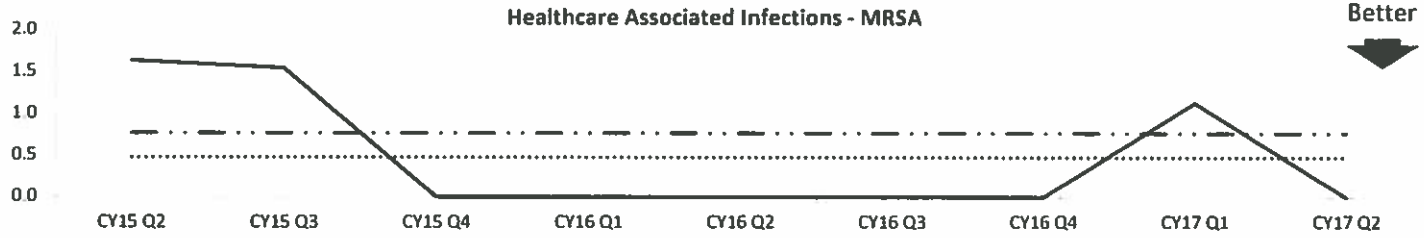
- April 2017 started implementing male external catheters (condom catheters). Cont use of female external catheter (Purewick).



Action Plan

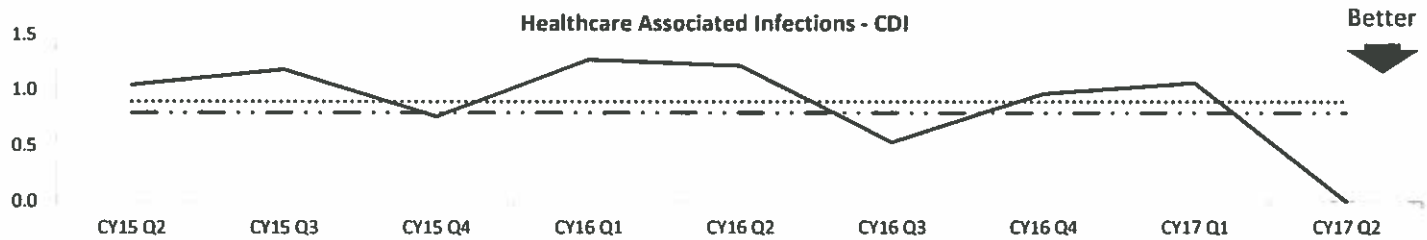
- Returned to using previous dressing.
- Develop standardized post-op drsg changes. Educate to sterile dressing technique.
- Ensure post-op care instructions are clear upon discharge.
- Adv Colorectal surg bundle now used by MD's besides Dr Ghandi.

Current Trending Measures



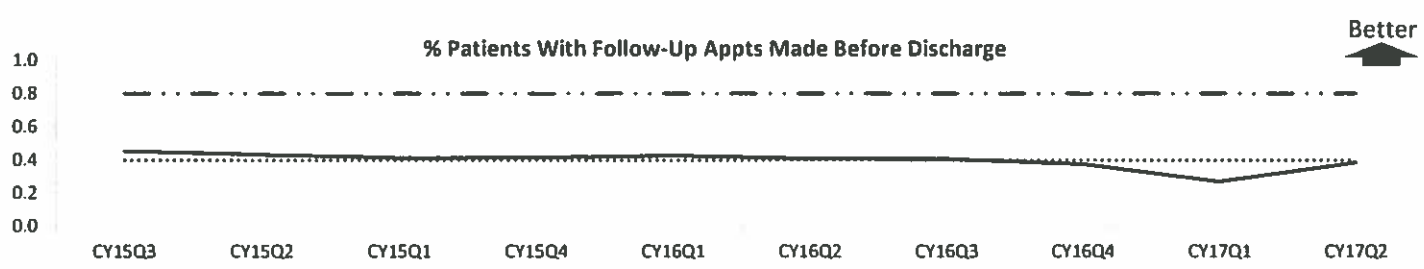
Action Plan

- Zero events in 2016. One event in 2017.
- Continue with current preventative measures (i.e. screening on admission, timely collection).



Action Plan

- Cont current preventative measures (Purple D sign, soap & water, bleach cleaning, timely spec collection).
- IC to implement Bristol Stool Chart for standardizing stool assessment & documentation for staff.
- ID pharmacist and physician to develop Cdiff pathway on appropriate testing and treatment guidelines.



Action Plan

- Compliance continued low
- Unit Sec charged with task
- Noting occasional communication of appt when appt not made. Data is therefore unreliably low.
- Communication of data to managers
- Working with VCC, NCHS and H.I.
- Ongoing education

Volume

*June data to be updated in September

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	28	22	13	25	27	23	19	24	25	25	30		261
FY16	49	29	30	30	23	29	23	28	32	27	27	29	356

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	9	9	5	13	12	11	10	8	15	8	12		112
FY16	20	19	15	23	12	13	16	15	15	17	8	15	188

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	8	11	8	13	12	8	12	10	12	11	17		122
FY16	9	10	8	8	13	11	9	13	14	8	8	9	120

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	18	18	17	14	20	22	20	16	18	13	17		193
FY16	16	19	13	4	7	9	15	20	15	13	17	15	163

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	31	35	29	42	34	29	31	30	31	37	28		357
FY16	40	36	37	44	34	33	45	39	38	39	38	50	473

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1		16.0
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5	15.2	14.5	15.3	17.6	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0		6.4
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6	5.0	6.5	5.5	6.3	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0		14.1
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3	13.5	16.0	17.1	13.4	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9		180.5
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0	186.7	200.7	183.9	189.2	191.9

Performance compared to prior year: Better Same Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	223	239	274	230	197	200	217	197	202	172	188		2339
FY16	215	214	252	227	232	220	216	183	209	189	208	200	2565

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	12	11	12	16	11	14	15	11	6	15	12		135
FY16	16	9	19	12	16	10	11	15	15	15	18	12	168

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	4	4	6	6	5	7	2	2	7	9	6		58
FY16	7	3	7	4	5	7	6	6	6	4	2	7	64

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	10	9	8	7	6	9	8	6	16	9	6		94
FY16	7	14	4	6	7	10	2	8	13	12	5	7	95

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71		1.70
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63	1.65	1.60	1.66	1.68	1.62

Performance compared to prior year: Better Same Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

*June data to be updated in September

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1		49.5	48-52
FY16	46.7	45.7	45.7	45.3	47.0	49.1	51.7	48.9	49.5	50.4	47.4	46.7	47.9	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6	79.9	81.5		83.2	75-100
FY16	83.6	85.8	92.1	88.7	84.0	82.5	83.6	81.1	81.4	81.1	81.1	80.7	84.1	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296		$371	$6,109
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315	($1,842)	$149	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%		0.12%	1.90%
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%	-0.77%	1.13%	1.09%	-6.82%	0.05%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)	$1,213	$1,558		$14,305	$20,431
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598	($558)	$13,379	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%		4.61%	6.37%
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%	3.56%	5.22%	5.55%	-2.07%	4.35%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18		6.11	6.04
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43	6.07	5.86	6.09	5.99	5.94	

TCHD Fixed Charge Coverage Covenant Calculation

	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	TTM Jun	Covenant	
FY17	1.37	1.37	1.37	1.59	1.73	1.50	1.35	1.37	1.51	1.32	1.35		1.10	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73	1.70	1.82	1.63	1.47	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9		
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5	$24.8	$28.0	$37.6	$31.7	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending 7/31/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7010	CERTIFICATION FOR CRISIS PREVENTION	117256	8,550.00	80934	HART, C-GILLUM, E-BENSON, H
7320	AABH CONFERENCE	71917	535.11	78031	SARAH JAYYOUSI
8390	CHA QUARTERLY	60817	279.96	81328	THERESA VIDALS
8420	CERTIFICATION FOR CRISIS PREVENTION	117256	2,850.00	80934	JONATHAN INGRAM
8610	SACRAMENTO TRAVEL	63017	498.36	81163	TERI DONNELLAN
8620	CHA GOVERNANCE MEETING	71217	462.90	81515	JAMES DAGOSTINO
8740	NRP INSTRUCTOR	70517	149.00	78896	EMELY BOLSTON
8740	HEART FAILURE SYMPOSIUM	71317	150.00	60897	LYDIA SERRIN
8740	ACLS COURSE	70517	155.00	82314	JACQUELYN COBBS
8740	ACLS COURSE	72117	200.00	6595	AKI D'ETTA
8740	APIC ANNUAL CONFERENCE	70617	200.00	42078	LISA F. MATTIA
8740	NEONATAL ALS CONFERENCE	71317	200.00	74380	DENA WILLIAMS-ALEXANDER
8740	ADVANCED CARDIAC LIFE SUPPORT	72117	200.00	81704	SONJA DAVILA
8740	ACLS COURSE	70517	200.00	82857	STACY COX
8740	BACHELOR'S PROGRAM	70517	2,000.00	81393	ROBERT FLORES
8740	RADIOLOGIC TECHNICIAN	70517	2,000.00	82924	ROBERT MONTEFALCON
8740	RN TO BSN	70517	2,285.00	81918	YAUHNET WOOLSEY
8754	ASHRM CONF 10/15-10/18, CALNOC CONF 10/22-10/24	71417	1,716.40	79284	JENESSA FRENCH

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending July 31, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.48	(a)	44,164.55	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	1,558	$2.39	(a)	4,917.74	01/27/17	05/31/20	**PCP Clinic - Venus** 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.80	(a)	10,380.72	4/1/2016	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.63	(a)	20,106.00	2/1/2015	01/31/20	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	15,184.80	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,642.26	12/01/15	12/31/20	**PCP Clinic - Clancy** 2375 Melrose Dr. Vista Vista, CA 92081
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.92	(a)	3,398.15	01/01/13	07/31/17	**Performance Improvement** 3927 Waring Road, Ste D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	10,112.83	09/01/12	08/31/17	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.35	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.00	(a)	25,580.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$1.10	(a)	5,039.70	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri-City Orthopedic Bldg Partners 3905 Waring Road Oceanside, CA 92056 **V#83020**	10,218	$2.50	(a)	27,970.32	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Total				**$ 186,598.08**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.