TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
November 10, 2016 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 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: New Facilities; Conference with Real Property Negotiators (Authority: Health and Safety Code, Section 32106, Gov. Code Section 54956.8) Property: 4002 Vista Way, Oceanside, CA 92056 Agency Negotiator: Steve Dietlin Negotiating Parties: Tri-City Healthcare District and United States Under Negotiation: Development program Date of disclosure: December 31, 2016		
	d. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matter)		
	e. Approval of prior Closed Session Minutes		
	f. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4		

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
	(1) Santana vs. TCHD San Diego Superior Court No. 37-2016-00017929-CU-MM-NC (2) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (3) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523 (4) Larry Anderson Employment Claims		
	g. Public Employee Evaluation: Chief Executive Officer (Authority: Government Code, Section 54957)		
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	Community Update 1) Supportive Care/Quality Update – Sharon Schultz 2) Diamond Ball Update – Glen Newhart	 15 min. 5 min.	 S. Schultz G. Newhart
13	Report from TCHD Auxiliary – Pat Morocco, President	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Acting Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Approval of a Physician Recruitment Agreement with Dr. Anton M. Kushnaryov, and North County Ear, Nose, Throat, Head and Neck Surgery	5 min.	J. Raimo, SVP
	b. Consideration to appoint Ms. Katheryn Fitzwilliam to an additional two-year term on the Audit, Compliance & Ethics Committee	5 min.	Standard
	c. Consideration of CEO Employment Contract	5 min.	Chair
17	Old Business a. Report from Ad Hoc Committee on electronic Board Portal	5 min.	Ad Hoc.

	Agenda Item	Time Allotted	Requestor
			Comm.
18	Chief of Staff a. Consideration of October 2016 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals b. Crisis Stabilization Unit Delegation of Services Between Physician Assistant and Supervising Physicians - Scope of Practice and Protocols	5 min.	Standard
19	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 October, 2016* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Sears – 0 *No meeting held in October, 2016* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) **D. Finance, Operations & Planning Committee** Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of the extension of the Clinical Coverage and Medical Director Agreement between TCHD and North County Oncology Medical Clinic, Inc. for a term of 36 months, beginning October 1, 2016 through September 30, 2019 as follows: Coverage Agreement, full time at $43,333.33 per month; Co-Medical Director Agreement at $6,666.67 per month (not to exceed 34 hours per month) for a total cost for the 36-month term of $1,800,000.00. 2) Approval of an agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning November 1, 2016 through October 31, 2017, for an annual cost of $32,820 and a total cost for the term of $32,820.	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	3) Approval of an agreement with Cerner for Workstations on Wheels Carts and Barcode for Medication Scanners and with SHI for HP ProBook Laptops for a total combined cost of $330,571. 4) Approval of the addition of Dr. Tara Quesnell to the currently existing ED On-Call Coverage Panel for Neurology for a term of 20 months, beginning November 1, 2016 through June 30, 2018. 5) Approval of the addition of Dr. Grant Seiden to the currently existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 20 months, beginning November 1, 2016 through June 30, 2018. 6) Recommendation to refer the Finance, Operations & Planning Committee Charter to the Governance Committee.		
	E. Professional Affairs Committee Director Mitchell, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Patient Care Services Policies & Procedures** a. Cardiac Cath Lab Standardized Procedure b. Catheter Clearance with Alteplase (Cathflo Activase) Procedure c. CERNER Downtime Policy d. Chest Tube Management Procedure e. Differentiating Intrauterine Fetal Demises from Miscarriages Procedure f. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure g. Haloperidol IV Administration Procedure h. Hazardous Drugs Procedure i. Local Anesthetic Prior to Intravenous Insertion Standardized Procedure j. Medical Equipment Brought into the Facility Policy k. Ordering 12 Lead ECG for Administration of Droperidol and /or Discontinuing Drug Standardized Procedure l. Pneumoccocal and Influenza Vaccine Screening and Administration and Procedure m. Sponge, Sharps and Instrument Counts prevention of Retained Surgical Objects n. Utilization of Staff, Staffing Patterns Policy 2) **Unit Specific** **Infection Control** a. Influx of Infectious Patients Epidemic Influenza OR Other Respiratory Transmitted Disease IC 15.0 **Medical Staff** a. Disaster Privileges		PAC

	Agenda Item	Time Allotted	Requestor
	NICU a. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and Very Low Birth weight Infant (VLBW) (DELETE) b. Non-Emergent Neonatal Endotracheal Intubation (DELETE) c. Palliative Care of the Neonates at the End of Life d. Peripheral Arterial Line Insertion, Maintenance and Removal of e. Staffing Ratios for Social services in the NICU f. Standards of Care- NICU 2016 g. Standards of Care NICU (DELETE) h. Visitation in the NICU **Women's and Newborn Services** a. Newborn Sepsis Care Guidelines 3) **Formulary Requests** a. Corticosteroid- Epidural Administration by IR b. Gadavist c. Formulary Line Item Additions/Deletions 1. Capsaicin Topical Cream 2. Ticagrelor 60 mg tablets 3. Albuterol oral solution 4. Potassium chloride 40meq/30 ml cup 5. Vitamin K 5mg		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 2 *No meeting held in October*		Gov. & Leg. Comm.
	G. Audit, Compliance & Ethics Committee Director Finnila, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Administrative Policies & Procedures**: a. 8750-560 – Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct Policy b. 8750-563 – Development and Revision of Code of Conduct and Policies; Introduction c. 8750-564 – Development and Revision of Code of Conduct and Compliance Policies d. 8750-565 – Revision of Code of Conduct and Compliance Policies (DELETE) e. 8750-568 – Development and Revision of Code of Conduct and Policies – Dissemination of New or Revised Code of Conduct and Policies (DELETE)		Audit, Comp. & Ethics Comm.
	(2) Minutes – Approval of: a) Regular Board of Directors Meeting – September 29, 2016		Standard
	(3) Meetings and Conferences - None		

	Agenda Item	Time Allotted	Requestor
	(4) Dues and Memberships – None		Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Construction Report – None (b) Lease Report – (September 2016) (c) Reimbursement Disclosure Report – (September, 2016) (d) Seminar/Conference Reports - None	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	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
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2.5 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
Physician Recruitment Proposal

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

Physician Name: Anton M. Kushnaryov, MD
Areas of Service: Otolaryngology

Key Terms of Agreement:

Effective Date:	February 1, 2017 or the date Dr. Kushnaryov becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff
Community Need:	TCHD Physician Needs Assessment shows significant community need for an Otolaryngologist
Service Area:	Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients
Income Guarantee:	None
Sign-on Bonus:	$25,000
Relocation:	$10,000
Total Not to Exceed:	$35,000 Loan Amount

Unique Features:

- Dr. Kushnaryov will join the group practice of North County Ear, Nose, Throat, Head & Neck Surgery, in Vista, CA headed by Dr. Mark Lebovits, a long time Tri-City Otolaryngologist, and Dr. Julie Berry.
- This agreement does not include an income guarantee; however, the amount provided (sign-on bonus and relocation) will be in the form of a loan. The total amount loaned will be forgiven over a two-year period provided Dr. Kushnaryov continues his practice in the service area, observes good business practices and complies with the terms of the agreement.

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Wayne Knight, Chief Strategy Officer

Motion:
I move that the Finance, Operations and Planning Committee recommend the Board of Directors find it in the best interest of the public health of the communities served by the District to approve the expenditure not to exceed $35,000, in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District. This will be accomplished through a Physician Recruitment Agreement with North County Ear, Nose, Throat and Head & Neck Surgery and Anton Kushnaryov, MD.

Kathryn E. Fitzwilliam

Kef5121@hotmail.com **(760) 941 3288**

PROFESSIONAL EXPERIENCE

Life Technologies Inc, Carlsbad, California 2007 – 2014

Director, Accounting & Finance

Reporting to the Chief Accounting Officer of a $3.5 billion biotech company, with a staff of 4 responsible, in a leadership role, for integration of specific accounting functions of acquired companies, design and implementation of a European Finance shared services, implementation, upgrades and enhancements of major ERP systems and the management of the Global SOX 404 program for both Finance and IT controls including internal control design and rationalization.

Gateway Inc, Irvine, California 2003 – 2006

VP, Internal Audit

Reporting to the Audit Committee and CFO with a staff of 10, responsible for financial, operational and IT audit activity for $4.0 billion technology company. Achievements include: the re-establishment of the audit department; development of a staffing model using internal and co-sourced resources; budget development; design and implementation of an audit methodology; project scoping, design implementation and execution of the Sarbanes Oxley 404 program. Specific responsibilities include: strategic, financial and fraud annual risk assessment; development of annual risk-based audit plan; audit execution, reporting and follow up; disclosure committee reporting; and strategic and tactical management of the successful Sarbanes Oxley program including process narratives, control matrices, process testing and remediation plan development.

The Walt Disney Company, Burbank, California 2000 – 2003

Director, Management Audit

Reporting to VP of Internal Audit, one of three Directors, responsible for: global risk assessment for all divisions of The Walt Disney Company; preparing an annual risk based audit plan; directing audit execution; communicating findings and required action plans to senior management; and monitoring company control self assessment results. Scope included all financial and operational areas and specific responsibilities for all IT processes. Direct reports of three managers and 10 professional staff. Achievements included implementing a co-sourced audit arrangement and new audit methodology resulting in 100% productivity improvement over 2 years.

Kelly Services, Inc., Troy, Michigan 1995 - 2000

Director, Business Systems 1998- 2000

Directed staff of 10 who maintained, developed and implemented systems for a subsidiary of Kelly Services. Responsible for: business process re-engineering; implementation of Oracle Financials, HRMS and Payroll; Y2K remediation of in-house UNIX systems; system security

and disaster recovery planning; selection and implementation of package software. Also conducted post implementation reviews of Oracle systems worldwide and provided project plans and project management to resolve issues.

Director Internal Audit 1997 -1998

Reporting to VP, Internal Audit managed Financial, IT, Operational and International subsidiary audits for $4.0 billion organization. Responsible for: identifying audit risk; preparing annual risk-based audit plan; planning audit engagements; developing and reviewing audit programs; performing fieldwork; due diligence reviews for acquisitions; communicating findings and recommendations to audit committee and senior management both verbally and in written audit reports.

IT Audit Manager 1996 -1997

Supervised IT Auditors and conducted technical audits including: application reviews; consulting on new applications; general control reviews; security and control audits. Conducted financial and IT audits for international subsidiaries and participated extensively with outside auditors during annual audits.

Senior Information Systems Auditor 1995 -1996

Conducted IT audits, prepared and delivered verbal and written audit reports.

Deloitte & Touche LLP, Detroit, Michigan 1992 - 1995

Senior Business Systems Consultant

Consulting Assignments

Consulted with clients in various businesses on projects including: strategic information system planning; system design and selection; system integration and implementation.

Accounting Assignments

Acted as interim Director of Finance for two separate companies undergoing major re-organizations. Benefits to clients included more efficient processes, dramatically improved cash flows, improved staff morale, and smooth transition to new incumbents.

Auditing Assignments

Supervised and managed annual financial audits for a wide variety of middle market clients including manufacturing, real estate, service and wholesale distribution clients.

Amerisure, Southfield, Michigan 1990 - 1991

Business Systems Analyst

As an internal consultant for a major insurance company, identified, designed, documented and implemented custom system enhancements for a comprehensive mainframe insurance package.

Fanuc Robotics, Auburn Hills, Michigan 1989 -1990

Interim Controller and MIS Director – UK subsidiary

Responsible for design and implementation of all accounting and information systems for newly acquired UK subsidiary. Managed accounting and administrative staff.

ParaData Computer Networks, Inc., Farmington Hills, Michigan 1983 - 1989

Senior Sales Account Manager
Product Development Manager
Customer Training and Support Manager

EDUCATION, PROFESSIONAL QUALIFICATIONS AND HONORS

Walsh College of Accountancy and Business Administration, Troy, Michigan
Bachelor of Accountancy, GPA 3.96/4.0, Presidential Scholarship, President's Honor Roll
Oakland Community College, Farmington Hills, Michigan
Associate Degree in Computer Science, Summa Cum Laude, GPA 4.00/4.00, and Dean's Honor Roll

Certified Public Accountant, licensed in State of Michigan, status registered
Certified Information Systems Auditor (non current on CPE's)

AICPA Elijah Watts Sells Award with High Distinction for CPA examination achievement (top 100 in country, out of 70,000)
Financial Executive Institute Award - Walsh College recipient for academic achievement

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
October 12, 2016

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 11/11/2016- 10/31/2018)

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 11/11/2016 through 10/31/2018:

- Guthrie, Carly M.D./Anesthesiology (ASMG)
- Jones, Pamela M.D./Neurosurgery (UCSD)
- Penry, Jackson M.D./Radiology (San Diego Imaging)
- Sliwa, Jan M.D./Anesthesiology (ASMG)
- Schoenfeld, William M.D./Anesthesiology (ASMG)
- Waters, Michael M.D./Family Medicine (e-Study)
- West, Justin M.D./Orthopedic Surgery (San Diego Sports Medicine)

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

- Penry, Jackson M.D./Radiology (San Diego Imaging)
- West, Justin M.D./Orthopedic Surgery (San Diego Sports Medicine)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
October 12, 2016

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 11/11/2016 -10/31/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/11/2016 through 10/31/18, 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:

- Barboza, Richard M., MD/Anesthesiology/Provisional
- Bentley, Christian D., MD/ Orthopedic Surgery/Active
- Bharne, Anjali A., MD/ Oncology/Active
- Capella, Marina N., MD/Pediatrics/Provisional
- Carr, Kenneth W., MD/ Cardiology/Active
- Chaturvedi, Sanjana, MD/ Internal Medicine/Affiliate
- Chiang, Pengta A., MD/Emergency Medicine/Active
- Clarkson, Chunjai P., MD/ Obstetrics & Gynecology/Active
- Cooperman, Andrew M., MD/ Orthopedic Surgery/Active
- Daugherty, David L., MD/ Orthopedic Surgery /Active
- Davies, James A., MD/ Ophthalmology/Consulting
- Evans, David G., MD/ Nuclear Medicine/Active
- Evtimov, Stoimen S., MD/ Internal Medicine/Active
- Gandhi, Dhruvil P., MD/ Colon & Rectal Surgery/Active
- Garner, Darin S., MD/ Emergency Medicine/Active
- Glasser, Judd L., MD/ Emergency Medicine /Active
- Holmes, Russell C., MD/ Family Medicine/Active
- Ivengar, Srinivas S., MD/ Ophthalmology/Provisional

Attachment B

- Jurewitz, William H., MD/ Obstetrics & Gynecology/Provisional
- Lopez, Sandra, MD/ Obstetrics & Gynecology/Active
- McCammack, Bradley D., MD/ Pediatrics/Provisional
- Miller, Jeffrey S., MD/ Diagnostic Radiology/Active
- Park, Christopher W., MD/Teleradiology/Associate
- Parker, Sherine B., MD/ Pediatrics/Active
- Pendleton, Robert B., MD/ Ophthalmology/Active
- Penvose-Yi, Jan R., MD/ Obstetrics & Gynecology/Provisional
- Samady, Joseph A., MD/Dermatology/Affiliate
- Shapiro, Mark., MD/ Nephrology/Consulting
- Showah, Henry F., MD/ Emergency Medicine/Active
- Slater, Madeline L., MD/ Infectious Disease/Provisional
- Urbanic, James J., MD/Radiation Oncology/Provisional
- Vogel, Curt A., MD/ Dermatology /Affiliate
- Wolff, James D., MD/ Teleradiology/Associate
- Yoler, Katharine A., MD/ Teleradiology/Associate
- Zimmerman, Andres, MD/ Internal Medicine/Affiliate

RESIGNATIONS: (Effective date 11/11/2016 unless otherwise noted)

Voluntary:

- Camberos, Alfonso, MD/ Plastic Surgery/Active
- Farrell, Melanie A., MD/ Nephrology/Provisional
- Grauer, Nancy M., MD/ Obstetrics & Gynecology/Active
- Johnson, Ebunoluwa O., MD/Emergency Medicine/Provisional

Attachment B

- **Mehta, Ritvik P., MD/ Otolaryngology/Courtesy**
- **Ngo, Donald, MD/Anesthesiology/Active**
- **Novak, Georganne K., MD/Family Medicine/Active**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
October 12, 2016

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

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 10/31/16.

- CLANCY John D.O. — Internal Medicine

STAFF STATUS CHANGES

- None at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
October 12, 2016

Attachment C

PROCTORING RECOMMENDATIONS (Effective 11/11/2016, unless otherwise specified)

• GRAMINS, Daniel M.D.	Cardiothoracic Surgery
• KIM, James M.D.	Anesthesiology
• LEE, Dandy M.D.	Anesthesiology
• MOHR, Andrew M.D.	Anesthesiology
• SEIF, David M.D.	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
October 17, 2016

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

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 AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 11/11/2016 through 10/31/2018:

- **FAZZINO, Dolores, NP, RFNA (Surgery/General/Vascular)**

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Allied Health Professionals:

None

TEMPORARY PRIVILEGES: Allied Health Professionals:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
October 17, 2016

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 11/11/2016 – 10/31/2018)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 11/11/2016 through 10/31/2018, 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:

- **Elamparo, Kaye L., NP/Allied Health Professional**
- **Forbes, Beth, RNFA/Allied Health Professional**
- **Hermann, Linda, PAC/Allied Health Professional**
- **Willett, Brie A, PAC/Allied Health Professional**

RESIGNATIONS: (Effective date 11/11/2016 unless otherwise noted)

- **DiCaro, Audra V., PAC/Allied Health Professional Supervising Physician**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE CREDENTIALS REPORT – Part 2 of 3
October 17, 2016

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 11/11/2016, unless specified otherwise)

PRIVILEGE RELATED CHANGES

- None at this time

STAFF STATUS CHANGES

- None at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE CREDENTIALS REPORT – Part 3 of 3
October 17, 2016

Attachment C

PROCTORING RECOMMENDATIONS (Effective 11/11/2016, unless otherwise specified)

- **CARNELIAN, Alissa, AuD** — **Allied Health Professional**
- **McQUEEN, Paula, CNM** — **Allied Health Professional**

DELEGATION OF SERVICES AGREEMENT BETWEEN

PHYSICIAN ASSISTANT AND SUPERVISING PHYSICIANS

SCOPE OF PRACTICE

AND PROTOCOLS

Tri-City Behavioral Health

Outpatient Crisis Stabilization Unit

4002 Vista Way

Oceanside, CA 92056

October 2016

Updated October, 2016

DELEGATION OF SERVICES AGREEMENT BETWEEN
SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT

This Delegation of Services Agreement ("Agreement") is entered into between (see Supervising Physician List on Pages 25-28) the physicians whose signatures appear on pages 25-28, each of which shall be referred to herein as "Supervising Physician" or "SP") and Carol Ann Jeffries ("PA"), in order to fulfill the purposes set forth below.

Physician Assistant ____ Carol Ann Jeffries
(Name)

Physician Assistant, Graduated from Pacific University, Forest Grove, OR
(Name)

Physician Assistant training program on May 2003 thru January 2006
(Date)

Carol Ann Jeffries was first granted licensure by the Physician Assistant Committee on: See HR file which expires on See HR file unless renewed.

I. **PURPOSE:** The purpose of this Agreement is to comply with the requirements of Title 16, Article 4, of the California code of Regulations, and Business and Professions code Section 1399.540 and Business and Professions Code Section 3500-3546 hereinafter referred to as the "Physician Assistant Regulations" or "PA Regulations." Per "PA Regulations", "A physician assistant may provide those medical services which are consistent with the
physician assistant's education, training and experience, and which are delegated by a supervising physician who is responsible for the patients cared for by that physician assistant." In this Agreement, Supervising Physician hereby delegates the performance of certain medical services to PA. "PA Regulations" sets forth requirements for supervision by a supervising physician when a PA is caring for patients. This Agreement shall set forth such requirements to be followed by PA and Supervising Physicians.

II. **QUALIFICATIONS:** PA is licensed by the California Physician Assistant Committee. Supervising Physician is a licensed California physician who has a locum tenens contract agreement, with Locum Tenens and Tri-City Medical Center. PA and Supervising Physicians are familiar with the requirements governing the performance of medical services by PA's, and the supervision of PA's by supervising physicians, as set forth in the Physician Assistant Regulations.

III. SETTING AND SCOPE OF PA PRACTICE (FUNCTIONS)

A. Setting

1. The PA may function within only those locations operated through Tri-City Medical Center (TCMC) in which the supervising physician is privileged for. The PA is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. Scope of PA Practice (Functions)

1. The Psychiatric PA will:

a) Assume responsibility for the psychiatric care of patients, under written delegation of services agreement and under the supervision of the TCMC medical staff member (physician).

b) Patients may be seen for the initial medication assessment by the PA with the agreement and under the supervision of the physician. The PA must consult the supervising physician if assessing a medication outside of the PA defined scope of practice as defined in delegation of services agreement. The supervising physician may choose to perform the initial medication assessment and then assign the PA to the responsibility for the psychiatric services required by the patient, subject to the supervision requirements of the TCMC medical staff.

c) Admit and discharge patients only with physician consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, including the crisis stabilization unit, under the order of a physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the PA. Telephone orders are systems directed for physician countersignature which is required within 48 hours.

d) Order medications as included in the Psychiatric Division Cerner Power Plans.

e) The PA 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.

f) The PA orders the medication and documents the information into the chart and in the clinical notes.

g) If a medication needed is not listed on a Power Plan the PA 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.

h) Administer medications (including an injectable) as necessary for patient needs. Medication administration by a PA does not require a standardized procedure. Supervising Physician shall review, countersign, and date the record of any patient for whom PA issues or carries out a drug order within seven days.

i) Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

j) Order and interpret specific laboratory studies for the patient as included in the Psychiatric Division Power Plans.

k) Provide or ensure case management and coordination of treatment.

l) Make referrals to outpatient primary care practitioners, and/or Mental Health Psychiatrists/Physicians for consultation or to specialized health resources for treatment, retaining responsibility for mental health care of the patient, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician.

m) Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of psychiatric medication in sufficient detail so that any Psychiatrist/Physician can review and evaluate the effectiveness of the care being given.

n) Identify aspects of PA care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

o) Utilize existing quality indicators or develop new indicators to monitor the effectiveness of care provided by the physician assistant.

p) Formulate recommendations to improve mental health care and patient outcomes.

q) Provide patient health education related to medications, psychiatric conditions and health issues.

IV. MANAGEMENT OF CONTROLLED SUBSTANCES

A. PA participates in the process of furnishing and ordering controlled substances under the scope of practice and protocols.

1. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

2. Schedule II through V drugs requires successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the Physician Assistant Regulations.

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.

3. When Schedule II through V drugs are furnished or ordered by a PA, 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.

V. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. As required, supervising physician shall:

1. Review, countersign and date within seven (7) days the medical record of any patient for whom PA issues or carries out a drug order. For other patients, Supervising Physician shall utilize one or more of the following mechanisms to supervise PA, as required by Section 1399.545 of the Physician Assistant Regulation

a. _____ Examination of the patient by Supervising Physician the same day as care is given by PA.

b. _____ Supervising Physician shall review, audit and countersign
every medical record written by PA within 30 days of the encounter.

c. ___X_____ Supervising Physician shall audit the medical records of at least ten percent (10%) of the patients managed by PA under protocols which shall be adopted by Supervising Physician and PA, pursuant to Section 1 399.545(e)(3) of the Physician Assistant Regulations. Supervising Physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his judgment, the most significant risk to the patient.

B. Supervision for purposes of this agreement is defined as supervision by a physician for the performance of standardized protocols and for furnishing or ordering drugs by PA pursuant to California (CA) business and professions code.

1. Each PA will at all times have a supervisory relationship with a specifically identified physician.

a. In the event the primary Supervising Physician is not available when needed, PA may call and/or refer patients to other authorized physicians (secondary Supervising Physicians) as designated by the Supervising Physician.

b. 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.

c. Ongoing case specific Supervision occurs as needed, with frequency determined by the PA and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

d. Additional Supervision occurs as described below under "Quality Improvement."

2. Supervisor notification and consultation is obtained under the following circumstances:

a) Emergent conditions requiring prompt medical intervention after stabilizing care has been started.

b) Acute exacerbation of a patient's situation;

c) History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.

d) Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.

e) Upon request of the patient, another clinician or Supervisor.

f) Upon request of the PA.

g) The supervising physician will examine the patient on the same day as care is provided by the PA for non-scheduled patient admissions.

VI. QUALITY IMPROVEMENT

A. PAs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.

1. The PA will complete clinical quality review reports when necessary and inform appropriate personnel.

2. The PA will note errors or inconsistencies in patient records and intervene to correct and resolve these.

3. PA 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 PA's performance, and gives input into the Annual Performance Evaluation.

5. The PA 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.

6. The PA will maintain and upgrade clinical skills as required to meet professional standards.

a) Documentation of participation in relevant continuing education activities.

Protocols FOR PHYSICIAN ASSISTANTS

Protocols for Physician Assistant Practice

Tri-City Medical Center has adopted the following books and Media resources as the protocols and clinical practice guidelines for the physician assistant practice of medicine:

MEDICAL MANAGEMENT

Current Medical Diagnosis and Treatment, Appleton & Lange
Merck Manual, Merck
The Washington Manual of Medical Therapeutics, Little Brown
Harrison's Principles of Internal Medicine, McGraw-Hill
The Sanford Guide to Antimicrobial Therapy, Antimicrobial Therapy, Inc.
Family Practice
Nurse Practitioner Certified Nurse Midwife Physician Assistant Protocols, Kaiser Permanente Southern California Permanente Medical Group
Emergency Medicine: A Comprehensive Study Guide Tintinalli
Atlas of Emergency Medicine Procedures
Diagnostic & Statistical Manual of Mental Disorders (DSM-5)/Edition 5, American Psychiatric Publishing, Incorporated.
Other

PHARMACOLOGY

Physician's Desk Reference
Physician's Desk Reference for Non-prescription Drugs
Drug Interactions Handbook by Lexicomp
Handbook of Clinical Pharmacology, Wallach
Other

LABORATORY MEDICINE

Interpretation of Diagnostic Tests, Little Brown
Widmann's Clinical Interpretation of Laboratory Tests, F.A. Davis
Other

The PA will utilize only those portions of these references that are consistent with the scope of his practice, including his training, experience, and skills. It is understood that referral to these sources will occur as often as the PA deems necessary, but will not supplant as much direct consultation as possible, when indicated, with the primary or secondary Supervising Physicians.

These textbooks and media resources will serve as PA practice references. They are supplements and references, not substitutes, for practicing the standard of care as determined by the Supervising Physician.

The current edition of these medical books shall provide the standards for the objective data references. The texts which are integrated into the PA's protocols shall include only those parts of the referenced text(s) that cover medications that are appropriate for use in the type of practice engaged in by the supervising physician.

It is understood that the supervising physician is the ultimate authority as to the correct treatment modalities.

As an agent of the supervising physician, the physician assistant is authorized to provide, administer, or initiate an order for a service, drug, device, or procedure specified in these protocols without a patient-specific order. Except as provided below, the physician assistant may initiate orders for the patient care services indicated in the medical books or computerized media without prior consultation with the supervising physician.

Physician consultation or referral is indicated for the management of patients that have diseases which are not included in these medical books and regarding any patient, task, procedure, or diagnostic problem that the physician assistant determines exceeds his level of competence. Also, prior approval by the supervising physician is required before issuing or carrying out any drug order for a controlled substance.

The protocols herein outline requirements for PA functions in the management, evaluation, diagnosis and treatment of the following:

I. Assessment and management of behavioral health CSU patients.

II. Any disease-specific or treatment-specific protocol or clinical guideline for the PA is to be used to supplement patient care, not to define it absolutely. Alterations and adjustments may be necessary to individualize patient care as described below:

A. Patient Management

1. Triage CSU admissions and management of patients on the CSU. Perform or assist in initial and follow-up history and physical examination and **discharge**. Review, discuss and confirm, as necessary, by a supervising physician.

2. Make assessments from the examinations and routine laboratory tests and record such information in the patient's record.

3. There will be regular communication between the physician assistant and the patient's physician regarding medication and toxicity.

4.The PA is authorized to assist in the performance of and to perform all further laboratory and screening procedures and all additional therapeutic procedures as directed by an SP and as determined by that SP to lie within the scope of the PAs training, skills, and experience. In certain situations, the SP may actually provide that training to the PA and monitor his performance during the training phase.

5. Responsible for ordering laboratory tests, diagnostic imaging, consultations and medicine orders.

6. Maintain thorough patient clinical records with appropriate documentation of pertinent data.

7. Responsible for obtaining informed consent.

8. Responsible for fielding telephone calls from patients, family and referring physicians.

9. Provide assessment, consultation and recommendations to other medical specialties as requested by those services needing immediate assistance or as requested.

10. Use universal precautions to reduce the risk of transmission of Infectious agents, in all appropriate settings.

11. Life-threatening situations:

a. Recognize and evaluate situations which call for immediate attention of the supervising physician.

b. Institute CPR (PA must be certified) as necessary to support life of the patient until relieved by a physician.

c. Have knowledge of patient-related outside health agencies and their roles.

B. Liaison Duties:

1. Coordinate physician referral of patients or families to appropriate health facilities, resources of the community or other physicians. Assist with placement to home or CSU Resource Centers by providing a review of treatment, therapy plans and medications with patient's family and other medical personnel.

2. Inform, explain and counsel patients and families regarding disease processes, mental health, and interim and long range treatment program.

3. Provide liaison information between consulting physicians, nurses, administrative staff, and other medical personnel.

PROTOCOL FOR MANAGEMENT OF PSYCHIATRIC ILLNESS AS IT PERTAINS TO CSU PATIENTS

I. Definition: This protocol covers the management of acute psychiatric illness seen in patients who are followed by the PA in the CSU at Tri-City Medical Center.

II. Data Base:

A. Subjective data

1. Obtain patient's description of current symptoms relevant to the presenting (chief) complaint
2. Obtain history of present illness, review of systems relevant to complaint, current medications and allergies.

B. Objective data

1. Physical examination appropriate to complaint.
2. Laboratory, x-ray and other diagnostic evaluations as appropriate.
3. Mental Status examination.

C. Assessments/Diagnosis:

1. Interim or final diagnosis consistent with subjective and objective data and DSM-5.
2. Assessment of level of acuity of the illness/event.

D. Plan/Treatment:

1. Diagnostic
   a) Order appropriate laboratory, x-rays and other diagnostic procedures.
   b) Initiate referral to other specialty when indicated.
2. Treatment

   a. Initiation and manipulation of medications (as covered in Medication Protocol below

   b. Physical, occupational and other therapies when appropriate.

   c. Diet and exercise prescription as indicated by level of illness/event and patient condition.
3. Education: Patient education will include, when appropriate, the following:
   a) Disease course, expected outcome, and prevention.
   b) Medications: Teach purpose, dosage, side effects, toxic effects, the importance of compliance with regimen, directions for taking drug, and, what to do and whom to contact if side effects occur.
   c) Activity and lifestyle counseling.
   d) Specify follow-up plan with patient.

4. **Consultation: Supervising physician consultation will be obtained as delineated in the Scope of Practice, Declaration of Service, and PA Protocols.**

MEDICATION PROTOCOL

I. Definition: This protocol covers the initiation, alteration, discontinuance, and renewal of medications for patients in the CSU at Tri-City Medical Center.

II. Approval to issue drug orders:

A. All Physician Assistants shall follow the law, "PA Regulations," when prescribing medications.

III. Physician's Prescriptions:

A. The PA may issue both to a pharmacist and to a nurse, SP's order(s) for medication(s) or medical device(s) requiring a physician's prescription in accordance with the pertinent sections of the PA statutes and regulations, particularly Business and Professions Code, Section 3502.1. Drug orders to a pharmacist shall be in accordance with the policies and practices of the Tri-City Emergency Medical Group, or in accordance with patient-specific orders from an SP, as shall orders to a nurse.

B. The PA may also enter written orders on the medical records of patients being followed at any site where health care is being provided within the purview of the supervising physicians of Tri-City Medical Center and in accordance with the PA regulations and other applicable statutes and regulations. These orders on a patient's medical record may include a record of orders to Pharmacists, as well as to nurses, concerning the administration of medications, the use of medical devices, or the performance of other nursing duties, again, in accordance with the pertinent sections of the PA statutes and regulations and the policies and practices of Tri-City Medical Center.

C. Any medication handed to a patient by the PA shall be authorized by the prescription order either via a transmittal order based on protocols and elements of this document or via a patient-specific order of an SP and shall be packaged and labeled in accordance with Sections 4047.5, 4048, and 4228 of the Business and Professions Code.

APPROVED SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION OF A PHYSICIAN ASSISTANT IN CONJUNCTION WITH PROTOCOLS

Tri-City Medical Center

3156 W. Vista Way, Suite 410

Oceanside, CA 92056-3622

October 2016

APPROVED SUPERVISING PHYSICIANS' RESPONSIBILITY FOR SUPERVISION OF A PHYSICIAN ASSISTANT IN CONJUNCTION WITH PROTOCOLS

SUPERVISORS (see Supervising Physician List "SP List") are physicians licensed to practice in California as physicians and surgeons who are members of the medical staff at Tri-City Medical Center (medical license numbers listed on SP List).

Hereinafter, the above-named approved physicians, shall be referred to as primary supervising physician (SP) along with others on SP List who shall be referred to as secondary SP, and together they shall jointly be referred to as "the SPs."

SUPERVISION REQUIRED: The Physician Assistant named in the Delegation of Service Agreement will be supervised by an approved primary or secondary SP in accordance with these guidelines set forth as required by PA Regulations, which have been read by the SP's whose signatures appear below.

1. Supervising Physician shall remain available at all times while PA is performing medical services, unless another approved supervising physician is so available.
2. The Primary SP will review the performance of the PA on a regularly planned and continuing manner. The review includes the need to examine an appropriate number of charts. To countersign and date those documents that require a countersignature, and to confer personally with the PA about the performance of his/her tasks and responsibilities.

Protocols: In the CSU at Tri-City Medical Center, written protocols exist as Guidelines for evaluation and management of patients. A protocol also addresses the aspects of clinical practice regarding medications. These protocols are found in the "Protocols for Physician Assistants at Tri-City Medical Center in the CSU.

A. Both the SPs and the PA recognize that validity and the applicability of the following principles that constitute responsible supervision:

1. For PAs and their SPs, responsible supervision is a vital, ongoing process, and not merely a legal refinement in the medico-legal arena.

2. No SP will be responsible for more than two PAs at any point during the SP's working hours

3. An SP will be continuously available during the PA's working hours either in person or by some form of electronic communication. It is understood that this stipulation does not require constant direct supervision when planned options for other forms of supervision and communications exist.

4. The PA will preserve his professional integrity by taking the following minimum steps where appropriate:

   a. Timely consultation with an SP, who generally recognizes that not every individual case requires specific or immediate attention from an SP; this consultation may be prior to the implementation of the treatment plan, though this will not invariably be so;

   b. Utilization of tacit, well-understood, and agreed-upon modes of assessment and therapy, as well as flexible, written protocols;

   c. Regular discussion of–and consistent accountability for–all patient care services that the PA performs;

   d. Recognition and affirmation of the ultimate dependency of the PA's role upon that of the SP's practice; and

   e. Further the development of a collegial supervisory relationship consistent with all of these principles defined herein.

Declaration: Our signatures below signify that we fully understand the foregoing agreement (Delegation of Service, Scope of Practice, PA Protocols, and SP Supervisory Responsibility for PA) – having received a copy of this agreement for our possession and guidance – and agree to comply with its' terms without reservation.

The PA is authorized to function as my agent per protocols of Tri-City Medical Center.

_____ Dated: _____

PHYSICIAN ASSISTANT

Supervising Physicians:

Name: _____ License Number: _____ Date: _____

Name: _____ License Number:_____ Date:_____

Unique Plan Description: CSU Admit Orders by Psychiatry
Plan Selection Display: CSU Admit Orders by Psychiatry
PlanType: Medical
Version: 1
Begin Effective Date: 9/13/2016 16:04
End Effective Date: Current
Available at all facilities

CSU Admit Orders by Psychiatry

Status

- ☑ Patient Admission Status
  T;N, Routine, Outpatient- Crisis Stabilization Unit, No, Psychiatric evaluation
- ☑ Requested Patient Location
  T;N, Crisis Stabilization Unit
- ☑ Code Status
  T;N, Full Code (DEF)*
  T;N, No Resuscitation
- ☑ Legal Status
  T;N, Routine, Voluntary (DEF)*
  T;N, Routine, 72-Hour Hold
  T;N, Routine, Conservator
- ☑ Isolation
  T;N, Standard Precautions

Vital Signs

- ☑ Vital Signs
  T;N, Routine, DAILY (DEF)*
  T;N, Q4HR-WA, for Detox
  T;N, Timed, BID, While Awake, for Detox

Activity

- ☑ Activity as Tolerated
  T;N, Routine

Nursing Orders

- ☐ Sitter
  T;N, Routine

Diet

- ☑ Regular Diet
  T;N, Routine, Nutrit Supplemnt/Protocol Yes
- ☐ Cardiac Diet
  T;N, Routine, Nutrit Supplemnt/Protocol Yes
- ☐ Carbohydrate Control Diet
  T;N, 1800 cal, Nutrit Supplemnt/Protocol Yes (DEF)*
  T;N, 2000 cal, Nutrit Supplemnt/Protocol Yes
  T;N, 2200 cal, Nutrit Supplemnt/Protocol Yes

Medications

*****Benzodiazepine Equivalents*****ALPRAZolam(Xanax) 0.5mgchlordiazePOXIDE(Librium) 10mg clonazePAM(Klonopin) 0.25mgclorazepate(Tranzene) 7.5mgdiazepam(Valium) 5mgestrazolam(Prosom) 1mgflurazepam(Dalmane) 15mglorazepam(Ativan) 1mgoxaxepam(Serax) 15mgtemazepam(Restoril) 15mgtriazolam(Halcion) 0.25mg(NOTE)*

- ☑ Tylenol
  650 mg, ORAL, Q6HR, PRN, Pain, tab, Pain
- ☑ Mylanta II
  15 mL, ORAL, Q4HR, PRN, Indigestion, Indication Indigestion, ORAL Soln
- ☐ Protonix
  40 mg, ORAL, DAILY, ER tablet, Control of stomach acid
- ☐ KlonoPIN

0.5 mg, ORAL, BID, PRN, Agitation, Duration: 2 days, tab, Agitation

☐ Vistaril
50 mg, ORAL, Q4HR, PRN, Other (see comment), cap, Anxiety (DEF)*
Comments: prn MODERATE anxiety; Not to Exceed 4 doses in 24hrs
50 mg, ORAL, Q6HR, PRN, Anxiety, T;N

☐ Vistaril
100 mg, ORAL, Q4HR, PRN, Other (see comment), Duration: 1 hr, cap, Anxiety
Comments: prn SEVERE anxiety; Not to Exceed 4 doses in 24hrs

☐ SEROquel
50 mg, ORAL, Q4HR, PRN, Agitation, tab

☐ BHU Standard Admission Medications(SUB)*
Choose one of the following for sleep(NOTE)*

☑ Restoril
15 mg, ORAL, QHS, PRN, Insomnia, cap, Insomnia
Comments: May Repeat X 1 dose before 0200.

☐ Ambien
5 mg, ORAL, QHS, PRN, Insomnia, tab, Insomnia

☐ Desyrel
50 mg, ORAL, QHS, PRN, Insomnia, tab, Insomnia (DEF)*
100 mg, ORAL, QHS, PRN, Insomnia, tab, Insomnia

☐ Remeron
15 mg, ORAL, QHS, PRN, Insomnia, tab, Insomnia (DEF)*
30 mg, ORAL, QHS, PRN, Insomnia, tab, Insomnia

Bowel Management

☐ Colace
100 mg, ORAL, BID, Duration: 1 hr, cap, Bowel Movement
Comments: Hold for GREATER or equal to 4 stools per 24hr

☑ MOM
30 mL, ORAL, DAILY, PRN, No Bowel Movement in 24hr, T;N, Indication Constipation, susp
Comments: no bowel movement in 24hr

☐ Dulcolax Laxative
10 mg, RECTAL, DAILY, PRN, Constipation, supp, Constipation
Comments: If MOM is not effective

☐ Senokot
2 tab, ORAL, BID, PRN, No Bowel Movement in 48hr, T;N, Indication Constipation, tab
Comments: IF no BM in 48hr

Consults

☐ Psych Eval
T;N, Routine, BHU staff Psychologist

☐ Consult to BHS Social Service
T;N, Routine

Rehab Services

☐ TR BHS Evaluation & Treatment

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: Discharge CSU
Plan Selection Display: Discharge CSU
PlanType: Medical
Version: 1
Begin Effective Date: 9/13/2016 15:09
End Effective Date: Current
Available at all facilities

Discharge CSU
Status

- ☑ Discharge Patient
  - *T;N, Routine* (DEF)*
  - *T;N, Routine, For Admission to Inpatient psychiatric care*
- ☑ Discharge Location
  - *T;N, Routine, Home Independently* (DEF)*
  - *T;N, Routine, Psychiatric Unit*
  - *T;N, Routine, Other*

Discharge

- ☑ Discharge Activity
  - *T;N, Routine, Activity as tolerated*
- ☑ Discharge Diet
  - *T;N, Routine, Regular* (DEF)*
  - *T;N, Routine, Low Fat Diet*
  - *T;N, Routine, Cardiac*
- ☐ Discharge Instructions
  - *T;N, Routine* (DEF)*
  - *T;N, Routine, Follow up with psychiatry. Call 911 or use ED if needed.*
- ☐ Return to Work/School
  - *T;N, Routine*

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Biploar-Mania
Plan Selection Display: BHU Biploar-Mania
PlanType: Medical
Version: 1
Begin Effective Date: 01/11/2012 12:25
End Effective Date: Current
Available at all facilities

BHU Biploar-Mania
Medications

- ☐ Trileptal
  - *150 mg, ORAL, BID, tab* (DEF)*
  - *300 mg, ORAL, BID, tab*
  - *600 mg, ORAL, BID, tab*
- ☐ Depakote
  - *125 mg, ORAL, TID, EC tablet* (DEF)*
  - *250 mg, ORAL, TID, EC tablet*
- ☐ Depakote ER 250 mg oral tablet, extended release
  - *250 mg, ORAL, DAILY, ER tablet* (DEF)*
  - *250 mg, ORAL, QHS, ER tablet*
  - *750 mg, ORAL, DAILY, ER tablet*
  - *750 mg, ORAL, QHS, ER tablet*
- ☐ Depakote ER 500 mg oral tablet, extended release
  - *500 mg, ORAL, DAILY, ER tablet* (DEF)*
  - *1000 mg, ORAL, DAILY, ER tablet*
  - *1,500 mg, ORAL, DAILY, ER tablet*
  - *2,000 mg, ORAL, DAILY, ER tablet*
  - *500 mg, ORAL, QHS, ER tablet*
  - *1000 mg, ORAL, QHS, ER tablet*
- ☐ Lithobid 300 mg oral tablet, extended release
  - *300 mg, ORAL, BID, ER tablet* (DEF)*
  - *600 mg, ORAL, BID, ER tablet*
- ☐ Eskalith-CR 450 mg oral tablet, extended release
  - *450 mg, ORAL, QHS, ER tablet* (DEF)*
  - *900 mg, ORAL, QHS, ER tablet*
  - *1,350 mg, ORAL, QHS, ER tablet*
  - *450 mg, ORAL, BID, ER tablet*
  - *900 mg, ORAL, BID, ER tablet*
  - *450 mg, ORAL, TID, ER tablet*

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Emergency Medications
Plan Selection Display: BHU Emergency Medications
PlanType: Medical
Version: 1
Begin Effective Date: 01/12/2012 08:13
End Effective Date: Current
Available at all facilities

BHU Emergency Medications
Medications

Plan 1(NOTE)*

- ☐ Thorazine
  100 mg, IM, ONCE, amp
- ☐ Benadryl INJ
  50 mg, IM, ONCE, injection
- ☐ Ativan INJ
  2 mg, IM, ONCE, injection

Plan 2(NOTE)*

- ☐ Haldol INJ
  5 mg, IM, ONCE, injection
- ☐ Cogentin
  1 mg, IM, ONCE, amp
- ☐ Ativan INJ
  2 mg, IM, ONCE, injection

Plan 3(NOTE)*

- ☐ Abilify
  9.75 mg, IM, ONCE, injection
- ☐ Abilify
  9.75 mg, IM, Q2HR, PRN, Agitation, Routine, injection
  Comments: MAX 30mg/24hr
- ☐ Ativan INJ
  2 mg, IM, ONCE, injection
- ☐ Haldol INJ
  3 mg, IM, ONCE, injection
- ☐ Cogentin
  2 mg, IM, ONCE, amp

Plan 4(NOTE)*

- ☐ Thorazine
  100 mg, IM, ONCE, amp
- ☐ Benadryl INJ
  50 mg, IM, ONCE, injection

Plan 5(NOTE)*

- ☐ Haldol INJ
  5 mg, IM, ONCE, injection (DEF)*
  10 mg, IM, ONCE, injection
- ☐ Cogentin
  1 mg, IM, ONCE, amp

Plan 6(NOTE)*

- ☐ Geodon
  10 mg, IM, ONCE, injection
- ☐ **+2 Hours** Geodon
  10 mg, IM, ON CALL, PRN, Agitation, 6 hr, injection
  Comments: If a repeat dose is needed 2 hrs after initial dose. Not to Exceed 40mg/24hr
- ☐ Ativan INJ

1 mg, IM, ONCE, injection (DEF)*
2 mg, IM, ONCE, injection

Plan 7(NOTE)*

☐ ZyPREXA
10 mg, IM, ONCE, injection recon
Comments: Not to Exceed 30mg/24hr

☐ Ativan INJ
1 mg, IM, ONCE, injection (DEF)*
2 mg, IM, ONCE, injection

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Alcohol and Benzodiazepine Detoxification
Plan Selection Display: BHU Alcohol and Benzodiazepine Detoxification
PlanType: Medical
Version: 1
Begin Effective Date: 01/05/2012 08:29
End Effective Date: Current
Available at all facilities

BHU Alcohol and Benzodiazepine Detoxification
Vital Signs

☑ Vital Signs
T;N, Routine, Q1-2HOURS, Q1HRWA x 6, Q4HRWA x 1 day, BID x 1 day, until detoxification is complete.

Medications

☐ Neurontin
800 mg, ORAL, TID, Routine, cap

☐ Theragran-M
1 tab, ORAL, DAILY, Routine, tab

☐ Vitamin B-1
200 mg, ORAL, BID, Routine, 5 days, tab (DEF)*
Comments: while in detox
100 mg, IM, BID, Routine, 5 days, injection
Comments: while in detox and unable to tolerate ORAL thiamine

☐ folic acid
1 mg, ORAL, DAILY, Routine, tab

☐ Bentyl
20 mg, ORAL, Q6HR, PRN, Cramps, Routine, tab
Comments: abdominal cramping

☐ Imodium
2 mg, ORAL, PRN, PRN, Loose stools, Routine, cap
Comments: Give 1 cap after each loose stool. Not to exceed 8 doses/24hr

☐ Lomotil
2 tab, ORAL, Q6HR, PRN, Diarrhea, Routine, tab

☐ Motrin
600 mg, ORAL, Q6HR, PRN, Pain, Routine, tab

☐ Robaxin
1,000 mg, ORAL, Q4HR, Cramps, Routine, tab
Comments: as needed for Muscle Cramps

Alpha2-Adrenergic Agonist

Clonidine Detox(NOTE)*
Clonidine Test dose(NOTE)*

☐ Catapres
0.1 mg, ORAL, ONCE, tab

If Patient's Systolic Blood Pressure is greater than 90mmHg 1Hr after Test dose(NOTE)*
For Patients weighing LESS than 150 pounds(NOTE)*

☐ Catapres
0.4 mg, TRANSDERMAL, QWEEK, Routine, 2 weeks, patch
Comments: If Systolic Blood Pressure is > 90mmHg 1 Hr after oral dose and patient weighs LESS than 150 lbs

☐ Catapres
0.2 mg, TRANSDERMAL, QWEEK, Routine, T+14;N, patch
Comments: For patient weighing LESS than 150 lbs

For Patients weighing Greater than 150 pounds(NOTE)*

☐ Catapres
0.6 mg, TRANSDERMAL, QWEEK, Routine, 2 weeks, patch

Comments: If Systolic Blood Pressure is > 90mmHg 1 Hr after oral dose and patient weighs GREATER than 150 lbs

☐ Catapres
0.4 mg, TRANSDERMAL, QWEEK, Routine, T+14;N, patch
Comments: For patient weighing GREATER than 150 lbs

PRN Clonidine Select the Next Two Options(NOTE)*

☐ Catapres
0.2 mg, ORAL, Q6HR, PRN, Other (see comment), 1 days, tab
Comments: Signs and Symptoms of Withdrawl

☐ Catapres
0.1 mg, ORAL, Q6HR, PRN, Other (see comment), T+1;N, 1 days, tab
Comments: Signs and Symptoms of Withdrawl

Benzodiazepine

Librium Detox(NOTE)*

☐ Librium
25 mg, ORAL, Q1HR, PRN, Other (see comment), Routine, Stop date T+1;0800, cap
Comments: Complaints of Tremors or Withdrawl. Not to exceed 300mg/24hr. Day 1

☐ Librium
25 mg, ORAL, QID, Routine, T+1;0900, 2 days, cap
Comments: Days 2 and 3

☐ Librium
25 mg, ORAL, Q2HR, PRN, Other (see comment), Routine, T+1;0900, 2 days, cap
Comments: Complaints of Tremors or Withdrawl. Days 2 and 3

☐ Librium
10 mg, ORAL, QID, Routine, T+3;0900, 1 days, cap
Comments: Day 4

☐ Librium
10 mg, ORAL, Q4HR, PRN, Other (see comment), Routine, T+3;0900, 2 days, cap
Comments: Complaints of Tremors or Withdrawl. Days 4 and 5

Serax Detox(NOTE)*

☐ Serax
15 mg, ORAL, Q2HR, PRN, Agitation, Routine, cap (DEF)*
Comments: Hold if patient is Sedated or Ataxic
15 mg, ORAL, Q2HR, PRN, Agitation, Routine, cap

☐ Serax
30 mg, ORAL, QID, Routine, Stop date T+0;2359, cap

☐ Serax
30 mg, ORAL, TID, T+1;0900, 1 days, cap

☐ Serax
15 mg, ORAL, TID, T+2;0900, 1 days, cap

☐ Serax
15 mg, ORAL, BID, T+3;0900, 1 days, cap

Ativan Detox(NOTE)*

☐ Ativan INJ
1 mg, IM, Q2HR, PRN, Agitation, Routine, injection
Comments: If unable to tolerate Serax. Hold if patient is Sedated or Ataxic

☐ Ativan
2 mg, ORAL, TID, T;N, 1 days, tab
Comments: Day 1 give 2mg TID.

☐ Ativan
2 mg, ORAL, BID, T+1; 0900, 2 doses/times, Day 2 give 2mg in AM, 1mg at noon and 2mg PM., tab

☐ Ativan
1 mg, ORAL, QNOON, T+1;1200, 1 doses/times, Day 2 give 2mg in AM, 1mg at 1200 and 2mg in PM., tab

☐ Ativan
1 mg, ORAL, TID, T+2;0900, 3 doses/times, Day 3, tab

☐ Ativan
1 mg, ORAL, BID, T+3;0900, 2 doses/times, Day 4, tab, A total of 10mg has been given

☐ Ativan
1 mg, ORAL, DAILY, T+4;0900, 1 doses/times, tab

Barbiturates

Phenobarbital Detox(NOTE)*

☐ phenobarbital
32.4 mg, ORAL, QID, Stop date T+0;2359, tab

☐ phenobarbital
32.4 mg, ORAL, TID, T+1;0900, Duration: 1 days, tab

☐ phenobarbital
16.2 mg, ORAL, TID, T+2;0900, Duration: 1 days, tab

☐ phenobarbital
16.2 mg, ORAL, BID, T+3;0900, Duration: 1 days, tab

Laboratory

☐ B12 Lvl
Blood, T;N, Routine collect

☐ Folic Acid Lvl
Blood, T;N, Routine collect

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Clozapine Titration
Plan Selection Display: BHU Clozapine Titration
PlanType: Medical
Version: 1
Begin Effective Date: 01/04/2012 12:41
End Effective Date: Current
Available at all facilities

BHU Clozapine Titration
Medications

- ☑ RX Clozaril
  Clozaril Registration, 1 app, N/A, DAILY, misc
  Comments: Pharmacy will not dispense clozapine until CBC Results Reviewed and verified WBC >3.5, ANC > 2, and pharmacy has registered patient with appropriate clozapine registry.

Pharmacy will not dispense clozapine until CBC Results Reviewed and verified WBC >3.5 and ANC > 2(NOTE)*
Give only when WBC are GREATER than 3.5 and Absolute Neutrophil Count is GREATER than 2(NOTE)*
Clozaril Titration(NOTE)*
Day 1(NOTE)*

- ☑ Clozaril
  12.5 mg, ORAL, ONCE, Routine, 1 doses/times, tab
  Comments: Day 1

Day 2(NOTE)*

- ☑ Clozaril
  12.5 mg, ORAL, DAILY, T+1;0900, Duration: 1 doses/times, tab
- ☑ Clozaril
  12.5 mg, ORAL, QHS, T+1;2100, Duration: 1 doses/times, tab

Day 3(NOTE)*

- ☑ Clozaril
  12.5 mg, ORAL, DAILY, T+2;N, Duration: 1 doses/times, tab
- ☑ Clozaril
  25 mg, ORAL, QHS, T+2;N, 1 doses/times, tab

Day 4(NOTE)*

- ☑ Clozaril
  25 mg, ORAL, QAM & QHS, T+3;N, 2 doses/times, tab

Day 5(NOTE)*

- ☑ Clozaril
  25 mg, ORAL, DAILY, T+4;N, Duration: 1 doses/times, tab
- ☑ Clozaril
  37.5 mg, ORAL, QHS, T+4;N, 1 doses/times, tab

Day 6(NOTE)*

- ☑ Clozaril
  37.5 mg, ORAL, QAM & QHS, T+5;N, 2 doses/times, tab

Day 7(NOTE)*

- ☑ Clozaril
  50 mg, ORAL, QAM & QHS, T+6;N, 2 doses/times, tab

Day 8(NOTE)*

- ☑ Clozaril
  50 mg, ORAL, DAILY, T+7;N, Duration: 1 doses/times, tab
- ☑ Clozaril
  75 mg, ORAL, QHS, T+7;N, 1 doses/times, tab

Day 9(NOTE)*

- ☑ Clozaril
  75 mg, ORAL, QAM & QHS, T+8;N, 2 doses/times, tab

Day 10(NOTE)*

☑ Clozaril
100 mg, ORAL, QAM & QHS, T+9;N, 2 doses/times, tab
Day 11(NOTE)*
☑ Clozaril
100 mg, ORAL, DAILY, T+10;N, Duration: 30 days, tab
Comments: This AM dose continues until renewed.
☑ Clozaril
125 mg, ORAL, QHS, T+10;N, 1 doses/times, tab
Day 12(NOTE)*
☑ Clozaril
150 mg, ORAL, QHS, T+11;N, 1 doses/times, tab
Day 13(NOTE)*
☑ Clozaril
175 mg, ORAL, QHS, T+12;N, 1 doses/times, tab
Day 14(NOTE)*
☑ Clozaril
200 mg, ORAL, QHS, T+13;N, tab
Comments: This order continues until renewed.
FazClo Titration(NOTE)*
Give only when WBC are GREATER than 3.5 and Absolute Neutrophil Count is GREATER than 2(NOTE)*
Day 1(NOTE)*
☐ FazaClo
12.5 mg, ORAL, ONCE, DIS tablet
Day 2(NOTE)*
☐ FazaClo
12.5 mg, ORAL, QAM & QHS, T+1;0900, DIS tablet
Day 3(NOTE)*
☐ FazaClo
12.5 mg, ORAL, DAILY, T+2;N, Duration: 1 doses/times, DIS tablet
☐ FazaClo
25 mg, ORAL, QHS, T+2;N, 1 doses/times, DIS tablet
Day 4(NOTE)*
☐ FazaClo
25 mg, ORAL, QAM & QHS, T+3;N, 2 doses/times, DIS tablet
Day 5(NOTE)*
☐ FazaClo
25 mg, ORAL, DAILY, T+4;N, Duration: 1 doses/times, DIS tablet
☐ FazaClo
37.5 mg, ORAL, QHS, T+4;N, 1 doses/times, DIS tablet
Day 6(NOTE)*
☐ FazaClo
37.5 mg, ORAL, QAM & QHS, T+5;N, 2 doses/times, DIS tablet
Day 7(NOTE)*
☐ FazaClo
50 mg, ORAL, QAM & QHS, T+6;N, 2 doses/times, DIS tablet
Day 8(NOTE)*
☐ FazaClo
50 mg, ORAL, DAILY, T+7;N, Duration: 1 doses/times, DIS tablet
☐ FazaClo
75 mg, ORAL, QHS, T+7;N, 1 doses/times, DIS tablet
Day 9(NOTE)*
☐ FazaClo
75 mg, ORAL, QAM & QHS, T+8;N, 2 doses/times, DIS tablet
Day 10(NOTE)*

☐ FazaClo
100 mg, ORAL, QAM & QHS, T+9;N, 2 doses/times, DIS tablet
Day 11(NOTE)*

☐ FazaClo
100 mg, ORAL, DAILY, T+10;N, Duration: 30 days, DIS tablet
Comments: This AM dose continues until renewed.

☐ FazaClo
125 mg, ORAL, QHS, T+10;N, 1 doses/times, DIS tablet
Day 12(NOTE)*

☐ FazaClo
150 mg, ORAL, QHS, T+11;N, 1 doses/times, DIS tablet
Day 13(NOTE)*

☐ FazaClo
175 mg, ORAL, QHS, T+12;N, 1 doses/times, DIS tablet
Day 14(NOTE)*

☐ FazaClo
200 mg, ORAL, QHS, T+13;N, DIS tablet
Comments: This dose continues until renewed.

Laboratory

Pharmacy will not dispense clozapine until CBC results reviewed and verified that WBC >3.5 & ANC >2.0.(NOTE)*

☐ CBC
Blood, T;N, ASAP collect

Pharmacy will register patient with appropriate clozapine registry prior to dispensing first dose.(NOTE)*

☐ CBC
Blood, T;N, Timed Study collect, QWEDNESDAY

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Invega Sustenna
Plan Selection Display: BHU Invega Sustenna
PlanType: Medical
Version: 1
Begin Effective Date: 05/19/2012 12:22
End Effective Date: Current
Available at all facilities

BHU Invega Sustenna
Nursing Orders

☑ Sub Phase
T;N, ONCE, 1, doses/times, This order will initiate the medications selected below.

Medications

☑ Invega Sustenna
234 mg, IM, ONCE, ER suspension

☑ **+4 Days** Invega Sustenna
156 mg, IM, QMONTH, ER suspension

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Anxiety
Plan Selection Display: BHU Anxiety
PlanType: Medical
Version: 1
Begin Effective Date: 01/12/2012 11:08
End Effective Date: Current
Available at all facilities

BHU Anxiety
Medications

☐ Ativan
0.5 mg, ORAL, Q4HR, PRN, Anxiety, tab (DEF)*
1 mg, ORAL, Q4HR, PRN, Anxiety, tab
2 mg, ORAL, Q4HR, PRN, Anxiety, tab

☐ KlonoPIN
0.5 mg, ORAL, Q6HR, PRN, Anxiety, tab (DEF)*
1 mg, ORAL, Q6HR, PRN, Anxiety, tab
2 mg, ORAL, Q6HR, PRN, Anxiety, tab

☐ Inderal
10 mg, ORAL, BID, tab (DEF)*
20 mg, ORAL, BID, tab
30 mg, ORAL, BID, tab
40 mg, ORAL, BID, tab
50 mg, ORAL, BID, tab
60 mg, ORAL, BID, tab
70 mg, ORAL, BID, tab
80 mg, ORAL, BID, tab
10 mg, ORAL, TID, tab
20 mg, ORAL, TID, tab

☐ BuSpar
5 mg, ORAL, BID, tab (DEF)*
Comments: Max Dose of 60mg/24hr
10 mg, ORAL, BID, tab
Comments: Max Dose of 60mg/24hr
15 mg, ORAL, BID, tab
Comments: Max Dose of 60mg/24hr
30 mg, ORAL, BID, tab
Comments: Max Dose of 60mg/24hr
5 mg, ORAL, TID, tab
Comments: Max Dose of 60mg/24hr
10 mg, ORAL, TID, tab
Comments: Max Dose of 60mg/24hr
15 mg, ORAL, TID, tab
Comments: Max Dose of 60mg/24hr
30 mg, ORAL, TID, tab
Comments: Max Dose of 60mg/24hr

Comfort Medications(NOTE)*

☐ Remeron
15 mg, ORAL, QHS, PRN, Insomnia, tab (DEF)*
30 mg, ORAL, QHS, PRN, Insomnia, tab
45 mg, ORAL, QHS, PRN, Insomnia, tab

☐ Desyrel
50 mg, ORAL, QHS, PRN, Insomnia, tab (DEF)*
100 mg, ORAL, QHS, PRN, Insomnia, tab
150 mg, ORAL, QHS, PRN, Insomnia, tab
300 mg, ORAL, QHS, PRN, Insomnia, tab

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Depression
Plan Selection Display: BHU Depression
PlanType: Medical
Version: 1
Begin Effective Date: 01/12/2012 10:10
End Effective Date: Current
Available at all facilities

BHU Depression
Medications

MAOI - Order Low Tyramine Diet(NOTE)*

☐ Eldepryl
5 mg, ORAL, BID, cap

SSRI/SSNRI(NOTE)*

☐ CeleXA
10 mg, ORAL, DAILY, tab (DEF)*
20 mg, ORAL, DAILY, tab
40 mg, ORAL, DAILY, tab
10 mg, ORAL, QHS, tab
20 mg, ORAL, QHS, tab
40 mg, ORAL, QHS, tab

☐ Pristiq
50 mg, ORAL, DAILY, ER tablet (DEF)*
100 mg, ORAL, DAILY, ER tablet
50 mg, ORAL, QHS, ER tablet
100 mg, ORAL, QHS, ER tablet

☐ Cymbalta
20 mg, ORAL, DAILY, cap (DEF)*
30 mg, ORAL, DAILY, cap
60 mg, ORAL, DAILY, cap
20 mg, ORAL, QHS, cap
30 mg, ORAL, QHS, cap
60 mg, ORAL, QHS, cap

☐ Lexapro
5 mg, ORAL, DAILY, tab (DEF)*
10 mg, ORAL, DAILY, tab
20 mg, ORAL, DAILY, tab
5 mg, ORAL, QHS, tab
10 mg, ORAL, QHS, tab
20 mg, ORAL, QHS, tab

☐ PROzac
10 mg, ORAL, DAILY, cap (DEF)*
20 mg, ORAL, DAILY, cap
40 mg, ORAL, DAILY, cap

☐ Paxil
10 mg, ORAL, DAILY, tab (DEF)*
20 mg, ORAL, DAILY, tab
30 mg, ORAL, DAILY, tab
40 mg, ORAL, DAILY, tab

☐ Zoloft
25 mg, ORAL, DAILY, tab (DEF)*
50 mg, ORAL, DAILY, tab
100 mg, ORAL, DAILY, tab

☐ Effexor
25 mg, ORAL, DAILY, tab (DEF)*
37.5 mg, ORAL, DAILY, tab

50 mg, ORAL, DAILY, tab
75 mg, ORAL, DAILY, tab
100 mg, ORAL, DAILY, tab
25 mg, ORAL, BID, tab
37.5 mg, ORAL, BID, tab
50 mg, ORAL, BID, tab
75 mg, ORAL, BID, tab
100 mg, ORAL, BID, tab

☐ Effexor XR 37.5 mg oral capsule, extended release
37.5 mg, ORAL, DAILY, CR capsule

☐ Effexor XR 75 mg oral capsule, extended release
75 mg, ORAL, DAILY, CR capsule (DEF)*
150 mg, ORAL, DAILY, CR capsule
225 mg, ORAL, DAILY, CR capsule

Tricyclic(NOTE)*

☐ Elavil
10 mg, ORAL, QHS, tab (DEF)*
25 mg, ORAL, QHS, tab
50 mg, ORAL, QHS, tab
75 mg, ORAL, QHS, tab
100 mg, ORAL, QHS, tab
125 mg, ORAL, QHS, tab
150 mg, ORAL, QHS, tab

☐ Anafranil
25 mg, ORAL, DAILY, cap (DEF)*
50 mg, ORAL, DAILY, cap
75 mg, ORAL, DAILY, cap

☐ Tofranil
10 mg, ORAL, QHS, tab (DEF)*
25 mg, ORAL, QHS, tab
50 mg, ORAL, QHS, tab

☐ Pamelor
10 mg, ORAL, QHS, cap (DEF)*
25 mg, ORAL, QHS, cap
50 mg, ORAL, QHS, cap
75 mg, ORAL, QHS, cap

☐ Vivactil
5 mg, ORAL, TID, tab (DEF)*
10 mg, ORAL, TID, tab

Miscellaneous Antidepressants(NOTE)*

☐ Wellbutrin
75 mg, ORAL, BID, tab (DEF)*
100 mg, ORAL, BID, tab

☐ Wellbutrin SR 100 mg oral tablet, extended release
100 mg, ORAL, DAILY, SR tablet (DEF)*
200 mg, ORAL, DAILY, SR tablet

☐ Wellbutrin SR 150 mg oral tablet, extended release
150 mg, ORAL, DAILY, SR tablet

☐ Wellbutrin XL 150 mg/24 hours oral tablet, extended release
150 mg, ORAL, DAILY, CR Tablet (DEF)*
300 mg, ORAL, DAILY, CR Tablet

☐ Serzone
50 mg, ORAL, BID, tab (DEF)*
100 mg, ORAL, BID, tab
150 mg, ORAL, BID, tab

200 mg, ORAL, BID, tab
250 mg, ORAL, BID, tab

☐ Desyrel

50 mg, ORAL, QHS, tab (DEF)*
100 mg, ORAL, QHS, tab
150 mg, ORAL, QHS, tab
300 mg, ORAL, QHS, tab

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Opiate Detox
Plan Selection Display: BHU Opiate Detox
PlanType: Medical
Version: 1
Begin Effective Date: 01/04/2012 14:20
End Effective Date: Current
Available at all facilities

BHU Opiate Detox
Medications

- ☐ Librium
  50 mg, ORAL, TID, Routine, cap
  Comments: Hold For Sedation
- ☐ Librium
  100 mg, ORAL, QHS, Routine, cap
  Comments: Hold For Sedation
- ☐ Zanaflex
  2 mg, ORAL, QID, tab
  Comments: Hold For Sedation or DBP LESS than 50mmHg. Not to excees 36mg in 24hrs (routine and prn combined)
- ☐ Zanaflex
  2 mg, ORAL, Q4HR, PRN, Muscle spasm, Routine, tab
  Comments: Hold For Sedation or DBP LESS than 50mmHg. Not to excees 36mg in 24hrs (routine and prn combined)
- ☐ Robaxin
  750 mg, ORAL, Q4HR, PRN, Muscle pain, Routine, tab
- ☐ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, QID, DIS tablet
- ☐ Catapres
  0.1 mg, ORAL, Q4HR, PRN, Systolic BP- see parameters in order com, tab
  Comments: SBP GREATER than 170 and/or DBP GREATER than 90
- ☐ Catapres
  0.2 mg, ORAL, Q4HR, PRN, Systolic BP- see parameters in order com, tab
  Comments: SBP GREATER than 170 and/or DBP GREATER than 90
- ☐ Catapres
  0.1 mg, ORAL, Q4HR, PRN, Other (see comment), tab
  Comments: prn opiate withdrawal. Hold for SBP < 90 and/or DBP < 60. Hold for sedation
- ☐ Motrin
  600 mg, ORAL, Q6HR, PRN, Pain, Routine, tab
- ☐ Imodium
  2 mg, ORAL, PRN, PRN, Diarrhea, Routine, cap
  Comments: 1 cap after each loose stool. Not to exceed 8 doses/24hr

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Psychosis
Plan Selection Display: BHU Psychosis
PlanType: Medical
Version: 1
Begin Effective Date: 01/11/2012 12:44
End Effective Date: Current
Available at all facilities

BHU Psychosis
Medications

Atypical(NOTE)*

☐ Saphris
- *5 mg, SUBLINGUAL, BID, tab* (DEF)*
- *10 mg, SUBLINGUAL, BID, tab*

☐ ZyPREXA
- *2.5 mg, ORAL, BID, tab* (DEF)*
- *5 mg, ORAL, BID, tab*
- *7.5 mg, ORAL, BID, tab*
- *10 mg, ORAL, BID, tab*
- *15 mg, ORAL, BID, tab*
- *20 mg, ORAL, BID, tab*
- *2.5 mg, ORAL, QHS, tab*
- *5 mg, ORAL, QHS, tab*
- *7.5 mg, ORAL, QHS, tab*
- *10 mg, ORAL, QHS, tab*
- *15 mg, ORAL, QHS, tab*
- *20 mg, ORAL, QHS, tab*

☐ Zyprexa Zydis 5 mg oral tablet, disintegrating
- *5 mg, ORAL, BID, DIS tablet* (DEF)*
- *10 mg, ORAL, BID, DIS tablet*
- *15 mg, ORAL, BID, DIS tablet*
- *20 mg, ORAL, BID, DIS tablet*
- *5 mg, ORAL, QHS, DIS tablet*
- *10 mg, ORAL, QHS, DIS tablet*
- *15 mg, ORAL, QHS, DIS tablet*
- *20 mg, ORAL, QHS, DIS tablet*

☐ Invega
- *1.5 mg, ORAL, QHS, ER tablet* (DEF)*
- *3 mg, ORAL, QHS, ER tablet*
- *6 mg, ORAL, QHS, ER tablet*
- *9 mg, ORAL, QHS, ER tablet*

☐ BHU Invega Sustenna(SUB)*

☐ Invega Sustenna
- *156 mg, IM, ONCE, T+7;0900, ER suspension* (DEF)*
- *234 mg, IM, ONCE, ER suspension*
- *156 mg, IM, ONCE, ER suspension*
- *117 mg, IM, ONCE, ER suspension*

☐ Invega Sustenna
- *117 mg, IM, QMONTH, ER suspension* (DEF)*
- *156 mg, IM, QMONTH, ER suspension*
- *156 mg, IM, QMONTH, T+7;0900, ER suspension*

☐ Abilify
- *2 mg, ORAL, DAILY, tab* (DEF)*
- *5 mg, ORAL, DAILY, tab*
- *10 mg, ORAL, DAILY, tab*
- *15 mg, ORAL, DAILY, tab*

20 mg, ORAL, DAILY, tab
30 mg, ORAL, DAILY, tab
2 mg, ORAL, QHS, tab
5 mg, ORAL, QHS, tab
10 mg, ORAL, QHS, tab
15 mg, ORAL, QHS, tab
20 mg, ORAL, QHS, tab
30 mg, ORAL, QHS, tab

☐ SEROquel
25 mg, ORAL, Q12HR, tab (DEF)*
50 mg, ORAL, Q12HR, tab
100 mg, ORAL, Q12HR, tab
200 mg, ORAL, Q12HR, tab
400 mg, ORAL, Q12HR, tab
25 mg, ORAL, QHS, tab
50 mg, ORAL, QHS, tab
100 mg, ORAL, QHS, tab
200 mg, ORAL, QHS, tab
400 mg, ORAL, QHS, tab

☐ Seroquel XR 50 mg oral tablet, extended release
50 mg, ORAL, QHS, ER tablet (DEF)*
100 mg, ORAL, QHS, ER tablet
150 mg, ORAL, QHS, ER tablet
300 mg, ORAL, QHS, ER tablet
50 mg, ORAL, Q12HR, ER tablet
100 mg, ORAL, Q12HR, ER tablet
150 mg, ORAL, Q12HR, ER tablet
300 mg, ORAL, Q12HR, ER tablet

☐ Seroquel XR 200 mg oral tablet, extended release
200 mg, ORAL, QHS, ER tablet (DEF)*
300 mg, ORAL, QHS, ER tablet
400 mg, ORAL, QHS, ER tablet

☐ RisperDAL
0.25 mg, ORAL, Q12HR, tab (DEF)*
0.5 mg, ORAL, Q12HR, tab
1 mg, ORAL, Q12HR, tab
2 mg, ORAL, Q12HR, tab
3 mg, ORAL, Q12HR, tab
4 mg, ORAL, Q12HR, tab
0.25 mg, ORAL, QHS, tab
0.5 mg, ORAL, QHS, tab
1 mg, ORAL, QHS, tab
2 mg, ORAL, QHS, tab
3 mg, ORAL, QHS, tab
4 mg, ORAL, QHS, tab

☐ RisperDAL M-Tab
0.5 mg, SUBLINGUAL, Q12HR, DIS tablet (DEF)*
1 mg, SUBLINGUAL, Q12HR, DIS tablet
2 mg, SUBLINGUAL, Q12HR, DIS tablet
3 mg, SUBLINGUAL, Q12HR, DIS tablet
4 mg, SUBLINGUAL, Q12HR, DIS tablet
0.5 mg, SUBLINGUAL, QHS, DIS tablet
1 mg, SUBLINGUAL, QHS, DIS tablet
2 mg, SUBLINGUAL, QHS, DIS tablet
3 mg, SUBLINGUAL, QHS, DIS tablet
4 mg, SUBLINGUAL, QHS, DIS tablet

☐ Geodon

20 mg, ORAL, BIDWM, cap (DEF)*
40 mg, ORAL, BIDWM, cap
80 mg, ORAL, BIDWM, cap

☐ Latuda 40 mg oral tablet
40 mg, ORAL, DAILY, tab (DEF)*
Comments: Daily with Meals
80 mg, ORAL, DAILY, tab
Comments: Daily with Meals

For Latuda 40mg daily x 3, then 80mg daily Check the Next Two Options(NOTE)*

☐ Latuda 40 mg oral tablet
40 mg, ORAL, DAILY, Duration: 3 days, tab
Comments: Daily with Meal

☐ Latuda 40 mg oral tablet
80 mg, ORAL, DAILY, T+3;N, tab
Comments: Daily with Meal

Conventional(NOTE)*

☐ Thorazine
10 mg, ORAL, TID, tab (DEF)*
25 mg, ORAL, TID, tab
50 mg, ORAL, TID, tab
100 mg, ORAL, TID, tab
200 mg, ORAL, TID, tab

☐ Prolixin
1 mg, ORAL, DAILY, tab (DEF)*
2.5 mg, ORAL, DAILY, tab
5 mg, ORAL, DAILY, tab
10 mg, ORAL, DAILY, tab

☐ Haldol
0.5 mg, ORAL, BID, tab (DEF)*
1 mg, ORAL, BID, tab
2 mg, ORAL, BID, tab
5 mg, ORAL, BID, tab
10 mg, ORAL, BID, tab
20 mg, ORAL, BID, tab
0.5 mg, ORAL, TID, tab
1 mg, ORAL, TID, tab
2 mg, ORAL, TID, tab
5 mg, ORAL, TID, tab
10 mg, ORAL, TID, tab
20 mg, ORAL, TID, tab

☐ Haldol
0.5 mg, ORAL, Q4HR, PRN, Agitation, tab (DEF)*
1 mg, ORAL, Q4HR, PRN, Agitation, tab
5 mg, ORAL, ONCE, tab
10 mg, ORAL, ONCE, tab

☐ Haldol Decanoate 50 mg/mL intramuscular solution
25 mg, IM, ONCE, amp (DEF)*
50 mg, IM, ONCE, amp
100 mg, IM, ONCE, amp

☐ Loxitane
5 mg, ORAL, BID, cap (DEF)*
10 mg, ORAL, BID, cap
25 mg, ORAL, BID, cap
50 mg, ORAL, BID, cap
5 mg, ORAL, ONCE, cap
10 mg, ORAL, ONCE, cap

25 mg, ORAL, ONCE, cap
50 mg, ORAL, ONCE, cap

☐ Trilafon
2 mg, ORAL, TID, tab (DEF)*
4 mg, ORAL, TID, tab
8 mg, ORAL, DAILY, tab
16 mg, ORAL, DAILY, tab

☐ Mellaril
10 mg, ORAL, DAILY, tab (DEF)*
15 mg, ORAL, DAILY, tab
25 mg, ORAL, DAILY, tab
50 mg, ORAL, DAILY, tab
150 mg, ORAL, DAILY, tab
200 mg, ORAL, DAILY, tab
10 mg, ORAL, BID, tab
15 mg, ORAL, BID, tab
25 mg, ORAL, BID, tab
50 mg, ORAL, BID, tab
150 mg, ORAL, BID, tab
200 mg, ORAL, BID, tab

☐ Navane
1 mg, ORAL, DAILY, cap (DEF)*
2 mg, ORAL, DAILY, cap
5 mg, ORAL, DAILY, cap
10 mg, ORAL, DAILY, cap
20 mg, ORAL, DAILY, cap
1 mg, ORAL, BID, cap
2 mg, ORAL, BID, cap
5 mg, ORAL, BID, cap
10 mg, ORAL, BID, cap
20 mg, ORAL, BID, cap

☐ Stelazine
1 mg, ORAL, BID, tab (DEF)*
2 mg, ORAL, BID, tab
5 mg, ORAL, BID, tab
10 mg, ORAL, BID, tab
1 mg, ORAL, ONCE, tab
2 mg, ORAL, ONCE, tab
5 mg, ORAL, ONCE, tab
10 mg, ORAL, ONCE, tab

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Unique Plan Description: BHU Suboxone Taper Off
Plan Selection Display: BHU Suboxone Taper Off
PlanType: Medical
Version: 1
Begin Effective Date: 01/30/2014 14:25
End Effective Date: Current
Available at: *TCMC*

BHU Suboxone Taper Off
Medications

- ☑ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, Q4HR, 4 doses/times
- ☑ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, QID, T+1;0900, 24 hr
- ☑ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, TID, T+2;0900, 48 hr
- ☑ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, BID, T+4;0900, 48 hr
- ☑ Suboxone 2 mg-0.5 mg sublingual tablet, disintegrating
  1 tab, SUBLINGUAL, DAILY, T+6;0900, 72 hr
  Comments: Then DC on day 11

***Report Legend:**
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase

Human Resources Committee
(No meeting held in October, 2016)

Employee Fiduciary Subcommittee
(No meeting held in October, 2016)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

MEMBERS PRESENT: CHAC Chair Julie Nygaard, BOD Chair Jim Dagostino, Director Larry Schallock, Dr. Victor Souza MD, Bret Schanzenbach, Rev. Carol Brooks, Carol Herrera, Gigi Gleason, Guy Roney, Linda Ledesma, Mary Murphy, Roma Ferriter, Rosemary Eshelman, Sandy Tucker, Xiomara Arroyo

MEMBERS ABSENT: Barbara Perez, Don Reedy, Dung M. Ngo, Jack Nelson, Marge Coon, Marilou de la Rosa Hruby, Mary Donovan, Mary Lou Clift, Ted Owen

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; David Bennett, Chief Marketing Officer; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO; Fernando Sanudo

NON-VOTING MEMBERS ABSENT: N/A

OTHERS PRESENT: Stephen M. ChavezMatzel, MSW, LCSW; Danielle Pearson, EMT-P, RN, BSN; Gwen Sanders; Brian Greenwald; Celia Garcia, CHAC Coordinator; Susan McDowell, CHAC Coordinator

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The October 20, 2016, Community Healthcare Alliance Committee meeting was called to order at 12:32 pm by Director and CHAC Chair Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Member Bret Schanzenbach motioned to approve the October 20, 2016 meeting agenda. The motion was seconded by Carol Herrera and unanimously approved.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments or announcements were made.		
RATIFICATION OF MINUTES	Linda Ledesma motioned to approve the September 15, 2016 CHAC meeting minutes. The motion was seconded by Rosemary Eshelman and unanimously approved. BOD Chair Jim Dagostino abstained.		
PRESENTATION: SANDAG Grant Stephen M. ChavezMatzel	Stephen M. ChavezMatzel, MSW, LCSW, addressed the group regarding the recently received SANDAG Grant noting the following: Only 2 of the 19 grants were awarded in California: • TCMC was the only hospital to receive funds • The grant will allow TCMC to pilot a new 18 month project to provide transportation to discharged patients with a focus on length of service and availability of open beds to waiting patients. Transportation after treatment is important for patients: • that live along or with disabled family members • whose family members work • who do not own or have access to a car • when public transportation is unreliable or difficult to access		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION: SANDAG Grant Stephen M. ChavezMatzel (con't)	• who are discharged in the early morning hours • to reduce wait time at the hospital and open faster access to inpatient beds Improved discharged patient transportation impacts hospital patient flow by reducing the length of stay of the discharged patient and opening beds to other patients waiting for service. Patients awaiting discharge will be sent to the Discharge Hospitality Center where a concierge will work with the nursing staff to identify and arrange the needed level of transportation. The anticipated outcomes of this pilot program include: • Timely discharges will increase patient satisfaction and safety, as well as reduced costs • Reduction in ED wait times • Reduction in readmissions due to the driver's ability to access the patient's home to watch for basic needs or problems while helping the patient get settled • Improved support systems for patients with limited support • Less missed work time for patient family members Stephen acknowledged that since this program is in its infancy, changes and adjustments are likely to happen, but it is hoped that the implementation of this program will greatly benefit the patients of TCMC.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO UPDATE **Steve Dietlin**	CEO Steve Dietlin updated the group with the latest TCMC news, noting the following: Steve provided a brief review of TCMC's recent accomplishments, including: • Improvements in the ED • CT Scanner • Crisis Stabilization Unit Opening (reduced wait times) • UCSD Affiliation • IORT (Only at TCMC for San Diego County) Steve also updated the group on the HUD long term financing plans noting: • The TCMC BOD unanimously approved moving forward • The application has been submitted and is currently in underwriting • The cost of the Wellness Center will be rolled into the amount financed • Long term interest expected to be at or below 5%		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO UPDATE Steve Dietlin (con't)	Committee member Rosemary Eshelman requested Steve to address the rumors of TCMC financial instability. Steve noted: • TCMC is not asking for a Bond Measure or public funding but is instead pursuing long term financing. • Members of the BOD and Exec Team accompanied Steve to a recent, successful meeting in Washington, D.C. with the U.S. Department of Housing and Urban Development (HUD) where TCMC was invited to submit an application for mortgage insurance. • A successful financing option would allow TCMC to refinance current debt in order to release capital for operations and campus development. • With our recent accomplishments, and the anticipated financing option available through HUD, TCMC is well positioned to be a sustainable and dynamic part of the district for many years to come.		
COO UPDATE Kapua Conley	COO Kapua Conley reiterated Steve's comments regarding the progress being made, making special note of the fact that ED wait times are down which is of benefit to the staff and patients.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CHIEF MARKETING OFFICER UPDATE David Bennett	Chief Marketing Officer David Bennett reported as follows: • Multiple events planned for the months of October and November. • Flu shot clinics are providing free flu shots to hundreds of district residents. • Marketing is working on Ads and community blasts for upcoming promotions. • Members were encouraged to check out TCMC after dark during the month of October as the building turns pink in honor of Breast Cancer Awareness month. At this time, committee member Rosemary Eshelman thanked David Bennett for TCMC's sponsorship support efforts on behalf of the Carlsbad Unified School District.		
APPOINTMENT	Chair Julie Nygaard introduced Danielle Pearson, EMT-P, RN, BSN, who requested consideration to become the City of Vista's Fire Department representative on the CHAC committee. Danielle spoke briefly, and the Committee accepted the recommendation.		
ETHICS TRAINING	In order to comply with AB1234, all members of the Committee must receive at least two hours of Ethics Training every two years. Information was provided to the committee members noting that a training session, to be hosted by Procopio, will be held on February 2, 2017 at 2:00pm. For members unable to attend the February 2nd meeting, information was provided for online training at www.localethics.fppc.ca.gov.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
APPROVAL OF THE CHAC CHARTER REVISIONS	The revisions to the CHAC Charter were approved.		
PUBLIC COMMENTS	No public comments.		
COMMITTEE COMMUNICATIONS	Xiomara Arroyo noted that she will be participating in the November 6th Susan G. Koman Walk for Breast Cancer and invited others to participate if desired. Roma Ferriter reminded the group of NCHS's upcoming 5K David Bennett thanked the NAACP (and Gwen Sanders who was present at the meeting) for their presentation of an award to Tri-City Medical Center for sponsorship and support of the recent Blue & Gold Gala. Gwen Sanders also expressed her thanks to TCMC for its contributions to the community. Gigi Gleason noted that the Oceanside Boys & Girls Club fundraiser event will be held on the 21st. Gigi also requested support from the members of the committee for the TCMC incumbents up for reelection on November 8th.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COMMITTEE COMMUNICATIONS (Con't)	Rosemary Eshelman discussed the Carlsbad Student Leadership Academy noting that this is a new program that trains students for business success. Carol Herrera discussed the *Got Your Back* program in Vista, noting that the program is in need of support and increased funding. This program feeds kids that may not have food available after school and on the weekends. Fernando Sanudo reminded the group of the upcoming VCC Gala and Holiday Home Tour. Fernando also discussed the *Fresh Start* program where volunteer MD's provide surgery for children under the age of 21 that would otherwise not be covered by insurance due to their surgical need being considered cosmetic in nature. Fernando noted that the surgeries are life changing for young people who have no other options for corrective procedures. Bret Schanzenbach noted the Vista Business Expo taking place on November 2nd.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
October 20, 2016
Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Next Meeting	The next meeting is scheduled for Thursday, November 17, 2016.		
Adjournment	The October 2016 CHAC Committee meeting was adjourned at 1:34pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
October 18, 2016

Members Present	Director James Dagostino, Director Julie Nygaard, Dr. Marcus Contardo, Kathleen Mendez, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter, Tim Keane
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO Wayne Knight, Chief Strategy Officer
Others Present	Director Laura Mitchell, Tom Moore, David Bennett, Jane Dunmeyer, Charlene Carty, Kathy Topp, Gentry Faulkner, Diane Sikora, Mary Diamond. Jeremy Raimo, Sherry Miller, Chris Miechowski, Terry Moede, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Director Cyril Kellett, Dr, John Kroener, Dr. Frank Corona

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:32 pm.		
2. Approval of Agenda	Director Dagostino announced that the Closed Session item appearing on the agenda, would be pulled.	**MOTION** **It was moved by Director Nygaard, Mr. Keane seconded, and it was unanimously approved to accept the agenda of October 18, 2016.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of September 20, 2016	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Contardo, Mr. Keane seconded, that the minutes of September 20, 2016, are to be approved without any requested**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		modifications. Director Nygaard and Mr. Marcuzzi abstained.	
5. Old Business			
a. Finance, Operations & Planning Charter	Cheryle Bernard-Shaw conveyed that a number of edits had been made to the Finance, Operations & Planning Charter, and that it had been reviewed by outside legal counsel for accuracy.	**MOTION** **It was moved by Dr. Contardo, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the revised Finance, Operations and Planning Charter.**	Chair
6. New Business			
a. Rady Children's Specialists Agreement for NICU ROP Testing	Mary Diamond explained this proposal is a renewal agreement with Rady Children's Specialists to provide ophthalmic consultation services for the NICU, and retinopathy of prematurity testing. She further explained that ROP testing is mandated by the State of California. Brief discussion ensued. Cheryle Bernard-Shaw requested that the write-up be amended to reflect that this write-up was not reviewed by outside legal counsel.	**MOTION** **It was moved by Director Nygaard, Mr. Keane seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning November 1, 2016, and ending October 31, 2017, for an annual cost of $32,820, and a total cost for the term of $32,820.** Write-up to be amended by Barbara Hainsworth	Mary Diamond
b. WOW Replacement Project	Kathy Topp conveyed that this was a one-time, approved capital budget purchase for replacement workstations on wheel carts (WOW's) with new laptop computers and bar code scanners. Significant discussion ensued.	**MOTION** **It was moved by Dr. Contardo, Ms. Mendez seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Cerner for**	Kathy Topp

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Workstations on Wheels Carts and Barcode for Medication Scanners and with SHI for HP ProBook Laptops for a total combined cost of $330,571.	
c. Physician Agreement for ED On-Call Coverage-Neurology • Tara Quesnell, D.O.	Sherry Miller conveyed that this write-up is to add Dr. Tara Quesnell as new physician to the existing panel for ED On-Call coverage for Neurology, with no increase in expense.	**MOTION** **It was moved by Mr. Keane, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Tara Quesnell, D.O. to the currently existing ED On-Call Coverage Panel for Neurology for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.**	Sherry Miller
d. Physician Agreement for ED On-Call Coverage-Orthopedic Surgery • Grant Seiden, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Grant Seiden as new physician to the existing panel for ED On-Call coverage for Orthopedic Surgery, with no increase in expense.	**MOTION** **It was moved by Ms. Mendez, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Grant Seiden, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.**	Sherry Miller
e. Financials	Ray Rivas presented the financials ending September 30, 2016 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 83,603 Operating Expense $ 83,622 EBITDA $ 5,094 EROE $ 1,246		Ray Rivas

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	TCMC – Key Indicators – FYTD Avg. Daily Census 184 Adjusted Patient Days 29,071 Surgery Cases 1,577 Deliveries 736 ED Visits 16,486 **TCHD-Financial Summary – Current Month** Operating Revenue $ 27,704 Operating Expense $ 27,383 EBITDA $ 2,015 EROE $ 746 **TCMC – Key Indicators – Current Month** Avg. Daily Census 181 Adjusted Patient Days 9,560 Surgery Cases 475 Deliveries 274 ED Visits 5,215 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 43.1 Days in Net A/R 50.2 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay • TCMC - Deliveries		
f. Work Plan – Information Only	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions.		Chairman

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Wellness Center	David Bennett reviewed the Wellness Center update document included in the agenda packet. Brief discussion ensued.		David Bennett
• Construction Report	No discussion		Chris Miechowski
• Infusion Center	No discussion. Director Dagostino raised the suggestion that the Infusion Center update remain on the Work Plan, as an annual update vs. the previous quarterly format. Committee members concurred.		Kapua Conley
• Dashboard	No discussion		Ray Rivas
• Medical Director, Surgery	Mary Diamond gave a brief PowerPoint presentation, reflecting the Outcome Performance report for the Surgery Medical Director. Brief discussion ensued.		Mary Diamond
7. Comments by Committee Members		None	Chair
8. Date of next meeting	November 15, 2016		Chair
9. Community Openings (none)			
10. Adjournment	Meeting adjourned 1:30 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2016
CLINICAL COVERAGE AND CO-MEDICAL DIRECTOR AGREEMENT with
NORTH COUNTY ONCOLOGY MEDICAL CLINIC, INC.

Type of Agreement	X	Medical Directors		Panel	X	Other: Coverage
Status of Agreement	X	New Agreement	X	New Agreement		Same Rates that hospital paid previously

Practice Name: North County Oncology Medical Clinic, Inc.
Area of Service: Oncology Medical Clinic & Chemotherapy Infusion Center
Term of Agreement: 36 months
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Services	Monthly Cost	36-month (Term) Cost
Infusion Center Coverage	$43,333.33	$1,560,000.00
Co-Medical Director	$ 6,666.67	$ 240,000.00
TOTAL	**$50,000.00**	**$1,800,000.00**

Description:

- Clinic Coverage – The on-site presence of a physician is required by CDPH for TCMC to own and operate a chemotherapy infusion service.
- This was vetted in 2016 with HealthCare Appraisers, Inc., and was verified to be at fair market value.
- The Medical Directorship Services will be provided by **multiple physicians**.
- Initial approval from BOD on March 29, 2012. This is a new three-year agreement with no rate increase from 2012 rates.

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

Person responsible for oversight of agreement: Wayne Knight, Chief Strategy Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors extend the Clinical Coverage and Medical Director Agreement between TCHD and North County Oncology Medical Clinic, Inc. for a term of 36 months, beginning October 1, 2016 and ending September 30, 2019 as follows: Coverage Agreement, full time at $43,333.33 per month; Co-Medical Director Agreement at $6,666.67 a month (not to exceed 34 hours per month), for a total cost for the 36-month term of $1,800,000.00.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 18, 2016
Rady Children's Specialists Agreement for NICU ROP Testing

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

Vendor's Name: Rady Children's Specialists of San Diego

Area of Service: NICU - Retinopathy of Prematurity Testing

Term of Agreement: 12 months, Beginning, November 1, 2016 - Ending, October 31, 2017

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$2,735	$32,820	$32,820

Description of Services/Supplies:

- Ophthalmic Consultation Services for NICU-Retinopathy of Prematurity Testing
- Requested increase of $150 (5.8%) per month, $1,800 per year/term

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

Person responsible for oversight of agreement: Mary Diamond, Sr. Director-Nursing, Surgical Services / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning November 1, 2016, and ending October 31, 2017, for an annual cost of $32,820, and a total cost for the term of $32,820.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 18, 2016
WOW Replacement Project

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

Vendor's Names: 1. Cerner for Workstations on Wheels (WOW) Carts and Barcode for Medication Scanners
2. SHI for HP ProBook Laptops

Area of Service: Clinical Areas (Business Critical Patient Care)

Term of Agreement: One time purchase fee beginning, November 1, 2016

Maximum Totals:

Items	Total Cost
110 Hand Scanners & 120 Ergotron Carts	$206,615
110 HP ProBook Laptops	$123,956
	Total: $330,571

Description of Services/Supplies:

- Replacement for Nursing Workstation on Wheels (WOW's) with new laptops, bar code scanners for medication administration and night lights
- Current WOWs and Panasonic tablets are inconsistently connecting due to age and interoperability connectivity. Bar code scanning statistics and ability to accurately document in a timely manner challenging due to problems with current technology.
- Clinicians conducted a device fair with 5 different carts and scanner vendors, than piloted the top two of each on all of the nursing units. The Ergotron cart and the 2600 Scanner were chosen by the nurses as the replacements that would work best for them.
- The Ergotron cart is easy to move and adjusts to sitting or standing, the light makes keyboard documentation easy during the night shift and the laptop screen is bigger which helps staff.

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

Person responsible for oversight of agreement: Kathy Topp, Director, Education & Clinical Information / Kapua Conley, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Cerner for Workstations on Wheels Carts and Barcode for Medication Scanners and with SHI for HP ProBook Laptops for a total combined cost of $330,571.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 18, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Neurology

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

Physician's Name: Tara Quesnell, D.O.

Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 20 months, Beginning, November 1, 2016 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Neurology
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$740	FY17: 365 FY18: 365	FY17: $270,100 FY18: $270,100
	Total:	**$540,200**

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurology specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Tara Quesnell, D.O. to the currently existing ED On-Call Coverage Panel for Neurology for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: October 18, 2016
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedic Surgery

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

Physician's Name: Grant Seiden, M.D.

Area of Service: Emergency Department On-Call: Orthopedic Surgery

Term of Agreement: 20 months, Beginning, November 1, 2016 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: YES
New physicians to existing panel, no increase in expense

Rate/Day – Orthopedic Surgery	Current Panel Days Per Year	Current Panel Annual Cost
Weekday $1,500	FY17: 253	$379,500
Weekend/holiday $1,650	FY17: 112	$184,800
Weekday $1,500	FY18: 253	$379,500
Weekend/holiday $1,650	FY18: 112	$184,800
	Total Term Cost:	**$1,128,600**

Position Responsibilities:

- Provide 24/7 patient coverage for all Orthopedic specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Grant Seiden, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 20 months, beginning November 1, 2016 and ending June 30, 2018.

TRI-CITY HEALTHCARE DISTRICT

FINANCE, OPERATIONS AND PLANNING

COMMITTEE CHARTER

The Finance, Operations and Planning Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide governance oversight and to make recommendations to the District's Board of Directors (the "Board") by overseeing the functions of the District directly related to Finance, Operations, and Planning. The Committee focuses on matters that are material to the District's operations. "Material" generally means financial impacts exceeding the Chief Executive Officer's approval limit as well as matters that, due to their nature, could expose the District to significant risks.

1. **Finance Oversight**: The Committee will oversee the Finance function of the District, including the following:

   a. Review monthly financial statements prepared by the Finance Department and presented by the Chief Financial Officer;

   b. Monitor the monthly financial statements for unusual trends and have the Chief Financial Officer provide a detailed explanation of the variances;

   c. Report to the Board regarding any issue involving the integrity or trustworthiness of the District's financial statements;

   d. Review any proposed changes to Finance-related policies and procedures, including Board Policy No. ~~10~~14-017 (investments) and ~~10~~15-013 (procurement).

2. **Operations Oversight:** The Committee shall:

   a. Review monthly report of operations metrics for departments noted on the Committee Work Plan;

   b. Review significant new services to be provided by the District and add to Committee Work Plan;

   ~~c. Review significant changes to existing services currently provided by the District; [?]~~

   ~~d. Review termination of services currently provided by the District; [?]~~

New contracts (not within the scope of another Board committee) as well as amendments and renewals of existing contracts that exceed the approval authority of the Chief Executive Officer as outlined in Administrative Policy and Procedure #232, Board Policy No. ~~10~~15-013 and state law.

3. **Planning Oversight:** The Committee shall perform initial screening and analysis for potential recommendation for advancement to the Board for consideration of the following:

   a. Proposed real estate transactions;

   b. Proposed ~~mergers,~~ acquisitions, and contractual joint ventures;

   ~~c. Complex strategic project transactions;~~

   Physician recruitments and other contracts with physicians;

   Procurements requiring approval by the Board under Administrative Policy and Procedure #232, Board Policy No. ~~10~~15-013, or state law;

   Material matters related to the integration between the District and independent physicians and physician groups.

II. Membership

The Committee shall consist of three Directors, five community members, and three physicians.

Each community committee member shall have a basic understanding of finance and accounting, and should have experience and familiarity with the specialized issues relating to healthcare finance. At least one community member of the Committee shall have accounting or related financial management expertise, as evidenced by the certified public accountant designation or other education and/or work-related credentials.

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all recommendations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the full Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved: 9/20/2011 by Board of Directors
Approved: 3/28/2013 by Board of Directors
Approved: 5/29/2014 by Board of Directors

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
October 13, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Director Ramona Finnila and Dr. Gene Ma.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Kathy Topp, Lisa Mattia, Rowena Okumura, Kathy R. Topp, Mary Diamond, Jim Dagostino, Oska Lawrence, April Lombardo, Lori Roach, Stephen Chavez-Matzel, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Scott Worman, Dr. Contardo, Dr. Johnson and Sharon Schultz, CNE/ Sr. VP.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications. There was a brief discussion on the meeting dates for November and December due to the holidays and also change of dates of the regular Board Meetings for the next two months.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Contardo. The group made a decision to cancel the November and December meetings for PAC.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
committee's consideration of the item.			
4. Ratification of minutes of September 2016.	Director Mitchell called for a motion to approve the minutes from September 8, 2016 meeting.	Minutes ratified. Director Schallock moved and Director Mitchell seconded the motion to approve the minutes from September 2016. Director Finnila abstain from voting since she was not present in the previous month's meeting.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Cardiac Cath Lab Standardized Procedure 2. Catheter Clearance with Alteplase (Cathflo Activase) Procedure 3. CERNER Downtime Policy 4. Chest Tube Management	 There was a clarification made on this policy that the Cath Lab results need to be available before starting any procedure on any patient. There was no discussion on this policy. There was no discussion on this policy. The procedural part of assisting the physician where Mosby's is referenced will	 **ACTION:** The Patient Care Services policies and procedures were approved. Director Finnila moved and Director Mitchell seconded the motion to approve the policies moving forward for Board approval.	 Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Procedure	will be modified.		
5. Differentiating Intrauterine Fetal Demises from Miscarriage Procedure	This policy outlines the differentiation of still birth and miscarriage. It was also noted that that the patient gets to keep the baby while waiting for the pathologist report on a stillbirth delivery.		
6. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure	The premise on the repisratory rate of a pediatric patient should be striked out since the hospital do not deal with that population.		
7. Haloperidol IV Administration Standardized Procedure	There was no discussion on this policy.		
8. Hazardous Drugs Procedure	It was recommended that the kinds of chemotherapy waste that are scheduled for disposal should be enumerated for further clarification. It was also mentioned that a 3rd category will be added to this policy in the future.		
9. Local Anasthetic Prior to Intravenous Insertion Standardized Procedure	There was no discussion on this policy.		
10. Medical Equipment Brought into the Facility Policy	The form on this policy (Patient Supplied Equipment Waiver) is in the process of being standardized to reflect the role of TCHD representative in the process.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Ordering 12 Lead ECG for Administration of Droperidol and/or Discontinuing Drug Standardized Procedure	No discussion on this policy.		
12. Pneumoccocal and Influenza Vaccine Screening and Administration Standardized Procedure	No discussion on this policy.		
13. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects	There was a question if there is separate procedure with the eyes; it was explained that the equipment used for the eyes is so tiny that nobody can even see it in xray. It was also mentioned that the staff had heightened awareness for this policy due to some incidents in the past.		
14. Utilization of Staff, Staffing Patterns Policy	The MFT/LCSW terminology will be updated.		
Unit Specific			
Infection Control			
1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Diseases IC 15.0	It was noted that different level of influx patients are triaged in the ED. Some items in the policy need a reference. Lisa will get together with Kevin to have the references be inserted for compliance purposes.	**ACTION:** The Infection Control policies and procedures were approved. Director Finnila moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Medical Staff 1. Disaster Privileges	Sherry Miller gave a brief summary of this policy. It aims to provide credentialing to volunteer practitioners and allied health professionals in times of disaster. It was also mentioned that the definition of AHP should be spelled out.	**ACTION:** The Medical Staff policy and procedure were approved. Director Schallock moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
NICU 1. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and very Low Birth Weight Infant (VLBW)	There was a brief discussion on the peripheral arterial for the NICU.	**ACTION:** Director Finnila moved, Director Schallock seconded and the NICU policies were approved to move forward for Board approval.	Patricia Guerra
2. Non-Emergent Neonatal Endotracheal Intubation	There was no discussion on this policy.		
3. Palliative Care of the Neonates at the End of Life	There was no discussion on this policy.		
4. Peripheral Arterial Line Insertion, Maintenance and Removal of	There was no discussion on this policy.		
5. Staffing Ratios for Social Services in the NICU	There was no discussion on this policy.		
6. Standards of Care- NICU 2016	There was no discussion on this policy.		
7. Standards of Care- NICU	There was no discussion on this policy.		
8. Visitation in the NICU	The committee had a consensus that		Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	visitors in the NICU need to be checked if they are sick and contagious for the safety of the infants in the NICU.		
Women's and Newborn Services 1. Newborn Sepsis care Guidelines	There was no discussion on this policy.	**ACTION:** The WCS procedure was approved. Director Finnila moved and Director Schallock seconded the motion to approve this policy moving forward for Board approval.	Patricia Guerra
Formulary Requests 1. Corticosteroid- Epidural Administration of IR	The corticosteroid is an approved drug that meets FDA guidelines as reported by Oska Lawrence.	**ACTION:** The formulary requests were approved. Director Schallock moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Gadavist	Gadavist is used manimly in Radiology and it is very cost comparable.		
3. Fomularry Line Item Additions/ Deletions • Capsaicin Topical Cream • Ticagrelor 60 mg tablets • Albuteroll oral solution • Potassium Chloride 40 meq/30 ml cup • Vitamin K mg	There was no discussion of these formularies.		
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Finnila moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 PM.		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 2:15 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
October 13th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Cardiac Cath Lab Standardized Procedure	2 year review, practice change	Forward to BOD for approval
2. Catheter Clearance with Alteplase (Cathflo Activase) Procedure	3 year review, practice change	Forward to BOD for approval
3. Cerner Downtime Policy	3 year review, practice change	Forward to BOD for approval
4. Chest Tube Management Procedure	3 year review, practice change	Forward to BOD for approval with revisions
5. Differentiating Intrauterine Fetal Demises from Miscarriages Procedure **Tracked** Differentiating Intrauterine Fetal Demises from Miscarriages Procedure **Clean**	3 year review, practice change	Forward to BOD for approval with revisions
6. Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure	2 year review, practice change	Forward to BOD for approval with revisions
7. Haloperidol IV Administration Standardized Procedure	2 year review, practice change	Forward to BOD for approval
8. Hazardous Drugs Procedure	3 year review, practice change	Forward to BOD for approval with revisions
9. Local Anesthetic Prior to Intravenous Insertion Standardized Procedure	NEW	Forward to BOD for approval with revisions
10. Medical Equipment Brought into the Facility Policy **Tracked** Medical Equipment Brought into the Facility Policy **Clean**	3 year review, practice change	Forward to BOD for approval with revisions
11. Ordering 12 Lead ECG for Administration of Droperidol and-or Discontinuing Drug Standardized Procedure	2 year review, practice change	Forward to BOD for approval
12. Pneumoccocal and Influenza Vaccine Screening and Adminstration Standardized Procedure	2 year review, practice change	Forward to BOD for approval
13. Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects **Tracked** Sponge, Sharps and Instrument Counts Prevention of Retained Surgical Objects **Clean**	practice change	Forward to BOD for approval
14. Utilization of Staff, Staffing Patterns Policy	3 year review, practice change	Forward to BOD for approval with revisions
Unit Specific		
Infection Control		
1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15.0	3 year review, practice change	Forward to BOD for approval with revisions

PROFESSIONAL AFFAIRS COMMITTEE
October 13th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Medical Staff		
1. Disaster Privileges	3 year review, practice change	Forward to BOD for approval with revisions
NICU		
1. Guideline for Care of the Extremely Low Birth Weight Infant (ELBW) and Very Low Birth Weight Infant (VLBW)	DELETE	Forward to BOD for approval
2. Non-Emergent Neonatal Endotracheal Intubation	DELETE	Forward to BOD for approval
3. Palliative Care Of the Neonates at the End of Life **Tracked** Palliative Care Of the Neonates at the End of Life **Clean**	2 year review, practice change	Forward to BOD for approval
4. Peripheral Arterial Line Insertion, Maintenance and Removal of	2 year review, practice change	Forward to BOD for approval
5. Staffing Ratios for Social Services in the NICU	2 year review, practice change	Forward to BOD for approval
6. Standards of Care - NICU 2016	2 year review, practice change	Forward to BOD for approval
7. Standards of Care NICU	DELETE	Forward to BOD for approval
8. Visitation in the NICU **Tracked** 9. Visitation in the NICU **Clean**	2 year review, practice change	Forward to BOD for approval
Women and Newborn Services		
1. Newborn Sepsis Care Guidelines	NEW	Forward to BOD for approval
Formulary Requests		
1. Corticosteroid – Epidural Administration by IR	practice change	Forward to BOD for approval
2. Gadavist	practice change	Forward to BOD for approval
3. Formulary Line Item Additions/Deletions • Capsaicin topical cream • Ticagrelor 60 mg tablets • Albuterol oral solution • Potassium chloride 40meq/30mL cup • Vitamin K 5 mg	practice change	Forward to BOD for approval

STANDARDIZED PROCEDURE: CARDIAC CATH LAB PROCEDURES

I. **POLICY:**

A. Function: Provide care for patients who will be receiving services through the Cardiac Cath Lab.

B. Circumstances:

1. Setting: Tri-City Medical Center (TCMC) Cath Lab
2. Supervision: None required.
3. Patient contraindications: None.

C. Expected Outcomes:

1. To outline personnel and duties involved in procedures in the Cath Lab.
2. To delineate steps in elective or emergent procedure in the Cath Lab.
3. To assure that any patient undergoing a cardiac procedure at TCMC will be assessed for pre procedure risk and will be directed to the appropriate level of care.

II. **PROCEDURE:**

A. **CARDIAC CATHERIZATION**

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   - a. Obtain previous lab and history and physical if available.
   - b. Cardiology:
     - i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   - c. Labs:
     - i. CBC
     - ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
     - iii. **PT/PTT/**INR
     - iv. Cardiac Troponin (Troponin I)
     - v. CKMB
     - vi. Labs may be drawn prior to procedure
   - d. Nurses Order
     - i. Start 22, 20 or 18 gauge IV
     - ii. Intravenous (IV) Normal Saline (NS) at 20 mL/hr
     - iii. Point of care (POC) blood glucose if patient diabetic
   - e. Diet:
     - i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

B. **PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY:**

- a. The RN shall order the following if previous results from greater than 90 days or no results available:
  - i. Obtain previous lab and history and physical if available.
- b. Cardiology:
  - i. **Perform** EKG, retrieve and print previous EKG if available
- c. Labs:
  - i. CBC
  - ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
  - iii. **PT/PTT/**INR
  - iv. Cardiac Troponin (Troponin I)

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Cardiology	Pharmacy and Therapeutics	Interdisciplinary Practice Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW 3/13; **4/14**	3/13; **4/14**	3/13; **05/14**	**02/16**	5/13, **03/16**	09/13, **07/16**	10/13, 09/16	10/16	10/13

v. CKMB
vi. Labs may be drawn prior to procedure

d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic

e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

C. **ELECTIVE CARDIOVERSION:**

1. The RN shall order the following if previous results from greater than 90 days or no results available:
a. Obtain previous lab & history and physical if available.
b. Cardiology:
i. **Perform** EKG. Retrieve and print any previous EKG, if available
c. Labs:
i. INR**, complete metabolic panel (Chem 12**~~**c7**~~**), CBC**
ii. Labs may be drawn prior to procedure
d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic
e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

D. **PERICARDIOCENTESIS:**

1. The RN shall order the following if previous results from greater than 90 days or no results available :
a. Obtain previous lab and history and physical if available.
b. Cardiology:
i. **Perform** EKG. Retrieve and print any previous EKG, if available
c. Labs:
i. CBC
ii. **Complete** Metabolic Panel ~~7~~**(Chem 12)**
iii. **PT/PTT/**INR
iv. Labs may be drawn prior to procedure
d. Nurses Order
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hr
iii. POC blood glucose if patient diabetic
e. Diet:
i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

E. IMPLANTABLE CARDIOVERTER DEFIBRILLATOR IMPLANT/CHANGE:

1. The RN shall order the following if needed:
a. Obtain previous lab and history and physical if available.
b. Cardiology:
i. Perform EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete ~~M~~metabolic ~~P~~panel (Chem 12)
iii. INR/ PT/ PTT
iv. BNP
v. Labs may be drawn prior to procedure

d. Nurses Order
- **i. Start 22, 20 or 18 gauge IV**
- **~~ii. IV D5W at 20 ml/hr~~**
- **iii. NS at 20 ml/hr**

e. Diet:
- i. **NPO after midnight except for small amounts of water to take oral medications.**

~~E.~~F. PERMANENT PACEMAKER INSERTION/CHANGE:

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   - a. Obtain previous lab and history and physical if available.
   - b. Cardiology:
     - i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   - c. Labs:
     - i. CBC
     - ii. **Complete ~~M~~metabolic ~~P~~panel ~~7~~(~~c~~Chem 12)**
     - iii. **PT/PTT/**INR
     - iv. Labs may be drawn prior to procedure
   - d. Nurses Order
     - i. Start 22, 20 or 18 gauge IV
     - ii. IV NS at 20 mL/hr
     - iii. POC blood glucose if patient diabetic
   - e. Diet:
     - i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

~~F.~~G. IMPLANTABLE LOOP DEVICE IMPLANT/EXPLANT:

1. The RN shall order the following if previous results from greater than 90 days or no results available :
   - a. Obtain previous lab and history and physical if available.
   - b. Cardiology:
     - i. **Perform** EKG. Retrieve and print any previous EKG, if available.
   - c. Labs:
     - i. CBC
     - ii. **Complete ~~M~~metabolic ~~P~~panel ~~7~~(~~c~~Chem 12)**
     - iii. INR
     - iv. Labs may be drawn prior to procedure
   - d. Nurses Order
     - i. Start 22, 20 or 18 gauge IV
     - ii. IV NS at 20 mL/hr
     - iii. POC blood glucose if patient diabetic
   - e. Diet:
     - i. Ensure NPO prior to procedure except for small amounts of water to take oral medications.

III. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

IV. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed orientation are authorized to direct and perform the Cath Lab Standardized Procedure.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CATHETER CLEARANCE WITH ALTEPLASE (CATHFLO® ACTIVASE®)**
Purpose:	Provide **assistance to Registered Nurses with** ~~a standard for~~ **identifying central venous catheter occlusions and instructions for**~~safely~~ restoring patency of occluded central venous catheters with alteplase (Cathflo® Activase®)~~, in the adult population and outline the process for opening central venous catheters with fibrin related occlusions~~**in the adult population.**
Supportive Data:	Skill Level: Registered Nurse (RN)– requires physician order
Equipment:	2 mg vial of **alteplase** (Cathflo® Activase®) from pharmacy ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** Catheter specific flush 6 alcohol pads x 2 Non–vented port protector or sterile needleless cap Sterile gloves (2) 10 mL sterile water 10 mL syringe filled with normal saline (2) 10 mL syringes Anti-reflux valves (Microclave) for each clotted lumen **Port Protectors** ~~Swabcap~~ for each clotted lumen (2) packages of 4x4 gauze

A. DEFINTIONS:

1. **Patency – a catheter that flushes easily, without resistance, aspirates easily with brisk, free-flowing blood return**
2. **Partial Occlusion – flushing or instilling into a catheter can be done but flow is sluggish or difficult to infuse**
3. **Persistent Withdrawal Occlusion – flushing or instilling is done without resistance; however there is no blood return**
   a. **Often caused by a fibrin tail hanging off of the end of the catheter.**
   b. **When flushing the catheter, the tail moves away from the distal tip of the catheter, but when withdrawing blood from the catheter, the fibrin tail acts as a flap which occludes the distal tip.**
4. **Complete Occlusion - inability to flush or withdraw blood from the catheter**

~~A.~~**B. PROCEDURE:**

1. Obtain physician**/Allied Health Professional (AHP)** order for alteplase (Cathflo® Activase®) to restore patency to each occluded central venous lumen.
2. Obtain reconstituted alteplase (Cathflo® Activase®) from pharmacy
   a. If not reconstituted by pharmacy **perform hand hygiene and perform steps outlined below**:
      i. Reconstitute alteplase (Cathflo® Activase®) to final concentration of 1 mg/mL.
      ii. Aseptically withdraw 2.2 mL of sterile water using 10 mL syringe. (Do not use Bacteriostatic Water)
      iii. Inject the 2.2 mL of sterile water into the alteplase (Cathflo® Activase®) vial. Slight foaming is not unusual; let the vial stand undisturbed to allow large bubbles to dissipate
      iv. Mix by swirling until the contents are completely dissolved. Complete dissolution should occur within 3 minutes. DO NOT SHAKE. The reconstituted alteplase (Cathflo® Activase®) is a colorless to pale yellow solution.
3. Perform hand hygiene ~~-~~and withdraw 2 mg (2 mL) of alteplase (Cathflo® Activase®) using a 10 mL syringe.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department or Division	Pharmaceutical & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/03, 5/08, 2/11, 7/14	03/11, 7/14, **08/16**	03/11, 7/14, **09/16**	n/a	9/14, **09/16**	04/11, 10/14, **09/16**	05/11, 11/14, **10/16**	7/03, 3/04, 3/06, 8/08, 05/11,12/14

4. Clamp clotted lumen
5. Disconnect **intravenous** (IV) tubing (if applicable); place sterile luer cap on end of tubing.
6. Open one package of 4x4 gauze, keep gauze on top of opened package, and place both the opened package and gauze under the clotted lumen.
7. Open three (3) alcohol preps using aseptic technique and place on opened 4x4 package~~.~~
   a. Remove anti-reflux valve and use alcohol pad to vigorously cleanse the threads of the clotted lumen.
   b. Repeat two times using a new alcohol pad each time.
8. Attach 10 mL syringe containing alteplase (Cathflo® Activase®~~)~~ to clotted port~~.~~
9. Unclamp catheter and instill alteplase (Cathflo® Activase®) slowly
   a. Do not force
   b. If resistance met, gently pump syringe to facilitate instillation of alteplase (Cathflo® Activase®)
10. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and **port protector** ~~Swabcap.~~
11. **Document the date and time alteplase (Cathflo® Activase®) was instilled on a alteplase (Cathflo® Activase®) "Do Not Flush" label. Place the label directly over the microclave.**

~~11. Apply label **Cathflo label** marked "Do not touch" directly **over**to microclave~~

12. Allow **catheter lumen** to dwell undisturbed for 30 minutes
13. Instruct patient to alert nurse performing alteplase (Cathflo® Activase®) procedure if any requests to draw from line by other staff during dwell time occur.
14. After 30 minutes, perform hand hygiene, don clean gloves, remove **the alteplase (Cathflo® Activase®)** label and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood return
   a. If resistance is met, gently pump syringe to facilitate movement of lysed clot, being careful not to flush lumen contents into the patient.
   b. Maintain negative pressure with the syringe for at least 30 seconds, then attempt to aspirate for blood return.
   c. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL ~~blood~~**blood to remove alteplase (Cathflo® Activase®) and residual clot,**, clamp lumen, and discard blood.
      ii. Unclamp lumen and flush with **5-10 mL of normal saline** ~~(Alteplase) catheter specific flush~~, then reclamp lumen
      iii. Remove syringe and clean lumen treads with alcohol pads
      iv. Attach a new microclave and **port protector** ~~Swabcap~~ or return to IV infusion
      v. Document administration of alteplase (Cathflo® Activase®) and flush volume on electronic medication administration record (eMAR)~~.~~
      vi. Document ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** catheter clearance in medical record
      vii. Discard any unused solution
15. If unable to aspirate blood return after 30 minutes, allow the alteplase (Cathflo® Activase®) to dwell **undisturbed** an additional 90 minutes (total dwell time is 120 minutes).
   a. Clamp lumen, remove syringe, and apply anti-reflux (Microclave) valve and port protector
   b. Reapply alteplase (Cathflo® Activase®) sticker~~label~~ directly over microclave, document the time (the time represent the last the an attempt was to access the port)

~~15.~~**c.** ~~Replace microclave with Swabcap and label and repeat patient education instructions.~~

16. After 120 minutes, perform hand hygiene, don clean gloves, remove ~~label~~ **alteplase (Cathflo® Activase®) sticker** and microclave using aseptic technique, attach a 10 mL syringe, unclamp lumen, and aspirate for blood.
   a. If blood easily aspirates, complete the following steps:
      i. Aspirate 5 mL of blood **to remove alteplase (Cathflo® Activase®) and residual clot,**~~,~~ clamp lumen, and discard blood.

ii. Unclamp lumen and flush with **5-10 mL of normal saline** ~~(alteplase) catheter specific flush~~, then reclamp lumen.
iii. Remove syringe and clean lumen treads with alcohol pads
iv. Attach a new microclave and **port protector** ~~Swabcap~~ or return to IV infusion
v. Document administration of alteplase (Cathflo® Activase®) and flush volume on **e**MAR
vi. Document (alteplase) catheter clearance in medical record
vii. Discard any unused solution

17. If unable to aspirate for blood return after 120 minutes:
    a. Discard unused alteplase (Cathflo® Activase®).
    b. Obtain equipment as outlined in the equipment section of procedure.
    c. Notify pharmacy and request a second dose of 2 mg of alteplase (Cathflo® Activase®~~)~~
    d. Repeat procedure beginning with step 1
18. If blood easily aspirates after using a total of 4 mg of alteplase (Cathflo® Activase®):
    a. Aspirate 5 mL blood, clamp lumen and discard blood
    b. Unclamp lumen and flush with ~~(~~alteplase~~)~~ **(Cathflo® Activase®)** catheter specific flush, then reclamp lumen
    c. Remove syringe and clean lumen treads with alcohol pads
    d. Attach a new microclave and ~~Swabcap~~ **port protector** or return to IV infusion
    e. Document administration of alteplase (Cathflo® Activase®) and flush volume on **e**MAR
    f. Document catheter clearance in medical record
    g. Discard any unused solution
19. If unable to aspirate for blood return after using a total of 4 mg of alteplase (Cathflo® Activase®):
    a. Clamp clotted lumen, remove syringe, and discard unused alteplase (Cathflo® Activase®)
    b. Clean lumen treads with a total of three alcohol wipes using aseptic technique
    c. Place microclave and ~~Swabcap~~ **port protector** on clamped clotted lumen
    d. Apply ~~l~~abel to microclave marked "Do Not Touch and date, time, and your initials."
    e. Document administration of alteplase (Cathflo® Activase®) on **e**MAR
    f. Notify physician and document unable to obtain patency of lumen in the medical record
    g. Communicate events during hand-off

C. RELATED DOCUMENTS:

1. Patient Care Services Procedure: Central Venous Access Devices

D. REFEERNCES:

~~g.~~**1. Genentech USA, Inc. (2016). Cathflo activase (alteplase) reconstitution, dosing, and administration. Retrieved from http://www.cathflo.com/dosing/index.jsp**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**8/03**	**SUBJECT:**	**Cerner Downtime**
REVISION DATE:	**2/04; 2/05; 5/05; 6/06; 9/08; 2/12**	**POLICY NUMBER:**	**IX.H**

Department Approval:	**07/16**
Clinical Policies & Procedures Committee Approval:	**~~02/12~~08/16**
Nurse Executive Committee Approval:	**~~02/12~~09/16**
Pharmacy & Therapeutics Committee Approval:	**09/16**
Medical Executive Committee Approval:	**~~03/12~~09/16**
Professional Affairs Committee Approval:	**~~05/12~~10/16**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. To outline steps that must be completed to initiate physician orders and allow for uninterrupted patient care when computer downtime occurs.

B. **DEFINITIONS:**

1. **Affinity: Electronic financial record application.**
2. **Bedside Medical Device Integration (BMDI): An application that pulls data from clinical devices such as vital sign monitoring equipment into the electronic health record (EHR).**
3. **Computer Downtime Admissions, Discharges, Transfers ~~, Births and Deaths~~ (ADT) Log**: Used to communicate patient transfers and discharges to Registration, Laboratory, Nutrition Services, and Pharmacy.
4. **Downtime (DT)**: those periods that Cerner will be out of service and unavailable for use. There are two types of downtime:
   a. **Scheduled downtime** – to be used for backups, upgrades, and maintenance. All or part of the system is not available for use during this period of time.
   b. **Unscheduled downtime** – an unforeseen **system** failure**/downtime**. ~~When all or part of the computer system is noted to be down, but no announcement has been made, staff may call the Help desk at 940-7370. Staff will provide detailed description of the event.~~
5. **Lab Downtime Log**: Used to track all future lab orders not required during the downtime. These orders will be entered when the system is restored.
6. **Medication Administration Record (MAR)**: Blank MAR to be used for new patient admissions that occur during the downtime.
   ~~a. A backup file of the MAR is created at 0015 and every four (4) hours on a daily basis and is saved to PC RXMOPC05 to be used for extended scheduled downtime or unscheduled downtime.~~
7. **PACS: Picture Archiving and Communication System.**
8. **Universal Requisition**: Used to communicate physician orders for ancillary orders such as **L**aboratory, **R**adiology, **P**ulmonary, Nutrition Services, EEG, **C**ardiology, and **R**ehab.
9. ~~An interface between medical devices and Cerner applications, associating patients to devices and to Cerner applications.~~

C. **POLICY:**

1. **Scheduled Downtime:**
   a. Planned downtime will be communicated to all patient care and associated support service areas in advance, by Cerner announcement screen, and email with a flyer for

posting. Immediately prior to beginning maintenance, an attempt will be made to notify all areas that the system will be going down and the expected duration of the downtime.

b. For Scheduled Maintenance, every attempt is made to perform the maintenance during off-peak processing times. In general, maintenance will be scheduled starting at 0001 on Thursday mornings and will be less than 4 hours in duration.

c. All nursing and ancillary areas will follow the policy and procedures listed below for order communication and completion, results notification, and clinical data documentation.

d. Once maintenance is complete, the system is brought back on-line and verified by Information Technology (IT).

e. All users will be notified when the system is back on-line and that they may resume normal operations by overhead paging and calling key departments.

2. **Unscheduled Downtime:**

a. During normal business hours staff members will contact the IT Help Desk at 760-940-7370 to check system status. After hours, staff members will check system status or report problems to the Administrative Supervisor **(AS)** ~~/Patient Flow Coordinator~~.

b. Management team will be notified by IT via email that the system is down. Management/AS will facilitate the communication of the need for above downtime procedures to be put into place, and end-users will be notified by overhead page.

c. Management/AS will stay in communication with IT for updates on progress of downtime repairs and communicate this to all affected departments.

d. All nursing and ancillary areas will follow the policy and procedures listed below for order communication and completion, results notification, and clinical data documentation.

e. Once the problem is fixed and the system is functional again, the system will be brought back on-line and verified.

f. Interfaces are brought back up (if applicable) by the IT Operations group and verified to be connected and passing data.

g. Users are notified when the system is back on-line by an overhead page and calls to the key departments to resume normal operations.

h. Each department will notify their offsite locations as appropriate. **IT to notify offsite locations and clinics as appropriate.**

D. **PROCEDURE:**

1. Powerchart/Orders/Tasks Lists/Documentation: Clinical Areas including Nursing and Ancillary Departments:

a. **Scheduled Downtime Preparation:**

i. Ensure the task list is updated to current time

ii. Print current census one hour before downtime

iii. Print additional patient labels for each inpatient

iv. Stop entering orders **60**~~30~~ minutes prior to Downtime

v. IT will "force" Operations Jobs as needed

vi. Universal downtime requisitions with unique tracking numbers and barcodes will be used for all orders

vii. Run **Active Order R**eports ~~as needed~~ for patient care **sixty (60) minutes prior to expected downtime** (e.g. ~~task lists, results~~**any**~~,~~ active orders)

viii. Obtain blank MARs for new patients

ix. IT to run MAR Report to print to the nursing units ~~thirty~~ **sixty** (~~3~~60) minutes prior to Downtime.

b. **Scheduled Downtime:**

i. Computer generated patient labels will be used, new patients will have handwritten labels for lab draws that are nurse collectables. The label will have patient name, medical record number (MRN), date of birth, and the logon **Identification (**ID) of the **Registered Nurse (**RN) collecting the specimen.

ii. Downtime Admit, Discharge, Transfer Log will be activated and all ADT transactions will be logged.

iii. Universal Downtime Requisition forms will be completed for all orders to be completed during Downtime and sent to the appropriate department. Phone notification will be used when appropriate. Routine orders not expected to be completed during the downtime should be entered when the system is back up by the ordering department/unit.

iv. All STAT orders will require a phone call to the servicing department

v. Lab: Any new routine orders to be done during the anticipated downtime should be forwarded to lab via the Universal Downtime requisition. Fax these requisitions to 4048.

1) All remaining future Lab orders, to be done post downtime, should have the order written on the manual tracking sheet on the nursing units for re-entry into Cerner. Any STAT labs will be called to the unit.

vi. Pharmacy: RNs will use the printed MAR for all inpatients. The RN will handwrite any new orders on this form as well as document all medications administered during downtime. All new patients will have medications handwritten on a blank MAR. Nurses must override for all new medication orders during downtime. New medication orders will not update on the Pyxis Medstation and new patients admitted during the downtime will have to be manually entered at the Pyxis MedStation. Caremobile and Careadmin devices will be unavailable during any system downtime.

vii. Radiology: Any order that needs to be performed during the downtime will be written on **a separate** ~~the~~ Universal Downtime requisition. **Each order needs a unique ID. No Universal Downtime Requisition copies will be allowed.** The original will be forwarded to the ancillary department, and the copy will be maintained in the requesting patient care area. Nursing staff will write the tracking number next to the order on the order sheet. Routine orders not expected to be done during the downtime should be entered when the system is back up by the ordering department/unit.

viii. Respiratory: All orders will be written on a manual downtime requisition and the Respiratory Care Practitioner (RCP) paged. The RCP will phone the unit and determine the priority of the order, then take appropriate action, (i.e. new start mini-neb- RCP will respond to the unit **as soon as possible** (ASAP), verify the order, pick up the requisition and start the therapy.) All charting will be completed on handwritten Pulmonary charting forms. Retain copies of charting for billing purposes, and place in chart.

ix. Manual requisitions should be stopped **60**~~30~~ minutes before the scheduled Cerner recovery time.

x. Clinical documentation: If the downtime is more than 4 hours, clinical data will be tracked on manual forms for the duration of the current shift. If the downtime is less than 4 hours electronic documentation will be completed upon recovery of the system.

xi. Nutrition Services: All diet orders need to be communicated to the central diet office at 4890.

c. **Scheduled Recovery:**

i. When back on-line, ensure adequate staffing to enter clinical data back into the system.

ii. If manual downtime requisitions have been forwarded to the appropriate department, do not enter into Cerner.

iii. All receiving Departments except Nutrition Services (i.e. Lab, Respiratory Therapy, Radiology, Social Services, Rehabilitation Services, Respiratory) will enter orders from requisitions received during downtime referencing the tracking number in the comment field, (the owner of the original copy of the requisition will enter the orders).

iv. Nursing refers to the manual Lab Tracking list and places orders not sent via the downtime requisitions during downtime.

v. Departments who use task lists shall update tasks as soon as possible to keep lists current

vi. Respiratory charting is to be entered and processed in Cerner once the system is up. Retain master copies and keep records of all order changes and updates when system is back up.

vii. Nursing must update all discharges and transfers for information from their ADT logs and verify admissions.

viii. If the downtime is 4 hours or less, Nursing must enter all clinical documentation back into the system. Priority is given to allergies, height, weight, **Input & Outputs (**I&Os**)**, vitals and meds given before clinical assessment data.

ix. If the downtime is more than 4 hours, nursing must reenter allergies, height, weight, I&Os, vitals and meds back into the system. All other documentation will remain on paper for the remainder of the shift.

~~ix.~~**x. If change of shift occurs, documentation must be completed by staff on paper or in the electronic health record (EHR) prior to leaving the shift.**

~~x.~~**xi.** During the Recovery Phase, Nursing will do a "chart check" to audit the orders and task list, the same as the midnight chart check. **Data can be entered by proxy if needed.**

d. **Unscheduled Downtime:**

i. When all or part of the computer system is noted to be down, but no announcement has been made, staff will call the Help desk at 940-7370. Staff will provide detailed description of the event.

ii. IT will investigate issue and determine if unscheduled system wide downtime has occurred and will notify departments if unscheduled downtime is confirmed.

iii. ~~Notify~~ IT Analyst ~~on call to~~will be notified immediately to start operation jobs for MAR printing.

~~i.~~**iv.** Printed labels will be used for inpatients, handwritten for any new admissions for lab draws that are nurse collectables. Handwritten labels will have **patient** name, Medical Record Number, date of birth, and the logon ID of the RN collecting the specimen.

~~ii.~~**v.** Activate ADT Log to track all Admits, Transfers, Births, and Deaths.

~~iii.~~**vi.** Complete manual Universal Downtime Requisitions for all new orders and use phone notification when appropriate.

~~iv.~~**vii.** All STAT orders require a phone call to the servicing department.

~~v.~~**viii.** Lab: Any new routine orders, to be done through the anticipated DT, should be forwarded to the lab via Universal Downtime requisitions. Fax these requisitions to 4048. All remaining future Lab orders, to be done post DT, write order on manual tracking log for re-entry into Cerner. Any STAT labs will be called to the unit.

~~vi.~~**ix.** Pharmacy: Hardcopy MAR sheets will be printed from the MAR backup file RXMOPC05 and sent to the nursing floors. ~~Nursing shall review~~ **Any new** medication orders **will be** ~~and~~ updated **on** their copy of the printed MARs from the time the MAR backup file was created to the current time. All meds given during downtime shall be documented on the printed MAR. All new meds will be handwritten on the printed MAR. For new patients, a blank MAR will be used. Nurses must override for all new medication orders during downtime. New medication orders will not update on the Pyxis Medstation and new patients admitted during the downtime will have to be manually entered at the Pyxis MedStation.

~~vii.~~**x.** Radiology: A manual downtime requisition will be required for all new orders and a call will be made to the department. **Each order needs a unique ID. No Universal Downtime Requisition copies will be allowed .**The unit will keep the

carbon copy of all orders sent. Nursing staff will write the tracking number next to the order on the order sheet.

~~viii.~~**xi.** Respiratory: All orders will be written on a manual downtime requisition and the RCP paged. The RCP will phone the unit and determine the priority of the order, then take appropriate action, (i.e. new start mini-neb, RCP will respond to the unit ASAP, verify the order, pick up the requisition and start the therapy.) All charting will be completed on handwritten Pulmonary charting forms. Retain copies of charting for billing purposes and place in chart. For **arterial blood gases (**ABGs**)**, use the manual ABG requisition for recording results.

~~ix.~~**xii.** Nutrition Services: All diet orders need to be communicated to the central diet office at 4890.

~~x.~~**xiii.** Manual requisitions should be stopped ~~30~~ **60** minutes before the Cerner recovery time, if information provided.

~~xi.~~**xiv.** If the downtime exceeds 4hrs, Nursing and Rehabilitation Services will begin to document all clinical data on existing manual forms and will continue for the duration of the current shift.

e. **Unscheduled Downtime Recovery:**

i. If manual requisitions have already been forwarded to the appropriate department, do not enter into Cerner. The department that has received the requisition will enter the order into the system when it comes back up.

ii. Except for Nutrition Services, all receiving Departments (i.e. Lab, **Respiratory Therapy (**RT**)**, Social Services, Rehab Services, Radiology, and Respiratory) enter orders received from requisitions received during downtime. This includes the manual ABG requisitions. The tracking number should be referenced in the order comment field.

iii. Nursing refers to the manual Lab Downtime Log and enters any lab orders not sent down via a requisition during the downtime.

iv. Nursing enters all other orders not sent to a department via a downtime requisition.

v. Respiratory charting is to be entered and processed in Cerner once the system is up. Retain master copies and keep records of all order changes and updates when system is back up.

vi. Departments who use task lists shall update tasks as soon as possible to keep lists current

vii. During the Recovery Phase, Nursing should do a "Chart Check" to audit the orders and task list, the same as the midnight chart check.

viii. All paper documentation will be labeled "Downtime Documentation" and kept in the medical record.

ix. If the downtime is 4 hours or less, Nursing must enter all clinical documentation back into the system. Priority is given to allergies, height, weight, I&Os, vitals and meds given before clinical assessment data.

x. If the downtime is more than 4 hours, nursing must reenter the following:
   1) Allergies
   2) Height and weight,
   3) I&Os,
   4) Vitals
   5) Medications given
   6) Admission Medication Reconciliation
   7) Admission Patient Histories

xi. All other documentation will remain on paper for the remainder of the shift.

2. **Enterprise Registration Management (ERM): Registration Department**

a. **Scheduled Downtime Preparation:**

i. Print census 15 minutes prior to the system scheduled down time for the current snapshot of room and bed assignments.

ii. Before downtime occurs, each Registration area will assemble their downtime tools (including Downtime Binder) in a central location to begin assigning account numbers as needed.
iii. A pool of financial numbers (FIN) are to be used for downtime, these numbers begin with a "9000" which differentiates them as a downtime encounter. Additional numbers if needed should be requested from the IT Department at least 24 Hours prior to the scheduled downtime.
iv. An Enterprise Master Patient Index (EMPI) search will be made on the alternative Medical Records database (Affinity) to check for possible medical record numbers for patients. A new MRN will not be issued until the system has been restored and the patient does not already have an MRN.
v. If a medical record number exists in the EMPI Search, it should be noted on the downtime registration facesheet in the medical record number field.
vi. All patient demographic, encounter specific and insurance information should be entered on the facesheet.
vii. Make multiple copies of the facesheet. One copy is for the nursing unit and/or servicing department, and the other is to keep in the Registration Department for entry when the system is active and for record keeping.
viii. Preprint labels with downtime numbers preprinted on them.

b. **Scheduled Downtime:**
i. If an armband is needed for a new admission during downtime, affix one manually written label to armband and apply to patient.
ii. Manual ADT using downtime numbers. (9000 numbers) All patient demographic, encounter specific and insurance information should be entered on the facesheet.
iii. Make copies of orders, insurance cards, and any other data that would be useful when the system is up.
iv. Enter all information into the downtime ADT Log.
v. Have patient sign all necessary consent forms.
vi. Keep all paperwork in one central location for re-entry when system is restored (if over 4 hours).
vii. Power Chart Maternity **(PCM)** – All **Obstetrics** (OB) Admissions **paperwork** will be routed through Main Registration during normal business hours and **Emergency Department** (ED) Registration during off hours regardless if downtime is scheduled or unscheduled downtime.
1) A communication notice will be sent to the Registration area with the patient information and admission details.
2) Registration will search the EMPI in the alternative system (Affinity) and assign the downtime financial number and communicate to OB.

c. **Scheduled Recovery:**
i. Complete all admit, discharge, transfer data from downtime ADT logs.
ii. ADT data to be re-entered in the following order: 1-Discharges, 2- Transfers, 3-Admits.
iii. All Admissions for OB must be entered through the Inpatient Downtime Conversation.
iv. Verify the WH TRACKING GROUP is entered during the admission to ensure these patients will show up on the PCM Tracking Shell.
v. All Mothers admissions should be done prior to any Newborn Admissions.
1) The newborn admit should be completed through the Admit Newborn Procedure which creates the link between mother and baby.
vi. The dirty Bed Queue will be updated AFTER the ADT reconciliation.
vii. The census will be balanced from downtime to current time and validated.
viii. IT and the departments are to be notified when all downtime ADT is complete.

d. **Unscheduled Downtime:**

i. If an armband is needed for a new admission during downtime, affix one manual label to armband and apply to patient.
ii. Manual ADT using downtime numbers. (9000 numbers)
iii. Make copies of orders, insurance cards, and any other data that would be useful when the system is up.
iv. Enter all information into the downtime ADT Log.
v. Have patient sign all necessary consent forms.
vi. Keep all paperwork in one central location for re-entry when system is restored (if over 4 hours).

e. **Unscheduled Downtime Recovery:**
i. Complete all admit, discharge, transfer data from downtime ADT logs.
ii. All Admissions for OB must be entered through the Downtime Conversation and linked to the WH TRACKING GROUP so these patients will show up on the PCM Tracking Shell.
iii. All Mother admissions should be done prior to any newborn admission.
1) The newborn admit should be completed through the Admit Newborn Procedure which creates the link between mother and baby
iv. ADT data to be re-entered in the following order: 1-Discharges, 2- Transfers, 3-Admits.
v. The dirty Bed Queue will be updated AFTER the ADT reconciliation.
vi. The census will be balanced from downtime to current time and validated.
vii. IT and the departments are to be notified when all downtime ADT is complete.

3. **Enterprise Scheduling Management (ESM): Scheduling - Ancillary Departments**
a. **Scheduled Downtime Preparation:**
i. Schedules will be printed out in advance of scheduled downtime, dependent on the needs of each department, (e.g.: Rehab Services: 1 week, Radiology 48 hours)

b. **Scheduled Downtime:**
i. Schedulers will not schedule appointments, or view/print schedules during downtime. When a patient calls to schedule an appointment, their information will be taken, including the patient's full name, birth date, phone number, name of test/procedure needed, reason for exam and ordering physician. It will be explained that they will be contacted as soon as possible when the system comes back up.

c. **Scheduled Recovery:**
i. Enter patient's information into system and either call with appointment times or schedule the appointment as soon as possible, dependent upon the department's needs.

d. **Unscheduled Downtime:**
i. Schedulers will not schedule appointments, or view/print schedules during downtime. When a patient calls to schedule an appointment, their information will be taken, including the patient's full name, birth date, phone number, name of test/procedure needed, reason for exam and ordering physician. It will be explained that they will be contacted as soon as possible when the system comes back up.

e. **Unscheduled Downtime Recovery:**
i. Enter patient information into system and either call them with appointment times or schedule the appointment as soon as possible, dependent upon the department's needs.

4. **FirstNet: Emergency Department (ED)**
a. **Scheduled Downtime Preparation:**
i. Organize pre-made downtime packets containing paper form and labels: Triage, Nursing Assessment (which contains documentation of med**ication**s and **intravenous [**IVs**] fluids**), Progress Notes, Cardiac Monitor Strip, after

care/Discharge instructions, for example; Universal Downtime Requisition, ADT Log and Policy.

ii. Unit Secretary/**Emergency Medical Technician** (EMT) to prepare Universal Downtime Requisition forms which use unique tracking numbers.

iii. Secure prescription pads for the ED Physicians.

iv. Print a copy of the FirstNet Tracking Screen for an accurate patient list prior to downtime.

v. Unit Secretary to retrieve the manual tracking board to be used by ANM/Charge RN for use during downtime.

~~iv.~~**vi. Unit Secretary will transfer the FirstNet data to the manual tracking board.**

~~v.~~**vii.** ED Registration to run in-house census and prepare Downtime Log Book.

~~vi.~~**viii.** Unit Secretary/EMT will maintain and update the ADT log.

~~vii.~~**ix.** Print additional patient labels for patients already fully registered in FirstNet.

~~viii.~~**x.** ED shift supervisor, ANM or designee to communicate with **Administrative Supervisor** (AS) to facilitate timely disposition of pending admissions.

b. **Scheduled Downtime:**

i. ED staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department.

ii. ED Physicians, Residents, and Physician Assistants will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iii. Downtime events in the ED will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all Stat orders should be called to the departments.

iv. ED physicians, Residents and Physician Assistants **(PA's)** will dictate their notes into Dragon or use transcription service. Scribes will document assessments and notes in a word document on their tablets and will copy these documents into a PowerNote when the system is back online.

v. ED Quick Reg will have stopped and backup forms will be used by Registration. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

1) ED Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

vi. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications.

c. **Scheduled Recovery:**

i. When FirstNet is back on line, ED Registration will ensure adequate staffing to enter data back into the system.

ii. New patients who arrived during the downtime period that are currently in the ED will be entered by ED Registration - these patients will then appear on the FirstNet Tracking board in their correct locations. Nursing is not to register any patients into the system at this time, all registration to be done by ED Registration using the following conversations:

1) ED Downtime Conversation – If the patient has an existing MRN, use this conversation to quickly enter the patient into FirstNet. Enter the FIN (9000) downtime number that was assigned.

2) Downtime Outpatient – If the patient does NOT have an existing MRN, use this conversation and the system will automatically assign a MRN to the patient. Enter the FIN – (9000) downtime number that was assigned.

3) Confirm patient displays on tracking shell in the correct location

a) If the patient does not display on tracking after the registration, use the ED QUICK REG (Ambulance Icon) from the Registration Tab in FirstNet and search and select the current downtime encounter from the visit search window and verify the information and bed

assignment and select OK. This should force the patient to the tracking shell.

4) Once all patients who are currently in the ED are registered, enter the remaining patients who have been discharged and place them in the ED Wait Room so that the ED Clinicians can complete their documentation and discharge patient accordingly.

5) ED Reg**istration** will notify the ED shift supervisor, ANM or designee when all patients have been entered back into FirstNet.

iii. ED shift supervisor, ANM or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen and updates screen as indicated with transfers and discharges.

iv. All receiving Departments (i.e. Lab, RT, Radiology, Social Services, Rehab Services) will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

v. Nursing documentation will be entered back into FirstNet dependent upon the length of the downtime for all patients still in the ED.

vi. If downtime lasts less than one hour:

1) All clinical documentation shall be reentered in Cerner after the patient has been entered into FirstNet.

vii. If downtime lasts more than one hour:

1) Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

2) During the Recovery Phase, each RN will do a chart check on his/her designated patients to audit the orders and tasks assigned during downtime for completion.

3) All patients that were discharged during the downtime period will need to be discharged in the system by the Unit Secretary/EMT/RNs under the shift supervisor or designee's supervision.

4) Validate all downtime patients are in ADT (Affinity), appropriate documentation is transcribed into Cerner and all Ancillary orders placed during downtime are viewable in Cerner.

d. **Unscheduled Downtime:**

i. ED Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.

~~i.~~**ii. Unit Secretary to retrieve the manual tracking board to be used by ANM/Charge RN for use during downtime. The Unit Secretary will gather all patient information from Stations A, B, C and D and transfer it to the manual tracking board to be used by the ANM/Charge RN.**

~~ii.~~**iii. ANM Charge will update the board for admissions and discharges during the downtime processes.**

~~iii.~~**iv.** ED staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department.

~~iv.~~**v.** ED Physicians, Residents, and Physician Assistants will write orders for medications and IVs on their paper chart and notify nursing of those orders.

~~v.~~**vi.** Downtime events in the ED will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.

~~vi.~~**vii.** ED physicians, Residents and Physician Assistants will dictate their notes into Dragon or use transcription service. Scribes will document assessments and notes in a word document on their tablets and will copy these documents into a PowerNote when the system is back online.

~~vii.~~**viii.** ED Quick Reg will have stopped and backup forms will be used by Registration. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

1) ED Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

~~viii.~~**ix.** Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. **Unscheduled Downtime Recovery:**

i. When FirstNet is back on line, ED~~R~~ Registration will ensure adequate staffing to enter data back into the system.

ii. ED shift supervisor or designee or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen.

iii. New patients who arrived during the downtime period that are currently in the ED will be entered by ED Registration - these patients will then appear on the FirstNet Tracking board in their correct locations. Nursing is not to register any patients into the system at this time, all registration is to be done by ED Registration using the following conversations:

1) ED Downtime Conversation – If the patient has an existing MRN, use this conversation to quickly enter the patient into FirstNet. Enter the FIN (9000) downtime number that was assigned.

2) Downtime Outpatient – If the patient does NOT have an existing MRN, use this conversation and the system will automatically assign a MRN to the patient. Enter the FIN – (9000) downtime number that was assigned.

3) Confirm patient displays on tracking shell in the correct location

a) If the patient does not display on tracking after the registration, use the ED QUICK REG (Ambulance Icon) from the Registration Tab in FirstNet and search and select the current downtime encounter from the visit search window and verify the information and bed assignment and select OK. This should force the patient to the tracking shell.

4) Once all patients who are currently in the ED are registered, enter the remaining patients who have been discharged and place them in the ED Wait Room so that the ED Clinicians can complete their documentation and discharge patient accordingly.

iv. ED shift supervisor, ANM or designee confirms that patient names and locations are correct on the FirstNet Tracking Screen and updates screen as indicated with transfers and discharges.

v. All receiving Departments (i.e. Lab, RT, Radiology, Social Services, Rehab Services) will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

vi. Nursing documentation will be entered back into FirstNet dependent upon the length of the downtime.

vii. If downtime lasts less than one hour:

1) Once the patient has been entered into FirstNet, all clinical documentation will be reentered in Cerner.

viii. If downtime lasts more than one hour:

1) Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

2) During the Recovery Phase, each RN will do a chart check on his/her designated patients to audit the orders and tasks assigned during downtime for completion.

3) All patients that were discharged during the downtime period will need to be discharged in the system by the unit secretary/EMT/RNs under the shift supervisor or designee's supervision.
4) Validate all downtime patients are in ADT (Affinity), appropriate documentation is transcribed into Cerner and all ancillary orders placed during downtime are viewable in Cerner.

5. **Laboratory - Microbiology, General Lab Blood Bank and Blood Gases**

a. **Scheduled Downtime Preparation:**
- i. Have an adequate number of Cerner downtime barcode labels printed.
- ii. Have an adequate number of reporting forms if manual forms are necessary.
- iii. Have phlebotomy review an "Unreceived List" for 8 hours in the past and future and mark any pending orders.
- iv. Lab to print the collection lists for the scheduled downtime after 2345 and include the 0600 Collection List for the AM run.

b. **Scheduled Downtime:**
- i. Nursing units will fax manual Downtime Requisitions to the fax in the Triage area (4048).
- ii. Specimens will come with a manual Universal Downtime Requisition on new orders only. Specimens from orders prior to DT will be ordered from the "Unreceived Specimen Log." All specimen-labeling needs to be checked against the written order information.
- iii. One set of Cerner DT barcode labels should be used for each Universal Downtime requisition. Place the label(s) on the appropriate manual requisition, specimen(s), or worksheet for the procedure and all setup media, slides, aliquots, attached to that procedure. Record specimen received date and time as well as set up date and time on the requisition.
- iv. For ongoing or manual procedures, use worksheets, work cards, Downtime Patient Results form, and other forms located in the downtime files to record bench workup. For online results use instrument printouts.
- v. For dispensing blood products, Nurse/Clinician will present the Transfusion Request Form handwritten with the Transfusion Service ID band number, patient's name, billing number and medical record number. Dispense information will be documented on the Downtime Patient Results form.
- vi. For reporting procedures, STAT results will be called to the units. Instrument printouts and manual Reporting forms will be used to distribute results to the ED. If there is an extended DT, this method of reporting will also be used for the nursing units. See specific Laboratory Downtime procedures for further details.
- vii. RCPs will continue to use the ABG Requisition Form to record results. A copy will be made for later recovery.

c. **Scheduled Recovery:**
- i. When Cerner is back on line, Lab orders will be entered using the Universal DT requisition and the appropriate Cerner DT barcode accession **numbers** ~~#~~.
- ii. Results will be entered into Cerner using the appropriate instrument printouts, manual report forms, or worksheets.
- iii. Blood product dispense information will be entered into Cerner.
- iv. ABG results will be entered from the ABG Requisition form.

d. **Unscheduled Downtime**
- i. Print the most current "Downtime Collection List" from LABPC06~~1~~ located at the **Chemistry Technical Specialist's** ~~Point of Care Coordinator's~~ desk **across from the blood gas analyzer** ~~adjacent to Triage~~ and give to the Phlebotomy team for draws already entered in Cerner.
- ii. Obtain the preprinted DT accession barcode labels.
- iii. Have an adequate number of reporting forms if manual forms are necessary.
- iv. Have phlebotomy review the last "Unreceived List" and mark any pending orders.

v. Nursing units will fax all Universal Downtime Requisitions for new orders to the Triage fax (4048).
vi. Specimens will come with a manual Universal Downtime Requisition on new orders only. Specimens from orders prior to DT will be ordered from the "Unreceived Specimen Log." All specimen-labeling needs to be checked against the written order information.
vii. One set of Cerner DT barcode labels should be used for each Universal Downtime Requisition. Place the label(s) on the appropriate manual requisition, specimen(s), or worksheet for the procedure and all setup media, slides, aliquots, attached to that procedure. Record specimen received date and time as well as set up date and time on the requisition.
viii. For ongoing or manual procedures, use worksheets, work cards, Downtime Patient Results form to record bench workup. For on line procedures use instrument printouts.
ix. For dispensing blood products, Nurse/Clinician will present the Transfusion Request Form handwritten with the Transfusion Service ID band number, patient's name, billing number and medical record number. Dispense information will be documented on the Downtime Patient Results form.
x. For reporting procedures, STAT results will be called to the units. Manual Reporting forms and instrument printouts will be used to distribute results to the ED to the units. If there is an extended DT, this method will also be used for reporting results to the nursing units. See specific Laboratory Department procedures for further details.
xi. RCPs will use the ABG Requisition form to record results. A copy will be made for later recovery.

e. **Unscheduled Downtime Recovery:**
i. When Cerner is back on line, Lab orders will be entered using the Universal DT requisition and the appropriate DT barcode accession number.
ii. Results will be entered into Cerner using the appropriate instrument printouts, manual report forms, worksheets,
iii. Blood product dispense information will be entered into Cerner.
iv. ABG results will be entered from the ABG Requisition form.

6. **PharmNet: Pharmacy**

a. **Scheduled Downtime Preparation:**
i. Call for one extra technician, one extra pharmacist depending on downtime duration.
ii. IT will force operation jobs to run extra MARs for all patients and pharmacists will attempt to enter all orders prior to run.
iii. Run IV batch early if due soon.
iv. Pre-printed IV labels will be available for most commonly dispensed products.
v. Confirm the most recent MAR backup file has been received by RXMOPC05

b. **Scheduled Downtime:**
i. Turn on "Critical Override" at Pyxis "Profile" MedStations just before the system goes down. Notify each profile nursing station, the Pharmacy Supervisor and/or the Director of Pharmacy that the system is on "Critical Override." Any new medication orders not in the Pyxis MedStation will be scanned down to the pharmacist by nursing.
ii. Down time pharmacy labels will be completed manually by Pharmacy.
iii. The responsible pharmacist will call down all new IVPB orders to the IV room. This information will then be recorded on the MAR along with date/time and the number of doses sent.
iv. The IV room will generate IV production off scanned orders

c. **Scheduled Recovery:**
i. When back on-line, ensure adequate pharmacist staff to enter orders.

ii. After new patients are admitted through the ADT system, pharmacists will begin to input orders into PharmNet.
iii. Nursing staff to enter allergies, height, and weight on all new admits so the pharmacist can complete medication order entry.
iv. Turn off "Critical Override" on all Pyxis "Profile" MedStations.

d. **Unscheduled Downtime:**
i. Turn on "Critical Override" at Pyxis "Profile" MedStations when the system goes down. Notify each profile nursing station, the Pharmacy Supervisor and/or the Director of Pharmacy that the system is on "Critical Override." Any new medication orders not in the Pyxis MedStation will be scanned down to the pharmacist by nursing.
ii. Call for one extra technician, one extra pharmacist and adjust staffing accordingly to workload and downtime duration.
iii. Orders for new admits will be recorded on a blank MAR located in the Pharmacy Computer Downtime Manual.
iv. Downtime Rx labels will be completed manually by Pharmacy. Pre-printed IV labels will be available for most commonly dispensed products.
v. The responsible pharmacist will call down all new IVPB orders to the IV room. This information will then be recorded on the MAR along with date/time and the number of doses sent.
vi. The IV room will generate IV production from the scanned orders
vii. Pharmacy will print a hard copy of the MAR from the MAR backup file on PC RXMOPC05 and send to the nursing unit. For extended downtime (over 24 hours), pharmacy will print a second hardcopy of the MAR from the MAR backup file for the pharmacy to use and manually update each patient's medication orders.

e. **Unscheduled Downtime Recovery:**
i. When back on-line, ensure adequate pharmacist staff to enter orders.
ii. After new patients are admitted through the ADT system, pharmacists will begin to input orders into Pharmnet.
iii. Nursing staff to enter allergies, height, and weight on all new admits so the pharmacist can complete medication order entry.
iv. Turn off "Critical Override" on all Pyxis "Profile" MedStations.

7. ~~Profile~~**HIM: Medical Records/Health Information**

a. **Scheduled Downtime Preparation:**
i. Medical Records will alert transcription team members of impending downtime. Medical Records will post the Downtime dictation instructions on each unit.

b. **Scheduled Downtime:**
~~i. Clinical units/departments will request old records from Medical Records/Health Information by phone.~~
~~1) Units will need to provide the medical record number for all charts being requested.~~
i. Physicians will continue dictating reports into the dictation system.
ii. Transcriptionists will continue transcribing reports into the transcription system, (ADT information will be based upon information sent to the system prior to downtime)
iii. Coding ~~staff will utilize the 3M encoder in stand-alone mode~~**will be suspended as documentation is not viewable**.
~~2) If the encoder is not available, coders will assign codes manually using the hard copy ICD-9 and CPT coding books.~~

c. **Scheduled Recovery:**
i. Cerner work queues will be tested and updated once all registration and discharge transactions have been entered.
ii. Reports transcribed without patient demographic information will be reviewed~~,~~ **and** edited **for viewing in PowerChart**~~, and routed for charting on the record~~.

iii. Each ~~Profile function~~**application** will be tested to ensure system integrity.
~~ii.~~**1)** ~~Coding staff will enter manually coded information~~.

d. **Unscheduled Downtime:**
i. Charts will be logged out of Medical Records on a manual log to identify location to which the chart has been taken.
ii. Physicians will continue to dictate reports into the dictation system.
1) If the dictation system is down, dictation is completed via back up dictation line ~~at 1-866-414-7522~~. Handheld dictation units are available if phone lines are down.
iii. Transcriptionists will continue transcribing reports (ADT information will be based upon information sent prior to downtime).
1) Transcribed reports will queue up in the transcription to Cerner interface until the system is on-line.
iv. Coding staff will be on standby.
v. Preparation of the record for scanning will continue.
vi. Analysis /Assignment of deficiencies to the physicians will be suspended until the system is available.

e. **Unscheduled Downtime Recovery:**
i. ADT interface to Transcription system will be tested.
ii. Interface to Cerner will be updated to pass transcribed reports to Powerchart.
iii. Each ~~Profile function~~**application** will be tested to ensure system integrity.
1) ~~Charts manually logged out of the department will be entered into the Profile Tracking application~~.
iv. **Master Patient Index (MPI) specialist to review MRN's assigned during downtime to confirm any combined MRN's needed.**

8. **RadNet: Radiology/Imaging Department**
a. **Scheduled Downtime Preparation:**
i. Print schedules for downtime plus 48 hours.
b. **Scheduled Downtime:**
i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed by registration for each patient.
ii. The ED Unit Secretaries and ED staff will call STAT radiology exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number. Outpatients will come from admitting with their hand written face sheet.
iii. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the PACS ID. The technologist will enter the downtime PACS ID into all digital modalities. Only one down time PACS ID may be used per exam.
iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name where indicated.
~~iv.~~**v. Completed exam downtime requisitions will be delivered to the film library for radiologist dictation. The radiologist will dictate the Universal Downtime number into the report.**
~~v.~~**vi. For existing Radiology requisitions d**~~D~~ictation will be completed as usual by entering the medical record into the dictation system.
~~vi.~~**vii.** Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

c. **Scheduled Recovery:**
i. Wait for ADT feed.
ii. Delete any duplicate orders.

iii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
v. The PACS supervisor will reconcile all downtime PACS ID numbers with the Cerner PACS ID in the PACS system.
vi. Reference Radiology Department specific policies for detailed downtime workflow.

d. **Unscheduled Downtime:**
i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed for each patient.
ii. The Unit Secretaries and ED will call STAT diagnostic imaging exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number.
iii. Outpatients will come from admitting with their hand written face sheet.
iv. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the PACS ID. The technologist will enter the downtime PACS ID into all digital modalities. Only one down time PACS ID may be used per exam.
v. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was use, the amount of contrast, and enter his/her full name where indicated.
~~iii.~~**vi.** **Completed exam downtime requisitions will be delivered to the film library for radiologist dictation. The radiologist will dictate the Universal Downtime number into the report.**
~~v.~~**vii.** Dictation will be completed as usual by entering the medical record into the ~~Lanier~~ dictation system.
~~vi.~~**viii.** Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

e. **Unscheduled Downtime Recovery:**
i. Wait for ADT feed.
ii. Delete any duplicate orders.
iii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
v. The PACS supervisor will reconcile all downtime PACS ID number with the Cerner PACS ID in the PACS system.
vi. Reference Radiology Department specific policies for detailed downtime workflow.

9. **Surginet: Surgery Scheduling, Pre-Op and Intraoperative Documentation**

a. **Scheduled Downtime Preparation:**
i. Have an adequate number of preoperative assessment, intra-operative worksheets, implant records, downtime schedule book and labels for each case / procedure made up for a minimum of one hundred-fifty (150) cases.
ii. Routine scheduling is not done during Surginet downtime. Surgery schedulers will call the surgeon's offices when the system is back up and running.
iii. Daily back-up of the next 3 months schedule is saved electronically to a USB drive.
iv. **Sterile Processing Department** (SPD) maintains a hard copy file of preference cards accessible to the OR staff.

b. **Scheduled Downtime:**

i. The circulating nurse will document the intra-operative phase of the cases or procedures on a hardcopy of intraoperative forms.
ii. Implants will be documented on a hardcopy of the implant record.
iii. Copies of the intra-operative forms and implant records will be placed on the patient record until the system is back up and running.
iv. TCMC will not be able to schedule appointments, view or print any Surginet Surgery schedules during the downtime.
v. Manual scheduling will go into effect.
vi. Add-on/urgent cases shall be manually scheduled during downtime. Schedule the cases in Surginet when the system is back up. Routine scheduling of elective cases is not done during Surginet downtime.
vii. Save copies of all downtime operative records for later entry (using late entry protocol) and charging.
viii. All peri-operative assessments and clinical case data (including implant information), will be manually documented during the Surginet downtime on a hard copy of the forms.
ix. Charges will be manually entered into Affinity during downtime on a daily basis.

c. **Scheduled Recovery:**
i. Enter future scheduled patients and data from the manual hard copy into the Surginet system.
ii. Print a new schedule if needed and validate the following: all manual schedules (Date of Procedure; OR Room Assigned, Start Time, Estimated OR Time, Patient's Name, Birth date, Social Security Number, Patient's home phone number, Pre-Operative Diagnosis, Procedure Scheduled, Surgeon, Name of Assistants, Special Equipment Needs, Name of Office Staff/Surgeon Scheduling, Insurance Information and the Initials of the Scheduling Secretary that documents the information etc) to the Surginet Schedule. Ensure there are no scheduling conflicts with rooms, equipment or supplies.
iii. Circulating nurses for the cases will back enter all clinical data for cases that occurred during the downtime following "Late Entry Protocol" into the Surginet System.
iv. Notify the physicians' office staffs that system is back online and verify that all patient information; procedures, dates and times are accurate.

d. **Unscheduled Downtime:**
i. The circulating nurse will document the intra-operative phase of the cases or procedures on a hardcopy of the intra-operative forms.
ii. Implants will be documented on a hardcopy of the implant record.
iii. Copies of the intra-operative forms and implant records will be placed on the patient record until the system is back up and running.
iv. TCMC will not be able to schedule appointments, view or print any Surginet Surgery schedules during the downtime.
v. Manual scheduling will go into effect.
vi. Add-on/urgent cases shall be manually scheduled during downtime. Schedule the cases in Surginet when the system is back up. Routine scheduling of elective cases is not done during Surginet downtime.
vii. Save copies of all downtime operative records for later entry (using late entry protocol) and charging.
viii. All peri-operative assessments and clinical case data (including implant information), will be manually documented during the Surginet downtime on a hard copy of the forms.
ix. Charges will be manually entered into Affinity during downtime on a daily basis.

e. **Unscheduled Downtime Recovery:**
i. Enter future scheduled patients and data from the manual hard copy into the Surginet system.

ii. Print a new schedule if needed and validate the following: all manual schedules (Date of Procedure; OR Room Assigned, Start Time, Estimated OR Time, Patient's Name, Birth Date, Social Security Number, Patient's home phone number, Pre-Operative Diagnosis, Procedure Scheduled, Surgeon, Name of Assistants, Special Equipment Needs, Name of Office Staff/Surgeon Scheduling, Insurance Information and the Initials of the Scheduling Secretary that documents the information etc) to the Surginet Schedule. Ensure there are no scheduling conflicts with rooms, equipment, or supplies.

iii. Circulating nurses for the cases will back enter all clinical data for cases that occurred during the downtime following "Late Entry Protocol" into the Surginet System.

iv. Notify the physicians' office staffs that system is back online and verify all patient information; procedures, dates, and times are accurate.

10. **Electrocardiogram (ECG~~EKG~~) Powerchart: ECG~~EKGs~~**

a. **Scheduled Downtime Preparation**

i. 30 minutes prior to downtime, download the modality worklist on all the **ECG**~~EKG~~ carts.

b. **Scheduled Downtime**

i. Continue acquiring and transmitting ECGs during Millennium downtime.

ii. If the order **staff**~~you~~ need to acquire is already on the cart's worklist, acquire the ECG with the appropriate order and transmit.

iii. If **staff**~~you~~ cannot download orders to the ECG cart, enter the patient data manually on the cart and transmit.

1) Print 3 copies of every ECG acquired during downtime

a) 1st copy goes to ordering physician for preliminary interpretation/viewing. Critical result notification process remains unchanged (**ECG technician**~~RT~~ will still add a comment on the ECG documenting the clinician they communicated critical results to).

b) 2nd copy goes to reading cardiologist bin

c) 3rd copy is kept by the **ECG technician**~~Respiratory Therapist~~. Retain these printed ECGs until downtime is over. They will be used to ensure all ECGs acquired during downtime have orders placed and match the order.

d) Be sure to attach an ADT (patient packet) sticker to each printed copy of the ECG.

c. **Scheduled Recovery -** when Millennium comes back up:

i. All ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order.

ii. When ~~you~~**staff** are notified that downtime is over, log into PowerChart.

iii. Review each printed ECG copy ~~you~~**staff** acquired during downtime.

1) If an order existed prior to downtime, verify that **the**~~your~~ transmitted ECG auto-matched and completed the order.

2) If no order exists for one of **the**~~your~~ printed ECGs, place an order for it using the ADT patient information that is on the patient's sticker. Then, verify that the ECG ~~you~~**staff** transmitted during downtime is available on the ECG match list, and match it to the order and finish **the**~~your~~ ECG process (right-click and stamp **staff**~~your~~ name on it as normal).

iv. **ECG technician**~~Respiratory Admin~~ will go to Cardiologist reading bin and collect all paper ECGs that were submitted to the Cardiologist during downtime.

1) **ECG technician**~~Respiratory Admin~~ will reconcile all signed paper ECGs with their corresponding order and matched ECG images to be sure that all

signed paper ECGs have orders placed and have been matched to their digital ECG images.

2) **ECG technician**~~Respiratory Admin~~ will then return the signed paper ECGs to the reading Cardiologist(s) and direct them to re-sign the digital copy for each printed ECG from their PowerChart ECG worklist.

3) Any unsigned paper ECGs will be discarded by the **ECG technician**~~Respiratory Admin~~ and the reading Cardiologist will read them from their PowerChart ECG worklist as normal.

d. **Unscheduled Downtime**

i. Continue acquiring and transmitting ECGs during Millennium downtime.

ii. If the order ~~you~~**staff** need to acquire is already on the cart's worklist, acquire the ECG with the appropriate order and transmit.

iii. If ~~you~~**staff** cannot download orders to the ECG cart, enter the patient data manually on the cart and transmit.

1) Print 3 copies of every ECG acquired during downtime

a) 1st copy goes to ordering physician for preliminary interpretation/viewing. Critical result notification process remains unchanged (**ECG technician**~~RT~~ will still add a comment on the ECG documenting the clinician they communicated critical results to).

b) 2nd copy goes to reading cardiologist bin

c) 3rd copy is kept by the **ECG technician**~~Respiratory Therapist~~. Retain to these printed ECGs until downtime is over. They will be used to ensure all ECGs acquired during downtime have orders placed and match the order.

d) Be sure to attach an ADT (patient packet) sticker to each printed copy of the ECG.

e. **Unscheduled Downtime Recovery -** when Millennium comes back up:

i. All ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order.

ii. When ~~you~~**staff** are notified that downtime is over, log into PowerChart.

iii. Review each printed ECG copy ~~you~~**staff** acquired during downtime.

1) If an order existed prior to downtime, verify that **the**~~your~~ transmitted ECG auto-matched and completed the order.

2) If no order exists for one of **the**~~your~~ printed ECGs, place an order for it using the ADT patient information that is on the patient's sticker. Then, verify that the ECG ~~you~~**staff** transmitted during downtime is available on the ECG match list, and match it to the order and finish **the**~~your~~ ECG process (right-click and stamp **staff**~~your~~ name on it as normal).

iv. **ECG technician**~~Respiratory Admin~~ will go to Cardiologist reading bin and collect all paper ECGs that were submitted to the Cardiologist during downtime.

1) **ECG technician**~~Respiratory Admin~~ will reconcile all signed paper ECGs with their corresponding order and matched ECG images to be sure that all signed paper ECGs have orders placed and have been matched to their digital ECG images.

2) **ECG technician**~~Respiratory Admin~~ will then return the signed paper ECGs to the reading Cardiologist(s) and direct them to re-sign the digital copy for each printed ECG from their PowerChart ECG worklist.

3) Any unsigned paper ECGs will be discarded by the **ECG technician**~~Respiratory Admin~~ and the reading Cardiologist will read them from their PowerChart ECG worklist as normal.

f. **ECG**~~EKG~~ **Downtime Scenarios**

i. All of Millennium is down

1) Impact:
   a) ~~Can't~~**Cannot** place ECG orders
   b) ~~Can't~~**Cannot** download orders to cart
   c) ~~Can't~~**Cannot** match ECGs
   d) ~~Can't~~**Cannot** unmatch ECGs
   e) ~~Can't~~**Cannot** view or sign ECGs
2) Downtime procedure:
   a) Enter patient information manually at the cart.
   b) Continue acquiring and transmitting ECGs as normal.
   c) Print any stat/critical ECGs and deliver to attending physician, since these will not be viewable in the chart until Millennium comes back up and they can be matched to their orders.
   d) Critical result notification process remains unchanged (**ECG technician**~~RT~~ will still add a comment on the ECG documenting the clinician they communicated critical results to).
   e) When Millennium comes back up, all ECGs that were transmitted during the downtime will be announced to Cerner and will either auto-match (if acquired with an order) or be available on the manual match list for matching to the order. At this point, they will be viewable in PowerChart/FirstNet.
   f) Print extra copies of all ECGs acquired during downtime, and place the ADT sticker/label on the ECG. These ECGs will be used to verify that all ECGs were transmitted and matched after we come out of downtime.
   g) Upon downtime completion (or cessation), **ECG technician**~~Respiratory Department~~ will place orders for all ECGs acquired during downtime, so that the transmitted ECGs can be matched to the orders.
   h) Any paper ECGs that are interpreted by Cardiologists during downtime will be collected by **ECG technician**~~Respiratory Administrator~~ at end of downtime. **ECG technician**~~Respiratory Admin~~ will reconcile all signed paper ECGs with their corresponding order and matched ECG images. **ECG technician**~~Respiratory Admin~~ will then return the paper ECGs to the reading Cardiologist(s) and direct them to sign the digital copy that is now available in their PowerChart ECG worklist.
3) Not impacted:
   a) Acquiring and transmitting ECGs.

ii. <u>MGate server is down</u>~~\~~
1) Impact:
   a) ~~Can't~~**Cannot** download new orders to cart.
   b) ~~Can't~~**Cannot** transmit ECGs to Cerner.
2) Downtime procedure:
   a) Continue to ask physicians to place orders for ECGs, even though ~~you~~**staff** ~~can't~~**cannot** download the orders to the cart or transmit the ECGs to Cerner for matching. This way orders will be present and ready to match to ECGs when they can be transmitted.
   b) Enter patient information manually at the cart.
   c) Print any stat/critical ECGs and deliver to attending physician, since these will not be viewable in the chart until the MGate comes back up and the ECGs can be transmitted and matched to their orders.
   d) Older ECGs that are already stored and matched can still be viewed and signed as normal.

e) When MGate comes back up, transmit all ECGs that were acquired during the downtime from the cart directory. Manually match the ECGs to their orders.

3) Not impacted:
   a) Placing ECG orders.
   b) Viewing and Signing ECGs already transmitted to Cerner.
   c) Matching ECGs.
   d) Unmatching ECGs.

11. **Fetalink: Fetal Monitoring System**

a. **Scheduled Downtime Preparation**

i. Planned Downtime will be communicated to Labor & Delivery in Advance.
ii. Labor & Delivery to finalize and disassociate all Fetalink episodes 15 minutes prior to scheduled downtime.
iii. For scheduled maintenance every attempt is made to perform the maintenance during off-peak times.
iv. Labor & Delivery will staff the unit for 1:1 monitoring during Fetalink Downtime.
v. Labor & Delivery Staff will ensure all fetal monitors in use have paper strips printing.

b. **Scheduled Downtime**

i. For Cerner scheduled downtime, finalize and disassociate all Fetalink episodes for patients not currently being monitored.
ii. Notification of downtime mode for users already signed into Fetalink is given by displaying the words "Downtime Mode" in the status bar of Fetalink.
iii. A warning message is given upon launching the application that "Fetalink is currently in downtime mode. Contact **the**~~your~~ system administrator for more information." Some features are unavailable at this time.
iv. During downtime user will have the ability to:
   1) Central/Bedside Monitor Patients.
   2) Make Annotations (including reason for monitoring).
      a) Annotations made during downtime post when Cerner goes back up as long as the patient is associated to the fetal monitoring episode.
      b) If Cerner goes back up and the patient was not already associated to the monitoring episode, the system will send the data to Cerner once the patient is associated to the fetal monitoring episode.
v. The following features are unavailable during Cerner downtime:
   1) Finalize Episode, Patient Archive, and printing Options are disabled.
   2) Extended view displays up to 24 hours of patient history data.
   3) Archive perspective is unavailable.
   4) An unassociated patient can be monitored, but not associated to a device.
   5) Strip annotation is available, but the annotations do not post to Cerner until the system is back up.

c. **Scheduled Downtime Recovery**

i. Once maintenance is complete the system is brought back online and verified by IT.
ii. Labor and Delivery staff will be notified once Fetalink is back up.
iii. Utilize P2DA to retroactively associate and finalize and/or disassociate patients to and from fetal monitors~~. according to the times documented on the PowerChart/Fetalink Downtime Log~~.
iv. Accurate documentation on the paper log during downtime is critical when retroactively associating patients.
v. Users should associate and disassociate patients from fetal monitors in order of earliest time to latest time.
vi. When multiple patients are associated to one monitor during Cerner downtime user may be asked a "question" to confirm that the user wants to override an

episode that is associated to a different patient. Ensure the time ~~you~~**staff** are entering is correct and say "Yes" to continue.

vii. ~~L~~launch a new episode of Fetalink.

viii. Ensure patients are associated to correct fetal monitor.

ix. Utilize P2DA/Scanner to associate new patients to fetal monitor.

d. **Unscheduled Downtime**

i. Notify Manager, Assistant Nurse Manager or designee or in off hours the Administrative Supervisor ~~or Patient Flow Coordinator~~ to communicate event to IT.

ii. Labor & Delivery Assistant Nurse Manager designee will make every attempt to staff unit to 1:1 ratio and will cancel all elective procedures until Fetalink is back up.

iii. Labor & Delivery Assistant Nurse Manager or designee will stay in contact with IT for updates on progress of downtime repairs.

iv. Notification of downtime mode for users already signed into Fetalink is given by displaying the words "Downtime Mode" in the status bar of Fetalink.

v. A warning message is given upon launching the application that "Fetalink is currently in downtime mode. Contact **the**~~your~~ system administrator for more information." Some features are unavailable at this time.

vi. During downtime user will have the ability to:

1) Central/Bedside Monitor Patients.

2) Make annotations (including reason for monitoring).

a) Annotations made during downtime post when Cerner goes back up as long as the patient is associated to the fetal monitoring episode.

3) If Cerner goes back up and the patient was not already associated to the monitoring episode, the system will send the data to Cerner once the patient is associated to the fetal monitoring episode.

vii. The following features are unavailable during Cerner downtime:

1) Finalize Episode, Patient Archive, and printing Options are disabled.

2) Extended view displays up to 24 hours of patient history data.

3) Archive perspective is unavailable.

4) An unassociated patient can be monitored, but not associated to a device.

5) Strip annotation is available, but the annotations do not post to Cerner until the system is back up.

e. **Unscheduled Downtime Recovery**

i. System is brought back online and verified by IT.

ii. Labor and Delivery staff will be notified once Fetalink is back up.

iii. Utilize P2DA to retro actively associate and finalize and/or disassociate patients to and from fetal monitors~~. according to the times documented on the PowerChart/Fetalink Downtime Log~~.

iv. Accurate documentation on the paper log during downtime is critical when retroactively associating patients.

v. Users should associate and disassociate patients from fetal monitors in order of earliest time to latest time.

vi. When multiple patients are associated to one monitor during Cerner downtime user may be asked a "Question" to confirm that they user does want to override an episode that is associated to a different patient. Ensure the time ~~you~~**staff** are entering is correct and say "Yes" to continue.

vii. Launch a new episode of Fetalink.

viii. Ensure patients are associated to correct fetal monitor.

ix. Utilize P2DA/Scanner to associate new patients to fetal monitor.

12. Interventional Radiology (IR)

a. Scheduled Downtime Preparation:

i. Organize pre-made downtime packets containing paper form and labels:

1) Nursing Assessment (which contains documentation of Meds and IVs), Progress Notes, Cardiac Monitor Strip, after care/discharge instructions, for example; Universal Downtime Requisition.

ii. Charge nurse will print current IR census one hour before downtime.

b. Scheduled Downtime:

i. IR staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department.

ii. IR physicians~~,~~ and Allied Health Professionals~~Physician Assistants~~ (AHP) will write orders for medications and IVs on their paper chart and notify nursing of those orders. Downtime events in IR will follow the established procedures in this document, i.e. utilization of the Universal Downtime Requisition.

1) Additionally, all Stat orders should be called to the departments.

iii. IR physicians and AHPs ~~Physician Assistants~~ will dictate their notes into Dragon or use the transcription service.

iv. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

v. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications.

vi. For patients that are transferred to designated locations e.g., SPRA, PACU or ICU, the IR RN will give the receiving department RN a hands-off report, and the downtime patient chart.

c. Scheduled Recovery:

i. New patients who arrived during the downtime period that are currently in IR will remain on downtown forms.

ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.

iii. Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).

iv. Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

d. Unscheduled Downtime:

i. Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.

ii. IR staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department.

iii. IR physicians~~,~~ and AHPs~~Physician Assistants~~ will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iv. Downtime events in the IR will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.

v. IR physicians~~,~~ and AHPs ~~Physician Assistants~~ will dictate their notes into Dragon or use transcription service.

vi. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart. All registration will be done manually using Registration's Cerner predetermined bank of account numbers.

vii. Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. Unscheduled Downtime Recovery:
   i. New patients who arrived during the downtime period that are currently in IR will remain downtown forms. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.
   ii. Radiology Techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).
   iii. Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.

13. Cardiology Department
   a. Scheduled Downtime Preparation:
      i. Print schedules for downtime.
   b. Scheduled Downtime:
      i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed by registration for each patient.
      ii. The ED Unit Secretaries and ED staff will call STAT cardiology exam orders to the department and will send the separate Universal Downtime Requisition for each order with a unique tracking number. Outpatients will come from Admitting with their hand written face sheet.
      iii. The technologist will substitute the full unique tracking number located on the Universal Downtime Requisition as the downtime medical record number. The technologist will enter the downtime medical record number into all digital modalities. Only one downtime medical record may be used per exam.
      iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name where indicated.
      v. Dictation will be completed as usual by entering the medical record into the dictation system.
      vi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.
   c. Scheduled Recovery:
      i. Delete any duplicate orders.
      ii. Enter and complete orders in Cerner using the unique Universal Downtime.
      iii. Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
      iv. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
      v. Reference Cardiology Department specific policies for detailed downtime workflow.
   d. Unscheduled Downtime:
      i. When Cerner is down, Registration will look up patients in Affinity to find a medical record number for admitted patients. If no medical record number exists, the patient will be assigned a "downtime medical record number." A handwritten facesheet will be completed for each patient.
      ii. Outpatients will come from admitting with their hand written face sheet.
      iii. The technologist will substitute the full unique tracking number located on the Universal Downtime Requisition as the downtime medical record

number. The technologist will enter the downtime medical record number into all digital modalities. Only one downtime medical record number may be used per exam.

iv. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was use, the amount of contrast, and enter his/her full name where indicated.

v. Dictation will be completed as usual by entering the medical record into the Lanier dictation system.

vi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

e. Unscheduled Downtime Recovery:

i. Delete any duplicate orders.

ii. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).

iii. Transcription will paste transcribed results from Word into Cerner and validate accuracy.

~~ix.~~iv. Reference Cardiology Department specific policies for detailed downtime workflow.

14. Cardiac Cath Lab (CCL)

a. Scheduled Downtime Preparation:

i. Organize pre-made downtime packets containing paper form and labels: Nursing Assessment (which contains documentation of Meds and IVs), Progress Notes, Cardiac Monitor Strip, after care/Discharge instructions, for example; and Universal Downtime Requisition.

ii. Charge nurse will print current CCL census one hour before downtime.

b. Scheduled Downtime:

i. CCL staff will revert to paper documentation on the forms listed above and others as needed, e.g. Sedation, Transfusion on all patients in the department. CCL will continue Hemodynamics charting in McKesson, will print a copy for the nursing units.

ii. CCL Physicians will write orders for medications and IVs on their paper chart and notify nursing of those orders.

iii. Downtime events in CCL will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition.

1) Additionally, all Stat orders should be called to the departments.

iv. CCL physicians will dictate their notes into Dragon or use transcription service.

v. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart.

vi. Nursing may have to manually add every patient with their Name and Financial Number (FIN) into the Med Pyxis during downtime to remove medications

vii. Patients that are transferred to designated locations e.g., SPRA, PACU or Unit the CCL RN will give the receiving department RN a hands-off report, and the downtime patient chart.

viii. The technologist will substitute the full unique tracking number located on the universal downtime requisition as the downtime medical record number. The technologist will enter the downtime medical record number into all digital modalities, only one downtime medical record number may be used per exam.

ix. The technologist will perform the exam and enter the "begin" and "end" times on the downtime requisition, indicate if IV contrast was used, the amount of contrast, and enter his/her full name.
x. Dictation will be completed as usual by entering the medical record into the dictation system.
xi. Transcription will use Word to transcribe dictated reports using the medical record received from the dictation system.

c. Scheduled Recovery:
i. New patients who arrived during the downtime period that are currently in CCL will remain on downtown forms and in McKesson hemodynamic system.
ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.
iii. Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).
iv. Enter and complete orders in Cerner using the unique Universal Downtime Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).
v. Transcription will paste transcribed results from Word into Cerner and validate accuracy.
vi. Nursing will document on downtime forms and in McKesson for the duration of the downtime and no data will be back entered into the system when the system comes back online.

d. Unscheduled Downtime:
i. Registration pulls Downtime Log Book and begins manual registrations using established downtime numbers.
ii. CCL staff will revert to paper documentation on the forms listed above and others as needed, i.e. Sedation, Transfusion on all patients in the department. Will continue to document hemodynamics in McKesson.
iii. CCL Physicians, will write orders for medications and IVs on their paper chart and notify nursing of those orders.
iv. Downtime events in the CCL will follow the established procedures as outlined in this document, i.e. utilization of the Universal Downtime Requisition. Additionally, all STAT orders should be called to the departments.
v. CCL physicians, will dictate their notes into Dragon or use the transcription service.
vi. Registration will prepare a manual sheet of labels and armband for the patient and place on the patient chart. All registrations will be done manually using Registration's Cerner predetermined bank of account numbers.
vii. Nursing may have to manually add every patient with their name and Financial Number into the Med Pyxis during downtime to remove medications.

e. Unscheduled Downtime Recovery:
i. New patients who arrived during the downtime period that are currently in CCL will remain downtown forms.
ii. All patients that were discharged during the downtime period will need to be discharged in the system by the RN or Technologist. The paper chart will go down to Medical Records.

iii. **Radiology techs will enter orders from requisitions received during downtime referencing the tracking number, (the owner of the original copy of the requisition will enter the orders).**
iv. **Enter and complete orders in Cerner using the unique Universal Downtime**
v. **Requisition tracking number and reference the FIN/Account Number (will be a 9000 number for downtime).**
vi. **Transcription will paste transcribed results from Word into Cerner and validate accuracy.**
~~x.~~**vii. Nursing will document on paper forms for the duration of the downtime and no data will be back entered into the system when the system comes back online.**

~~12.~~**15. BMDI: Bedside Medical Device Integration**

~~b.~~**a. Scheduled Downtime Preparation**

i. Nursing Manager will ensure each patient has the appropriate unit specific barcoded flow sheet.
ii. Nursing will retrieve all current BMDI clinical data 15 minute prior to the system down time. Nursing is not required to disassociate the Devices during the downtime.

~~c.~~**b. Scheduled Downtime**

i. If downtime is more than 4 hours; clinical data will be tracked on the unit specific flow sheet for the duration for the current shift. If the downtime is less than 4 hours, electronic documentation will be completed upon recovery of the system.

~~d.~~**c. Scheduled Downtime Recovery**

i. When back on-line, nursing will associate the newly admitted patients to the appropriate devices in order to start data collection.
ii. When back on-line nursing will ensure patients are associated with the appropriate devices. In the event the patient is not associated, nursing will reassociate to the appropriate devices.
iii. ~~If the downtime is 4 hours or less, n~~**N**ursing must use Viewed Acquired Data to pull in values and clinical data from the devices for their shift. Nursing must enter all clinical documentation back into the system. Vital signs and all bedside monitoring device data should be pulled into the EMR at the ordered interval (**every**~~q~~15min, 1h**our**, etc).
iv. In the event the View Acquired Data is unavailable, nursing is to use unit specific monitor history to gather clinical data to complete clinical documentation.
~~v. If downtime is greater than 4 hours, documentation will remain on paper for the remainder of the shift and will be part of the permanent record.~~
~~vi.~~**v.** During the Recovery Phase, nursing will instruct physicians and all ancillary departments where to locate the unit specific clinical documentation.

~~e.~~**d. Unscheduled Downtime**

i. Nursing will utilize the unit specific flow sheets until the system is back on-line or, the duration of their shift.

~~f.~~**e. Unscheduled Downtime Recovery**

i. When back on-line, nursing will associate the newly admitted patients to the appropriate devices in order to start data collection.
ii. When back on-line; nursing will ensure patients are associated with the appropriate devices. In the event the patient is not associated, nursing will reassociate to the appropriate devices.
iii. ~~If the downtime is 4 hours or less, n~~**N**ursing must use Viewed Acquired Data to pull in values and clinical data from the devices for the shift. Nursing must enter all clinical documentation back into the system. Vital signs and all bedside monitoring device data should be pulled into the EMR at the ordered interval (q15min, 1hr, etc).

iv. In the event the View Acquired Data is unavailable, nursing is to use unit specific monitor history to gather clinical data to complete clinical documentation.

v. If downtime is greater than 4 hours, documentation will remain on paper for the remainder of the shift and will be part of the permanent record.

vi. During the Recovery Phase, nursing will instruct physicians and all ancillary departments where to locate the unit specific clinical documentation.

~~g.~~**f. BMDI Application Downtime**

i. In the event ~~the~~ BMDI **(ibus servers)** ~~application is~~ **are** down and the ability to chart in Cerner occurs, ~~nursing is to utilize the department specific flow sheets to capture the patient's vital signs. If the downtime is less than 4 hours, nursing will associate the newly admitted patients as well as existing patients to the appropriate devices~~ **users will manually enter data from monitoring devices**. Once associated, nursing will reenter vital signs into IView based on the ordered intervals.

ii. If the downtime is greater than 4 hours nursing will continue documenting on the unit specific flow sheet for the remainder of the shift. The paper flow sheet is scanned down to HIM and placed in the patients chart as part of the permanent EMR.

iii. Once the BMDI application comes back up, nursing will associate all newly admitted patients and existing patients to the appropriate devices. Nursing will resume documentation of all BMDI clinical data into Cerner.

E. ~~Electronic~~ **FORMS** ~~available on the Intranet~~:

1. Downtime – Admission/Discharge/Transfer Log **Sample**
~~2. Downtime – Fetalink/PowerChart Maternity Log~~
~~3.~~**2.** Downtime – Laboratory Cerner Log **Sample**
~~4.~~**3.** Downtime – Medication Administration Record **Sample**
~~5.~~**4.** Downtime – Surgery Add-On Profile Sheet **Sample**
~~6.~~**5.** Downtime – Universal Requisition Form (Sample Only, must use NCR)

Downtime - Admission/ Discharge/Transfers Log Sample

Computer Downtime Log
Admissions – Discharges - Transfers

DATE	PATIENT NAME	ADM TIME	D/C TIME	DISCHARGE DESPOSITION	TRANSFER TIME	TRANSFER TO	ACCOMMODATION CODE/PT SERVICE

Downtime - Laboratory Cerner Log Sample

TCMC LABORATORY CERNER DOWNTIME LOG

During Cerner downtime, use this form to log any future Lab specimens. If Cerner is back on line before the scheduled test, use this log to enter the orders into Cerner. If Cerner is still down during any of these scheduled tests, make a manual Universal Downtime Requisition and send to Lab. DO NOT SEND THIS LOG TO LAB

PATIENT NAME	TESTS	ORDER DATE	ORDER TIME	ORDERED IN COMPASS	REQ. SENT TO LAB	USER ID

Downtime - Medication Administration Record Sample

Patient Name: _____ MRN: _____ Allergies: _____
Unit: _____ Room/Bed: _____ Admission Date: _____ Page _____ of _____
Age: _____ Sex: _____ Height (cm): _____ Weight (kg): _____ Physician: _____
Reason for Visit: _____ Administration Period: ____/____/____ from 0000 - 2359

Medication Dose Route Frequency	Start Time	Stop Time	Day Shift 0701 – 1900	Night Shift 1901 – 0700

Initials	Signature

Site Codes-site, route & initial must be on injectables

Ant. Thigh Left = 2	Ant. Thigh Right = 1
Gluteal Region Left = 4	Gluteal Region Right = 3
Deltoid Muscle Left = 6	Deltoid Muscle Right = 5
Abdominal Left = 8	Abdominal Right = 7

Omitted Dose Codes = Circle hours and reason

A-NPO Diagnostic	B-NPO Surgery	C-Patient Refusal	D-Nausea	E-Hold Dose	F-Pt off Floor	G-Other (see notes)

*Must chart doses in Powerchart when system returns

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

8720-1012
(Rev. 8/12)

DOWNTIME MEDICATION ADMINISTRATION RECORD

Downtime – Surgery Add On Profile Sample

ADD-ON PROFILE SHEET

Date/Time Scheduled:

Date/Time of Surgery:

Add On #:

Patient and Procedure Information Read Back-by: _____

Patient: _____ DOB: _____ Age: _____

Location: _____ MR #: _____ NPO Status: _____

Procedure: _____

_____

If procedure is craniotomy/mass or brain biopsy Use Neurosurgery Screening Tool

Diagnosis: _____

Surgeon: _____ Assistant: _____

Equipment/Instruments Needed:

_____

Loaner Inst/Trays:

_____

Expected Arrival: _____

Rep. Notified: _____

SPD Notified: _____

Positioning:

_____

Cardiac/Medical Hx:

_____

Surgeon Availability:
Estimated OR Time:

ER/Floor/Pt Nurse notified:

Pre-Op Notified:

PACU Notified:

E-PRIV ☐ FLUORO ☐

X-Ray Tech Notified:

C-Arm ☐ Fluoro: ☐

Scheduled by: _____

In Computer: ☐ Yes ☐ No:

Out/In Patient Information

Phone #: _____ SS#: _____

Insurance: _____

ADD-ON PROFILE SHEET

Time Surgeon called OR to schedule case _____

Requested time for case _____

Time OR room is available _____

Pt already seen by Surgeon: Yes No

Time Patient seen by Surgeon: _____

Time Anesthesiologist is contacted_____/arrival time_____

Time Pt's nurse contacted for handoff _____

Comments:

_____

_____

_____

_____

Time handoff report taken: _____

Time OR aide sent for Pt: _____

Time Pt arrived in OR suite: _____

Time Pt on OR table: _____

Time Surgeon contacted_____/Surgeon in OR room_____

Revised 9-02-15 lg

Downtime – Universal Requisition Form Sample

G 35079

Requested by: _____ Phone: _____

Date: _____ Time: _____

Ordering Physician: _____

Diagnosis / Reason for exam _____

Special Instructions (i.e. Allergy / Isolation / Impairment / Work Comp.): _____

PRIORITY
- ☐ STAT ☐ NOW ☐ TIMED _____
- ☐ ROUTINE ☐ PRE-OP
- ☐ SURGERY: DATE & TIME: _____

TRANSPORTATION MODE
- ☐ WHEELCHAIR ☐ GURNEY
- ☐ PORTABLE ☐ BED

☐ LABORATORY: MULTIPLE LAB TESTS CAN BE ORDERED PER REQUISITION EXCEPT FOR MICROBIOLOGY

- ☐ CHEM 12 ☐ CHEM 7 ☐ DIGOXIN
- ☐ TROPONIN ☐ CPK/CKMB ☐ BNP
- ☐ MAGNESIUM ☐ POTASSIUM ☐ GLUCOSE
- ☐ AMY ☐ LIP ☐ TOX SCREEN
- ☐ ACETA ☐ SAL ☐ ALC
- ☐ ABG

- ☐ CBC ☐ CBCD ☐ SED RATE
- ☐ PT ☐ PTT ☐ FIBRINOGEN
- ☐ D-DIMER ☐ UA W/MICRO ☐ UCtF
- ☐ UHCG

- ☐ NEOPANEL ☐ RPR
- ☐ HBSAG ☐ BLOOD CULTURE
- ☐ BILIRUBIN ☐ RUBELLA
- ☐ OTHER LABORATORY _____ ☐ GBS
- ☐ OTHER LABORATORY _____

- ☐ TRANSFUSION - FFP-PLATELETS-CRYO-PRBC ☐ TYPE + SCREEN ☐ BLOOD GROUP/RH
- ☐ TYPE + CROSS _____ UNITS ☐ C + S _____ SOURCE
- ☐ GRAM STAIN _____ SOURCE

ADDITIONAL PROCEDURE / TEST
- ☐ CARDIOLOGY ☐ EEG ☐ ECG
- ☐ PHYSICAL THERAPY
- ☐ OCCUPATIONAL THERAPY ☐ PULMONARY
- ☐ SPEECH THERAPY
- ☐ DIETARY
- ☐ OTHER _____
- ☐ OTHER _____
- ☐ COMMENT _____

☐ RADIOLOGY: Only 1 Radiology procedure per requisition

- ☐ CXR Single View ☐ CT Head & Contrast
- ☐ Ultrasound Abdomen ☐ CT
- ☐ CXR Two Views ☐ MRI
- ☐ Ultrasound Pelvic ☐ Nuclear Medicine
- ☐ ABD Single ☐ Interventional Radiology
- ☐ CT Head / no contrast ☐ CT ABD / Pelvis-Contrast
- ☐ ABD Acute BUN _____
- ☐ OTHER RADIOLOGY CR _____

EXAM: _____

Performed by: _____ Date / Time: _____

Ancillary Use Only

Procedure: Begin Time: _____ End Time: _____ Exam Done: _____

Tech Initials: _____ Contrast: _____ Amount: _____ Results to Floor: Called _____ Hardcopy: _____

Recovery Documentation: Entered by: _____ Date / Time: _____

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

1081-1001
(Rev. 12/08)

UNIVERSAL DOWNTIME REQUISITION FORM
(To be used for immediate orders during Downtime only)

Affix Patient Label

Original – to Department (White) Copy – to Ordering Unit (Yellow)

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEST TUBE MANAGEMENT**
Purpose:	To define the nursing interventions for assisting with the insertion of chest tubes for the adult and adolescent patients. To define nursing management of adult and adolescent patients with chest tubes.
Supportive Data:	Closed chest drainage systems are used to facilitate the evacuation of fluid, blood, and air from the pleural space, ~~or~~ the mediastinum or both; **to** restore negative pressure to the pleural space; and promote reexpansion of a collapsed lung. Mosby's Chest Tube Insertion Procedure Mosby's Chest **Tube:** Closed Drainage System Procedure
Equipment:	1. One 250**mL**~~m-L~~ bottle of Normal Saline 2. Chest Tube Dressing Change Equipment a. Silvasorb Gel or Povidone-Iodine Ointment b. 2-inch silk tape **or micropore** d. Normal Saline e. 4x4 gauze sponges f. 4x4 gauze drainage sponges 3. Chest Tube Removal Kit a. Suture removal kit b. ChloraPrep (triple swabsticks) c. Silvasorb Gel, Bacitracin Zinc, and Povidone-Iodine ointment d. 2 Kelly clamps e. 4x4 gauze sponges (package of 10) f. Chux g. 2 zip holders e. 1 large red bag

A. **PROCEDURE:**

1. Assisting with the Insertion of a Chest Tube

a. Place Chest Tube Insertion Cart in patient's room.

~~2. Assisting With Chest Tube Insertion~~

i. Set up chest drainage device (Refer to ~~Mosby's~~**Online Clinical Skills** Chest-Tube: Closed Drainage System ~~Procedure Extended Text~~). ~~See resource available on Intranet: Teleflex Pleur-Evac insert.~~

ii. Assisting physician (Refer to ~~Mosby's~~**Online Clinical Skills** Chest Tube Insertion ~~Procedure~~)

iii. Ensure chest x-ray is completed per physician's order.

~~3.~~**2.** Chest Tube Monitoring, Nursing Assessment and Care

a. Refer to ~~Mosby's~~**Online Clinical Skills** Chest-Tube Insertion ~~Extended Text~~.

b. **Ensure a** ~~Have~~ Chest Tube Removal Kit readily available **in patient's room**~~.~~**.**

i. Attach Chest Tube Removal Kit to Intravenous (IV) pole on Telemetry, Acute Care Services (ACS), and **Progressive Care Unit**~~Forensics~~.

c. **Secure chest drainage system to the IV pole using two zip holders. Silk tape may be used to secure the drainage system.** ~~Ensure chest tube drainage system is secured.~~

~~i. Secure chest drainage device drainage system to an IV pole using two zip holders on Telemetry and Forensics.~~

d. Monitor the amount and type/color of drainage per the physicians' orders

e. Mark the collection chamber at the end of every shift and PRN with the ~~date and time~~**date, time, and initials**. Document the drainage amount in the medical record.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Staff Department or Division	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/09; 5/12; **11/15**	06/12, **12/15**	06/12, **01/16**	n/a	10/12, 09/16	11/12, **10/16**	12/12

~~d.~~**i. The amount of drainage within the first two hours after insertion may be approximately 100 to 300 mL, t~~T~~he amount of drainage should begin to decrease over the next few hours and days.**

f. Assess the patient as ordered after chest tube insertion. If no order for assessment, assess as outlined in ~~Mosby's~~Online Clinical Skills Chest Tube: Closed Drainage Systems ~~procedure~~.

~~e.~~**g.** Discuss **with the physician** and obtain an order to perform range of motion exercises for shoulder on the side of the chest tube site to prevent frozen shoulder **secondary to immobility.**~~r.~~

i. Discuss the need for physical therapist assistance with the physician.

h. Ambulate patient per physician's order.

i. If there is no order to ambulate ensure patients sits on the side of bed to enhance ventilation, maximize lung inflation and improve gas exchange.

ii. **Discuss the need for activity orders with physician.**

~~f.~~**i.** Patient positioning:

i. Elevate head of the bed (HOB) 30 to 45 degrees or per physician's order.

ii. Lobectomy and all other lung surgeries: position patient on the non-operative side or per physician's order.

iii. Pneumonectomy: position supine or on the operative side.

~~iii.~~**iv. Reposition patient at least every two hours**

j. Incentive Spirometry (IS)

i. Ensure patient uses the IS as ordered by physician/Allied Health Professional.

~~4.~~**3.** Dressing Change: Chest Tube Insertion Site

a. Change chest tube insertion site dressing every other day and PRN, unless ordered otherwise by physician.

b. Remove dressing and discard in appropriate receptacle.

c. Clean chest tube insertion site with normal saline applied to sterile 4x4 gauze sponge.

d. Pat insertion site dry with 4x4 gauze sponge.

e. Apply Silvasorb gel or follow physician's order.

f. Anchor chest tube to patient's skin.

g. Apply one to two 4x4 drain sponges underneath the chest tube and 1-2 on top of the chest tube. Ensure chest tube is not kinked.

h. Apply two to three 4x4 gauze sponges on top drain sponges.

i. ~~Secure dressings with 2-inch~~ **Apply** silk tape **or micropore over 4 x 4 dressing**. (Do not use paper, form or elastoplast tape to secure chest tube dressing.)

j. Ensure drainage tubing is visible, not kinked, and properly positioned. Do not position or secure drainage tubing behind patient's back.

k. Do not reinforce chest tube dressing. If dressing becomes saturated or soiled:

i. Remove dressing

ii. Assess connections

iii. Apply a new dressing

iv. Notify physician

~~5.~~**4.** Chest Tube Removal

a. Ensure a Chest Tube Removal Kit is readily available and assist physician as needed.

b. Monitor the patient for the following:

i. Obtain chest x-ray as ordered

ii. Ensure adequate respiratory status. Assess the following:

1) Breath sounds

2) Heart rate

~~1)~~**a) Monitor cardiac rhythm on Cardiac Monitoring Units**

~~2)~~**3)** Respiratory rate and quality

~~3)~~**4)** Oxygen saturation

~~4)~~**5)** Notify physician for abnormal findings

iii. Monitor insertion site for bleeding. If bleeding is found, apply pressure and place a tight occlusive dressing over site. Notify the physician for persistent bleeding. (Persistent bleeding from the insertion site could mean the chest tube was against a vein of the chest wall before removal.)

iv. Monitor suture site and surrounding skin. Notify physician for abnormalities such as excessive redness, dark or inflamed skin with necrotic areas.

v. Monitor the site for signs of infection.

vi. Monitor insertion area for development of subcutaneous emphysema (Crepitus), which is an indication of an air leak into the surrounding tissues.

vii. Monitor for signs and symptoms of pericardial effusion or cardiac tamponade. i.e. distant heart tones, decreased blood pressure, tachycardia, pulsus paradoxus, narrowed pulse pressure

viii. Assess pain and medicate per physician orders

~~6.~~**5.** Heimlich Chest Drain Valve

a. The Heimlich Chest Drain Valve is used for uncomplicated pneumothorax with little or no drainage. The valve allows air and fluid to pass in one direction.

b. There is a flutter valve which replaces an under water drainage bottle system.

c. Observe the flutter every shift and ~~prn~~ **PRN** to ensure air is escaping from the pleural space.

d. Never clamp, close the ends of the valve, or use an airtight dressing or rubber glove over the valve.

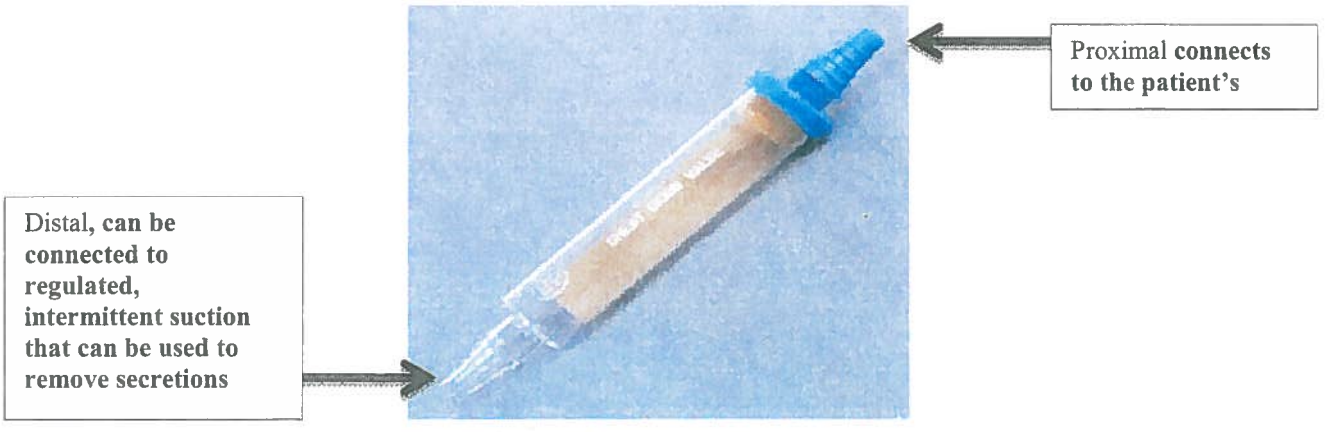
i. If there is drainage from the valve, place gauze on the valve and secure with tape ensuring not to occlude or cover valve.

e. Assess the patient's vital signs including oxygen saturation and assess for signs of respiratory distress. Notify physician of abnormal findings.

f. Ensure the proximal end of the valve is attached to **the patient's chest tube catheter** ~~chest tubing~~.

g. Ensure the distal end of the valve, if ordered, is attached to a drainage bag or regulated suction.

h. Assess patient insertion site and surrounding skin. Notify the physician of abnormal findings.



Heimlich Chest Drain Valve

B. EXTERNAL LINKS:

1. Online Clinical Skills: Chest Tube Insertion

2. Online Clinical Skills: Closed Drainage System Management

~~B.~~C. REFERENCES:

~~1. Wiegand, D. & Carlson, K. (2011). American association of critical-care nurses: Procedure manual for critical care. (6th ed.). St. Louis, MO: Elsevier Saunders.~~

1. **Becton, Dickinson & Company. (2015). Heimlich valve. Retrieved from http://www.bd.com/medical-surgical/products/heimlich.asp**
2. Elsevier:~~Mosby's~~**Online Clinical Skills** Nursing Skills. (2006-201~~1~~**5**). Chest **tube insertion.**~~closed drainage system. Retrieved May 10, 2012 fr~~**from** Tri-City Medical Center interanat.
3. Elsevier: ~~Mosby's~~**Online Clinical Skills** Nursing Skills. (2006-201~~1~~**5**). Chest tube**: Closed drainage device.** ~~device~~: Retrieved from Tri-City Medical Center Intranet ~~Pleur-evac. Retrieved March 20 2009, from http://app32.webinservice.com/MosbySkills/skillsMain.asp~~
4. **Teleflex Medical. (2009). Understanding chest drainage. Retrieved from http://www.teleflex.com/en/usa/ucd/index.php**

~~Med Instrum, 1983 Jan-Feb:17(1):29-31. Retrieved May 17,2012 from http://www.ncbi.nlm.nih.gov/pubmed/6843411~~

~~4.~~**5. Urden, L.D., Stacy, K. M., & Lough, M. E. (2014). Critical care nursing. Diagnosis and Management. (7th ed.). St. Louis, MO: Elsevier**

~~C. RESOURCE AVAILABLE ON THE INTRANET:~~

~~1. Teleflex Pleur-Evac insert.~~

Tracked Changes Copy

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MISCARRIAGE AND STILLBIRTH IDENTIFICATION AND DISPOSITION PROCESS ~~DIFFERENTIATING INTRAUTERINE FETAL DEMISE FROM MISCARRIAGE~~**
Purpose:	To outline the proper steps in differentiating between stillbirths (fetal **death in utero at equal to or greater than 20 weeks gestational age** ~~demises~~) and miscarriages. **A s**~~S~~tillborn **delivery requires the family to make disposition arrangements with a mortuary/ funeral home and** ~~s~~ requires an "autopsy permit" before **it is evaluated by the pathology department**~~they are evaluated~~. **If no autopsy is requested, the stillbirth** ~~remain~~ **is taken to the hospital morgue.** A miscarriage ~~does not require a permit and~~ shall be handled as a routine surgical specimen **and be**~~;~~ **sent to the histology department with a tissue specimen requisition**~~.~~
Supportive Data:	A fetus which satisfies **any two of the following three criteria** will be classified as a stillbirth: 1. Foot length (heel to toe) greater than 3.1 **centimeters** ~~millimeters~~ 2. Crown-rump (CR) length: greater than 16.5 centimeters 3. Gestational age by dates: equal to or greater than 20 weeks
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. Chux 5. Disposable drape 6. Specimen bag 7. Tissue lab slip

A. DEFINITIONS:

1. **MISCARRIAGE: Pregnancy loss before 20 weeks gestation without signs of life. Refer to ~~See other measurement criteria, per Tri-City Medical Center (TCMC), Pathology department as referenced in~~ the Ssupportive Ddata section above,**
   a. **Hospital is responsible for the disposition of the remains which is usually by incineration.**
   b. **The Family may request to have remains taken to mortuary, but incur the associated costs**
2. **STILLBIRTH: Fetal death occurs before the baby is born and after 20 reported weeks of gestation. Refer to the Supportive Data section above.~~(The fetus shows no signs of life at birth). See other measurement criteria, per TCMC pathology department as referenced in "Supportive Data" section.~~**
   a. **The family is responsible for coordinating the disposition of the fetal remains with a funeral home.**
   b. **A "fetal death certificate" is prepared by the birth clerk.**
3. **NEONATAL DEATH: The death of a newborn within the first 28 days of life. (Fetus is born alive regardless of gestational age, but then dies within the first 28 days.)**
   a. **The family is responsible for coordinating the disposition of the remains with a funeral home.**
   b. **A birth certificate is issued AND a ~~"~~death certificate~~"~~ is completed by the provider verifying the death.**

~~A.~~B. PROCEDURE:

1. Perform hand hygiene and don gloves.

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Department of Pathology	Department of OB/GYN	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
12/08, 06/11, **04/15**	04/11, **05/15**	04/11, **05/15**	03/16	**04/16**	05/11, **04/16**	06/11, **10/16**	06/11

2. Complete measurements to determine if fetus is stillbirth or miscarriage. Criteria for stillbirth require 2 or more of the following:
   a. Foot Length (heel to big toe) : > greater than 3.1 centimeters (cm)
   b. Crown- rump Length (head to buttocks): > greater than 16.5 cm
   c. Gestational Age by dates: Equal to or > greater than 20 weeks
3. If the fetal parameters/measurements are determined to be borderline, ~~and the clinician is not confident making the distinction between a miscarriage and stillborn,~~ the fetus must~~should~~ be sent to the Histology lab for final determination of whether or not it is a miscarriage or stillbirth.
   a. The tissue requisition accompanying the fetus/specimen needs to include the ~~clinician's~~ anatomic measurements, gestational age by dates and "Borderline Measurements" indicated.
   b. The staff member transporting the specimen to the laboratory will stay until the pathologist confirms the measurements and then returns to the department and reports the result findings so disposition option can ~~then~~ be discussed with the family. ~~will then make the determination and the findings will be communicated to the provider listed on the tissue requisition form.~~
   ~~Disposition options can then be discussed with the family.~~
      i. If after hours, the charge nurse will arrange to have a second staff member complete the measurements as a second validation.
4. Stillbirth
   a. A stillbirth's remains are transferred to the Morgue.
      i. If pathological examination is desired, an autopsy permit must be obtained and the Histology department notified of this request.
      ii. Staff in the ED and L&D unit ~~the Family~~ shall ensure~~complete~~ the Rrelease of the Ddeceased fForm~~, if possible~~ is updated and has the required patient signature before discharge. ~~And t~~The form will be given to the charge nurse for final review, then ~~form~~ forwarded to the Administrative Supervisor~~patient office for follow-up coordination. (Form goes to the AdministrativeNursing Ssupervisor, if after normal work hours)~~.
      iii. The fetal remains will only be released to a designated mortuary.
5. Miscarriage:
   a. If the fetus fails to meet at least two of the stillbirth measurement criteria, it is considered a miscarriage and shall be taken to the lab for processing.
      i. The tissue requisition form that accompanies the specimen to the Histology department shall have the anatomic measurements, gestational age and suspected diagnosis indicated by the attending provider.
         1) The fetus will be processed by the H~~h~~istology department as a surgical pathology specimen
      ii. If the family desires to make arrangements for the miscarriage remains disposition with a mortuary or funeral home this MUST be indicated on the tissue requisition form: "DO NOT PROCESS,~~HOLD SPECIMEN,~~ FAMILY DESIRES DISPOSITION"
         1) Staff in Emergency Department/Labor & Deleivery/Post Anesthesia Care Unit ~~Family~~ shall complete the "Authority for Miscarriage Remains Release" ~~Ddisposition of miscarriage form~~, ~~if possible,~~ before discharge and the charge nurse will forward form to the Administrative Supervisor (AS)~~patient relations patient advocate office. (Nursing supervisor, if after normal work hours)~~.
         2) The AS~~patient relations patient advocate office~~ will communicate with the family no less than weekly to update~~determine~~ funeral home/mortuary arrangements.

3) **Once arrangements are made by the family, the AS~~patient relations representative~~ will notify the Histology Department~~,~~.**
4) **~~so~~ The Laboratory staff will transfer the remains ~~can be transferred from the lab~~ to the morgue ~~for eventual disposition~~.**
   a) **The remains ~~fetus~~ will only be released to a designated mortuary.**
5) **If arrangements for disposition are not made by the family within 30 days, the AS will notify the Histology department to~~will~~ dispose of the remains by incineration based on Health and Safety Code 7054.3.**
   a) **Reasonable efforts will be made by the AS~~patient relations office~~ to contact the family before the deadline is reached.**

~~2. Any newborn, regardless of gestational age who shows any sign of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles will be considered a live birth with an Apgar score given. Any infant meeting the criteria of a live birth requires a medical record number and a birth certificate.~~
~~a. In the event of a live birth, the representative for the specified donor organ and tissue procurement organization must be notified (refer to Authority for Release of Deceased form).~~
~~b. The infant will also require the completion of the newborn assessment.~~
~~3. Weigh and measure newborn (refer to Patient Care Services, *Deceased Patient Care and Disposition* procedure). Accuracy is important in differentiating the parameters.~~
~~a. Newborn/specimen guidelines:~~
~~i. Measure and record foot length.~~
~~ii. Measure and record crown-rump length.~~
~~iii. Compute and record gestational age by last menstrual date (LMP).~~
~~iv. Weigh and record in grams.~~
~~b. Criteria for stillbirth requires two or more of the following:~~
~~iii. Foot length (heel to toe): greater than 31 mm~~
~~i. Crown-rump length (C-R length): greater than 16.5 cm~~
~~ii. Gestation age by dates: equal to or greater than 20 utero-gestational weeks (23 weeks from LMP)~~
~~4. If the newborn fails to meet at least two of the three criteria, the delivery will be classified as a miscarriage.~~
~~a. The parents may choose to have the remains buried, cremated, or interred even if the newborn fails to meet stillbirth criteria.~~
~~i. This newborn will be handled as a stillbirth, rather than as a pathology specimen.~~
~~ii. The parents must make arrangements with a mortuary. The mortuary of choice must be communicated to the patient representative. The fetus will only be released to the designated mortuary.~~
~~5. Miscarriages will be placed in the specimen bag with a completed tissue requisition and be taken to Tri-City Medical Center's pathology/histology department. The tissue requisition must include the anatomic measurements, the gestational age by dates, and the conclusion that has been drawn from this information and what has been told to the patient. Please indicate if the measurements and or dates are "borderline measurements." The pathologist will make the determination and communicate the findings to the physician listed on the tissue requisition form. The physician will inform the mother and complete the appropriate records.~~
~~6. A stillborn infant will be handled according to the Patient Care Services *Deceased Newborn/Stillborn, Care of* procedure.~~
~~A labor and delivery summary must be completed for all obstetric patients experiencing a pregnancy loss.~~

~~7.~~**6.** Documentation:

a. Document **the date and time of the miscarriage/ delivery** ~~date, time~~ **as a clinical note entry in the patient's electronic health record and indicate where the remains were sent.** ~~, weight, length and disposition of newborn remains in the patient care record.~~
b. **A**~~The~~ stillborn ~~infant will~~ requires a **fetal** death certificate to be completed by the Birth Clerk ~~**and is sent to the morgue**~~.
c. A miscarriage ~~will~~ requires a tissue requisition **and is sent to the histology department in the lab**.

~~B.~~C. TECHNICAL NOTES:

1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.
2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."
3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."

D. FORM(S)/RELATED DOCUMENT(S):

1. **Authority for Miscarriage Remains Release Sample**

~~C.~~E. REFERENCES:

1. TCMC Pathology Department – Histology Policy and Procedure Manual.
2. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.).* Philadelphia: Saunders.
3. California Health and Safety Code Section 7050.~~50~~-7055
4. California Penal Code Section 643
5. California Perinatal Quality Care Collaborative (CPQCC) Network Database, version 1.10. (11/09/2010). Manual of definitions for infants born in 2010. Retrieved on 12/28/2010: http://www.cpqcc.org/data/cpqcc_downloads
6. ~~Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs), Conditions for Coverage (CfCs): Identification of Potential Organ, Tissue, and Eye Donors Questions and Answers (2004). Retrieved on 12/28/2010: http://lifesharing.org/images/stories/resources/medicalProfession/rulesandreg/cmshospqa.pdf~~

Authority for Miscarriage Remains Release Sample

A miscarriage is validated when the Estimated Gestational Age (EGA) is less than 20 weeks and/or when the head to buttocks length is **less than 16.5 cm** and the **heel to toe length is less than 3.1 cm** per Patient Care Services Miscarriage and Stillbirth Identification and Disposition Process Procedure.

Do the pregnancy remains meet miscarriage criteria?

YES_____ Please transfer the miscarriage remains to the Laboratory and review disposition options below.

Nurse Name_____ Date_____ Provider Name _____Date_____

Please be advised that you have choices concerning the final disposition of miscarriage remains, if desired.

HOSPITAL DISPOSITION

According to regulations, the hospital will dispose of the miscarriage under the terms and conditions customarily used. The hospital cannot return the remains to you.

I wish for Tri-City Medical Center to arrange for the disposition of remains under the terms and conditions customarily used.
Patient Signature _____ Date_____

ARRANGED DISPOSITION

If you would like to make alternate arrangements, the remains must be released to an approved agency for proper burial or cremation by a licensed funeral director or mortuary. **PLEASE READ and INITIAL the items BELOW:**

1. I wish to make arrangements with a licensed funeral director or mortuary and understand that I am responsible for all expenses. YES____
2. I understand that if arrangements are not made with a funeral home/mortuary within 30 days, the Laboratory Department will dispose of the remains under the terms and conditions customarily used by the hospital. YES_____
3. Due to regulatory guidelines, there may be reasons the remains may not be able to be released. YES_____

I _____ **hereby authorize Tri-City Medical Center to release the remains to:**
Patient

To _____ (____)_____
Mortuary/Procurement Agency — Area Code/Phone Number

Date	Signature	Area Code/ Phone Number	Email address

Mortuary Notified: Date_____ Time_____ Initials _____

MORTICIAN'S RECEIPT OF REMAINS

Received from TRI-CITY MEDICAL CENTER, the pregnancy remains from, (Name) _____

_____ (Date) _____ (Time) _____ (Signature of Mortuary Transporter)

Released By: _____ Date: _____ Time: _____

Public Administrator Notified: _____ Date: _____ Time: _____ Initials _____

Affix Patient

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

AUTHORITY FOR MISCARRIAGE REMAINS RELEASE

B72B-

White: Medical Record — Make (4) copies (1) Patient, (2) Administrative Supervisor (3) Laboratory (4) Mortuary

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
~~**STANDARIZED PROCEDURES MANUAL**~~

STANDARDIZED PROCEDURE: DISCHARGE FROM OUTPATIENT POST–ANESTHESIA SERVICE

I. **POLICY:**
- A. Function: To provide a timely and appropriate discharge of the stable patient from Post Anesthesia Care Unit (PACU).
- B. Circumstances:
  1. Setting: PACU
  2. Supervision: None required
  3. Physicians Orders: The physician orders must clearly reflect an **R**~~r~~egistered **N**~~n~~urse **(RN)** may discharge a patient when discharge criteria have been met.
  4. Patient Contraindications: The anesthesiologist is to be notified of any patient who does not meet discharge criteria within four hours of admission post procedure, or any patient who has hemodynamic instability, surgical complications or fails to respond to treatment/interventions.

II. **PROCEDURE:**
- A. A patient will be ready for discharge ~~-~~as determined by the following criteria:
  1. Airway:
     a. Intact airway protective reflexes
     b. Patent airway (no sign of airway obstruction and no need for airway support)
  2. Ventilation/Oxygenation:
     a. Respiratory rate **greater than or equal to** ≥10 per minute/adult~~, age appropriate for pediatric patient~~
  3. Cardiovascular:
     a. Blood pressure, heart rate, cardiac rhythm within patient's acceptable baseline parameters, and temperature greater than 36°C (96.8°F)
     b. Stable, no significant changes for at least 30 minutes
  4. General Condition:
     a. Awake and follows commands per baseline
     b. Adequate intake and output, able to take oral fluids
     c. Comfort level meets target pain level
  5. Vomiting controlled and/or patient able to tolerate present state of nausea
  6. Ambulation
     a. Motor function/mobility progressing toward optimal level
     b. Demonstrates understanding of assistive devices as appropriate
  7. Post-procedural/operative bleeding controlled
  8. Psychosocial issues identified and addressed
  9. Provision made for safe transport home
  10. Discharge from PACU with a Modified Aldrete score of 9 – 10 or per physician written orders.
  11. Last set of vital signs documented immediately before discharge.

III. **PROCESS:**

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Pharmacy and Therapeutics	Department of Anesthesiology	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/99, 4/00; 02/09;02/11; **07/13; 4/15**	02/11;7/13, **08/15**	03/11;**07/13 , 09/15**	**09/15**	**01/16**	04/11;09/13, **07/16**	6/11;10/13, **09/16**	**10/16**	6/11;10/13

A. Discharge
   1. When the patient meets the above criteria, initiate standardized procedure as appropriate.
   2. Prepare patient or responsible party by reviewing patient education.
      a. Patient care provider verbalizes understanding of all discharge instructions.
      b. Written discharge instructions will be signed by the accompanying responsible adult and a copy provided upon discharge.
      c. Questions by patient/responsible adult invited and answered.
   3. Follow-up
      a. Post-Op phone call made the following day by RN
   4. Document in the patient's medical record
      a. Goals/outcomes met
         i. Deviations from expected outcomes to be documented on nursing record
      b. Patient education
      c. Follow-up phone call including any unexpected effects along with RNs instructions to patient or support person. ~~QRR completed when applicable.~~
      d. RN signature completed on all **physician**~~MD~~ orders and nursing documentation.
      e. Completion of Patient Charge document
      ~~f. Surginet log/**Special Procedure Recovery Area (**SPRA) log~~
      ~~g.~~**f.** Discharge in Cerner
   ~~5.~~

IV. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**
A. A current California RN license.
B. A current **Advanced Cardiac Life Support (**ACLS) certification
C. Initial Evaluation: During orientation period to include a nursing competency check-off list on discharge criteria.
D. Ongoing Evaluation: Annually through skills lab.

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
A. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.
B. Review: Every two (2) years.

VI. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**
A. All RN's who have successfully completed requirements as outlined above are authorized to direct and perform Discharge from Outpatient Post-Anesthesia Nursing Service Standardized Procedure.

Tri-City Medical Center
Oceanside, California

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: HALOPERIDOL (HALDOL), INTRAVENOUS (IV) ADMINISTRATION

I. **POLICY:**

A. Function: To provide direction for the use of intravenously administered Haloperidol at Tri-City Medical Center (TCMC).

B. Circumstances:
   1. Setting: Emergency Department (ED), Intensive Care Unit (ICU), or Telemetry at TCMC
   2. Supervision: None

C. Definitions:
   1. The safe IV administration of haloperidol requires that the QTc interval on the 12 Lead **electrocardiogram (**ECG**)** be less than 450 milliseconds.
   2. The safe IV administration of haloperidol requires that the patient be monitored continuously for cardiac dysrhythmias for two (2) hours after the drug is given.
   3. The maximum drug amount for each IV dose of haloperidol is 5mg.
   4. The maximum cumulative drug amount for IV haloperidol dosing is 30mg per 24 hours.
   5. QT interval represents the duration of ventricular depolarization and subsequent repolarization measured from the beginning of the QRS complex to the end of the T wave using manual or electronic calipers
   6. QTc interval is a heart rate adjustment measurement for the QT interval. It is measured using a calculation and is not the same measurement as the QT interval.
      i. Nursing shall use the QTc interval listed on a 12 Lead ECG.

D. Exceptions:
   1. Haloperidol IV may be given in emergent situations to patients without a 12-lead ECG if the ordering physician determines the benefit to outweigh the risk of treatment.

II. **PROCEDURE:**

A. The attending physician initiates the process by ordering IV haloperidol for the patient.

B. The **Registered Nurse (RN)** shall check the chart for the most recent 12 Lead ECG.
   1. RN shall order a base line 12 Lead ECG if:
      i. There is not an ECG that was done within the past 24 hours available on the chart.
      ii. Patient at risk for prolonged QT intervals:
         a) Atrioventricular (AV) blocks
         b) History of Torsades de Pointes (TdP)
         c) Long QT Syndrome
         d) History of Myocardial Infarction (MI)
      iii. When recommended by pharmacy based on drug interaction that prolongs the QT interval.
      iv. When the QT interval on an ECG strip measured with calipers, prolongs exceeding the patient's baseline and/or exceeds 450 milliseconds
   2. Patients receiving 30 mg or more of haloperidol IV per day, order a 12 lead every other day, if not ordered by the physician to monitor the QTc.

C. The RN or physician shall check the QTc interval that is electronically measured and printed on the 12 Lead ECG.
   1. Do not administer haloperidol if the QTc interval is greater than 450 milliseconds.

epartment Review	Clinical Policies & Procedures	Nurse Executive Committee	Division of Cardiology	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/12, **9/15**	8/12, **10/15**	10/12, **10/15**	**01/16**	11/12, **01/16**	02/13, **07/16**	2/13, **09/16**	**10/16**	2/13

Discontinue the haloperidol and notify the physician for an alternative route or medication.

2. If the physician specifically orders haloperidol despite QTc greater than 450 milliseconds, document QTc and physician awareness of QTc.

D. The RN shall document the QTc interval on the medication administration record (MAR).

E. The patient shall be monitored for the following for 2 hours after haloperidol has been administered:

1. Cardiac effects (new onset tachycardia, **orthostatic** hypotension, hypertension, **abnormal T waves, prolongation of the QT from baseline** and ventricular dysrhythmias)
2. Signs of neuroleptic malignant syndrome (new fever greater than 37.7 celsius, tachycardia, diaphoresis, labile blood pressure, cardiac dysrhythmias)
3. Extrapyramidal reactions, including:
   i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis)
   ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano.)

~~4. Notify the physician and document symptomatic dysrhythmias or changes from the patient's baseline rhythm in the medical record.~~

~~Notify the physician and document signs of neuroleptic malignant syndrome and extrapyramidal reactions in the medical record.~~

F. Physician Notification and Documentation

1. Notify the physician and document n the medical record the presence of the following:
   i. Cardiac effects
   ii. Signs of neuroleptic malignant syndrome
   iii. Extrapyramidal reactions

2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.
   i. Not required if a screening process triggers the order.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.
B. Current A**dvanced Cardiac Life Support** card.
C. Primary RN staff on with continuous cardiac monitoring at T**CMC.**~~ri-City Medical Center.~~
D. **Initial Evaluation: During Department Orientation.**
E. **Ongoing Evaluation: Annually during Skills Lab.**

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All R**N**~~segistered Nurses~~ **who have** successfully completing ~~the~~ requirements **as** outlined above are authorized to direct and perform Haloperidol, Intravenous (IV) Administration Standardized Procedure.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**HAZARDOUS DRUGS**
Purpose:	To ensure the safety of our employees/patients during the administration and patient care of those receiving hazardous drugs within Tri-City Medical Center (TCMC)
Supportive Data:	National Institute of Occupational Safety and Health (NIOSH) and Center for Disease Control (CDC)
Equipment:	Cytotoxic bin, yellow chemo waste bags, N-95 mask, double gloves, gown, splash goggles or face shield, protective shoe covers

A. **DEFINITION:**

1. Hazardous drugs are drugs known to cause:
   a. Genotoxicity – the ability to cause a change or mutation in genetic material
   b. Carcinogenicity – the ability to cause cancer in animal models, humans or both
   c. Teratogenicity – the ability to cause defects on fetal development or fetal malformation
2. Hazardous drugs are known to have the potential to cause fertility impairment, which is a major concern for most clinicians.
3. These hazardous drugs can be classified as antineoplastic, cytotoxic agents, biologic agents, antiviral agents and immunosuppressive agents.
4. Safe handling of hazardous drugs is crucial for both the patient and the provider.

B. **POLICY:**

1. TCMC staff working with hazardous drugs and the body fluids of patients receiving these drugs shall adhere to this procedure and reference Patient Care Services **(PCS) Procedure:** Disposal of Chemotherapy Waste~~.~~ **such as** ~~B~~**b**ody fluids includ**inge** ~~sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.~~
2. Only a TCMC trained registered nurse (RN) may administer a hazardous drug. Training consists of:
   a. Completion of the initial Net-Learning "Administering a Hazardous Drug" module
3. ~~Hazardous Drug List – Located on the TCMC Intranet under clinical references.~~

C. **PROCEDURE:**

1. **Administering a Hazardous Drug**
   a. Hazardous drugs will be identified by pharmacy and a warning will be placed in both the medication Pyxis and the electronic medical record (eMAR) to alert the nurse. **See Hazardous Drug List.**
   b. Ensure a yellow puncture-proof cytotoxic waste container is available on the unit (i.e., medication room or designated area).
   c. Hazardous drugs may not be handled with bare hands.
      i. Always double glove prior to handling a hazardous drug and its packaging.
   d. Never score or crush hazardous drugs (prevents inhalation of the drug.)
   e. Notify pharmacy if a hazardous drug must be administered via gastric tube (i.e. nasogastric or oral gastric small bore feeding tube).
   f. Document all hazardous drug patient education in the Education All Topics Ad-hoc form under "Medication Topics."
2. **Hazardous Drug Disposal and Waste**
   a. Dispose the following in a yellow puncture proof cytotoxic waste container:
      i. Needles and syringes used when administering hazardous drugs
      ii. Non-sharp materials exposed to a hazardous drug (i.e. pill packaging, IV tubing/empty IV bags, and gloves)

Department Review	Clinical Policies & Procedures Committee	Nursing Executive Council	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
08/10, 02/11;3/12, 6/16	3/12, 7/16	3/12, 07/16	n/a	09/16	4/12, 09/16	5/12, 10/16	5/12

iii. Hazardous drugs in a pill form that have been contaminated or just need to be wasted

b. Notify environmental services (EVS) when any yellow puncture proof cytotoxic waste container is ~~¾~~**2/3** full.

3. **Preventing Exposure to Body Fluid and Contaminated Linen**
   a. Precautions must be taken during administration and until 48 hours after last dose.
   b. Wear appropriate personal protective equipment (PPE) which may include the following:
      i. N-95 mask
      ii. Double gloves
      iii. Gown
      iv. Splash goggles or face shield
      v. Protective shoe covers
   c. Disposing of body fluid
      i. Dispose of body fluids in the toilet
      ii. **DO NOT USE THE TOILET SPRAYER.** Rinse containers with a cup of water to prevent splashing.
      iii. Before flushing toilet, cover open toilet with **new** chux. ~~(New chux to be used with each flush.)~~
      iv. Flush toilet twice**, and discard chux. (New chux to be used with each flush).**
      v. Place PPE and chux in chemotherapy waste bag**.**
      vi. Non-Oncology units contact EVS to dispose of chemo waste bag when they become**2/3** ~~¾~~ of the way full**.**
      vii. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit**.**
   d. All linen exposed to a hazardous drug or body fluid of a patient that is currently receiving or has received agents in the past 48 hours, must be placed (using gown and double gloved) in a yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
   e. Skin care of incontinent adult receiving hazardous drugs**.**
      i. Clean patients skin after voiding or having a bowel movement**.**
      ii. Apply protective barrier ointment or cream before diapering**.**
   f. All disposable equipment (i.e. foley catheter, bedpan, graduated cylinder, and diapers) used in caring for these patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

4. **Exposures and Prevention Related to Hazardous Drugs and Contaminated Body Fluids**
   a. In the event of skin exposure to a hazardous drug, remove any contaminated garment and immediately wash contaminated skin with soap and water.
   b. In case of eye exposure, immediately flush the eye with saline solution or water for at least 5 minutes.
   c. All linen exposed to a hazardous drug or body fluid of a patient currently receiving (or received) agents in the past 48 hours, must be placed (using gown and double gloved) in a yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
      i. Contact EVS when chemo waste linen bag is ~~¾~~**2/3** full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.
   d. Place any disposable contaminated materials into a sealed, leak proof chemo waste plastic bag. Use the yellow puncture proof cytotoxic containers for sharps or breakable items.
   e. All containers will be clearly labeled citing the hazardous nature of the contents.
   f. Report any exposures or spills to your Assistant Nurse Manager/Relief Charge Nurse/supervisor.

g. Report any employee exposure to employee health services and/or emergency department.
h. Complete an Illness/Injury Investigation Report.
i. Report patient exposures to the patient's healthcare provider and per institution policy.

5. **Handling of Hazardous Drugs – Pharmacy Department**
   a. All storage bins will be labeled with a "Hazardous Drug" sticker.
   b. Use chemo gloves when handling hazardous drugs for:
      i. Unit dosing
      ii. Admixing
      iii. Preparing for feeding tube
      iv. If the packaging is not intact
   c. Any hazardous drug sent from the pharmacy (not dispensed from Pyxis) will have a "Hazardous Drug" label attached.
   d. Admixing and crushing of hazardous drugs will be done in the chemo hood. The chemo closed system is not necessary.
   e. All hazardous drugs will have warnings on the eMAR and the Pyxis system.
   f. All vials, bottles, packaging, syringes, etc. will be disposed of in the trace chemotherapeutic waste container.

D. **RELATED DOCUMENTS:**
1. **PCS Procedure: Disposal of Chemotherapy Waste**
2. **Hazardous Drug List**

E. **REFERENCES:**
1. Health Waste Management (HCWM). (2006). The 10 categories of hcrw-#9 genotoxic/cytotoxic waste.
2. National Institute for Occupational Safety and Health. (2004). Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings. ~~Retrieved November 17, 2010 from the NIOSH website at~~ http://www.cdc.gov/niosh/docs/2004-165/#c
~~3. Hazardous Drug List – located on the TCMC internet under clinical references.~~

TRI-CITY MEDICAL CENTER
HAZARDOUS MEDICATIONS

GENERIC LIST		TRADE LIST	
Generic Name	Trade Name	Trade Name	Generic Name
Abatacept	Orencia	Androgel, Androderm	Testosterone
Azathioprine	Imuran	Arava	Leflunomide
Chloramphenicol	Chloromycetin	Avodart	Dutasteride
Colchicine	Colchicine	Cellcept, Myfortic	Mycophenolate mofetil
Cyclosporin	Neoral, Sandimmune	Cervidil, Prostin	Dinoprostone
Dinoprostone	Cervidil, Prostin	Chloromycetin	Chloramphenicol
Dutasteride	Avodart	Colchicine	Colchicine
Efavirenz	Sustiva	Cytovene	Ganciclovir
Estradiol	Estrace, Climara, Depo-Estradiol	Estrace, Climara, Depo-Estradiol	Estradiol
Estrogen-progestin combinations	Estratest HS	Estratest HS	Estrogen-progestin combinations
Estropipate	Ogen	Evista	Raloxifene
Finasteride	Proscar	Imuran	Azathioprine
Ganciclovir	Cytovene	Methergine	Methylergonovine
Gonadotropin, chorionic	Pregnyl	Neoral, Sandimmune	Cyclosporin
Infliximab	Remicade	Neutrexin	Trimetrexate glucuronate
Leflunomide	Arava	Ogen	Estropipate
Medroxyprogesterone Acetate	Provera	Orencia	Abatacept
Methylergonovine	Methergine	Pentam, Nebupent	Pentamidine isethionate
Methyltestosterone	Testred	Pitocin	Oxytocin
Mycophenolate mofetil	Cellcept, Myfortic	Podocon-25	Podophyllum resin
Nevirapine	Viramune	Pregnyl	Gonadotropin, chorionic
Oxytocin	Pitocin	Prograf	Tacrolimus
Pentamidine isethionate	Pentam, Nebupent	Prometrium	Progesterone
Podophyllum resin	Podocon-25	Proscar	Finasteride
Progesterone	Prometrium	Provera	Medroxyprogesterone Acetate
Raloxifene	Evista	Rapamune	Sirolimus
Ribavirin	Rebetol, Virazole	Rebetol, Virazole	Ribavirin
Sirolimus	Rapamune	Remicade	Infliximab
Tacrolimus	Prograf	Retrovir	Zidovudine
Tenofovir	Viread	Sustiva	Efavirenz
Testosterone	Androgel, Androderm	Testred	Methyltestosterone
Thalidomide	Thalomid	Thalomid	Thalidomide
Trifluridine	Viroptic	Valcyte	Valganciclovir
Trimetrexate glucuronate	Neutrexin	Viramune	Nevirapine
Valganciclovir	Valcyte	Viread	Tenofovir
Zidovudine	Retrovir	Viroptic	Trifluridine

Hazardous Drug Administration:

1. Hazardous drugs shall be administered by a TCMC trained licensed nurse.
2. Hazardous drugs should not be handled with bare hands.
3. Always double glove when handling a hazardous drug and it's packaging.
4. Never score or crush hazardous drugs.
5. Notify pharmacy if a hazardous drug must be administered via a gastric tube.
6. If directed, dispose of packaging and gloves in a yellow cytotoxic waste container. See order comments for disposal directions.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: LOCAL ANESTHETIC PRIOR TO INTRAVENOUS INSERTIONS

I. **POLICY:**

A. Function:

1. Administration of a local anesthetic for pain management during insertion of intravenous (IV) lines.

B. Circumstances:

1. Setting: Patient Care areas
2. Population: Adult, Pediatrics and infant patients
3. Contraindications: Allergy to ~~Lidocaine~~**lidocaine or prilocaine**
4. Supervision: None required

II. **PROCEDURE:**

A. Pre procedure

1. Criteria for use:

a. Deeper insertion
b. Patient anxiety due to IV insertion
c. Difficult insertion
d. Patient request

~~1.~~**2.** Assess for appropriate IV insertion site
~~2.~~**3.** Explain rationale for use of topical anesthetic prior to IV insertion to patient/parent/caregiver/significant other

B. Procedure

1. Topical Anesthetic Cream (**lidocaine and/or prilocaine**~~EMLA/ELA-MAX~~) Administration
   a. Equipment: Tegaderm patch or tape
      i. Alcohol or chlorhexidine wipe
      ii. Topical Anesthetic Cream (EMLA/ELA-MAX)
   b. Administration:
      i. Swab insertion site with alcohol or chlorhexidine wipe
      ii. Apply generous 1 inch square of topical anesthetic cream over insertion site.
      iii. Cover with Tegaderm or tape per manufacturer's instructions.
      iv. Wait for minimum amount of time per manufacturer's instructions.
   c. Insert IV per policy
2. Intradermal Lidocaine Administration
   a. Equipment:
      i. TB syringe with appropriate 27 g needle attachment
      ii. Alcohol or chlorhexidine wipe
      iii. Lidocaine 1% without epinephrine
   b. Administration:
      i. Draw up 0.1 mL of Lidocaine in a syringe
      ii. Swab insertion site with alcohol or chlorhexidine wipe
      iii. Inject Lidocaine intradermally to form a wheal at insertion site
      iv. Wait at least 1 minute
      v. Insert IV per ~~**Mosby's Procedure**~~**Online Clinical Skills: Intravenous Therapy: Initiation** ~~policy~~
3. Post procedure
   a. Assess and monitor the following:

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Interdisciplinary Practice Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/15	09/15	09/15	n/a	12~~1~~/15	07/16	09/16	10/16	

i. Erythema
ii. Swelling
iii. Potential allergic reaction

b. Educate patient/parent/caregiver/significant other on complications listed above

III. **DOCUMENTATION:**

A. Complete documentation in the Electronic Health Record (EHR)
B. Enter order for initiation of standardized procedure per policy.
C. Medications are documented in the Medication Administration Record (MAR).
D. Insertion procedure and patient response is documented in the IVIEW band.

IV. ~~RELATED DOCUMENTS~~EXTERNAL LINKS:

~~D.~~A. ~~Mosby's Procedure~~Online Clinical Skills: Intravenous Therapy~~:~~ Initiation

~~IV.~~V. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current California RN license
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Ongoing

~~V.~~VI. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine and Administration.
B. Review: Every 2 years or review procedure per Hospital policy.

~~VI.~~VII. V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Local Anesthetic Prior to Intravenous Insertions

Tri-City Medical Center
Oceanside, California

Tracked Changes Copy

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 6/02

SUBJECT: ~~Patient Owned/Supplied~~ Medical Equipment Brought into the Facility

REVISION DATE: 7/05, 7/07, 3/10, 6/12

POLICY NUMBER: XI.E

Department Approval Date(s):	**02/16**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~08/16**
Nurse Executive Committee Approval:	**09/16**
Pharmacy & Therapeutics Committee Approval:	**09/16**
Medical Executive Committee Approval:	**09/16**
~~Patient Care Quality Committee Approval:~~	**~~07/12~~**
Professional Affairs Committee Approval:	**~~08/12~~10/16**
Board of Directors Approval:	**08/12**

A. **POLICY:**

1. To provide guidelines for patient owned/supplied equipment that is brought into the center.

B. **DEFINITION:**

1. Patient-Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay~~.~~ (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.)

~~C. **STANDARD OF PRACTICE:**~~

~~1. It shall be the standard practice at Tri-City Medical Center (TCMC) to not allow patients to bring in their own equipment for use during their hospital stay. Equipment that is not the property of the medical center or under a rental agreement may not be used in the care of patients unless there is no comparable equipment available. However, there may be instances in which the patient must bring in their own equipment. When these situations arise, this policy will describe how TCMC employees and physicians should respond. This policy will apply to limited types of patient supplied equipment.~~

~~D.~~**C. POLICY~~PROCEDURE~~:**

1. ~~Patient and/or family request's the use of PSE. The nurse caring for the patient should explain to the patient that~~ **Tri-City Healthcare District's (TCHD)** ~~TCMC's~~ standard of care is to use hospital-owned equipment whenever possible ~~and that exceptions are made only when TCMC is unable to provide similar equipment~~.
   a. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.
   b. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):
      i. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States;
      ~~ii. High-risk equipment e.g.,~~
      ~~1) Defibrillators~~

~~2) Automated External Defibrillator (AED)~~
~~3) Patient-controlled analgesia (PCA) pumps~~
~~4) Anesthesia machines~~
~~5) External Medication pumps~~
~~6) Home Dialysis equipment~~

~~1.~~**c.** Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals**.**

~~c.~~**d.** Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:

i. If the equipment requires audible alarms that cannot be provided~~;~~
ii. If the equipment has alarms that can be defeated without clinical staff intervention~~;~~
iii. If the patient should become incapacitated or is otherwise unable to maintain their, equipment the hospital may provide substitute equipment~~.~~
iv. Any reason that TCMC deems reasonable that may place the patient's safety at risk~~.~~

2. Upon the patient's request to use PSE, **the nurse caring for the patient should explain to the patient that TCHD's standard of care is to use hospital owned equipment whenever possible.**

a. If patient is agreeable to the use of hospital equipment, change the PSE to hospital equipment and send PSE home with family member (if family member available)

~~2.~~**b. If the patient refuses hospital equipment and requests use of PSE** the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.

~~3.~~**i.** If the equipment is deemed medically appropriate~~, and the clinical staff deems that the patient or family members can safely and adequately use the equipment on his/her own,~~ the physician will authorize use with an order.

~~Once the physician's order is obtained, the clinical staff in the department where the patient is being treated will complete a basic check of the device following the steps in Section 8 and a visual inspection of the device prior to use. Clean as needed.~~
~~Bio-Med must be contacted to perform an operation and safety check on the device.~~

~~4.~~**3.** Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will ~~verify/complete the following for patient supplied equipment (PSE).~~**:**

a. **Verify** ~~A~~**a** physician**'s** order has been **obtained and** entered in Cerner approving the use of the patient's equipment.

b. Ensure~~Prior to use of the PSE while in the facility,~~ the patient or legal representative ~~must~~ sign**s** a liability waiver (See Patient-Supplied Equipment Waiver) for use of PSE.

i. The signed waiver shall be placed in the patient's chart.
~~a.~~**ii.** If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital.

~~b.~~**c.** ~~Clinical nursing staff has completed a v~~**V**isuall**y** inspecti~~on~~ **the PSE** (assessing for damage to the device, infestation with insects, excessively soiled.)

~~c.~~**d.** ~~The exterior shall be thoroughly w~~**W**iped down **the PSE** with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at ~~E~~**extension**~~.~~ **7410 or 5696** ~~3007~~.

~~d.~~**e. Notify** Bio-Med ~~shall be notified~~ as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (**Monday-Friday**).

i. If the device is brought in during the weekend, ~~then~~ the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.
ii. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center, (Off hours and weekends contact the Administration Supervisor to notify Bio-Med).

~~e.~~**f.** Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.

~~f.~~**g.** If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well being (example: pulse oximeter).

~~g.~~**h.** ~~The patient or legal surrogate has signed a liability release for patient supplied medical equipment and this has been placed in the patient's chart.~~

~~i.~~**4.** ~~Note:~~**For** ~~A~~**a**ny concerns or questions, please contact:

~~h.~~**a.** The Director of Risk Management for risk issues

~~i.~~**b.** The Chief Nurse Executive for patient care issues

~~j.~~**c.** The Management of Clinical Engineering for medical equipment issues.

~~E.~~D. SPECIAL CONSIDERATIONS:

1. Insulin Pumps:

a. See Patient Care Services (PCS) Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient

2. Wearable Defibrillator:

a. See PCS Policy: Wearable Defibrillator (LifeVest)

3. Implanted Pain Pumps:

a. The admitting physician will be notified immediately ~~-~~the patient has an implantable pain pump.

~~2.~~b. The admitting physician will attempt to contact the original prescribing physician of the pain pump for information on continuing, stopping or disconnecting.

c. The admitting physician will enter orders regarding the status of the pain pump.

i. If the medication will continue during hospitalization, the medication that is being infused by the pain pump must be entered into the electronic health record.

1) This will include the drug, dose, total volume, rate and volume infused.

2) The order must specify that the drug is infusing through pain pump.

~~1)~~3) The nurses will document on the electronic medication record (eMAR) daily.

4. Ambulatory Infusion Pump (AIP):

a. The admitting physician will be notified immediately that the patient is wearing an AIP.

b. Admitting physician will attempt to contact the original prescribing physician of the AIP for information on continuing, stopping or disconnecting.

i. Admitting physician may also call the number located on the AIP for other information.

ii. If the medication is a chemotherapeutic agent, the medication must be administered/discontinued by TCHD Chemotherapy Competent Registered Nurse (see PCS Procedure: Chemotherapy Administration).

c. The admitting physician will enter orders regarding the status of the AIP

i. If the medication will continue during hospitalization, the medication that is being infused by the AIP must be entered into the electronic health record.

~~2.~~1) **This will include the drug, dose, total volume, rate and volume infused.**
2) **The order must specify that the drug is infusing through AIP.**
~~b.~~3) **If the AIP is continued, nurses will document on the eMAR daily.**

~~F.~~E. FORMS ~~LOCATED ON INTRANET~~:

1. Patient-Supplied Equipment Waiver **Sample**

F. RELATED DOCUMENTS

1. **Outpatient Infusion Center Procedure: Ambulatory Infusion Pumps**
2. **PCS Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient**
~~1.~~3. **PCS Policy: Wearable Defibrillator (LifeVest)**
4. **PCS Procedure: Chemotherapy Administration**

PATIENT SUPPLIED EQUIPMENT WAIVER SAMPLE

This Patient Supplied Equipment Waiver between Tri-City Healthcare District (Tri-City) and _____ (Patient) is entered into on _____, 20__. Patient or legal representative must initial each statement in order to use Patient Supplied Equipment in Tri-City Healthcare District facility.

Type of Device used: _____ (Do not use for Insulin Pump, refer to Insulin Pump Policy)

_____ I understand that I have voluntarily brought my equipment into a Tri-City facility for my use during my stay at a Tri-City facility.

_____ I certify that I have been trained on how to use and repair this equipment, and that I am fully capable of using and repairing the equipment.

_____ I understand that Tri-City performed an inspection of my equipment. This inspection is not a warranty that the device is safe or free from defects. I am not relying on Tri-City's inspection of the equipment to ensure its safety or my proper use.

_____ I understand that Tri-City may unilaterally determine without warning to me that I may no longer use my equipment. Tri-City may replace my equipment with its own equipment.

_____ I understand that by signing this document, I hereby waive any claim or right of action against Tri-City related to my use of my equipment. I release Tri-City and its employees, agents, and assigns from any and all liability resulting from the use, operation, damage to, and repair of my equipment by myself, Tri-City, and any of its employees.

By agreeing to the above terms and conditions, I expressly assume the risks that may result from bringing personal medical equipment into a Tri-City facility. I release Tri-City from any damages, and agree to indemnify, hold harmless, and defend Tri-City, its employees, affiliates, directors, officers, subsidiaries, and agents against any and all liability arising out of the negligent operation of use of the medical equipment by me or my family or visitors. I acknowledge and agree that in no event shall Tri-City be liable for any indirect, special, consequential, incidental, or punitive damages, loss, or expense associated with the use of personal medical equipment by me or my family and/or visitors. This agreement shall be legally binding on me and my designated family member(s) and/or visitors operating my personal medical equipment. My signature below indicates I have read this agreement, understand it, and agree to be bound by its terms.

_____ _____
Patient or Legal Surrogate Date

_____ _____
Family Member if Operating Equipment **Date**

_____ _____
~~Witness~~**Tri-City District Hospital Representative** Date

Tri-City Medical Center
Oceanside, California

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: ~~ORDERING 12 LEAD ECG FOR~~ DROPERIDOL ADMINISTRATION, MONITORING, ~~OF DROPERIDOL~~ AND/OR DISCONTINUING DRUG

I. **POLICY:**

A. Function: To provide direction for the use and monitoring of droperidol at Tri-City Medical Center **(TCMC)**.

B. Circumstances:

1. Setting: Cardiac Cath Lab, cardiac monitoring nursing units (Intensive Care Unit **(ICU)** or Telemetry) Tri-City Medical Center
2. Supervision: None
3. Patient Contraindications: 12 Lead **electrocardiogram** (ECG) QTc greater than 440 milliseconds

C. Definitions:

1. The safe administration of droperidol requires the QTc interval on the 12 Lead ECG be less than 440 milliseconds.
2. The safe administration of droperidol requires that the patient be monitored continuously for cardiac dysrhythmia for three (3) hours after the drug is given.
3. Current is defined as during the present hospitalization.
4. QTc is the corrected QT interval that is independent of a heart rate.

II. **PROCEDURE:**

A. The attending physician initiates the process by ordering droperidol for the patient.

B. The **Registered Nurse (RN)** checks the chart for the most recent 12 Lead ECG.

1. RN shall order a 12 Lead ECG**,** if there is not a **recent**~~n~~ ECG ~~that is done~~ **completed** during this hospitalization available on the chart.

C. RN or physician shall check the QTc interval ~~that is~~ electronically measured and printed on the 12 Lead ECG

1. Do not administer droperidol if QTc interval is greater than 440 milliseconds.
2. Discontinue droperidol and notify the physician for alternative medication.
3. If physician specifically orders droperidol despite QTc greater than 440, document QTc and physicians awareness of QTc.

D. The RN shall document the QTc interval on the medication record as soon as possible after the order is transcribed.

1. Right click 'Comments' and document the QTc interval.

E. The patient shall be monitored for the following for 3 hours after the droperidol has been administered:

1. Cardiac effects (new onset tachycardia, orthostatic hypotension, hypertension, abnormal T waves, prolongation of the QT from baseline and ventricular tachycardia.)
   i. If prolongation of the QT from baseline is noted, obtain a 12 lead ECG and check the QTc.
2. Extrapyramidal reactions, seizures or any of the following:
   i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis)
   ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements

epartment Review	Clinical Policies & Procedures	Nurse Executive Committee	Division of Cardiology	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06,8/04,3/08 11/10,2/13, **9/15**	12/10, 2/13, **10/15**	12/10, 2/13, **10/15**	**1/16**	1/11, 7/13, **01/16**	1/11, 10/13, **07/16**	2/11, 10/13, **09/16**	**10/16**	8/04,7/03,9/06, 12/08, 4/09,2/11, 10/13

of the fingers may appear as though the patient is playing an invisible guitar or piano.)

iii. Pseudoparkinsonian signs and symptoms

3. Increased drowsiness and sedation

~~4. Notify the physician and document symptomatic dysrhythmias or changes from the patient's baseline rhythm in the medical record.~~

F. The RN shall recheck the QTc interval if giving repeated doses of droperidol using the most recent ECG.

1. Repeat process outlined in steps A - E when administering subsequent doses of droperidol.

G. Documentation

1. Notify the physician and document in the medical record the presence of the following:

i. Cardiac effects

ii. Extrapyramidal reactions~~, seizures and any of the following~~:

iii. Pseudoparkinsonian signs and symptoms

2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.

i. Not required if a screening process triggers the order.

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current California RN license.

B. Current Advanced Cardiac Life Support card.

C. ~~Core~~ Primary RN staff ~~of a unit~~**on** with continuous cardiac monitoring at T**CMC**~~ri-City Medical Center~~.

D. Initial Evaluation: During Department Orientation.

~~C.~~E. Ongoing Evaluation: Annually during Skills Lab.

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

A. All R**Ns** ~~egistered Nurses~~ who have successfully completed requirements as outlined above are authorized to direct and perform **this standardized procedure.** ~~Ordering 12 Lead ECG for Administration of Droperidol and/or Discontinuing Drug Standardized Procedure.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PNEUMOCOCCAL AND INFLUENZA VACCINE SCREENING AND ADMINISTRATION

I. **POLICY:**

A. Function:

1. To provide guidelines to the Registered Nurse (RN) when administering Pneumococcal and/or Influenza Vaccine(s) to the appropriate patient(s) as indicated per criteria set forth by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
2. To provide guidelines when a physician does not want the patient to receive the vaccine(s).

B. Circumstances for Pneumococcal Vaccine:

1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in ~~Labor and Delivery~~**the laboring patient** and women currently pregnant will be according to physician orders and not this standardized procedure
4. Patient indications:
   a. Pneumococcal Vaccine Risk Assessment for all patients ~~6~~ **65** years and older.
   b. ~~The~~ **Prevnar 13**~~Pneumococcal Vaccine~~ should be given ~~if any of the following indications are met:~~**to patients age 65 and older who have never received Prevnar 13, Pneumovax 23 or have unknown vaccination history**
      ~~i. Age 65 or older and never received Pneumococcal vaccine or is unsure~~
      ~~ii. Age 6 to 64 and have never been vaccinated:~~
         ~~1) Chronic cardiovascular disease~~
         ~~2) Chronic renal failure, or nephrotic syndrome~~
         ~~3) Chronic pulmonary disease~~
         ~~4) Diabetes mellitus~~
         ~~5) Sickle cell~~
         ~~6) Alcoholism~~
         ~~7) Cirrhosis~~
         ~~8) Chronic liver disease~~
         ~~9) Cerebrospinal fluid leaks~~
         ~~10) Splenic dysfunction or absence~~
         ~~11) Cochlear implants~~
         ~~12) Immunocompromised, including those with HIV infections, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, malignancy~~
         ~~13) Immunosuppressive therapy (including long term systemic corticosteroids)~~
         ~~14) Age 19 through 64 years who is a smoker or has asthma.~~
   c. If the patient does not meet ~~any of the above indications, patient is NOT at high risk. Do~~**criteria above, do** not immunize.
5. The Pneumococcal Vaccine should NOT be routinely given without a physician's order if the patient:
   a. Has a contraindication:

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Infection Control Committee	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/06, 1/15	12/11, 2/15, 06/15, **01/16**	12/1, 07/15, **01/16**	07/15, **03/16**	1/12, 07/15, **01/16**	1/12, 09/15, **07/16**	2/12, 09/15, **09/16**	10/15, **10/16**	2/12; 10/15

~~i. Less than 6 years of age~~
~~ii.~~**i.** Had a previous reaction to the Pneumococcal vaccine
~~iii. Age 6 – 18 and have received a conjugate vaccine within last 8 weeks~~
~~iv.~~**ii.** Received a bone marrow transplant within the past ~~12~~ **6** months
iii. ~~Is currently receiving a scheduled course of chemotherapy or radiation therapy~~**Has received chemotherapy or radiation within the last 2 weeks**
~~v.~~**iv.** **Has received the shingles vaccine (Zostavax) within the last 4 weeks**

b. Ordered not to have vaccine by physician
c. Refuses or advocate refuses

6. If no exclusion criteria identified, then immunize

C. Circumstances for Influenza Vaccine:
1. Setting: Tri-City Medical Center
2. Supervision: None required
3. Exclusions: Immunization in ~~Labor and Delivery~~**the laboring patient** will be according to physician orders and not this standardized procedure
4. Patient indications
   a. Influenza Vaccine Risk Assessment for all patients 6 months of age and older:
   b. The Influenza Vaccine should be given to patients admitted and/or discharged during the normal flu season until the vaccine is no longer available, if any of the following indications are met:
      i. Age 6 months and older
      ii. Women who will be pregnant during the influenza season (October through March) NOTE: Influenza vaccine is not contraindicated at any stage of pregnancy
      iii. Women who are knowingly pregnant shall receive single-dose preservative free* vaccine (*Not to exceed 1mcg of Thimerosal per 0.5mL dose.)
         1) Pharmacy to provide single-dose syringe/vial for knowingly pregnant women if available
      iv. Influenza immunization history is unknown by patient or advocate
5. The Influenza Vaccine should NOT be given if the patient:
   a. Has contraindication
      i. Has allergy to eggs or reaction to prior influenza vaccine (i.e., anaphylactic allergic reaction)
      ii. Had diagnosis of Guillian-Barre Syndrome within six (6) weeks of vaccination (will be left up to the individual healthcare provider to decide if recommended)
      iii. Received bone marrow transplant within past six (6) months
      iv. Had a previous influenza immunization this flu season~~)~~
   b. Ordered not to have vaccine by physician
   c. Refuses or advocate refuses
6. If no exclusion criteria identified, then immunize

II. **PROCEDURE:**

A. During the initial assessment, the RN will complete the Pneumococcal /Influenza Vaccination Adult Immunization Assessment Screen in Cerner to determine whether or not the vaccinations are indicated according to the following criteria:
1. If the patient meets any inclusion criteria and no exclusion criteria, the RN will inform the patient/advocate that they are eligible for the vaccination(s), give the patient/advocate the vaccination information sheet(s), and plan to administer the vaccination(s).
2. If the RN is unsure of whether the patient is a candidate for the vaccine(s), the physician should be contacted for specific orders.

B. Unless the physician has signed an order to withhold the Pneumococcal and/or Influenza vaccine, remove the age appropriate dose assigned by pharmacy from the Pyxis Medication station and administer the vaccine(s).
C. For patients in the Emergency Department, the Pneumococcal and/or Influenza vaccine should be administered at the time the physician order is received.

III. **DOCUMENTATION**:
A. Document the vaccine administration in the medical record.
B. Document vaccine lot number and site of administration.
C. Document that the Vaccination Information Sheet was given to the patient.
D. Document refusal of immunizations.
E. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record
1. Not required if a screening process triggers the order

IV. **PATIENT EDUCATION:**
A. If the patient meets inclusion criteria, the RN will review the Pneumococcal and Influenza Vaccine Information sheet(s) with the patient and give the patient a copy.
B. For transfers to skilled nursing facilities and other hospitals, print and send a copy of the Immunization Tab indicating vaccine(s) administered, with a copy of the Medical Record.

V. **REQUIREMENTS FOR R.N. INITIATING STANDARDIZED PROCEDURE:**
A. Current California RN license
B. Initial evaluation: Orientation
C. Ongoing evaluation: **Annually with Skills Lab/Skills Validation**~~Ongoing~~

VI. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every 2 years or review procedure per Hospital policy.

VII. **CLINICIANS AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:**
A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pneumococcal and/or Influenza Vaccine.

Tracked Changes Copy

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**SPONGE,SHARPS & INSTRUMENT COUNTS, PREVENTION OF RETAINED SURGICAL ~~OBJECTS~~ ITEMS**
Purpose:	To outline nursing responsibilities and accountability regarding ~~sponges,~~**sponges** sharps, and instrument counts in the surgical/**procedural** areas.
Supportive Data:	Sponges, sharps, and instrument counts are ~~done~~**performed** ~~in~~**during** surgery/**invasive procedures** to provide for safe patient care **and prevent retained surgical items.** ~~as an avenue of accountability and legal responsibility.~~ **Counts for sponges/soft goods, sharps, and instruments are performed to account for all items used on the surgical field and to lessen the potential for injury to the patient as a result of a retained surgical item.** All items are to be counted except those used for storage or disposal of items.
Equipment:	White Board, White Board Marker, Count Sheet(s), Sponge holders ~~Countable items include, but are not limited to:~~ ~~Blades~~ ~~Rubber shods~~ ~~Yankauer Tips~~ ~~Bulldogs~~ ~~Suture Needles~~ ~~Staple re-load cartridges~~ ~~Cotton balls~~ ~~Vessel loops~~ ~~Cottonoids~~ ~~Umbilical tape~~ ~~Detachable portions of equipment~~ ~~Wingnuts~~ ~~X-ray 4x4's~~ ~~Instruments~~ ~~Penrose drain~~ ~~Lap sponges~~ ~~Cautery tips~~ ~~Ligaclip boats~~ ~~Hypodermic needles~~ ~~Packing~~ ~~Peanuts (Kittners /Dissectors)~~ ~~X-ray detectable towels~~ ~~Defogger solution bottle, cap and sponge~~

A. **POLICY:**

1. Sponges, sharps and miscellaneous items **counts are required** ~~shall be counted~~ on all procedures **except eyes and cystoscopies.** ~~in which the possibility exists that these items can be retained.~~
   ~~a. Sponge counts are exempt on eyes, minor ENT cases and cystoscopies.~~
   ~~b. Needle counts may be omitted on minor eye procedures.~~
2. All counts shall be conducted **both** audibly and visually.
   a. Counted items shall be visualized by both the scrub person and **circulator/designee, one of whom must be a Registered Nurse (RN).** ~~the circulating Registered Nurse (RN) or designee (one of whom shall be an RN).~~
   b. At time of permanent relief of either the scrub or circulating RN, direct visualization may not be possible**; the team shall account for all items**.
3. A count may be initiated by any member of the perioperative team. ~~involved in the counting process.~~
4. Unnecessary activity and distractions should be omitted during the counting process.
~~4.~~**5. To the extent possible, the initial count shall be completed before the patient is brought into the OR.**
6. Counts may be omitted in an ~~extreme~~ emergency.
   a. The emergent nature of a procedure or an unexpected change in the condition of the patient may necessitate omission of counts to preserve patient life or limb. In such cases, counts may be waived on order of the surgeon. The surgeon will document the omission of the count and rationale for the practice variation in the medical record.
   b. If counts were omitted due to ~~extreme~~an emergency, x-ray shall be performed and read prior to the ~~beginning of wound closure~~completion of skin closure.
   ~~**Ensure X-ray is read prior to the completion of wound closure.**~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Operating Room Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/03, 4/06, 08/09; 05/12;01/13;05/14; **4/15; 09/15**	06/12; 7/13: 5/14, **11/15; 02/16**	06/12; 2/13; 5/14; **02/16**	**6/14, 01/16**	07/12;7/14; **09/16**	08/12;10/14, **10/16**	08/12;11/14

i. **Document events regarding the nature of the emergency.**
ii. **Document the name of physician reading the x-ray and the x-ray results.**
~~2.~~iii. **Complete an incident report.**

~~3.~~7. ~~**Procedures may have multiple parts and/or multiple tables or set-ups. Procedures with multiple incisions require closing counts for closure of each incision, and all countable items (from all tables/set-ups) must be included in the closing counts.**~~

8. **If a patient is transferred to another department for completion of the procedure (i.e., transferred from OR to Interventional Radiology or transferred from Labor and Delivery to OR), an x-ray must be performed and read for retained surgical items prior to the completion of ~~wound~~skin closure.**

~~5.~~9. **Sponge, sharps and miscellaneous item** ~~C~~counts shall be written on the white board. **Instrument counts shall be recorded on the instrument count sheet(s).**

~~4. Items added by a circulator other than the primary circulator, require the item to be initialed by the secondary circulator.~~

~~5. **Sponges shall be counted in order from largest sponge to smallest sponge (eg, laps to baby laps to raytex).**~~

~~6. Sharps shall be documented as part of the count:~~

~~a. Multi-packed needles shall be counted according to the number marked on the outer package for counts until they are opened for use.~~

~~i. When opened for use, multi-packed needles shall be verified by the scrub person and the circulating RN.~~

~~Counting number of needle packages may not be used to reconcile an incorrect needle count.~~

~~**All used needles are to be placed in a puncture-proof needle counter box.**~~

~~**Place one needle in each numbered slot; do not double-up needles in a numbered slot.**~~

~~b. **Obtain an additional needle counter box if the initial needle counter box is full.**~~

B. PROCEDURE:

~~6.~~1. ~~The sponge, sharps, and miscellaneous item count shall be performed as follows~~**Surgical counts are classified as**:

a. Baseline count: **Count** ~~B~~**b**efore the procedure **begins** to establish the baseline and identify manufacturer packaging errors.

b. New item count: ~~When~~**Count** new items ~~are~~ added to the field **after the baseline count is complete**.

c. Relief count: **Count** ~~A~~**a**t the time of permanent relief of the scrub or RN circulator.

~~c.~~**i. The relief count is performed by the incoming scrub and/or circulator who are assuming responsibility for the count as it stands at the time of relief.**

~~c.~~**d.** Cavity count: **Count** ~~B~~**b**efore closure of a cavity ~~within a cavity~~ (eg. Uterus, bladder, **stomach,** peritoneum, **placement of mesh to close a space**)

~~d.~~**e.** Closing count: ~~When~~ **Count before** wound closure begins

f. Final count: **Count** ~~A~~**a**fter skin closure or end of procedure, when surgical items are no longer in use and all sponges (used ~~or~~**and** unused) are passed off the field**,** separated into sponge holders and confirmed by the surgical team.

2. Count in the following order:
a. Sponges
b. Needles
c. Other sharps and miscellaneous items
d. Instruments

3. Count items in the following sequence:
a. Operative field
b. Mayo stand
c. Back table

~~e.~~d. Items off field

~~7. Instruments shall be documented on the instrument count sheet:~~

4. Items passed off or dropped from the sterile field shall be retrieved by the circulating nurse, isolated from the field and included in the final count. **Countable items must never be subtracted from the count or removed from the operating room.**
5. Members of the surgical team shall account for broken or separated instruments**/items** within the surgical field.
~~7.~~**6. Multi-part items shall be counted as one unit (eg, hypo and cap is counted as one unit), unless otherwise specified on the count sheet/whiteboard. Account for all individual pieces of multi-part items.**
~~8.~~**7.** Items added to the field need to be recorded at the time they are added.
   a. Once the count has begun, recalled memory and/or counting packages cannot be used to reconcile a count.
   b. The number on the whiteboard/count sheets must match the number of items on the field at the time of the count, or the count is considered incorrect.
8. **The count is to be recorded on the count board using a horizontal superscript running total format (i.e., $10^{10}20^{10}30^{10}40$). No additional slashes, initials, equal signs or extraneous marks are to be made.**
9. **The person adding countable items to the field is responsible for recording the items on the count board.**
   a. **If items are added by anyone other than the primary RN circulator, the person adding the items shall verbally report the additions to the primary RN circulator.**
10. **Inform primary surgeon of the count outcomes.**
11. **Incorrect Counts:**
   a. **Inform primary surgeon of count discrepancies**
   b. **The surgeon should perform a methodical wound examination and a thorough search of all areas should be completed by the surgical scrub and circulating nurse.**
   c. **Search the total room including floor, trash and linen:**
      i. **If item is not found, an X-ray of the patient must be taken prior to patient leaving the operating room.**
         1) **X-ray is not required if the missing item is not X-ray detectable.**
      ii. **If item missing is micro or CV needle (C-1 or smaller), X-ray is not needed.**
      iii. **Complete an incident report.**
   d. **Ensure sterile field remains sterile until item is found or x-ray is read**
   e. **Inform Assistant Nurse Manager (ANM)/charge nurse/designee of count discrepancies**
12. **X-ray interpretation for incorrect counts, emergencies, and X-ray in lieu instrument counts:**
   a. **When possible, it is highly recommended that a radiologist read the X-ray before the ~~wound~~skin is closed and the results of the reading, along with the name of the person who read the X-ray, are documented.**
   b. **At a minimum, the surgeon must interpret the film intraoperatively.**
13. **If an item is used to occlude the colpotomy during a da Vinci hysterectomy (i.e., asepto or glove), it becomes a countable item and must be accounted for at the end of the case.**

C. **<u>SPONGES/SOFT GOODS COUNT</u>:**

1. Sponges (laps, baby laps, raytex) are issued in groups of ten.
2. **The following counts are required for sponges/soft goods:**
   a. **Baseline count**
   b. **New item count**
   c. **Relief count**
   d. **Cavity count**
   e. **Closing count**

f. Final count

~~9.~~**3. Baseline sponge counts shall be performed in the quantity as packaged by the manufacturer in order to identify manufacturer packaging errors (i.e., laps are counted in multiples of five and raytex are counted in multiples of ten), total count in multiples of ten.**

4. If a package of sponges/soft goods is found to be defective when opened (e.g. wrong number, damaged, contaminated) the package and its contents will be removed immediately from the field, placed in a plastic bag, labeled and removed from the operating room.

5. Sponges shall be counted in order from largest sponge to smallest sponge (eg, laps then baby laps, then raytex).

6. All sponges shall be X-ray detectable.

a. Never use X-ray detectable sponges for wound dressings

7. Count each sponge and separate from other sponges during the count

8. Remove all packing and wrapping materials and promptly discard in the trash

~~a.~~**9.** All sponges must be opened and visualized during closing counts and separated into sponge holders.

~~i.~~**a.** At the end of skin closure ALL sponges are passed off the field, separated, opened to full length and placed in sponge holders.

~~ii.~~**b.** Use a separate sponge holder for each sponge type (i.e. one for laps, one for raytex).

~~iii.~~**c.** Only one sponge should be placed in each pocket of the sponge holder.

~~iv.~~**d.** Load the sponge holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process will make visual determination of the filled holder easier to see from the OR table so empty pockets will be clearly visible to all in the room.

~~v.~~**e.** Place the sponge inside the pocket with the blue tag or blue stripe visible.

~~vi.~~**f.** Place one sponge per pocket, two sponges per ~~pouch (or row~~), and 10 sponges per sponge holder.

~~vii.~~**g.** When a holder has 10 sponges, there will be no empty pockets.

~~viii.~~**h.** The final sponge count ~~cannot~~ **CANNOT** be considered completed until ALL sponges opened during the case are bagged and visualized by the surgical team.

~~ix.~~**i.** The sponge holders are not disposed of until the patient leaves the OR.

10. Towels used in an open wound shall be x-ray detectable and shall be included in the count as miscellaneous items.

a. Scrub person ~~to~~shall notify the circulating RN when ~~the~~ a towel is placed in a wound/cavity and when it has been removed ~~from the abdomen~~

~~B.~~

D. <u>SHARPS AND MISCELLANEOUS ITEMS COUNTS</u>:

1. The following counts are required for sharps and miscellaneous items:

a. Baseline count
b. New item count
c. Relief count
d. Cavity count
e. Closing count
f. Final count

2. Packaged needles containing an incorrect number shall be removed from the room.

3. All used needles are to be placed in a puncture-proof needle counter box.

a. Place one needle in each numbered slot; do not double-up needles in a numbered slot.

b. Obtain an additional needle counter box if the initial needle counter box is full.

4. Counting number of needle packages may not be used to reconcile an incorrect needle count.

~~B.~~**E. <u>INSTRUMENT COUNTS</u>:**

1. **The following counts are required for instruments:**
   - **a. Baseline count**
   - **b. Relief count**
   - **c. Closing count**
2. **The instrument count is driven by the instrument count sheet, used as a checklist. The circulating nurse/designee directs the instrument count by reading off the instrument count sheet and visualizing the counted instruments with the scrub.**
   - a. All instruments shall remain within the OR during the procedure until all counts are completed and resolved
     - i. Individual pieces of assembled instruments shall be accounted for within the instrument count~~,~~ **(**e.g., suction tips, wingnuts, blades, sheaths**)**.

~~2.~~**3.** Instrument~~s shall be counted on all procedures in which the likelihood exists that an instrument can be retained.~~ **counts are required for cases entering the abdominal, thoracic, mediastinal, and retroperitoneal cavities.**

- **a.** Instrument count**s** ~~is~~**are** required for any procedure where the ~~chest or peritoneum is entered and the~~ incision is large enough for an instrument **(including instrumentation, such as screws)** to pass through.
- ~~a.~~**b.** Instruments shall be counted at the start of all **hernia repairs,** laparoscopy, thoracoscopy and robotic procedures since the possibility of converting to an open procedure **or extending the incision** exists.
  - i. If the procedure does not convert to an open procedure **or the incision is not extended to be larger than the smallest instrument used on the case,** the **closing** instrument count ~~does not need to be verified at the end of the case~~**may be waived**.
- **c. Closing ~~i~~instrument counts are required for ~~V~~vaginal ~~H~~hysterectomies and ~~L~~laparoscopic ~~A~~assisted ~~V~~vaginal ~~H~~hysterectomies. For all other vaginal procedures the surgeon is to perform a ~~sweep~~methodical wound examination of the vaginal cavity at the conclusion of the procedure to ensure items are not retained in the vagina.**
- **d.** ~~Instrument counts may be omitted in~~**Instrument counts may be omitted in certain cases with numerous and/or complex instruments or instrumentation. An X-ray is taken before the ~~start of wound~~completion of skin closure to confirm instruments are not left in the wound. The following cases shall use an X-ray in lieu of instrument count:**
  - **i. All** anterior, posterior, and lateral spine cases
  - **ii. Cervical spine cases**
  - **iii. Total joint replacements (hips, knees and shoulders)**
  - **iv. Any orthopedic case using trays of screws, wires, or other complex instrumentation**
  - **v. Any case using loaner trays or large numbers of instruments which is prohibitive of completing an accurate instrument count.**
  - **vi.** ~~. At the end of the procedure, an X-ray is completed.~~ **If fluoroscopy is being used on the case, a fluoroscopic image may substitute for an X-ray if a permanent copy of the image can be recorded and retained.**
  - **vii.** ~~The surgeon or~~ **When possible, it is highly recommended that a** radiologist ~~may~~ read the X-ray **before the patient leaves the OR** and the results of the reading, along with the name of the person who read the X-ray, are documented. **At a minimum, the surgeon must interpret the film intraoperatively.**
- ~~i.~~**e. Reverse total shoulder replacements: the surgeon shall announce when the humeral protector is placed into the wound and when it is removed and the RN circulator shall record it on the whiteboard.**

C. **PROCEDURE:**

1. Pre-incision: RN Circulator and Scrub Person
    a. Performs a baseline count of sponges, sharps and miscellaneous items. Use a marker to write the numbers per category on the white board. (Refer to policy statement). **The count board is used to rectify closing counts.**
    b. Ensure the sponges included in the count have their x-ray detectable strings and/or markings.
        i. Count each sponge and separate from other sponges during the count
        ii. Remove all packing and wrapping materials
        iii. Remove pre-packaged laps or 4 X 4's containing an incorrect count from the room
        iv. X-ray detectable towels shall be included in the count
    c. Ensure multi-pack needles are counted according to the number marked on the outer package until they are opened for use.
    d. Remove packaged needles containing an incorrect number from the room
        i. For cases requiring an instrument count, perform a baseline count of the instruments and document this number on the instrument count sheet. Document extra instruments on the count sheet.
1. Post-incision: RN Circulator and Scrub Person
    a. Added Sponges, Needles, and Small Items: RN Circulator and Scrub Person
    b. Count additional sponges, needles and small miscellaneous items as they are added to the field.
        i. If items are added by a circulator**anyone** other than the primary RN circulator, the item shall be initialed on the count board.
    c. Count added instruments and the RN circulator shall document the number and items on the instrument count sheet.
    d. Verify s**S**ponge, sharps, miscellaneous items, and instruments counts are**must be** completed prior to the relief of the primary RN circulator or primary scrub person.
        ii.**i.** **The relief count is performed by the incoming scrub and/or circulator who are assuming responsibility for the count as it stands at the time of relief.** The count shall be performed prior to the primary RN circulator or scrub person leaving the room.
2. Closure: RN Circulator and Scrub Person
    a. Count the sponges, sharps, miscellaneous items and instruments at the beginning of closure of body cavities (such as uterus, bladder, pericardium, anterior/posterior vaginal mucosa, **insertion of mesh**).
    b. Count in the following order:
        i. Sponges
        ii. Needles
        iii. Other sharps and miscellaneous items
        iv. Instruments
    c. Count items in the following sequence :
        i. Operative field
        ii. Mayo stand
        iii. Back table
        iv. Items off field
    d. Count all sponges, needles other sharps, and miscellaneous items, followed by instruments at closure of the pleura or peritoneum.**the beginning of wound closure.**
    e. Count at subcuticular closure of the wound/**skin closure**.
        i. All items except instruments are counted
        ii. Inform primary surgeon of the preliminary count outcome
            1) It is the legal responsibility of the RN circulator to ensure the primary surgeon is notified
    f. All sponges must be opened and visualized during closing counts and separated into sponge holders.

~~i. At the end of skin closure ALL sponges are passed off the field, separated, opened to full length and placed in sponge holders.~~
~~ii. Use a separate sponge holder for each sponge type (i.e. one for laps, one for raytex).~~
~~iii. Only one sponge should be placed in each pocket of the sponge holder.~~
~~iv. Load the sponge holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process will make visual determination of the filled holder easier to see from the OR table so empty pockets will be clearly visible to all in the room.~~
~~v. Place the sponge inside the pocket with the blue tag or blue stripe visible.~~
~~vi. Place one sponge per pocket, two sponges per pouch (or row), and 10 sponges per sponge holder.~~
~~vii. When a holder has 10 sponges, there will be no empty pockets.~~
~~viii. The final sponge count cannot be considered completed until ALL sponges opened during the case are bagged and visualized by the surgical team.~~
~~ix. The sponge holders are not disposed of until the patient leaves the OR.~~
~~g. Broken sharps or instruments must be accounted for in their entirety during closing counts.~~
~~h. Incorrect Counts:~~
~~i. Inform primary surgeon of any discrepancies~~
~~ii. Search the total room including floor, trash and linen:~~
~~1) If item is not found, an X-ray of the patient must be taken prior to patient leaving the OR suite~~
~~2) If item missing is micro or CV needle (C-1 or smaller), X-ray is not needed~~
~~3) A quality review report (QRR) must be completed.~~
~~i. Ensure sterile field remains sterile until item is found or x-ray is read~~
~~j. Inform Assistant Nurse Manager (ANM)/charge nurse/designee of any discrepancies~~
~~i. If counts were omitted due to extreme emergency, x-ray shall be performed per primary surgeon prior to patient leaving the OR suite.~~
~~1) Ensure X-ray is read prior to patient leaving the OR suite~~
~~2) Document pre and post events regarding the nature of the emergency. Documentation of the events is mandatory~~
~~3) Document the name of physician reading the x-ray and the x-ray results~~

~~C.~~F. DOCUMENTATION:

1. Document verification of all counts in the OR record.
   a. Types of counts (sponges, sharps, and instruments)
   b. Cavity count must be written as a count
   c. The number of counts
   d. Names and titles of persons performing counts
   e. Results of counts
      ~~i. Notification of primary surgeon~~
      i. Actions taken if count discrepancies occur
      ii. Rationale if counts are not performed or completed

~~ii.~~**f.** Complete an incident report for all incorrect counts **or waiver of counts in the event of an emergency**.

~~D.~~G. REFERENCES:

1. ~~AORN Perioperative Standards and Recommended Practices (2013). "Recommended Practices for Prevention of Retained Surgical Items". Denver: Association of periOperative Registered Nurses, Inc.~~ **AORN Guidelines for Perioperative Practice, 2015 Edition.**

~~1.~~**2. Verna Gibbs, MD. NoThing Left Behind®: Prevention of Retained Surgical Items Multi-Stakeholder Policy (2015).**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 3/02	**SUBJECT: Utilization of Staff, Staffing Patterns**
REVISION DATE: 6/03; 8/05; 5/06; 8/08; 6/09; 3/12	**POLICY NUMBER: VIII.A**

Department Approval:	**09/16**
Clinical Policies & Procedures Committee Approval:	**~~04/12~~09/16**
Nursing Executive Committee Approval:	**~~04/12~~09/16**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~07/12~~10/16**
Board of Directors Approval:	**07/12**

A. **POLICY:**

1. Staffing patterns shall follow mandatory state regulations. In addition, patient acuity shall be assessed to ensure appropriate staffing levels.
2. The Director/ Manager have accountability for staffing and work schedules.
3. Nursing staff to assist the Registered Nurse (RN) in the provision of patient care may be utilized as follows:
   a. Administrative Supervisor (AS):
      i. Assumes responsibility for supervision of staff as a representative of Administration.
      ii. Assumes administrative authority for the level of patient care and standards of care.
      iii. Acts as liaison between all hospital staff, patients, families, physicians, directors and administration for routine administrative decisions for their shift.
      iv. Manages internal and external supplemental staff in the absence of the ~~Operations Manager of Staffing Resource~~ **Director, Education, Clinical Informatics and Staffing.**
   b. Assistant Nurse Manager (ANM)/designee:
      i. Works under the direction of the Clinical/Operations Manager and/or Director.
      ii. Oversees direct and indirect patient care assignments.
      iii. Ensures patient care assignments are in writing and based on the following:
         1) Patient – Level of care (intensity of care needs, treatments, and medications, as determined by the Patient Classification System)
         2) Environment: unit geography; location of assigned patients in relation to each other; and safety
         3) Technology: hemodynamic equipment, respiratory support equipment, and frequency of required monitoring activities
         4) Supervision: staff competence, skills/abilities; staff mix and workload ability
         5) Competency of delegating RN to carry out clinical and managerial responsibilities
         6) Availability of delegating RN for appropriate supervision of assigned staff in relation to activity of unit and patient assignment of charge personnel
         7) Regular staff members are responsible for overseeing students, per diem, registry staff, and orientees
      iv. Document patient assignments each shift and include the following:

1) Name of Assistant Nurse Manager/designee
2) Name of RN responsible to supervise and/or orient any RN or non-RN personnel performing patient care, students, registry or traveler staff, or private duty nurses.
3) Name of each caregiver by licensure category and specific assignments listed by individual patient
4) Assigned break coverage for each licensed staff member to ensure minimum staffing ratios are maintained at all times.
   a) Documentation of break coverage shall include specific time of break relief.
   b) The same licensure or higher is required for break relief coverage.

v. Cerner staff assignment information will be electronically maintained in the "Staffing Acuity" shared drive folder.

c. Registered Nurse (RN):
   i. Works under the direct supervision of the Assistant Nurse Manager/designee.
   ii. Plans, supervise, and evaluate the care of all patients by using the nursing process.

d. **Procedural**~~Interventional Radiology~~ Nurse:
   i. RN whose primary responsibility is to assist with ~~inpatient Interventional Radiology~~ **invasive** procedures.
      1) Additional duties may be assigned by the Clinical Manager/designee based on the hospital needs.
      ~~ii. The Interventional Radiology nurse shall be utilized as scheduled even during a low census to ensure coverage of unscheduled bronchoscopies.~~
   ~~1)~~**ii.** If census and activity is low throughout the day, **staff**~~the Interventional Radiology nurse~~ may be flexed.

~~e. Admission Nurse:~~
~~i. RN who assists with inpatient admissions in the Emergency Department~~
~~ii. Shall be utilized as scheduled even during a low census to ensure support with patient flow.~~

~~f.~~**e.** Unit Secretary **(US)**:
   i. A clerical worker who enters information into the computer system and assists with reception duties.
   ii. The ~~ANM/Designee~~ **US** works under the direction of the RN and is supervised by a charge nurse or clinical manager on duty.

~~g.~~**f.** Monitor Technician:
   i. A trained person who has demonstrated competency in recognition of cardiac arrhythmias.
   ii. Works under the direction of the RN and is supervised by a**n** ANM or designee on duty.

~~h.~~**g.** CNA/ACT/Nursing Assistant/Mental Health Worker (MHW):
   i. A trained person who has been taught to perform tasks involving direct care services for patients.
   ii. Works under the direction of the RN and is supervised by a ANM or designee on duty.

~~i.~~**h.** Technicians:
   i. A trained person who demonstrates competency in caring for patients in designated area of specialty.
   ii. Works under the direction of the RN and is supervised by the ANM or designee on duty.

i. Psychiatric Liaison:
   i. A trained person (for example licensed MFT/LCSW) who is primarily responsible to complete LPS patient assessments and provides complete

crisis intervention, including admission/transfer to a Crisis House and or inpatient Behavioral Health Unit if necessary.

~~j.~~**ii. Works under the direction of the Psychiatric Liaison Supervisor who reports directly to the Behavior Health Unit Manager.**

4. Volunteers, student nurses, patient-acquired private duty staff, externs, and patient safety technicians may be utilized per policies.
5. Shift-To-Shift Staffing (if applicable)
   a. Acuity Measurement - A Patient Classification assessment is conducted once per shift for patients in all nursing units.
      i. Labor & Delivery & Emergency Department are excluded and utilize census only numbers.
   b. The Assistant Nurse Manager/designee ensures all Patient Classification are completed for their units by 1400 and 0200.
   c. The Assistant Nurse Manager/designee then completes the **staffing needed for the next shift based on the acuity of the patients, minimum staffing ratios and the expected patient volume.** ~~Staffing Calculator which encompasses minimum staffing ratios and the acuity of the patients to determine the number of staff needed for the next shift.~~
   d. This information is communicated to the Staffing Office.
   e. Staffing Office **R**~~r~~epresentatives shall place calls as requested by the Administrative Supervisor or designee.
   f. After all TCMC available resources have been effectively utilized, the Assistant Nurse Manager/designee shall evaluate staffing the units using the TCMC tool.
      i. Staffing needs or staffing reductions due to periods of decreased census and patient requirements shall be coordinated by the Staffing Office, Managers, Directors, and/or Administrative Supervisors. This includes ensuring rotations are fair and equitable and specialized unit needs are covered.

B. **RELATED DOCUMENTS:**

1. **Patient Care Services (PCS) Policy: Allied Health Students in the Patient Care Areas**
2. **PCS Policy: Nursing Students in Patient Care Areas**
3. ~~1.~~ **PCS Policy: Volunteers, Patient Care Services Departments**

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL MANUAL

SUBJECT: Influx of Infectious Patients: Epidemic Influenza or Other Respiratory Transmitted Disease

ISSUE DATE: **POLICY NUMBER: IC15.0**

REVIEW DATE(S): 10/12
REVISION DATE(S): 10/09

Department Approval Date(s):	~~10/12~~04/16
Infection Control Committee Approval Date(s):	~~10/12~~04/16
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	~~11/12~~09/16
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	11/12

~~TRI-CITY MEDICAL CENTER DISTRICT~~ ~~Infection Control~~ ~~Infection Control Committee 10/12~~ ~~Reviewed 10/12~~ ~~Revised 10/09~~ ~~MEC and Board: 11/2012~~	~~Section:~~ ~~Infection Control~~ ~~Subject:~~ ~~Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*~~ ~~Policy Number: IC 15.0~~

A. **PURPOSE**:
1. Provide a plan to manage patients requiring Droplet or Airborne Precautions when the availability of rooms, staff, supplies or other recourses are limited. This plan is intended to provide a decision pathway for initiating Code Triage and Code Orange status.

B. **SUPPORTIVE DATA:**
1. Influenza epidemic or pandemic are different from many threats for which public health and the health-care system are currently planning[1,2,3]:
   a. A pandemic will last much longer than most other emergency events and may include "waves" of influenza activity separated by months (in 20th century pandemics, a second wave of influenza activity occurred 3 to 12 months after the first wave).
   b. The numbers of health-care workers and first responders available to work can be expected to be reduced; they will be at high risk of illness through exposure in the community and in health-care settings, and some may have to miss work to care for ill family members.
   c. Because of how widespread an influenza pandemic may turn out, resources in many locations could be limited.

[1] Preparing for an Influx of Infectious Patients, Joint Commission:The Source, **June 2009, Volume 7, Issue 6**~~August 2004~~
[2] Influenza Pandemic Response Plan. California Department of Health Services, September 2001
3 California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies, 2008

C. **POLICY**:

1. Most likely scenarios that would result in an influx of infectious patients include, but are not limited to:
   a. Epidemic influenza
   b. Epidemic gastroenteritis
   c. Epidemic exposure to suspected biological agent
   d. Epidemic biological agent (such as smallpox)

D. **PROCEDURE**:

1. Influx is localized to **the Emergency Department (**ED) due to:
   a. Worried well seeking information or prophylaxis
   b. Necessity for treatment of influenza symptoms which will result in discharge from ED:
      i. Initiate Code Triage- during code triage implement limited command center during business hours.
      ii. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed- Administrative ~~Coordinator~~**Supervisor**
      iii. Refer to Disaster Lockdown policy in the event of uncontrolled access.
   ~~iii.~~**c. The Emergency Operations Plan will be initiated as needed.**
2. **Level 1: 1-5** patients waiting for bed placement requiring isolation precautions
   a. Notify Administrative Supervisor - ED ~~lead~~ **Charge Nurse**
   b. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed- Administrative **Supervisor**~~Coordinator~~
   c. Notify Pulmonary lead (760) 802-1974 perform ventilator inventory
   d. Assess all current inpatients for discharge or transfer potential- Bed ~~Coordinator~~**Supervisor**
   e. Contact local skilled nursing facilities for bed availability- Case manager
   f. Contact Public Health Department for coordination of patient placement- Infection Control
   g. Exceed the state mandated nurse-patient ratio, if needed- Chief Nurse Executive
   h. Post security at ED entrances
   i. Refer to Disaster Lockdown policy in the event of uncontrolled access.
3. **Level 2: 6-10** patients waiting for bed placement requiring isolation precautions
   a. Implement Patient Care Procedure, Code Triage Alert, Emergency Department
   b. Assess all current inpatients for discharge or transfer potential- Bed Coordinator
   c. Consider contacting local skilled nursing facilities for bed availability- Case manager
   d. Consider contact**ing the** Public Health Department for coordination of patient placement- Infection Preventionist/Safety Officer
   e. Refer to Disaster Lockdown policy in the even of uncontrolled access.
4. **Level 3: More than 11 patients** waiting for bed placement requiring isolation precautions
   a. Activate Code Orange- Chief Executive Officer (See Emergency Operations Plan)
      i. An internal disaster is declared when surge progresses beyond the ability of an initial localized response to contain or suppress the event.
      ii. In the event of an incident occurring outside of the Hospital, the need for mass casualty support will be identified by the **C**county Office of Emergency Services and a **"Annex D"** notification will be transmitted by County Communications System to the Emergency Department (ED). An "Annex D" indicates an event has occurred somewhere and that patients with epidemic influenza or respiratory transmissible disease may be sent to the hospital. The ED will notify the Administrator-on-Call or Operations Supervisor of the Annex

D notification, who will in turn advise the other members of the Emergency Command Staff. See Appendix A for Pandemic Alert Phases.

1) **Contact the County of** San Diego **Public Health:** ~~County Contact point- Station M-~~**at** 858-565-5255**. Ask for Station M. - This is available 24/7 and to be utilized for emergencies only.**~~(24/7 availability)~~

2) Activate Code Orange (if not already activated)

iii. Consider isolating a section of ED (Contact Engineering to facilitate)

b. For Novel viruses - Patients with oral temperatures >101˚F on two successive readings will require Standard and Droplet Precautions. If the suspect pathogen is found to be transmitted via airborne route, than Standard and Airborne Precautions will be initiated, if available. If the suspect pathogen is found to be transmitted via direct/indirect (fomite) routes, then Contact Precautions will be added.

c. Use Airborne Illness Isolation Rooms for admissions: 143, 243, 443, 287, 387, 487 and MCH rooms 200, 201

d. When AIIR's are fully utilized, use **a** private room with portable HEPA filter (call Engineering)

e. Expedite discharge of inpatients who are able – Case Management

f. Consider available options for designating an inpatient isolation precautions unit or clinical area.

g. Consult with Staffing Department for staff resource management.

h. In the event of Epidemic gastroenteritis

i. Assess need for:

1) Contact Precautions

2) Inventory private rooms available

3) When necessary cohort with like condition

4) Create a cohort patient care area using available facilities and considering all options (e.g. in the Assembly Rooms 1-3 move Child Care off site)

5) Create patient care areas in the parking lot

i. Supplies

i. MDC to perform daily inventory of medical supplies, and isolation supplies and report

ii. Supplies maintained on a three tier level

iii. Local inventor of stock (floor stock) will be maintained at higher levels

iv. When depleted utilize central storage (in-house) of critical supplies including PPE, and strategic medical supplies will be maintained

v. When central storage is depleted distributer will maintain supply of inventory readily available for distribution when needed.

j. Quarantine - Tri City Medical Center would most likely be a Type C Quarantine facility. Type C facilities care for actual and suspect cases. This would include individuals with:

i. Compatible symptoms and laboratory confirmation of the specific pandemic strain of influenza (**confirmed case**)

ii. Compatible symptoms following suspected/known exposure with pending laboratory confirmation (**probable case**)

iii. Atypical clinical symptoms following suspected or known exposure (**suspect case**)

iv. Contacts under surveillance that become febrile with oral temperatures > 101° F (38°C) on two successive readings.

v. Individuals with other associated symptoms such as coughing and fever

vi. Ill persons requiring specialized health care may be isolated in a hospital, but, depending on their medical needs, persons may also be isolated at home or in a designated health care facility or community-based facility.
vii. For non-hospital isolation, home/personal residence isolation is preferred and will be utilized first unless a contraindication exists such as homelessness, non-compliance with isolation or at-risk persons in the home with inability to maintain separation.
viii. Transportation to an isolation facility will be coordinated with the EMS DOC.

k. Bed availability
i. If there **are~~is~~** no hospital bed**s** available, contact **the County of San Diego Public Health** Station M **for guidance ~~.~~858-565-5255.**

l. Prophylaxis Immunization requirements:
i. Implement mass prophylaxis protocols.
ii. Required for entry to facility if vaccine is available. NOTE: Prophylaxis may not be available.
iii. If no prophylaxis is available, individuals working with confirmed and suspect cases must use Standard, and Airborne Precautions.
iv. Strict respiratory hygiene to include frequent hand hygiene and masks must also be enforced.
v. The **Safety and Security Officer** or designee will ensure that all personnel who enter the facility have been recently prophylaxed with vaccine or antivirals if available and are on the list of individuals who may enter the facility

m. Staffing:
i. Maintain pre-epidemic staffing levels, if possible
ii. If the number and types of staff are insufficient to meet the needs of the number of people being contained, additional staff may be requested through the County Emergency Operations Center (EOC)
iii. **Planning Chief** will compile a list of individuals who can enter the facility. This should be established in collaboration with the Public Health Officer and/or the authorized designee.
iv. The list will include the smallest possible number of people required for patient care, disease investigation, and facility maintenance (physicians, nurses or aides, laboratory personnel, housekeeping, dietary, and maintenance personnel, etc.)
v. This list will be kept by the **Personnel Pool Unit Leader** or designee.
vi. Consider cross training of staff to facilitate work flow
vii. If isolation unit is established consider ancillary staffing including on-unit Radiology, Lab and Respiratory Care staffing.
viii. If child care is provided**,** screening for signs of illness including temperature reading and recording may be indicated.

n. The **Employee Health Director** or designee will:
i. Ensure that employees monitor and report their temperature and any symptoms every 12 hours until-
1) 14 days after they are vaccinated or
2) 14 days after they completed their antiviral prophylaxis or
3) 5 days after the date of last patient contact
ii. Those personnel on the list to enter the facility that are not vaccinated or on prophylaxis drugs will also monitor and report their temperature and any symptoms every 12 hours and use personal protective equipment (PPE) while in the facility until 14 days after they have been vaccinated, placed on antiviral therapy when it becomes available or 5 days from date of last contact.

iii. This access monitoring system will include a confidential log of all persons who enter and leave, including staff, and will include each person's vaccination, antiviral treatment status, temperature and any symptoms reported.

iv. Until 14 days after immunization, once vaccine is available, or completion of antiviral therapy, all personnel will check their temperature every 12 hours. At the beginning of each shift, they are to report their temperatures or any illness to the person assigned to monitor employees' health. On off days, they are required to be in telephone contact each morning to report their temperatures. Once the waiting period is over, personnel are not required to routinely check their temperatures. They are still required to report any illness.

v. Staff with febrile oral temperatures >101˚F on two successive readings will not be able to work.

o. **Medical Staff Office**

i. Refer to Medical Staff Disaster Plan (See Med**ical Staff Policy #8710-553)** ~~Staff Policy # 4045)~~

p. Extended Epidemic- PRIORITIES

i. Sustained staffing
ii. Vaccine acquisition and distribution
iii. Antiviral medication acquisition and distribution
iv. Mask supply and reuse
v. Bed availability
vi. Security

	2 weeks	4 weeks	2 months	6 months
Staffing and possible quarantine	Consider housing staff at hospital	Request staff from outside effected areas	Train additional staff to perform non-critical functions	
Medication supply	Request additional vaccine and antiviral medications	Reprioritize vaccination and antiviral distribution strategies		
Supplies	Request additional masks tissues, disposal bags and hand sanitizer	Consider changes to infection control practice related to reuse of supplies	Consider making gauze masks, if supply of disposables is nearly exhausted	
Bed availability	.Use available private rooms; cohort with like illness	Consider transfer to another facility		
Security	24 hour restricted access to essential staff only			

E. RELATED DOCUMENTS:

1. Emergency Operations Plan

Appendix A -

World Health Organization (WHO) Stages of Alert Phases of a Pandemic
Pandemic Stage Definition

Novel (new) Virus Alert
- Novel virus detected in one or more humans
- Little or no immunity in the general population
- Potential, but not inevitable precursor to a pandemic

Pandemic Alert
- Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area

Pandemic Imminent
- Novel virus causing unusually high rates of morbidity and mortality in widespread geographic areas

Pandemic
- Further spread with involvement of multiple continents

Second Wave
- After the number of cases falls and the pandemic appears to be ending, typically a second wave of cases occurs within several months

Pandemic Over
- Cessation of successive pandemic "waves", accompanied by the return (in the U.S.) of the more typical wintertime "epidemic" cycle

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 4/09	**SUBJECT:** Disaster Privileges
REVISION DATE: 9/09	**POLICY NUMBER:** 8710-553

Medical Staff Department Approval:	08/16
Credentials Committee Approval:	08/16
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval:	08/16
Professional Affairs Committee Approval Date(s):	10/16
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide a process to credential and grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or Allied Health Professionals (AHP's), as appropriate, in the event of a disaster when the HICS plan has been activated and the hospital is unable to meet immediate patient care needs.

~~1.~~2. SCOPE and RESPONSIBILITY includes the Medical Staff Services Department of Tri-City Medical Center or Designee and the designated Disaster Coordinator.

~~2. To identify criteria for granting disaster privileges to non-members of Tri-City Medical Staff when the TCMC Emergency Management Plan has been activated and/or the immediate needs of the organization are unable to meet immediate patient needs.~~

B. **DEFINITIONS AND TERMS:**

~~1. Disaster Privileges: Disaster Privileges are time-limited privileges, which may be granted to physicians and allied health professionals (AHP) when the emergency management plan has been activated and the organization is in need of additional resources and appropriate expertise to handle the immediate patient needs during a disaster. The Chief Executive Officer (CEO), chief of staff, or designee may grant such privileges (also refer to Medical Staff Policy #4045: Emergency Preparedness Management).~~

1. The following definitions shall apply for purposes of this policy and procedure only.
   a. Practitioner: A physician (M.D., D.O.), podiatrist (D.P.M.), dentist or oral maxillofacial surgeon (D.D.S., D.M.D.)
   b. Allied Health Professional (AHP): All health care professionals other than Practitioners, as defined above, who ~~are classified as Dependent practitioners to~~ work ~~as a physician extender~~ under the direction of a supervising physician and required by law and regulation to have a license, certificate or registration to practice their profession and.
   c. Surgical Tech, Orthopedic Tech shall be credentialed as follows:
      i. If a "tech" is employed by another hospital, they will be sent to Human Resources for appropriate credentialing.
      ii. Any "tech" who is not employed by another hospital will be credentialed per this policy.
   d. Volunteer Practitioner or AHP: A Practitioner who is not currently a member of the medical staff of Tri-City Medical Center, or an AHP who has not been credentialed as an AHP by the facility.
   e. Disaster Clinical Privileges: Clinical Privileges granted to a Practitioner, as defined above, pursuant to this policy and procedure.
   ~~a.~~f. Disaster Practice Prerogatives: Practice prerogatives granted to an AHP, as

defined above, pursuant to this policy and procedure.

~~C. POLICY:~~

~~1. In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of Chief of Staff, the Vice-Chief of Staff, may grant disaster privileges.~~

~~a. In the absence of the Chief of Staff and Vice-Chief of Staff and Department Chair(s), the CEO or designee may grant the disaster privileges consistent with this policy.~~

~~b. The grant of privileges shall be on a case-by-case basis at the sole discretion of the individual authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges shall be continued.~~

~~2. The verification process of the credentials and privileges of individuals who receive disaster privileges, shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:~~

~~a. Identifies in writing the individual(s) responsible for granting disaster privileges.~~

~~b. Describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.~~

~~c. Describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.~~

~~d. Addresses the verification process as a high priority.~~

~~e. Ensures the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control.~~

~~3. The process for disaster privileges is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.~~

~~4. Members of the medical staff shall oversee those granted disaster privileges.~~

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

1. Upon presentation to the hospital, Volunteer Practitioners and/or AHPs shall be directed to the Hospital Representative responsible for disaster credentialing under the HICS plan.

a. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows:

i. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:

1) A current hospital photo ID badge that clearly identifies professional designation;

2) A current license, certificate or registration to practice, as appropriate;

3) Identification indicating the individual is a member of a Disaster Medical Assistance Team (*DMAT*), or Medical Reserve Corps (*MRC*), Emergency System for Advanced Registration of Volunteer Health Professionals (*ESAR-VHP*), or other recognized state or federal organizations or groups;

4) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a deferral state, or municipal entity); or

5) Identification of Volunteer Practitioners by current hospital or medical staff members(s) who possess personal knowledge regarding the Practitioner's ability to act as a licensed independent Practitioner during a disaster and of Volunteer AHPs by current hospital member(s) who possess personal knowledge regarding the

AHP's qualifications.

b. Required Documentation on the Disaster Privileges/Prerogative Approval Form:
   i. Name of Volunteer Practitioner or AHP (printed and signed)
   ii. Specialty or AHP Category
   iii. Office Address and Phone Number
   iv. Professional License/Certificate/Registration Number and Expiration Date
   v. Driver's License or Passport Number and Expiration Date
   vi. Date of Birth
   vii. Name of Professional Liability Insurance Carrier and Limits of Liability
   viii. Name of Professional School and Year of Graduation
   ix. Hospital Affiliation(s) and Staff Status

c. Verification Process:
   i. The Hospital Representative shall verify professional licenses/certificates/ registrations as follows:
      1) Primary Source Verification:
         a) Query the appropriate licensing/certification/registration board on-line, e.g.= Medical Board of California website = *www.medbd.ca.gov* – use for M.D.s, D.P.Ms and PAs; California Osteopathic Medical Board = *www.ombc.ca.gov* – use for D.O.s, California Board of Registered Nursing = www.rn.ca.gov – use for R.N.F.A.s, N.P.s, C.N.M.s and other R.N.s; Board of Behavioral Sciences = www.bbs.ca.gov --- use for M.F.C.C.s and L.C.S.W.s; California Psychology Board = www.psychboard.ca.gov –use for clinical psychologists, and print verification if possible.
      2) If computer access is not available, a copy (if possible) of the Volunteer Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification shall be made and attached to the Disaster Privilege/Prerogative Approval Form. If a copier is not available, the Hospital Representative shall perform a visual verification of the above documents, and document such verification.
      3) If primary source verification of professional licensure/certification/ registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control and completed no later than seventy-two (72) hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours (e.g., no means of communication or lack of resources) it shall be accomplished as soon as possible. In this extraordinary circumstance, the following must be documented:
         a) Why primary source verification could not be performed in the required timeframe;
         b) Evidence of the Volunteer Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
         c) Attempt(s) to rectify the situation as soon as possible.
      4) The Medical Staff Services Representative or designee shall query the National Practitioner Data Bank (NPDB) and other sources as needed as soon as the emergency situation has been contained.
      5) Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment and services under the Disaster Clinical Privileges or Practice Prerogatives, as

appropriate.

d. Who May Grant Disaster Clinical Privileges/Practice Prerogatives:

i. As described in the Medical Staff Policies~~Bylaws~~, the Chief Executive Officer (CEO) or Chief of Staff or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the hospital's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.

e. Temporary Badges:

i. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:

1) Name
2) Specialty or AHP category
3) Practicing with Disaster Clinical Privileges or Practice Prerogatives, as appropriate.

f. Oversight:

i. The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges or Practice Prerogatives. Oversight shall be accomplished whenever possible by partnering the Volunteer Practitioner or AHP with a current credentialed medical staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP. If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Staff Officer designated under the *HICS* plan.

g. Termination of Disaster Clinical Privileges/Practice Prerogatives:

i. A Volunteer Practitioner's or AHP's Disaster Clinical Privileges or Practice Prerogatives shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Volunteer Practitioner or AHP is not capable of exercising Disaster Clinical Privileges or Practice Prerogatives. Disaster Clinical Privileges and Practice Prerogatives are time-limited and shall expire automatically at the time the CEO or designee declares the disaster to be over, or that the services of Volunteer Practitioners or AHPs are no longer required.

~~E. **PROCEDURE:**~~

~~1. Disaster privileges may be granted to volunteers eligible to be Licensed Independent Practitioners and Allied Health Professionals upon presentation of a valid picture identification issued by the state, federal, or regulatory agency and at least one of the following:~~

~~a. A current picture hospital identification card clearly identifying professional designation.~~

~~b. A current license to practice.~~

~~c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.~~

~~d. Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.~~

~~e. Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.~~

~~2. Disaster Response:~~

~~a. All non-Medical Staff who are granted disaster privileges will respond to the Physician Labor Pool in Physicians Dining Room and appropriate name badge provided (appropriate name badge is defined by Medical Staff Policy #8710-521, *Name Tags for*~~

~~*Health Practitioners*).~~

~~3. Pending Verifications Process:~~

~~a. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours.~~

~~i. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:~~

~~1) The reason(s) verification could not be performed within 72 hours of the practitioner's arrival.~~

~~2) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.~~

~~3) Evidence of an attempt to perform primary source verification as soon as possible.~~

~~4. Oversight of Volunteer Practitioner:~~

~~a. The Medical Director or designee will provide oversight of the care, treatment and services provided by the volunteer practitioner, by either direct observation, mentoring or chart review and will determine whether the volunteer practitioner's disaster privileges will be continued for the duration of the disaster situation. Within 72 hours, the organization will make a decision on information that is obtained from the Medical Director or designee to continue the volunteer practitioner's practice.~~

~~i. When the disaster situation no longer exists, these disaster privileges terminate.~~

~~F.~~D. REFERENCES:

1. The Joint Commission Standards

~~1. Inside the Joint Commission, Vol. 13 No. 4, March 3, 2008.~~

~~2. The Joint Commission Standards EM.02.02.13 and EM.02.02.15~~

APPLICATION FOR DISASTER PRIVILEGES

To be completed by the Volunteer Licensed Independent Practitioner/Volunteer Practitioner

Full Name:_____
Cell Phone Number:_____
Social Security Number:_____
Date of Birth:_____
Office Address, City, State, Zip Code:_____
_____
Office Telephone:_____
Photo Identification Type (i.e., driver's license, government I.D.)
_____
Identifying Number:_____
Issuing State/Agency:_____
(If copy not obtained, list other information):_____
_____
License (certification or registration) Number:_____
Issuing State:_____
Expiration Date:_____
(If copy not obtained, list issuing agency name/address/phone/other information)
_____
Malpractice Insurance Carrier Name:_____
Telephone Number (if available):_____

Current Hospital Affiliation(s) – Facility(s) Name(s)
Address(s), City(s), State(s), Zip Code(s)
Telephone Number(s)
_____
_____
_____

LIP/Volunteer Practitioner's Signature:_____

VERIFICATIONS/APPROVAL

Review all documents and attach copies if possible. Conduct verification of information as possible

License/Certification/Registration:_____

Affiliation(s):_____

Insurance:_____ NPDB:_____OIG:_____Other:_____

On Site Medical Staff Member's Name:_____

Responsibilities (following interview with volunteer Health Care Practitioner):_____

_____

_____

Assigned Partner:_____

Approved by: (print name, signature, title):_____

CONSENT, ACKNOWLEDGEMENT & RELEASE OF INFORMATION FOR DISASTER PRIVILEGES

I, the undersigned, hereby apply for disaster privileges as requested on this application. I acknowledge and agree to abide by the Medical Staff Bylaws, Rules and Regulations and applicable hospital policies. By applying for disaster privileges, I accept the following conditions during the processing and consideration of my application and for the duration of my privileges, regardless of whether or not I am granted the privilege requested:

1. I agree the information provided in conjunction with this application is accurate and represents the current level of my training, experience, capability, health status and competence to practice the disaster privileges requested.

2. I fully understand and agree that any significant misrepresentation, misstatement or omission from this application, whether intentional or not, shall constitute cause for denial of requested disaster privileges. In the event that disaster privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary termination of disaster privileges.

3. I hereby authorize my professional liability insurance carrier to notify the Chief of Staff or his agent, in the event that my insurance coverage is terminated, canceled, modified or otherwise acted upon.

4. I understand and agree that as an applicant for disaster privileges that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, health status, and other qualifications and for resolving any doubts about such qualifications. I agree to make myself available for interviews with regard to my application and any peer review related matters during the time that I hold disaster privileges.

5. I agree to provide continuous care for my patients either personally or through an identified qualified member of the medical staff.

6. Immunity is extended to the fullest extent permitted by law and I release from liability all persons, organizations, committees and their agents from participating in good faith in requesting or supplying information relative, but not limited to: (a) applications for appointment and/or clinical privileges; (b) periodic reappraisals undertaken as part of the peer review process; (c) investigations, reprimands, corrective action, suspension or reduction of clinical privileges, or other disciplinary action; (d) hearings and appellate reviews: (e) reviews before the governing board; (f) case evaluations; (g) utilization reviews: (h) other hospital, medical staff or departmental, service or committees activities relating to the quality of patient care or my professional conduct; (i) inquiries concerning my professional qualifications, character, ethics, physical or mental health status, or behavior; and (j) any other matter that may affect patient care, or the orderly operation of this or any other hospital, and I hereby authorize and consent to the release of such information.

7. I understand and agree that after I submit this application it is my sole obligation to promptly report to the Chief of Staff or his designee of any: (1) change in the contents of this application; (2) change in my physical or mental health that could impair my ability to practice; (3) change in my staff membership or privileges at any other health care facility; (4) investigation or accusation with regard to my license or DEA; or (5) conviction of, or plea of guilty or no contest, or its equivalent, to a felony in any jurisdiction; (6) sanction and/or exclusion from participation in any Federal health care program; or (7) change in the status of my professional liability insurance coverage.

8. I present this application and arrange for the submission of other information with the understanding: (1) that such information is requested by the peer review committee(s) of this hospital as part of the credentialing process; (2) that the confidentiality and privacy of this information will be preserved; and (3) that this information and materials will only be released or disclosed as part of current or future credentialing, peer review or quality improvement processes as described above and in the medical staff bylaws, rules and regulations.

9. I understand that the completion of this application is my sole responsibility. I declare that the information on this application is true and without omission to the best of my knowledge. I hereby apply for disaster privileges.

SIGNATURE: _____ DATE: _____

SUBJECT: GUIDELINE FOR CARE OF THE EXTREMELY LOW BIRTHWEIGHT INFANT (ELBW) AND VERY LOW BIRTHWEIGHT INFANT (VLBW) SPECIAL CARE/MINIMAL STIMULATION

ISSUE DATE: 12/07 REVISION DATE: 04/09, 06/11, 8/12

Department Approval Date(s):	**06/16**
Perinatal Collaborative Practice Approval Date(s):	**08/16**
Division of Neonatology Approval Date(s):	**08/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**09/16**
Professional Affairs Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	

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

~~1. To minimize the negative impact of care giving interventions on the very low birth weight/extremely low birth weight infant during the period of greatest vulnerability.~~

~~2. To provide a safe, supported means of parental interaction with the very low birth weight/extremely low birth weight infant.~~

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

~~1. Extremely Low Birth Weight (ELBW) patients are defined as having a birth weight less than 1000 grams and/or born at less than 28 weeks.~~

~~2. Very Low Birth Weight (VLBW) patients are defined as having a birth weight less than 1500 grams.~~

~~C. **PROCEDURE:**~~

~~1. All patients admitted to the NICU with birth weight less than 1000 grams and/or born at 28 weeks gestational age or less are placed on minimal stimulation care for the first two weeks of life (minimum duration). Nursing discretion will determine if patients larger than 1000 grams require minimal stimulation care.~~

~~2. This policy applies to all caregivers, consultants, and other persons within the NICU.~~

~~3. This guideline defines the usual routines for practice with this population. Physician/Nursing discretion may require modification based upon individual patient needs.~~

~~4. Initiate ELBW/VLBW guidelines in process intervention.~~

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

~~1. At birth or upon admission (at first contact with NICU team), include minimal stimulation in care planning.~~

~~a. Hands-on (full) assessment every 4 - 6hours.~~

~~i. The first assessment of the shift will be a full hands-on assessment, correlating the vital signs with the monitor vital signs.~~

~~ii. Initiate exam by gentle vocalization and touch to improve infant's readiness for handling.~~

~~iii. Prioritize assessment to ensure most important parameters assessed first.~~

~~b. Minimal stimulation (non-contact) vital signs every 1 to 2 hours and prn. PRN includes, but is not limited to, recent history of instability of given parameter and/or alteration in clinical status.~~

~~i. Obtain heart rate from monitor.~~

~~ii. Observe respiratory rate.~~

~~iii. Axillary temperature with full assessments and prn.~~

iv. Blood pressure via arterial catheter transducer. If arterial catheter not present, with full assessment and prn (remove external BP cuff after each BP taken).

2. Optimize thermal stability per "Thermoregulation for VLBW Infants <32 weeks and/or 1500 grams."
   a. For those with birth weight less than 750 grams use a chemical blanket set at 38.9 to 40.6 degrees C only if a hybrid warmer/incubator is not available.
   b. Wean Chemical blanket before ambient heat. Remove Chemical blanket at 37.8 degrees C.
   c. Consider use of humidity (per physician's order), for infants < 30 weeks.
      i. Infants <30 weeks shall be admitted to giraffes and placed in humidity of 70% - 90% for first seven days. Petrolatum is not used during this time unless otherwise ordered by neonatologist or on a localized skin breakdown.
      ii. Use only sterile water in humidifier reservoir and check level each shift.
      iii. Decrease humidity to 50% after first seven days of life and continue until infant reaches 28 days of life. Petrolatum may be used at this level of humidity if there is evidence of skin breakdown.
      iv. If rainout occurs, decrease humidity by 5% until no further rainout is present.
   d. Maintain infant on servo mode.
   e. Alter above regimen based on infant's response to maintain stable temperature of 36.6° to 37.5° C.
   f. Use petrolatum sparingly every 8 to 12 hours, per physician order if **not in humidity**.
3. Coordinate exams with physician.
   a. Exam time ideally occurs at time of scheduled full nursing exam.
   b. Use physician findings for scheduled nursing exam, as applicable.
   c. Support infant during exam.
4. Monitor patient tolerance of assessment.
   a. Stop exam and provide supported time-out for signs of stress (apnea, desaturation, bradycardia, color changes, decreased blood pressure, etc.).
   b. Allow recovery before continuing, including full recovery of heart rate, oxygen saturation, and breathing.
5. Position to promote rest and appropriate flexion of extremities.
   a. Head of bed elevated 30°.
   b. Avoid hyperextension of neck.
   c. Minimize endotracheal tube movement.
   d. If in supine position, maintain positioning as close to midline as possible, but without direct pressure on the back of the head.
   e. Use positioning aides to promote slight adduction of shoulders and hips – minimize diaper bulk between legs.
   f. Nest infant with developmentally supportive devices. .
   g. Use other supportive devices – gel mattresses, beanbags, etc., as indicated (do not use gel or water-filled devices under head or torso if high-frequency ventilator in use).
   h. Keep extremities in slight flexion.
6. Minimize hand-ventilation. If necessary for resuscitation, use minimum amount of pressure and rate possible. If available, have T-piece respirator at bedside.
7. Suctioning: In collaboration with Respiratory Care Practitioner:
   a. Use extreme caution with suctioning, due to high risk of negative impact (de-compensation, pneumothorax, etc.).
   b. Only for clinical indications:
      i. Audible or visible ETT secretions with:
         1) increasing oxygen requirement, hypoxia, hypercapnia, etc.
         2) signs listed in b. may be due to other causes – judge carefully before choosing to suction.
   c. Minimize loss of functional residual capacity (FRC).
      i. Use in-line suction catheters.
      ii. Use maximum vacuum pressure of 60mmHg.
      iii. Support via ventilator (with settings changed as per suctioning policy), rather than manual ventilation whenever possible.

iv. Minimize suction time per catheter pass and number of catheter passes.
d. Do not use lavage, unless secretions are thick and/or occlusive.
e. Do not suction nares, nasopharynx.
f. Minimize suctioning of oropharynx.

8. Minimize environmental stimuli.
   a. Ideally, infant will be stabilized and admitted per Thermoregulation Procedure in a hybrid warmer/incubator. If this is not possible, move the infant to incubator on day one or two of life.
      i. Maintain incubator on "servo" or "skin" mode at 36.6 – 37.5° C.
   b. Limit conversation at bedside (quantity and volume).
   c. Minimize other auditory stimuli.
      i. No radios, tape players, etc. in warmer/isolette/hybrid.
      ii. Bed positioned away from admission bed and other high traffic areas, if possible.
      iii. Silence alarms prior to interventions known to trigger alarms.
      iv. Close incubator doors softly.
      v. Do not set objects down on top of incubators.
      vi. Do not tap on sides of incubator.
      vii. Do not chart on isolette.
      viii. Heartbeat simulator may be used, if tolerated.
   d. Minimize olfactory stimuli.
      i. Avoid personal used of scented soaps, lotions, and perfumes.
      ii. Minimize the use of scented products on the patient.
      iii. Provide unscented pacifiers.
      iv. Breast milk scent is not contraindicated.
   e. Minimize visual stimuli.
      i. Keep light exposure low.
         1) Use incubator cover when possible (leave corner of incubator uncovered so that the infant can be viewed at all times).
         2) Minimize ambient lighting as much as safe and practical.
         3) When necessary to use procedure lights, or when incubator cover not in use in high ambient lighting, cover eyes (but maintain head exposure to radiant heat, if in use).
      ii. Avoid leaving objects in infant's sight line, especially those with bright colors or black and white.
      iii. Avoid extended eye contact.
   f. Minimize vestibular and tactile stimuli.
      i. Use facilitated tucking and stabilizing touch – no stroking or patting.
      ii. Use slow, gentle position changing techniques, maintain flexion and boundaries.
      iii. Use pre-warmed linens, diapers, and equipment.
      iv. Utilize bed scale.
      v. Minimize bed transfers during first two weeks of life.
9. Support consultants and other NICU workers to comply with minimal stimulation concepts.
10. Do not apply pressure to the abdomen or bladder.
11. Minimize procedure-related stimuli.
   a. Group procedure and exam components for same time, as much as possible.
   b. Utilize facilitated tucking techniques to support infant throughout.
   c. Provide rest periods for infant indications of stress.
   d. Signs of stress include:
      i. Color change: cyanosis, mottling, pallor
      ii. Desaturations
      iii. Apnea
      iv. Hiccoughs
      v. Bradycardia
      vi. Sudden state change, especially "shutting down"
      vii. "Halt-hand", eye aversion, or other "time-out" signs
      viii. Facial grimace
   e. Allow full recovery of heart rate, oxygen saturation, and breathing before continuing.

f. Maintain arterial catheter for blood specimens, as possible.
g. Minimize labs and procedures.
i. Use least invasive techniques available.
ii. Unless labs are indicated emergently, limit cutaneous access (arterial, venous, or heel puncture) to no more frequently than every eight hours.
iii. When teaching is accomplished with infant, allow only demonstration (i.e., instructor demonstrates) – no handling of infant by student.
iv. Transition to standing scale when stable or per physician order.
1) Use in-bed scale, if available.
2) Zero/weigh on external scale with warmed blankets in use (pre-warm in isolette).
h. Use x-ray cassette tray for AP imaging, if available.

12. Support parents in positive interaction with infant.
a. Educate parents regarding minimal stimulation concepts.
b. Demonstrate/support/provide feedback regarding facilitated tucking and stabilizing touch techniques.
c. Reinforce importance of parental interactions within the framework of minimal stimulation.
d. Explain rationale prohibiting holding during initial two weeks of life (i.e., extreme postural changes result in extreme changes in cerebral blood flow, increasing risk of IVH) – offer alternatives as appropriate.

E. ANATOMIC AND PHYSIOLOGIC DIFFERENCES IN NEONATAL SKIN:

1. Underdevelopment of the stratum corneum: There are ten to twenty layers of stratum corneum in the adult and full-term infants, which provide control of evaporative heat loss and trans-epidermal water loss. Premature infants have fewer layers of stratum corneum – at 30 weeks they may have only two to three layers and at 24 weeks, they may have virtually none, thus the protective functions of the stratum corneum are deficient. Although the barrier function of the stratum corneum does mature at an accelerated rate during the first 14 days of life, skin barrier function is immature for 6 to 8 weeks in the premature, (25 weeks or less).
2. Diminished cohesion between epidermis and dermis: The fibrils which connect the epidermis to the dermis are widely spaced and fewer in the premature infant. They are at higher risk for injury from adhesive removal and for blistering from friction and thermal injury. Certain adhesives may have a stronger bond to the epidermis that that of the epidermis to the dermis, and epidermal stripping may result during adhesive removal.
3. Dermal instability: Collagen is deposited in the dermis during the last trimester and prevents the accumulation of fluid in this layer. Premature infants therefore, exhibit more edema, which puts them at risk for ischemic injury because of reduced blood flow. Protection from pressure and injury includes routine turning and the use of sheepskin.
4. Skin pH: An acid skin surface (pH <5), seen in adults has protective qualities against microorganisms. ("Acid Mantle"). If there is a shift in pH to neutral there may be an increase in numbers of bacteria and a shift in species. At birth, full term newborns have an alkaline skin surface (pH 6) but within four days, the pH falls to 4.95. It can take four weeks for premature infants' pH to fall below 5.

F. SKIN CARE:

1. Measures will be taken to prevent the skin breakdown of all infants at risk.
2. Adhesives will be used sparingly to promote skin integrity. No bonding agents or band-aids shall be used.
3. Emollients will be used to protect or restore skin integrity.
4. A combination of techniques to reduce transepidermal water loss and minimize evaporative heat loss in premature infants ≤ 30 weeks gestation will be used in the NICU.
5. Moist healing will be provided for all areas of breakdown/wounds.
6. Assess the neonatal skin at least every 12 hours with careful attention to skin folds, observing for any sign of skin breakdown. Skin folds are to be wiped with sterile water every shift.

G. BATHING:

1. Skin should be cleansed only using warm sterile water during the first two weeks of life. Use soft materials such as gauze pad or cotton balls. Rubbing should be avoided and if areas of breakdown are evident use warm sterile water. Water can be squeezed onto the skin during rinsing.

H. EMOLLIENTS:

1. Use of petrolatum (aquaphor):
   a. Requires a physician's order.
   b. At the first sign of dryness, fissures, flaking or skin breakdown, apply petrolatum every 12 hours, (or as needed to provide moist healing of any areas of breakdown) if no humidity used.
   c. Observe carefully for the development of systemic infections, such as coagulase negative staphylococcus infections, especially in neonates <750 grams.
   d. Emollients may be used during phototherapy or while under radiant warmer.

I. TRANS-EPIDERMAL WATER LOSS (TEWL), HEAT LOSS IN INFANT <32 WEEKS GESTATION

1. Pre-heated polyurethane wrap covering the body, torso and extremities is to be used immediately after delivery during stabilization to reduce the postnatal temperature decrease caused by excessive evaporative heat loss. If wrap needs to be removed for life saving measures, dry the infant with a pre-heated towel to prevent evaporative heat loss. The wrapping should be removed after the neonate has been admitted to the NICU.
2. Port-a-warm mattresses are to be used in the delivery room and transport to NICU from L&D with the very low birth weight infants to help prevent excessive heat loss.
3. A knitted cap will be placed on the head of the infant immediately after delivery.
4. Infants <32 weeks shall be admitted to giraffes.
5. Infants < 30weeks shall be placed in humidity of 70% - 90% for first seven days, decrease to 50% until 28 days of life. **Petrolatum is not used during this time unless otherwise ordered by the neonatologist or on a localized area of skin breakdown.**

J. SKIN BREAKDOWN PREVENTION

1. To prevent pressure sores, place any infant <32 weeks gestation or any vented infant on memory foam mattress. Infants <30 weeks gestation may be placed on a memory foam mattress or a combination of gel pillows/memory foam mattresses so that the infant's entire body is upon gel/memory foam.
2. Petrolatum may be applied to the groin and creases of very low birth weight infants.
3. Infants will be turned every 3 to 6 hours, as condition tolerates.
4. Oximetry probe sites shall be changed every 8 hrs and prn.
5. Those infants on a paralytic medication shall have lacrilube put in their eyes a minimum of once per shift. If needed, paper tape may be used sparingly to ensure the eyes remain closed.
6. Commercial heel warmers only will be used for warming extremities.
7. Cannulaides will be used to protect the nasal septum of infants on nasal CPAP.

K. DOCUMENTATION

1. Document skin care assessment on the NICU assessment form in the electronic medical record (EMR). Indicate any variance from normal and any intervention required.
2. Document completion of initial bath in the EMR.
3. Assessment of skin breakdown will be documented on the EMR.
4. Document in the care plan the humidity order with the initiation and discontinuance dates.

L. EXTERNAL LINKS:

M. REFERENCES

1. AWHONN/NANN. (2008). Evidence-Based Clinical Practice Guideline. Neonatal Skin Care, 2nd Edition,
2. Drugs.com (obtained from the Internet on 9/25/06), Silver Sulfadiazine – Topical.

3. Edwards, E., Conner, J., & Soll, R. (2004). The Effect of Prophylactic Ointment Therapy on Nosocomial Sepsis Rates and Skin Integrity in Infants with Birth Weights of 501 to 1000 grams. *Pediatrics,* 113(5).
4. JOGNN. (2001) Neonatal Skin Care: Evaluation of the AWHONN/NANN Research Based Practice Project on Knowledge and Skin Care Practices, 30(1).
5. JOGNN (2001). Neonatal Skin Care: Clinical Outcomes of the AWHONN/NANN Evidence-Based Clinical Practice Guideline, 30(1).
6. Lund, C., Lane, A., & Raines, D. (1999). Neonatal Skin Care: The Scientific Basis for Best Practice. *JOGNN, 28*(3).
7. Lund, C. & Osborne, J. (2004). Validity and Reliability of the Neonatal Skin Condition Score, Journal of Obstetric, Gynecologic and Neonatal Nursing (JOGNN), 33(3).
8. Nurses Society Position Statements (1996). Pressure Ulcers, WOCN: Wound Ostomy and Continence.

N. APPROVAL PROCESS

1. Clinical Policies & Procedures Committee
2. Nurse Executive Council
3. Medical Executive Committee
4. Professional Affairs Committee
5. Board of Directors

DELETE -- Procedure is obsolete and is no longer needed.

Tri-City Medical Center	Women's an - NICU

PROCEDURE: NON-EMERGENT NEONATAL ENDOTRACHEAL INTUBATION

Equipment:

1. Laryngoscope
2. Blades and suggest weight range:
   a. Size "OO" <700 gms
   b. Size "0" Miller <700-3500 gms
   c. Size "1" Miller >3500 gms
3. Endotracheal Tubes (ETT) and Suction Catheter Size:
   a. 2.5mm 5-6 Fr
   b. 3.0mm 8 Fr
   c. 3.5mm 8 Fr
   d. 4.0mm 8 or 10 Fr
4. Stylet (if necessary)
5. Anesthesia bag connected to 100% oxygen source to keep saturations ≥95%
6. Face masks
   a. Large
   b. Small
7. Skin prep/ETT adapter
8. Suction equipment
9. Pedi-cap end tidal CO_2 detector
10. Pulse oximeter and audible heart rate monitor
11. Meconium aspirator (optional)
12. 1. Shoulder roll (optional)

Issue Date: 8/12 Revision Date:

A. **Rationale:**

1. Endotracheal intubation involves passing an endotracheal tube (ETT) through either the nares or the mouth to the mid trachea. This painful procedure is routinely performed in the NICU and without premedication is associated with adverse physiological effects, including bradycardia, changes in blood pressure, hypoxia, increased pulmonary hypertension and increases in intracranial pressure (ICP). Indications for endotracheal intubation include resuscitation at delivery, obstructive lesions of the airway, inter-operative airway management, prolonged apnea, diaphragmatic hernia, and respiratory failure.
2. The American Academy of Pediatrics (AAP) consensus statement on prevention and management of pain and stress in the neonate recommends use of appropriate environmental, non-pharmacologic and pharmacologic interventions to prevent, reduce or eliminate stress and pain in neonates.
3. Multiple trials have concluded that premedication for endotracheal intubation "significantly improve intubating conditions, decreases the time and number of attempts needed to complete the intubation procedure, and minimizes the potential for intubation-related airway trauma." A recent study by Roberts et al. concluded that premedication in combination with a short-acting muscle relaxant should be considered for all non-emergent intubations in the NICU. They also concluded that intubation was successfully completed in ≤ 2 attempts more than twice as often when a muscle relaxant was administered.
4. A recent consensus statement from the International evidence-based group for neonatal pain concluded, "tracheal intubation without the use of analgesia or sedation should be performed only for resuscitation in the delivery room or for life threatening situations associated with the unavailability of intravenous access."

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

5. Intubation without premedication is acceptable in the delivery room, during resuscitation or if there is sufficient risk/benefit ratio not to use premedication such as in newborns with difficult airways anomalies such as Pierre Robin sequence.
6. Current recommendations are to administer supplemental oxygen as needed via properly sized face mask followed by a vagolytic agent then analgesic and/or hypnotic medication before infusion of a muscle relaxant. A vagolytic such as Atropine prevents bradycardia. The analgesia such as Morphine or Fentanyl will provide pain relief and finally a muscle relaxant such as Cisatracurium or Vecuronium.

B. POLICY:

Intubations must be performed by healthcare workers with additional training who have successfully completed NRP training. All patients will be assessed prior to intubation for pre-medication needs by attending physician. Medications for planned non-emergent neonatal intubations include Atropine, Fentanyl or Morphine, and Cisatricurium or Vecuronium. Intubations will be documented as per TCMC documentation standards in the EMR.

C. RESPONSIBLE PARTIES:

1. All Neonatologists, WCS RNs and respiratory care practitioners.

D. PROCEDURE:

1. All responsible staff are present and responsibilities assigned prior to and during the procedure.
2. Infants undergoing the procedure receive continuous cardiorespiratory monitoring, oxygen saturation, blood pressure monitoring.. Intravenous access is established prior to the procedure. An end tidal carbon dioxide detector is readily available at the bedside.
3. An oxygen source with appropriate sized face mask, endotracheal tubes, stylet, laryngoscope and wall suction are available for use throughout the procedure.
4. Pre-medications for planned neonatal intubation should be available and checked by the intubation physician prior to administration.
5. Medications and dosages are as follows:
   a. Atropine 20mcg/kg IV followed in 1-2 minutes by Fentanyl 2-4mg/kg IV given slowly over 2 minutes OR Morphine 0.05-0.1 mg/kg IV followed in 1-2 minutes by Vecuronium 0.1 mg/kg/dose or Cisatricurium 0.1 mg/kg/dose.
      i. ***Precautions:*** *Fentanyl can cause chest wall rigidity and make it difficult to effectively oxygenate. This can be reduced by slow administration and can be treated with either naloxone or muscle relaxants.*
6. Confirmation of endotracheal intubation is required via auscultation of chest, end tidal dioxide detector and follow-up of chest x-ray to confirm ETT placement.

E. EXTERNAL LINKS:

F. REFERENCES:

1. American Heart Association (AHA) & American Academy of Pediatrics (AAP). (2010) *Neonatal Resuscitation Textbook, 6th ed.*
2. American Academy of Pediatrics (AAP). (2000). Prevention and Management of Pain and Stress in t Neonate. *Pediatrics,* 105(2), 454-461.
3. Anand, K.J.S. (2001). International Evidence-Based Group for Neonatal Pain. Consensus statement the prevention and management of pain in the newborn. *Arch Pediatric Adolescent Med,* 155(2); 17
4. Barrington, K.J., Finner, N.N., & Etches, P.C. (1989). Succinylcholine and atropine for premedication of the newborn before nasotracheal intubation; a randomized, control trial. *Critical Care Medicine*, 17(12), 1293-6.
5. Friesen R.H., & Thieme, R.E. (1987). Changes in anterior fontanel pressure in preterm neonates during tracheal intubation. *Anesthesia & Analgesia*, 66, 874-8.
6. Goldsmsith, J.P. & Karotkin, E. (2011). Pulmonary Care. *Assisted Ventilation of the Neonate.* Philadelphia: Elsevier Saunders.

7. Kumar, P. et al. (2010). Clinical Report-Premedication for Nonemegency Endotracheal Intubation in t Neonate. American Academy of Pediatrics. *Pediatrics,* 125, 608-615.
8. Khammash, H.M., Dunn, M.S., Jefferies, A.L., & Perlman, M. (1993). Blunting of hypertensive response to endotracheal intubation in neonates by premedication. *Paediatric Research*, 33(4), 218A
9. Millar, C, & Bissonnette, B. (1994). Awake intubation increases intracranial pressure without affecting cerebral blood flow velocity in infants. *Canadian Journal of Anaesthesia*, 41(4), 281-7.
10. Pokela, M.L., & Koivisto, M. (1994). Physiological changes, plasma beta-endorphin and cortisol responses to tracheal intubation in neonates. Acta Paediatrica, 83(2), 151-6.
11. Stow, P.J., Burrows, F.A. et al. (1980). Anterior fontanelle pressure responses to tracheal intubation and anesthesia in infants. *Journal of Pediatrics*, 96(5), 860-2.

G. 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

Tracked Changes Copy

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: **PALLIATIVE CARE OF THE NEONATE AT THE END OF LIFE**

ISSUE DATE: **07/07**
REVISION DATE: **05/08, 4/09, 6/11, 8/12**

Department Approval Date(s):	**05/16**
Perinatal Collaborative Practice Approval Date(s):	**08/16**
Division of Neonatology Approval Date(s):	**08/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**09/16**
Professional Affairs Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	

A. **PURPOSE**:

1. To provide a supportive atmosphere for grieving families who have experienced a newborn death. ~~and assist them in resolving their grief.~~
2. **To provide interventions in caring for the dying patient that is directed toward maximizing comfort and providing support for the patient/family/significant others**.
3. **To provide emotional, spiritual, and cultural support with respect for patient/family/significant others values and preferences.**

B. **POLICY:**

1. Palliative care focuses on relieving the newborn's pain and symptoms while extending emotional and spiritual support for the newborn and family. Palliative care provides non-curative interventions that address the physical, emotional, social, cultural, and spiritual needs of neonates and their families at the end of life.
   a. Palliative care seeks to ensure that bereaved families are able to remain functional and intact.
   b. Palliative care includes the control of pain and other symptoms and addresses the psychological, social or spiritual problems of the neonate and family.
   c. The needs and feeling of the parent (s) will be respected.
   d. The institution of palliative care should be prompt.
   e. Decisions should be collaborative and clearly communicated.
   f. The following guidelines apply to the care of neonates in either of three situations:
      i. Following the decision not to resuscitate (i.e. non-viability, conditions incompatible with life)
      ii. From the point at which resuscitative efforts/treatments are withdrawn
   g. The palliative care neonate is a 1:1 or no greater than a 1:2 assignments due to the needs of the family during the dying process.

C. **EQUIPMENT:**

1. Personal protective equipment
2. Infant scale
3. Disposable tape measure
4. Memory box
5. Baby clothes: hats, booties, blanket
6. Camera/film
7. Bathing supplies

D. **PROCEDURE:**

~~1. No Resuscitation~~

~~a. Before delivery:~~

~~i. Assess caregiver and family psychosocial status.~~

~~ii. Initiate checklist for newborn loss and palliative care.~~

~~iii. Request consultations as needed (neonatology, pastoral care, social work, parent support group).~~

~~iv. Offer spiritual/pastoral care (baptism, blessing, other family rituals)~~

~~b. After delivery (**with parental involvement**) – in no specific order:~~

~~i. Provide privacy for caregiver/family.~~

~~ii. Place hat on newborn's head and wrap in blanket~~

~~iii. Give newborn to caregiver/family to hold: when not held, place in isolette or crib.~~

~~iv. Request consultation as needed (neonatology, pastoral care, social services, parent support group) if not done before delivery.~~

~~v. Offer spiritual/pastoral care (baptism, blessing, other family rituals) if not done before delivery.~~

~~vi. Check newborn heart rate every 30 minutes.~~

~~vii. Provide mementos at the request of caregiver.~~

~~c. After delivery (**without parental involvement**) – in no specific order:~~

~~i. Place hat on newborn's head and wrap in blanket.~~

~~ii. Take the infant to the NICU if comfort care is not possible in Labor and Delivery.~~

1. **Process:** ~~Care of the infant in the NICU – in no specific order~~

~~d.~~**a. When a transition to palliative end-of-life care is made, a quiet and comforting environment is created**:

i. Alarms are turned off. Pagers/phones are turned to silent to avoid disturbing those in attendance.

ii. Routine vital sign measurement and lab analyses are ceased.

iii. Pain assessments should be continued and may need to be done more frequently to identify infant distress.

iv. No painful assessments (heel sticks, blood gases) are done.

~~i.~~**v.** Provide privacy for patient and family. If unable to provide a quiet area in NICU, a room on OB may be requested.

vi. Assist parent/family to hold newborn; when not held, place in isolette or crib.

~~ii.~~**vii. Visiting hours and sibling restrictions are waived.**

~~iii. Request consultation as needed if not done before delivery.~~

~~iv. Offer spiritual/pastoral care (baptism, blessing, family rituals).~~

~~v. Check newborn heart rate every 30 minutes.~~

~~Provide mementos as appropriate~~

b. Care of family is a central focus.

~~vi.~~**i. Physical, emotional, and spiritual comfort is provided**.

~~vii.~~**ii. Mothers may need normal postpartum nursing assessments and interventions and will need assistance with lactation cessation or milk donation.**

c. Making memories is an important part of palliative and end-of-life care.

i. Family photographs have been found helpful in many cultures. Many communities have photographers who specialize in this work. Photographs of the child can be kept on file for families who may not wish to have them at the time of death.

ii. Handprints, footprints, and locks of hair have been appreciated.

iii. Special spiritual or religious ceremonies can provide comfort.

iv. Introducing the child to the extended family can be important.

v. Kangaroo care has provided family comfort.

vi. There are occasions of multiple births in which some infants die and some infants live. These families will need special attention, such as photos of all

the infants together; there are special community support groups for this type of loss.

2. ~~Withdrawal of Life-Prolonging Therapies~~ **Palliative care may include removal of life-sustaining technology:**
   a. Ensure physician has confirmed decision to withdraw life-prolonging therapies.
   b. Offer family support as needed, allow for support personnel requested by family to be present with them.
   c. Stop all infusions except for pain and/or sedation; IV converted to saline lock.
   d. Administer analgesia as needed based on clinical signs.
   e. Place hat on newborn's head and wrap newborn in blanket.
   f. Allow parent/family to hold infant;
      i. When not held, place in isolette or crib.
   ~~g. Provide mementos: Picture of infant, footprints and handprints will be taken if requested by family and placed in memory box.~~
   ~~h.~~**g.** An RN will weigh, measure, and bathe infant if needed.
   ~~i.~~**h.** Patient and family will be allowed adequate time with infant prior to morgue or pathology.
3. **Removal of ventilatory support**
   a. Infants should be weaned off any neuromuscular-blocking agents.
   b. Vasopressors and antibiotics may be ceased.
   c. Parents can decide who should be present and how the process will go.
   d. Nurses should explain the process to parents, including as many details as the parent wishes to hear.
   e. Infants should be held in a parent's or staff member's arms. Some parents may not wish to hold a dying infant.
   f. Gentle suction of the endotracheal tube may be done and the endotracheal tube is removed.
   g. Tape and additional lines can be removed.
   h. Frequent pain and symptom assessment continues.
   i. If respiratory discomfort exists, medication such as morphine should be given. Oxygen usually is not given.
4. **Support services also should be offered to all members of the healthcare team. Facilitated debriefing after difficult deaths is essential.**

~~3.~~**5.** Complete the following after the family viewing (preparation for the morgue):
   ~~i. Take photos (if requested by family).~~
   ~~ii.~~**i.** Attach identification bracelet to arm of newborn. This allows correct identification for mortuary or correct disposition of fetal remains.
   ~~iii.~~**ii.** Place newborn on disposable drape, wrap in receiving blanket, and a second disposable drape and secure with tape.
   ~~iv.~~**iii.** Arrange for body to be taken to the Morgue.
   ~~v.~~**iv.** If the patient requests to see infant again notify the Unit or Administrative Supervisor who will call transport to retrieve the infant from the morgue or pathology.
   ~~vi.~~**v.** The infant will be re-dressed and taken to the mother's room or to a pre-arranged private area.

E. **DOCUMENTATION:**
1. Caregiver's psychosocial response to perinatal loss and interaction with infant in patient's medical record.
2. Complete unit log book with time of birth/delivery, time of expiration.
3. Comfort measures provided.

~~F. EXTERNAL LINKS:~~

~~G.~~**F.** **REFERENCES:**
1. Engler, A., Cusson, R., Brockett, R., Cannon-Heinrich, C., Goldberg, M., West, M., et al. (2004). Neonatal staff and advanced practice nurse's perceptions of bereavement/end of life care of families of critically ill and/or dying infants. American Journal of Critical Care; 13 (6): 489 – 498.

2. Nelson, R., Botkin, J., Kodish, E.M. Levetown, J., Truman, J., Wilfond, B., et al. (2000). Palliative care for children. Pediatrics; 106 (2): 351 – 357.
3. **National Association of Neonatal Nurses (2011). Policy: Palliative Care. Policies, Procedures, and Competencies for Neonatal Nursing Care.**
~~3.~~**4.** Stringer, M., Shaw, V., & Savani, R. (2004). Comfort care of neonates at the end of life. Neonatal Network; 23 (5): 41 - 45.

PROCEDURE:	**PERIPHERAL ARTERIAL LINE (PAL): INSERTION, MAINTENANCE, AND REMOVAL OF**
Purpose:	To facilitate the efficient aseptic and complication free insertion of a peripheral arterial line for monitoring blood pressure and obtaining arterial blood samples.
~~Supportive Data:~~	
Equipment:	1. Non-sterile Gloves 2. ~~Cholrhexidine~~**2% chlorhexidine gluconate** swabs 3. Infusion solution 4. IV tubing 5. transducer 6. 3 ml syringe 7. Leur-lock ~~(preferred) or Slip-tip~~ t-connector 8. 22 or 24 gauge angiocath**eter** 9. Tape 10. Transparent dressing 11. IV infusion pump 12. Light source transilluminator 13. IV board 14. Cotton balls

A. **POLICY:**

1. Placement of a peripheral arterial line is done by a physician **or allied health professional (AHP)**.
2. Transparent dressing will be placed over the site for stabilization and to allow continuous visualization of skin around catheter insertion site.
3. Excessive extension of extremity is to be avoided to prevent occlusion of artery.
4. Fingertips or toes are to be exposed so that circulatory status can be monitored.
5. Usual infusion is ½ NS or NS with 1 ~~to 2~~ units heparin/ml at a rate of 0.5 to 1 ml/hour. Infusions into PALs should not exceed 1 ml/hour.
6. Infusion is to run continuously on an infusion pump with a transducer to monitor blood pressure.
7. No medications, glucose, blood products or any rapid bolus will be administered through a PAL.
8. The physician **or AHP** will be notified if there is blanching, cyanosis, circulatory compromise, bleeding, dampened waveform or difficulty drawing blood from the PAL.

B. **PROCEDURE (ASSISTING WITH PAL INSERTION):**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system~~. Refer to Patient Care Services "Identification, Patient" (IV.A) policy~~
3. Immobilize patient with developmentally supportive methods, such as swaddling.
4. Attach syringe containing **heparinized** flush solution to leur-lock T-connector- **and flush the connector.** ~~(preferred) or slip-tip T-connector~~.

~~5. Flush T-connector.~~

~~6.~~**5.** Dim lights if transilluminator is being used to visualize artery.

~~7.~~**6.** Provide pain management as indicated.

~~8.~~**7.** Don non-sterile gloves.

8. Assist with immobilizing the extremity during catheter insertion.

9. **Assist the physician or AHP as necessary with cleansing the area of insertion using 2% chlorahexidine gluconate for 30 seconds and allow to dry for 1 minute. .**
10. Assist physician **or AHP** as necessary with securing the line.

NICU Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/14, **4/16**	06/14	06/14	**n/a**	**07/14, 08/16**	08/14, **10/16**	08/14

11. Connect the flushed tubing with the Luer-Lok adapter to the arterial catheter.

~~11.~~**12.** Assist with taping or placement of an occlusive dressing.

~~12.~~**13.** Apply an arm or foot board. Dressing is applied in a manner as to display all digits as much as possible.

~~13. Once artery is cannulated, attach t-connector firmly to cannula, gently flush and clamp. If slip-tip T-connector is used, make sure it is taped securely to prevent accidental disconnection and blood loss.~~

14. Attach T-connector- to transducer and IV tubing. Unclamp the T-connector -and begin fluid administration.

15. Discard used supplies in appropriate receptacles, remove gloves, and perform hand hygiene.

16. Documentation of insertion in patient's medical record:
    a. Cannula size and type
    b. Location of arterial site
    c. Date and time of procedure
    ~~d. How procedure was tolerated~~
    ~~e. Estimated blood loss~~
    ~~f.~~**d.** Characteristics of waveform on monitor
    ~~g.~~**e.** Perfusion of extremity

C. **MAINTENANCE:**

1. Assess the neurovascular and peripheral vascular status of the cannulated extremity immediately after catheter insertion and hourly or more often if warranted.
2. The transducer is calibrated once a shift and PRN:
    a. Open the transducer stopcock to air by turning it off to the patientand loosening the non-vented cap while maintaining sterility..
    b. Maintain transducer at the level of the infant's right atrium.
    c. Press "zero" on the monitor.
    d. Replace cap and close stopcock to air by opening stopcock to infant.
    e. If waveform dampens:
        i. Check connections.
        ii. Flush transducer if bubbles are present.
        iii. Check selected pressure scale on monitor.
        iv. Recalibrate transducer.
        v. Compare cuff blood pressure (BP) to arterial reading.
        vi. Change stopcock and transducer.
        vii. Notify physician if interventions do not correct waveform.
3. Daily Documentation:
    a. **Hourly invasive ~~B~~blood p~~P~~ressure** ~~and vitals~~ per Standards of Care.
    b. ~~Correlating c~~**C**uff BP once per shift **and prn**
    ~~c. Location~~
    ~~d.~~**c.** Hourly site checks including: **location,** site status, extremity color, waveform assessment

D. **BLOOD SAMPLING:**

1. Equipment:
    a. Non-sterile Gloves
    b. ~~Cholrhexidine~~**2% chlorhexidine gluconate** swabs
    c. ABG syringe sampling kit/lab tubes
    d. 22-25 gauge needle
    e. 2x2 gauze
2. Procedure:
    a. Perform hand hygiene.
    b. Confirm patient identity using two-identifier system.
    c. Don non-sterile gloves.

d. Place 2x2 gauze under t-connector port.
e. Clean diaphragm with ~~Cholrhexidine~~**2% chlorhexidine gluconate** swab for 30 seconds. Allow to dry for 30 seconds.
f. Clamp -t-connector close to the hub with attached clamp. Keep infusion pump running.
g. Insert needle into t-connector port.
h. Allow three drops of blood to flow onto 2x2 **gauze**.
i. Fill lab tubes directly from the needle hub by allowing the blood to drip directly into the lab tube.
j. For ABG sample, adjust plunger on the ABG syringe to the 0.2ml mark then insert the syringe into the needle hub and allow the syringe to fill.
k. Withdraw the needle carefully and activate the safety mechanism.
l. Release clamp on the t-connector, allowing backpressure from pump to flush line.
m. Dispose of needle in the sharps container.
n. Remove gloves and perform hand hygiene.
o. Label labs with the appropriate patient information.

E. CATHETER REMOVAL:

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system. ~~Refer to Patient Care Services "Identification, Patient" (IV.A) policy~~
3. Don non-sterile gloves.
4. Turn infusion pump off **and clamp the T-connector**.
5. Remove dressing and tape.
6. Pull catheter out**, applying pressure with a sterile gauze pad over the site while removing the catheter** and assess intactness of catheter.
7. Apply pressure over insertion site with sterile 2x2 gauze ~~,for a minimum of five minutes and re-evaluate every five minutes until bleeding stops.~~
8. Discard used supplies in appropriate receptacles.
9. Remove gloves and perform hand hygiene.
10. Document the procedure in the patient's medical record.

F. REFERENCES

1. Bailey, T. (2015). Common invasive procedures. In M.T. Verklan, M. Walden (Eds.), *Core curriculum for neonatal intensive care nursing* (5th ed., pp. 282-315). St. Louis: Saunders.
~~1.~~**2.** Ikuta, L.M. & Beauman, S.S. (Eds.). (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. National Association of Neonatal Nurses.
3. Infusion Nurses Society (INS). (2011). Standards of practice. Vascular access site preparation and device placement. *Journal of Infusion Nursing, 35*(Suppl. 1), S44-S45.
~~2.~~**4.** MacDonald, M. G., Ramasethu, J. & Rais-Bahrami, K. (Eds.). (2012). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.
5. O'Grady, N.P. and others. (2011). Guidelines for the prevention of intravascular catheter-related infections, 2011. Centers for Disease Control and Prevention. Retrieved April 27, 2015, from http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf
~~3. O'Shea, J. (2009). A comparison of blood pressure measurements in newborns. American *Journal of Perinatology, 26*(2), 113-116.~~
~~4. Ramasethu, J. (2008). Complications of vascular catheters in the neonatal intensive care unit. *Clinical Perinatology, 35*(1), 199-222~~
~~5. Verklan, M. T. & Walden, M. (2010). Core Curriculum for Neonatal Intensive Care Nursing, 4th ed. St. Louis: Elsevier Saunders.~~

SUBJECT: STAFFING RATIOS FOR SOCIAL SERVICES IN THE NICU

ISSUE DATE: 8/06
REVISION DATE: 05/08, 4/09, 06/11, 8/12

Department Approval Date(s):	**09/16**
Division of Neonatology Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To ensure appropriate staffing of social workers in the neonatal intensive care unit (NICU), as well as maintaining compliance with California Children's Services (CCS) regulations.

B. **POLICY:**

1. **Social work services shall be provided in the NICU by a CCS-paneled medical social worker (MSW) holding a master's degree in social work that has expertise in psychosocial issues affecting the families of seriously ill neonates/infants.**
2. **For every 15 patients in the NICU, there shall be one full-time equivalent MSW.** ~~It is the policy of Tri-City Medical Center to assign a full-time social worker for every 15 babies in the NICU. The full-time social worker will be CCS paneled with experience in the NICU and have expertise in community resources and psychosocial issues affecting the families of ill neonates.~~
~~1.~~**3. There shall be 24-hour coverage by a MSW for the NICU, which includes on-call coverage.**

C. **PROCEDURE:**

1. When the NICU census is over fifteen (15), CCS standards will be maintained. Assistance will be provided by a CCS paneled social worker to ensure that staffing ratios are maintained.
2. If additional assistance is required, the NICU social worker will request assistance from other staff social workers through the Social Services Supervisor.
3. All social workers providing assistance in the NICU will be CCS paneled.
4. The NICU social worker will determine which cases the additional social worker will assist with during the high census.
   a. This decision is based on the complexity of the case, family's history, expected length of stay and current needs.
5. The social worker may be asked to assist with cases including: completing assessments on short-term admits with limited needs; a weekly follow-up with a family whose infant has an expected short-term stay; or a weekly follow-up with a family whose infant is experiencing a long-term stay, but infant is stable.
6. If there are no patients that meet the above criteria, the NICU social worker will need to assess which families have the least need at that time. The social worker may also be asked to assist with patients that are discharging.
7. When the NICU census returns to fifteen, the full-time NICU social worker will resume care of the patient/family.

D. **REFERENCES:**

1. **American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (2012). Guidelines for Perinatal Care, 7th ed.**

~~1.~~**2. California Department of Health Care Services (1999).** California Children's Services Manual **of Procedures~~,~~ Chapter 3.25** ~~1999~~.

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN'S SERVICES (WNS)
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: STANDARDS OF NURSING CARE – NICU

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

Department Approval Date(s):	**08/16**
Perinatal Collaborative Practice Approval Date(s):	**08/16**
Division of Neonatology Approval Date(s):	**08/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**09/16**
Professional Affairs Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	

A. **PREAMBLE:**

1. Neonatal nursing care is delivered in an environment that respects the goals, preferences, and patient rights of the neonate and their family from admission, through the continuum of care, to discharge. The specially trained nursing staff functions within established policies and procedures and adheres to the standards and guidelines set forth by the California Nurse Practice Act and the National Association of Neonatal Nurses. Care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant, and is grounded on evidence based practice.

B. **POLICY**:

1. To provide guidelines that describe the basic level of care all patients can expect to receive.
2. All nursing care is provided in collaboration with the multidisciplinary healthcare team and the family to implement an individualized plan of care. Neonatal nurses will assess, plan, implement, evaluate, and document the patient's plan of care to promote optimal outcomes.
3. Nursing staff in the neonatal care areas will be knowledgeable about and adhere to all applicable unit and hospital policies.
4. Nursing staff will be competent in the care of infants to whom they are assigned.

C. **DEFINITIONS:**

1. **Standards of Care:** "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable" (ANA, p.77). "Standards of care describe a competent level of nursing care as demonstrated by the nursing process" (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.
2. **Nursing Process:** Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to patients and their caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care. "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and

above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care" (ANA, 2010).

a. The nursing process includes the following:
   i. **Assessment:** The neonatal nurse collects comprehensive data on the healthcare needs of the infant and family.
   ii. **Diagnosis:** The neonatal nurse analyzes the assessment data in determining nursing diagnosis.
   iii. **Outcomes Identification:** The neonatal nurse identifies expected individualized outcomes of care based on needs of the infant and infant's family.
   iv. **Planning:** The neonatal nurse develops a plan of care that prescribes interventions to attain expected outcomes.
   v. **Implementation:** The neonatal nurse implements the interventions identified in the plan of care.
   vi. **Coordination of Care:** The neonatal nurse coordinates care across the continuum by providing information to families.
   vii. **Health Teaching and Health Promotion:** The neonatal nurse employs strategies to promote a healthy, safe and nurturing environment.
   viii. **Evaluation:** The neonatal nurse evaluates the progress of the infant and family toward the attainment of established, expected outcomes.

3. **Patient:** Recipient of nursing care.
4. **Health Care Providers:** Individuals with special expertise who provide healthcare services or assistance to clients.
5. **Significant Others:** Family members and/or those significant to the patient.
6. **Reasonable and a Timely Manner:** Defined as within 4 hours after completion of assessments or care provided.
7. **Extremely Low Gestational Age Newborn (ELGAN):** defined as any neonate born at less than 28 completed weeks gestation.

D. PATIENT ADMISSION:

1. Outcome criteria:
   a. Neonatal nurses will provide ongoing nursing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The plan of care is continuously evaluated and updated.
2. Process criteria: The admitting neonatal nurse will
   a. Perform an initial comprehensive, age-appropriate, physical assessment of all systems, including vital signs and pain, within 10-30 minutes and document within 2 hours of admission to the NICU
   b. Assess and record vital signs (HR, RR, T, BP) on admission and every 1hour until stabilized.
   c. Temperature on the Extremely Low Gestational Age Newborn (ELGAN) should be done more frequently (i.e. q15 mins for 1st hour) to ensure temperature stability.
   d. Measure and record length, weight, head circumference, and gestational age on the appropriate growth chart and in the medical record.
   e. Complete a blood glucose test upon admission (Critical Level = < 45 mg/dl, > 180 mg/dl).
   f. Complete a Ballard exam within 12 hours of delivery, if applicable.
   g. Ensure that an emergency medication reference is completed based on current weight within 2 hours and posted in designated area. The emergency medication reference is updated weekly with the current weight.
   h. Check that two identification bands are present on the infant.
   i. Initiate a computerized multidisciplinary plan of care upon admission.
   j. Ensure that the admission history is completed within 24 hours of admission.
   k. Orient parents/families to the unit and inform parents/families regarding hand-washing and visitation policies. Document parent orientation to unit.

E. ONGOING PATIENT CARE:

1. Outcome criteria:
   a. Neonatal nurses will provide ongoing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The care plan update is documented a minimum of every 24 hours to reflect the patient's current needs.
   b. Maintain vital signs within parameters:
      i. RR 30-60
      ii. HR
         1) Term: 80-160
         2) Pre-term: 100-160
      iii. Axillary temperature should be maintained at
         1) 36.5 °C–37.5 °C (97.7 °F–99.5 °F) in full-term infants
         2) 36.5 °C–36.9 °C (97.3 °F–98.6 °F) in preterm infants.
2. Process criteria: The neonatal nurse will
   a. Perform an initial shift assessment on patients who are NPO within one hour from the beginning of the shift, to include complete systems assessment and update of the patient plan of care.
   b. Complete systems assessment at the time of first feeding during the shift on patients who are not NPO. If more than three hours will lapse before the next feeding, then monitor vital signs will be recorded within one hour of the start of the shift.
   c. Weigh patients nightly unless an order indicates otherwise, document weight in the patient's medical record and appropriate growth chart.
   d. Measure head circumference and length weekly (Sunday night) and document on the appropriate growth chart and in the patient's medical record.
   e. Document a complete physical assessment every 3-6 hours based on acuity
   f. Complete a visual assessment every 1 - 4 hours, based on acuity. Visual assessment will include state, color, work of breathing, and position.
   g. Skin and air temperatures should be recorded with visual assessments.
   h. Assess and record vital signs (HR = heart rate; RR = respiratory rate) as follows:
      i. Apical Pulse with first hands-on assessment
      ii. BP q shift minimum (see cardiovascular section)
      iii. HR/RR q 1-2 hour for 1:1 acuity
      iv. HR /RR q 2 hour for 1:2 acuity
      v. HR /RR q 3-4 hours for 1: 3 acuity
      vi. Axillary temperatures with full assessments and prn
   i. Assess pain using the NPASS tool with every routine vital sign and prn. Reassess and document patient's pain level 30 minutes after a score of > 3.
   j. Cluster care by coordinating touch times with necessary care team members (i.e. physician/allied health provider (AHP), RCP,OT/PT) to minimize procedure-related stimuli for any infant less than 34 weeks or that is medically unstable:
      i. Utilize facilitated tucking techniques to support infant throughout.
      ii. Provide rest periods for infant indications of stress.
   k. Complete blood glucose test as follows: (Critical Levels: < 45 mg/dl, > 180 mg/dl)
      i. Q 12 hours and prn while on IV fluids containing dextrose.
      ii. Q 12 hours and prn while on steroids.
      iii. 30 minutes after dextrose solution bolus or per physician/AHP order.
      iv. Within 2 hours of change in dextrose concentration or any new bag containing dextrose.
      v. Within 2 hours of changing the IV rate, if clinically indicated.
      vi. Discontinuation of IV fluids containing dextrose:
         1) For infants without a diagnosis of hypoglycemia, blood glucose testing will be done before feedings, times one. No further testing will be needed if glucose is > 45.
         2) For infants with a diagnosis of hypoglycemia, a blood glucose will be done before feedings, times two. If glucose is > 50, no further testing is needed.

If glucose is < 50, a third glucose test will be done before the next (third) feeding. If glucose remains <50, notify physician/AHP.

l. Reposition infant with every hands on assessment. If this is not possible due to a patient's condition, pressure-reducing measures should be implemented.
m. Replace monitor leads and the oxygen saturation probe during baths or when items become loose or soiled.
n. Reposition the pulse oximeter probe at minimum every 8 hours.
   i. Infants less 32 weeks or 1500gms, pulse oximeter may be repositioned with each hands-on assessment or PRN, as tolerates.
o. Provide oral care with colostrum/breastmilk or sterile water at least every 4 hours and as needed, per physician/AHP order.
p. Notify the physician/AHP and the charge nurse regarding significant changes in a patient's condition.
q. Document any physician/AHP notification in the patient's medical record, including any further assessment or treatment ordered.
r. Facilitate a patient care conference between the family and caregivers any time there is a change in the patient's health status and/or other needs arise or at the family's request.

F. **NEUROLOGICAL ASSESSMENT:**
   a. Outcome criteria
      i. Neonatal nurses continually assess all data pertinent to the patient's neurological function and update the nursing care plan to promote optimal neurological status.
   b. Process criteria: Neonatal nurses assess
      i. The anterior fontanel every shift and as needed
      ii. Level of consciousness/behavior with vital signs and as needed unless ordered otherwise
      iii. Muscle tone, cry, and symmetrical movement each shift
      iv. Suck, swallow reflex present upon admission and with feedings via nipple or breast.
      v. Midline positioning for the first 72 hours for all infants less than 32 weeks or less than 1500gms.

G. **CARDIOVASCULAR ASSESSMENT:**
   1. Outcome criteria
      a. Neonatal nurses continually assess all data pertinent to the patient's cardiovascular system and update the nursing care plan to promote optimal cardiac function.
   2. Process criteria: The neonatal nurse will
      a. Ensure that all patients are on cardio/respiratory monitor for the duration of their stay in the NICU.
      b. Document heart rate, respiratory rate, color, capillary refill time, perfusion, oxygen saturation, and any changes in heart sounds in the patient's medical record.
      c. Assess blood pressure at least every 12 hours:
         i. Infants with arterial lines in place will have a transducer in-line. Blood pressure should be documented at least every 2 hours for these patients.
         ii. Document blood pressure every 4 hours or per order for infants on steroids or anti-hypertensives.
         iii. Document blood pressure every hour if the infant is on vasopressors/ antihypertensive drips.
      d. Calibrate the blood pressure transducer with change of caregiver, change of IV tubing, and as indicated.
      e. Print monitor strips if an arrhythmia occurs.

H. **RESPIRATORY ASSESSMENT:**
   1. Outcome criteria

a. Neonatal nurses continually assess all data pertinent to the patient's respiratory system and update the nursing care plan to promote optimal respiratory function.

2. Process criteria: Neonatal nurses assess
   a. Breath sounds at least every 4 hours and as needed
   b. Status of respiratory effort with each infant interaction (at least every 4 hours)
   c. Oxygenation saturation and document the values every 2 hours for infants on oxygen and at least every 4 hours for infants on room air. A pulse oximeter should be in use for every infant.
   d. Episodes of desaturation, whether on oxygen or room air, should be assessed; any action taken for recovery must be documented.
   e. Any necessary respiratory support at least every 2 hours. This may be done by the nurse or respiratory care practitioner (RCP).
   f. Ventilator Parameters:
      i. The RCP will be responsible to set up equipment.
      ii. Transcutaneous monitoring as needed per physician/AHP's order.
      iii. All ventilator settings are determined per physician/AHP's order with the exception of needed or necessary FiO2 changes by RN/RCP.
      iv. An RN and an RCP must transport mechanically ventilated patients.
   g. ETT
      i. Stabilization:
         1) Two licensed health care personnel are required for securing and/or changing the ETT holder.
         2) Two licensed health care personnel, inclusive of one RCP, are required for ETT adjustment. ETT adjustments require a physician/AHP's order.
      ii. Suctioning:
         1) All intubated patients will have an in-line suctioning device set up upon intubation.
         2) Suction depth should be posted at bedside.
         3) FIO2 requirements will be adjusted to maximize patient's tolerance of suctioning procedure.
         4) Frequency and duration of suctioning should be limited and only when needed based on clinical symptoms.
         5) Suction pressure to be no greater than 80 mmHg.
         6) For ELGAN infants, suction pressure to be no greater than 60 mm Hg.
   h. Oxygen saturation parameters:
      i. 23-30 weeks gestation:
         1) Target saturation goals: 88%-90%
         2) Alarm settings: 82%-92%
      ii. 30+1-35 weeks gestation:
         1) Target saturation goals: 90%-94%
         2) Alarm settings: 88%-96%
      iii. >35+1 weeks gestation
         1) Target saturation goals: 94%-98%
         2) Alarm settings: 92%-98%

I. **GI/GU ASSESSMENT:**

1. Outcome criteria
   a. Neonatal nurses continually assess all data pertinent to the patient's GI/GU system and update the nursing care plan to promote optimal GI/GU function.
2. Process criteria: Neonatal nurses will
   a. Measure abdominal girth, at the umbilicus, upon admission and as needed for feeding intolerance.
   b. Inspect and document abdominal abnormalities.

c. Auscultate all abdominal quadrants for presence and character of bowel sounds every shift and as needed if feeding intolerance, increased abdominal girth, or change in frequency or characteristics of stool occurs.
d. Notify Physician/AHP if no stools within 48 hours.

J. **SKIN AND TISSUE INTEGRITY:**

1. Outcome criteria:
   a. Neonatal nurses continually assess all data pertinent to the patient's skin and tissue integrity and update the nursing care plan to promote and maintain optimal skin and tissue integrity.
2. Process criteria: Neonatal nurses will
   a. Complete a "Neonatal skin condition scale" every shift.
   b. Complete a "Neonatal skin risk assessment" ad hoc form weekly (Sunday day shift).
   c. Perform baths using the following criteria:
      i. Initial bath will be given no sooner than 24 hours of life and only if the infant is stable including stable temperature and respiratory status. Infants visibly soiled with meconium or blood can be bathed once stable after 2-4 hrs of life.
      ii. Gloves should be worn when touching all infant's that have not been bathed.
      iii. Use mild non-alkaline cleanser for greater than or equal to 32 weeks.
      iv. Use warm sterile water for less than 32 weeks: avoid rubbing.
      v. Removal of vernix is not necessary.
      vi. Routine bathing two times weekly individualized to infant schedule and stability.
      vii. Immersion/swaddle bathing is the preferred method for stable infants without central lines.
   d. Perform eye care daily and prn with sterile water.
      i. Infants on a paralytic medication shall have lubricant eye oinment administered a minimum of once per shift, per physician/AHP orders.
   e. Disinfect skin surfaces with Chlorhexadine Gluconate (CHG) 2% or povidone-iodine 10% aqueous solution prior to invasive procedures such as insertion of central venous catheters, placement of PIV, umbilical line catheterization, chest tube insertion, injections, venipuncture, or heel sticks for laboratory samples. Wipe away all disinfectants (CHG, alcohol, betadine) with sterile water or saline wipes once procedure is complete.
   f. Use only commercial heel warmers for warming extremities, per manufacturer's guidelines.
   g. Avoid use of alcohol as primary disinfectant or for removing povidone-iodine or CHG. Isopropyl alcohol has been shown to be less effective in reducing infection and carries a risk of damage to the stratum corneum.
   h. Use semi-permeable dressings to anchor umbilical lines, PIVs, PICCs, nasal cannulas, nasal or oral gastric tubes.
   i. Use hydrocolloid barriers for skin protection when securing NG/OG tubes and cannulas.
   j. Minimize use of tape and minimize contact with skin by "backing" tape or applying cotton to adhesive
   k. Avoid use of solvents for adhesive removal. Remove adhesives slowly and carefully with water soaked cotton balls or gauze, saline wipes or petrolatum.
   l. Avoid use of enhanced bonding agents (Benzoin, Mastisol) as much as possible.
   m. Assist in reducing Transepidermal Water Loss in the infant less than or equal to 32 weeks or less than 1500gms by using the following :
      i. Infants <32 weeks shall be admitted to giraffes and placed in humidity of 70% for first seven days. Humidity may be increased up to 85% for infants <1000gms if needed, per physician/AHP orders. Emollients are not used during this time unless ordered by physician/AHP.
      ii. Use only sterile water in humidifier reservoir and check level each shift.
      iii. Humidity may be decreased to 50% after first seven days of life and continued until infant reaches 28 days of life per physician/AHP orders if needed. Petrolatum may be used at this level of humidity if there is evidence of skin breakdown.

iv. If rainout occurs, decrease humidity by 5% until no further rainout is present.

n. Use emollients for dry skin, cracking or fissures on skin surfaces:
   i. For infants less than 32 weeks, use a preservative-free topical ointment sparingly per physician/AHP order.
   ii. For infants greater than 32 weeks or after 30 days of age, petrolatum may be used at the discretion of the physician/AHP.

o. Use natural drying for umbilical cord care.
   i. Expose umbilical stump to air by keeping diaper folded off of umbilical stump.
   ii. If the umbilical cord stump becomes soiled with urine or stool, clean the area with water.
   iii. After cleansing with water, dry thoroughly with clean absorbent gauze to remove excess moisture, and then discard the gauze.

p. Notify Physician/AHP of IV infiltrates requiring medical evaluation and/or intervention.

q. Notify physician/AHP of any nasal or septum breakdown. Infants on NCPAP will need more frequent assessment of skin integrity around the nasal septum and behind the ears.

K. **NUTRITION**:

1. Outcome criteria:
   a. Neonatal nurses continually assess all data pertinent to the patient's nutrition and update the nursing care plan to promote optimal nutrition.
2. Process criteria: Neonatal nurses will
   a. Reconfirm tube placement prior to the first feeding of the shift by measuring the distance from the tip of the nose to base of the ear, then halfway between the xiphoid process and the umbilicus.
   b. Measure and record abdominal girth at umbilicus prior to feedings for infants at risk for or demonstrating signs of feeding intolerance.
   c. Adhere to the following residual protocol:
      i. Check residuals with all NG feedings on preterm infants. Residuals on continuous feeds are not checked.
      ii. Acceptable Findings:
         1) Residual volume of < 5ml regardless of infant's feeding volume.
         2) Residual volume of ≤ 30% of feeding volumes (if there are no additional signs of feeding intolerance and the clinical evaluation is normal.)
         3) Residuals ≤ 30% shall be refed and continue with feeding order without deducting residual from feeding volume.
         4) Residuals >30% shall be refed and subtracted from the feeding volume.
         5) Do not refeed residuals that are bloody, brown and/or dark green bilious.
         6) Residuals that appear light green or yellow are considered a normal gastric residual.
   d. Notify the physician/AHP for any of the following signs/symptoms:
      i. Residuals that are bloody, brown and/or dark green bilious.
      ii. Residuals greater than 50%.
      iii. Residuals that persist at 30-50% x 2 consecutive feedings of the current feeding volume.
      iv. Abnormal abdominal exam as evidenced by but not limited to:
         1) Increased distension: greater than 2 cm increase in abdominal girth
         2) Discoloration (ie. Red and/or grayish black/blue)
         3) New onset visible bowel loops
         4) Tenderness
      v. Repeated emesis
      vi. Change in characteristic of stool
      vii. The nurse may notify the physician/AHP at any time there is concern of feeding intolerance.
   e. Assist with establishing and maintaining milk supply by:
      i. Encourage pumping within 3-6 hours of delivery

ii. Pumping 8-12 time in 24 hours, including after breastfeeding with the goal of complete breast emptying at each pumping session.
iii. Promote breast massage and hand expression techniques used in conjunction with pumping.
iv. Encourage use of hospital grade pump.
v. Provide containers and labels to collect milk.
vi. Encourage skin to skin as often as possible.
vii. Monitor milk supply totals, initiate early intervention for decrease in milk supply (milk supply should increase by 3-5 days postpartum).
viii. Facilitate lactation consultations as needed.
ix. Utilize colostrum/breastmilk in the order pumped for the first two weeks of feeding.
x. Introduce breastfeeding before bottle feeding, bottle feeding is to be avoided for infant's less than 34 weeks unless otherwise ordered by physician/AHP.
xi. Initiate non-nutritive or "dry" breasfeeding when infant is 32 weeks PCA and physiologically stable when held.
xii. Initiate nutritive breastfeeding when infant is able to handle own secretions and shows sucking behavior on a finger, pacifier, or the emptied breast.

L. **FLUID AND ELECTROLYTE:**

1. Outcome criteria:
   a. Neonatal nurses continually assess all data pertinent to establish and maintain homeostasis as evidenced by:
      i. Weight gain 15-45 gms/day (average).
      ii. Soft, flat fontanel; sutures approximate
      iii. Urine output 1-5 ml/kg/hr
      iv. Good skin turgor
2. Process criteria: Neonatal nurses will
   a. Maintain strict I&O on all:
      i. Infants receiving steroids
      ii. Infants receiving diuretics
      iii. Infants receiving continuous IV therapy
      iv. Infants who are NPO
      v. Infants less than 1500 grams unless otherwise ordered by Physician/AHP.
   b. Notify the physician/AHP if urine output is <1 mL/kg/hr.
   c. Assess and document peripheral IV and PICC site status every hour. Assess and flush saline lock insertion sites with each hands-on assessment.
   d. Use birth weight until the infant surpasses this weight, then daily weight, to calculate I&O for previous 24 hours. A "NICU Calorie Count" ad hoc form is to be completed every morning in patient's medical record.
   e. Always physically trace each IV line from the solution, through the pump and into the patient and reconcile the accuracy of the solution and pump settings against a source document, e.g. order, medication record.

M. **PSYCHOSOCIAL SUPPORT:**

1. Outcome criteria
   a. Neonatal nurses continually assess all data pertinent to the patient and family's psychosocial needs in a supportive manner.
2. Process criteria: Neonatal nurses should
   a. Assess and document the patient and family's psychosocial status upon admission and daily in the patient's medical record.
   b. Listen to family concerns in a supportive manner.
   c. Encourage parents and families to participate in care as appropriate.
   d. Give emotional reassurance to families as needed.
   e. Identify family support systems upon admission and as needed.
   f. Enter appropriate consults/referrals into the patient's medical record as needed.

g. Refer to social work as needed.

N. **PATIENT EDUCATION:**

1. Outcome criteria
   a. The family/caregivers will have their educational needs regarding the patient's hospitalization addressed in a timely manner.
2. Process criteria: Neonatal nurses will
   a. Encourage families to be involved in the development of the plan of care from admission through discharge and whenever changes in the plan are needed at the level they choose.
   b. Include the family and/or caregiver in teaching to increase their understanding of the infant's needs during hospitalization and upon discharge.
   c. Orient parents and families to the unit guidelines/routines upon admission and throughout hospitalization.
   d. Explain all procedures and interventions and the plan of care and encourage questions and discussion.
   e. Assess learning needs upon admission and regularly thereafter. Document needs in the patient's medical record.
   f. Provide the family/caregiver with educational materials as needed regarding the ongoing care of the infant and discharge information.
   g. Begin discharge education as soon as the parents are able to participate in care and may include but is not limited to the follow topics:
      i. Hearing Screening (Ages and Stages)
      ii. Newborn Metabolic Screen
      iii. CPR
      iv. Car Seat Challenge (< 37 weeks gestation or < 2500gms)
      v. Safe Sleep Guidelines
      vi. Car Seat Safety
      vii. Shaken Baby Syndrome prevention
      viii. Breast feeding support/education/resources
   h. Document all teaching and response to learning in the patient's medical record.

O. **PATIENT SAFETY:**

1. Outcome criteria
   a. Neonatal nurses continually provide care in a safe manner.
2. Process criteria: Neonatal nurses will
   a. Complete environmental checks whenever a change of caregiver occurs. Environmental checks include ensuring that two infant identification bands are on the infant and that the cardiopulmonary/oxygen saturation monitor is attached to patient.
   b. Ensure that critical alarms include HR and apnea are set as follows unless otherwise ordered:
      i. HR: 80-220 if non-ventilated and 32 corrected weeks or greater or if 38 weeks or greater (on positive pressure or not)
      ii. 100-220 all other infants
      iii. Apnea: 20 second delay
      iv. Audibility of HR and apnea alarms on monitors will be validated by ensuring each is set as a crisis alarm (in alarm parameter levels) and 70% volume adjusted up or occasionally down as warranted for audibility in the pod.
      v. Critical alarms will be checked at the beginning of each 12 hour shift and more frequently as the patient condition warrants for alarm limits, function and audibility. This check will be validated and documented in the medical record when limits are recorded.
   c. Ensure that all continuous infusions are clearly labeled with the name of the medication that is infusing as close as possible to the medication infusion site.
   d. Ensure that the patient's emergency drug sheet is updated and the bedside.
   e. Not leave infants unattended on any scale or flat, unprotected surface.

f. Ensure that bed wheels are locked at all times except during transfer.
g. Ensure that side rails on radiant warmers and open cribs are up at all times unless a caregiver is next to the bedside.
h. Use locks on isolette doors, portholes, and warmer side rails all times.
i. Utilize appropriate shielding and protection with use of x-ray equipment.
j. Use volume control infusion pumps with all IVs. No more than 1 hour of fluid infusion should be set.
k. Use safety belts when infants are placed in swings, car seats, vibrating chairs, or strollers.
l. Scan all medications and breast milk per hospital policy prior to administration.

P. **EMERGENCY EQUIPMENT:**

1. Outcome criteria
   a. Neonatal nurses have appropriate emergency equipment available for patient use.
2. Process criterial:
   a. A neonatal crash cart will be available on the unit at all times and checked according to hospital policy.
   b. Admission bed supplies are checked at the beginning of each shift.
   c. Emergency equipment present at the bedside should include
      i. Mechanical suction with suction catheters
      ii. Oxygen
      iii. Resuscitation bag and appropriately sized mask
      iv. Bulb syringe

Q. **TRANSFER OF CARE:**

1. Outcome criteria
   a. Neonatal nurses assess all information pertinent to the transfer of care. They will communicate accurate and correct patient information to facilitate and support safe care, situational awareness, collaborative decision making, and continuity of care.
2. Process criteria: Neonatal nurses will
   a. Provide a report to the oncoming neonatal nurse, per hospital policy, including review of the patient's plan of care and outcome goals following the situation, background, assessment and recommendation format.
   b. Review all physician/AHP orders placed throughout the shift and verify status.
   c. Review the medication administration record.
   d. Assess the integrity of all vascular access sites, tubes, and drains.

R. **REFERENCES:**

1. American Academy of Pediatrics (AAP) & The American College of Obstetricians and Gynecologists (ACOG). (2013). Guidelines for Perinatal care. 7th ed. Elk Grove Village, IL.
2. Fanaroff, A.A. & Martin, R.J. (2001). Neonatal-Perinatal Medicine Diseases of the Fetus and Infant, 7th ed., Mosby.
3. Furdon, S.A. & Benjamin, K. (2010). Physical assessment. In Verklan MT, Walden M. Core curriculum for neonatal intensive care nursing. Saunders: Philadelphia. p. 120-55.
4. Merenstein, G. & Gardner, S.L. (2016). Handbook of Neonatal Intensive Care, 8th ed., Mosby.

Tri-City Medical Center

DELETE – see new Standards of Care NICU 2016

STANDARDS OF CARE

CARE OF THE PATIENT IN THE NICU

I. SCOPE OF PRACTICE: Registered Nursing Staff

II. SUPPORTIVE DATA/DEFINITION OF TERMS:

NICU Patient Admission: Any premature or newborn infant less than 14 days of age or as otherwise directed by the Neonatologist.

III. COMPETENCIES:

Unit Based Competencies

IV. DESIRED PATIENT/FAMILY OUTCOME(S):

A. Through a partnership with the family, healthcare team and community, the infant will achieve optimal health and appropriate neurodevelopment.

B.A. The infant will be discharged to their family who are knowledgeable and comfortable with the care of their infant.

V. STANDARDS OF NEONATAL NURSING PRACTICE:

STANDARD 1 - ASSESSMENT: The neonatal nurse collects comprehensive data on the healthcare needs of the infant and family.

1. ASSESSMENT

- A focused physical assessment must be done within 30 minutes of admission to the NICU and documented in the patients' medical record.
- The admission history must be completed within 24 hours of admission, including psychosocial assessment, discharge planning and educational needs.
- Gestational age estimation utilizing the Ballard Score will be done within the first 12 hours of life.
- Weight on admission and daily
- Frontal occipital circumference (FOC) and length: on admission and weekly
- Chest circumference on admission.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

V. STANDARDS OF NEONATAL NURSING PRACTICE:

- Abdominal circumference on admission and prn feeding intolerance.
- Full, head-to-toe assessments will be done every 3 - 6 hours, based on acuity.

A. Visual assessments will be done every 1 - 4 hours, based on acuity. Visual assessment will include state, color, work of breathing, and position. Vital Signs: Continuous cardio-respiratory monitoring (*HR = heart rate; RR = respiratory rate*)

- Apical Pulse with first hands-on assessment
- HR/RR q 1-2 hour for 1:1 acuity
- HR /RR q 2 hour for 1:2 acuity
- HR /RR q 3-4 hours for 1: 3 and 1:4 acuity
- Axillary temperatures with full assessments every 3-6 hours and prn
- Skin and air temperatures should be recorded with visual assessments.

B. Continuous pulse oximetry on all patients or per physician order (utilize oxygen target saturation for all infants on oxygen).

C. Blood Pressure

- Blood pressure on admission
- Hourly while on inotropic support
- Every 4 hours while on steroids
- Q shift when stable unless otherwise ordered
- Zero arterial lines at first shift assessment, when accuracy of the pressure obtained is in question, and with IV tubing changes

D. Thermal Environment (refer to "Thermoregulation for VLBW Infants" and "Weaning from Thermal Support.")

- Individualized, developmentally appropriate education is provided to the family based on the desire for knowledge, readiness to learn, and overall psychosocial state.
  - Provide information about the mechanics of heat loss through evaporation, convection, conduction, and radiation in the high-risk neonate; assure the family that heat loss is an expected area of intervention in all neonates.
  - Explain the need to monitor regularly neonates' body temperature, and discuss how the need for heat production can affect energy reserves and oxygen consumption in neonates.
  - Explain the need to consider the environment and all objects that touch the neonate as potential avenues of heat loss.
  - Explain the possible need for equipment such as radiant warmers and double-walled isolettes to provide thermal support for the neonate.
  - Encourage the family to ask questions, and answer them as they arise.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

V. STANDARDS OF NEONATAL NURSING PRACTICE:

ion to ba

E. Pain assessment using the NPASS tool is performed with every routine vital sign and prn. Reassess and document patient's pain level 30 minutes after a score of > 3.

F. Blood glucose test on admission (Critical Level = < 45 mg/dl, > 180 mg/dl Notify MD)

- Q 12 hours and prn while on IV fluids containing dextrose.
- Q 12 hours and prn while on steroids.
- 30 minutes after dextrose solution bolus or per physician order.
- within 2 hours of change in dextrose concentration or any new bag containing dextrose.
- within 2 hours of changing the IV rate, if clinically indicated
- Discontinuation of IV fluids containing dextrose:
  - For infants without a diagnosis of hypoglycemia, blood glucose testing will be done before feedings, times one. No further testing will be needed if glucose is > 45.
  - For infants with a diagnosis of hypoglycemia, a blood glucose will be done before feedings, times two. If glucose is > 50, no further testing is needed. If glucose is < 50, a third glucose test will be done before the next (third) feeding. If glucose remains <50, notify physician.

- Strict I&O is measured on all infants < 1500 gm, receiving IV fluids (exception for "to keep open" rate of 1ml/hr), on diuretics, or showing signs of fluid retention. In addition, all infants will remain on strict I&O until > 1500 gm and receiving full feeds.

STANDARD 2 – NURSING DIAGNOSIS: The neonatal nurse analyzes the assessment data in determining nursing diagnosis.

STANDARD 3 – OUTCOME IDENTIFICATION: The neonatal nurse identifies expected individualized outcomes of care based on needs of infant/family.

STANDARD 4 – PLANNING: The neonatal nurse develops a plan of care that prescribes interventions to attain expected outcomes.

- Interdisciplinary Plan of Care (IPOC) will be initiated on admission.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

V. STANDARDS OF NEONATAL NURSING PRACTICE:

- Families are encourage to be involved in the development of the plan of care from admission through discharge and whenever changes in the plan are needed at the level they choose.
- Interventions should support the transition from intensive care to home.
- Interventions should be evidenced based as well as supportive to the developmental, functional and cultural needs of the child and family.

STANDARD 5 – IMPLEMENTATION: The neonatal nurse implements the interventions identified in the plan of care.

- Ensures that implementation of care is systematic and ongoing.
- Utilizes interventions that are consistent with the established plan of care.
- Organizes interventions to provide an environment that supports the infant's physical and developmental wellbeing.
- Implements interventions in a manner that promotes family involvement and acquisition of progressive care giving skills.
- Implements interventions in a safe, timely, and appropriate manner.
- Documents interventions in a retrievable form.
- Individualizes interventions based on the specific needs of the infant and family.

5. CARE

A. Infection Prevention

- RN disinfects care area beginning each shift
- Gloves are worn for suctioning, diaper changes, anticipated contact with bodily fluids and prior to 1st bath.
- Disinfect all shared equipment between patient use i.e. scales.
- Soiled diapers should be placed in designated "dirty" area, avoid placing on clean surfaces.
- Isolettes/cribs/hybrid beds are to be wiped down with first assessment and changed every two weeks.

B. Developmental Care

- Maintain proper body alignment: flexed, midline and contained.
- Provide healing environment
  - Maintain decibel level ≤ 45 per AAP Recommendations
  - Maintain Light levels ≤ 60 ftc at infant eye level

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

V. STANDARDS OF NEONATAL NURSING PRACTICE:

C. Assess IV and site hourly and document any changes.

D. Long-term enteral feeding tubes are to be labeled with date inserted and changed every 30 days and prn.

E. Skin Care

- Wipe away all disinfectants (CHG, alcohol, betadine) with sterile water or saline wipes.
- Cord Care: keep cord clean and dry, clean only with sterile water/saline wipe if soiled with urine or stool.
- Infants > 32 weeks may be bathed within 2-4 hours of birth if not in acute respiratory distress and VS stable, and then the infant may be bathed 2-3 times per week.
- Infants < 32 weeks should be bathed in the fir
stable, then 2-3 times per week using pH-bala

Replacing with new format and new content

- Rubbing/Scrubbing is not recommended when bathing, some vernix is recommended to provide antibacterial protection and promote healing.
- Swaddled Bathing is the preferred method for submersion baths.
- Provide septum protector for infants on NCPAP.
- Change temperature probe site daily.
- Change oximeter probe site every 8 hours and prn.
- Eye care q shift and prn (using sterile water or saline wipes)
- Eye assessment/care while under phototherapy with every full assessment.

STANDARD 5A – COORDINATION OF CARE: The neonatal nurse coordinates care across the continuum be providing information to families on:

- Orient to NICU including procedure for hand hygiene, parent handbook, and visitation policy.
- Disease/diagnosis/medications including pathophysiology, signs and symptoms
- Treatment plan - expected course of events

STANDARD 5B – HEALTH TEACHING AND HEALTH PROMOTION: The neonatal nurse employs strategies to promote a healthy, safe and nurturing environment.

- Provides family/caregiver teaching that addresses healthy lifestyles, risk-reducing behaviors, developmental needs, and normal/specific infant care and safety.
- Use health promotion/health teaching methods appropriate to situation and family or caregiver's developmental level, learning needs, readiness, ability to learn, language preference and culture.
- Seeks opportunities for feedback and evaluation of the effectiveness of the strategies used.

STANDARD 6 - EVALUATION: The neonatal nurse evaluates the progress of the infant and family toward the attainment of established, expected outcomes.

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

V. STANDARDS OF NEONATAL NURSING PRACTICE:

- Coordinates implementation of the plan involving resources that enhance delivery of care across continuum.
- Discharge teaching should begin as soon as parents are able to participate in care.

VI. DISCHARGE:

A. Discharge teaching to all parents will include education on the follow topics: (*V=Video, L=Literature*)
- Hearing Screening (L)
- CPR (V, L)
- Car Seat Challenge (≤ 37 weeks gestation or ≤ 2500gms)
- Back to Sleep (V, L)
- Car Seat Safety (V)
- Shaken Baby Syndrome prevention (V)

Other educational resources will be available in the NICU Parent Education Resource file cabinet.

B. Teaching to parents may also include but not limited to education on the following topics:
- Medications
- High Risk Infant Follow-up Clinic (HRIF) (L)
- ROP (L)
- RSV Prophylaxis (L, V)
- Special Needs Teaching
- Basic Infant Care

VII. SAFETY:

- Hand off communication
  - Shift change/change of responsibility report will be done in person with ability to ask and respond to questions.
  - The off-going and on-coming nurse will make IV site/line checks at the beginning of each shift and perform 12 hour chart check.
- Two Identification bands are to be on the patient at all times.
- Check connections and trace all patient tubes and catheters back to their source.
- Suction, ambu bag and mask at bedside, tested and functional at the beginning of each shift.
- Two patient identifiers (medical record # and patients name) will be used for lab draws, procedures, breast milk verification and medication administration, blood transfusion will include ID # and Blood Band #

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

Tri-City Medical Center

STANDARDS OF CARE

CARE OF THE PATIENT IN THE NICU

VII. SAFETY:

- Universal Protocol will be followed for invasive procedures.
- Emergency drug sheet at all bedsides.
- Bedsides securely up on warmers and cribs. Doors securely shut on isolette/hybrid beds.
- Infants will not be left unattended on any scale or flat, unprotected surface.
- Infants will not be left on any warmer unless the sides are up and locked in position, except when contraindicated by medical procedure/equipment in use.
- Infants will not be left unattended in any isolette unless the doors and portholes are closed.
- Bulb syringe placed at head of bed.
- Stuffed toys are not permitted in infant bed
- Appropriate shielding and protection will be utilized with use of x-ray equipment.
- Volume control infusion pumps to be used with all IVs. No more than 1 hour of fluids set.
- Intubation supplies, Umbilical catheter tray/supplies, Chest tube insertion tray/supplies and chest drainage system readily available.
- Two licensed nurses to verify identification of breastmilk.
- Back to sleep by week of discharge unless otherwise ordered.

VIII. REPORTABLE CONDITIONS:

- Significant change in vital signs or assessment.
- Critical lab/test studies. (POC, labs. blood gases, xray)
- New or increased apnea/brady or desaturation episodes.
- Decreased urine output or output <1mL/kg/hr over 12 hours.
- Weight loss or consistent inability to gain weight
- Temperature instability (hypothermia and hyperthermia)

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

IX. ~~REFERENCES:~~

A. ~~Pain Assessment: The Fifth Vital Sign, AAP Guidelines for Thermoregulation, BRN Advisory Statement, Spring 2000.~~

B. ~~Merenstein, Gerald B. MD FAAP and Gardner, Sandra L. RN, MS, PNP, Handbook of Neonatal Intensive Care, 5th ed., Mosby, 2002.~~

C. ~~Fanaroff, Avroy A. and Martin, Richard J., Neonatal-Perinatal Medicine Diseases of the Fetus and Infant, 7th ed., Mosby, 2001.~~

D. ~~Wong, Donna L. RN, PhD, PNP, CPN, FAAN, Whaley and Wong□s Nursing Care of Infants and Children, 7th ed., Mosby, 2002.~~

~~E.~~**A.** ~~Neonatal Nursing: Scope and Standards of Practice, 2004. Published by ANA and NANN.~~

Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/16	08/16	08/16	n/a	09/16	10/16	

SUBJECT: VISITATION IN THE NICU

ISSUE DATE: 7/07
REVISION DATE(S): 01/09, 04/09, 06/11, 8/12

Department Approval Date(s):	**03/16**
Division of Neonatology Approval Date(s):	**03/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**09/16**
Professional Affairs Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	

A. **POLICY STATEMENT:**

1. **The following guidelines are intended to support** ~~To facilitate~~ family visiting in the neonatal intensive care unit (NICU) embracing the Family Centered Care concept while maintaining a safe, quiet environment.
   - **a. "Family" is defined as any person(s) who play a significant role in an individual's life inclusive of person(s) not legally related to the individual.**
   - ~~1.~~**b. Members of family include spouses, domestic partners, step-parents, both different-sex and same-sex significant others, and any other persons operating in a caretaker role.**
2. Only those visitors, including siblings, that are appropriate to visit in the NICU as defined in this policy, will be admitted past the first set of doors and be allowed to sit in the unit lounge.
3. ~~1.~~ **These guidelines are flexible to support the diverse needs of our families.**

B. **PROCEDURE:**

1. Staff shall greet **family and** visitors in the NICU entryway to identify who they are and whom they are visiting. Parents ID bands must be checked upon entrance. Take this opportunity to instruct families/visitors about the NICU visitation guidelines.
   - **a. Parents/banded individuals have 24-hour access to the NICU, inclusive of change of shift.**
   - **b. Visitors may visit with a parent/banded individual at any time except during change of shift (0645 to 0745 and 1845 to 1945).**
   - ~~a.~~**c.** ~~Parents may visit as often as they wish, any time., except during change of shift (0645 to 0745) and (1845 to 1945). Exceptions will be made for breast-feeding mothers.~~ **~~Visitors accompanying banded individuals may be asked to move to the waiting room during change of shift (0645-0745 and 1845-1945).~~ Banded individuals who are in the unit at the beginning of change of shift may remain. Banded individuals requesting entrance into the unit during change of shift will be asked to wait in the waiting room until the conclusion of change of shift unless they have been requested to enter by the nurse for feeding purposes.**
   - ~~b.~~**d.** Visitors who are not parents or siblings may not visit unless they are 18 years or older.
   - ~~c.~~**e.** Visitors are limited to two (2) visitors per patient at the bedside at any one time.
     - i. One of the bedside visitors must be a banded parent/individual. (Please note this will include employees.)
       - ~~1) Adoptive parents must have an ID band and be a banded person.~~
       - 1) Foster parents as designated by Department of Health Services and with valid identification.

2) Each multiple may have up to two visitors; only one banded individual is required per family.

~~d.~~**f.** Siblings **must be** 12 years and older **to visit unless they are the previously discharged sibling of a multiple. They** are encouraged **to visit with the following conditions:**~~and are considered as visitors – see below for health status.~~

i. An adult must supervise siblings at all times.

ii. All siblings **12 years and older** must show proof of up-to-date immunizations before **entering the NICU**~~visiting~~.

iii. All siblings will be health screened each time they enter.

~~ii.~~**iv. All siblings under the age of 18 will be prohibited during RSV/Flu season, inclusive of the previously discharged sibling of a multiple.**

~~e.~~**g.** All Visitors will be interviewed including but not limited to the following for admittance to the NICU:

i. Exposures: visitors who have had exposure to chickenpox, measles, tuberculosis will not allowed to visit

ii. Fever: No admittance will be granted to the NICU if the visitor presents with a temperature greater that 100.4 degrees Fahrenheit. Re-admittance to the NICU will be allowed when the visitor is afebrile for 24-hours.

1) Exception: Mother's that are febrile as a result of infections of non transmissible concern may visit if:

a) The mother is afebrile times one

b) Fever is cleared by OB as being of a non-transmissible origin.

iii. Signs of infection: visitors with signs of infection including but not limited to nausea, vomiting, cough sneezing, sore throat ,conjunctivitis and draining wounds (does not include scrapes or small cuts that are scabbed over) will not be allowed to visit for the duration of the illness. e.g. the signs and symptoms are resolved.

iv. Skin Lesions/Herpes Simplex (Oral Herpes Lesion)

1) No admittance will be granted to the NICU if the visitor presents with: skin lesions, including open abscesses and oral herpes lesions (cold sore) that are open or draining,

2) Re-admittance to the NICU can occur when the neonatologist has examined the visitor and the herpes lesion is completely crusted over. The visitor will be instructed to wear a mask and not to allow the sore to touch the infant.

v. Shingles

1) No admittance will be granted to the NICU of the visitor presents with shingles that are blistered or weeping.

2) Re-admittance to the NICU can occur when the shingles are dry and crusted. Visitor is instructed to not touch the affected area and not allow the lesion to touch the infant.

vi. Rashes

1) No admittance will be granted to the NICU if the visitor presents with an undiagnosed rash. Visitors with undiagnosed rash will be instructed to see their personal physician for diagnosis of origin. No admittance will be allowed until confirmation of origin is obtained and a non-contagious diagnosis is made.

2) No admittance will be granted to the NICU for visitors who have not had chicken pox or been vaccinated and has been exposed to anyone with chicken pox in the past three weeks. No admittance will be allowed from day 8 to day 21 after exposure.~~ Authorized visitors who are non-immune to chicken pox or measles will wear a surgical mask during visitation.~~

3) Visitors who are diagnosed with measles or rubella will not be allowed to visit until 7 days after the onset of rash.

~~f.~~**h.** Instruct all family members/visitors to follow the hand washing procedure prior to handling the baby. Refer to Hand Hygiene in the NICU Policy.

~~g.~~**i.** Encourage patient/family confidentiality.

~~h.~~**j.** The RN staff reserves the right to monitor and/or restrict visitation based upon unit activity and critical status of any infant.

~~i.~~**k.** At any time, the unit may close for medical purposes.

~~j.~~**l.** During seasons where there are more colds and flu, the visiting policy may be restricted further. Changes will be posted outside the NICU.

~~B. **EXTERNAL LINKS:**~~

~~C. **REFERENCES:**~~

~~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	Women and Newborn Services
PROCEDURE:	**NEWBORN SEPSIS CARE GUIDELINES**
Purpose:	To outline the nursing management of newborns demonstrating signs and symptoms of sepsis that may require further evaluation and management.
Supportive Data:	Any newborn with signs of sepsis should receive ~~a~~ **an initial** ~~full~~ diagnostic evaluation, **a review of maternal and newborn risk factors,** and receive antibiotic therapy pending the results of the evaluation. The evaluation should include a blood culture, a Complete Blood Count (CBC) including manual count differential and platelet count, a chest radiograph (X-ray) if any abnormal respiratory signs are present. Therapy should include antimicrobial agents active against Group B Streptococcus (GBS) as well as other organisms that might cause newborn sepsis such as E. coli.

A. **PURPOSE:**

1. To identify newborns with risk factors and **who develop** signs and symptoms **that may indicate neonatal** sepsis. ~~who may require treatment and possible Neonatal Intensive Care Unit (NICU) admission.~~
2. Newborns at risk for sepsis can include but are not limited to these indications:
   a. Positive maternal GBS status without receipt of Intrapartum Antibiotic Prophylaxis (IAP) within 4 hours of delivery
   b. Prolonged maternal rupture of membranes (ROM) greater than 18 hours
   c. Premature delivery, less than 37 weeks estimated gestational age (EGA)
   d. Unknown GBS status with ROM history greater than 18 hours ~~and/or prematurity~~
   e. **Maternal** Chorioamnionitis
   ~~f. History of maternal temperature of 101 F/ 38.3 C or higher, at any time during her current hospital stay~~
   ~~g.~~**f.** Maternal history of genital herpes
   ~~h.~~**g.** Newborn with traumatic delivery history
   ~~i. Newborn with 10 minute Apgar score less than 7~~
3. Signs and Symptoms of Newborn sepsis can include but are not limited to:
   a. Respiratory Distress
      i. Tachypnea
      ii. Grunting
      iii. Retractions
      iv. Nasal flaring
      v. Decreased breath sounds or adventitious breath sounds i.e.(wheezing, rhonchi, rales)
      vi. Apnea
      vii. Cyanosis
   b. Temperature instability
   c. Lethargy ~~or poor tone~~
   ~~c.~~**d.** **Hypertonia (poor tone)**
   ~~d.~~**e.** Irritability
   ~~e.~~**f.** ~~Consistent p~~**P**oor feeding
   ~~f.~~**g.** Hypoglycemia
   ~~g.~~**h.** **Poor perfusion (m**~~M~~ottled skin pattern**)**

~~h.~~**B.** **SPECIFIC SCENARIOS:**

1. Positive or Unknown Maternal GBS Status and/or Prematurity:

Department Review	Department of OB/GYN	Division of Neonatology	Department of Pediatrics	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW	n/a	n/a	2/16	09/16	09/16	10/16	

a. Please refer to Unit Specific Procedure: GBS Prevention and Treatment in Labor and Newborn follow-up

~~4.~~**2. Maternal Chorioamnionitis:**

a. A maternal diagnosis of Chorioamnionitis requires immediate newborn evaluation and admission to the Neonatal Intensive Care Unit (NICU).

b. **The** Diagnos**is of** ~~ing~~ maternal chorioamnionitis is the responsibility of the Obstetrical (OB) provider and is defined by:

i. Maternal temperature greater than or equal to (100.4 F or 38 C) **AND** (2) other signs/ symptoms listed below:

1) Fetal tachycardia
2) Maternal tachycardia
3) Maternal White Blood Cell(WBC) Count greater than or equal to 15,000
4) Uterine tenderness
5) Foul smelling amniotic fluid

c. A ~~maternal~~ diagnosis of **Maternal** Chorioamnionitis requires immediate newborn evaluation and admission to the Neonatal Intensive Care Unit (NICU).

3. Maternal Fever:

a. If a maternal fever of 100.5 or higher is obtained, the newborn's provider should be called to determine if any further evaluation, monitoring or treatment is needed based on the condition of the newborn and any maternal or intrapartum risk factors.

b. A newborn that is asymptomatic may remain in couplet care to facilitate the opportunity for exclusive breastfeeding until symptoms and/or laboratory results indicate a reason for NICU admission.

4. Newborn with signs and symptoms of sepsis:

~~5)~~**a. The nurse shall contact the newborn's provider immediately to determine further evaluation, monitoring and treatment plans.**

~~B.~~C. PROCEDURE:

1. If a n**ewborn** presents with signs and symptoms of sepsis~~,~~ **or** -has known maternal risk factors, the nurse should obtain an initial set of vital signs and consider a point of care glucose screening.
   a. Newborns with temperature instability shall be placed on a radiant warmer and warmer placed on servo mode for temperature regulation.
   b. Newborns with hypoglycemia shall be managed per the Blood Glucose Newborn Monitoring Standardized Procedure.
2. A pulse oximeter shall be placed on the newborn to obtain a baseline oxygen saturation value with an oxygen source nearby for use as indicated.
   a. For newborns with respiratory distress and/or cyanosis, apply supplemental oxygen for pulse ox readings of less than 95% and per provider order
3. Placement of cardiac leads for ongoing monitoring can be considered.
4. ~~The newborn's provider shall be called immediately and clinical concerns reported.~~ If lab work is requested, the provider orders may include~~: obtaining:~~
   a. Neonatal Complete Blood Count (CBC with manual differential)
   b. CRP
   c. Blood Culture
   d. Chest X-ray
5. The newborn, who has unresolved clinical symptoms and/or abnormal laboratory results, shall be prepared for transport to the NICU. ~~.~~
6. Document clinical findings, nursing interventions and provider notification.

~~C.~~D. REFERENCES:

1. American Academy of Pediatrics ~~(AAP)~~ and American College of Obstetricians and Gynecologists ~~(ACOG)~~ **(2012).** ~~-~~*Guidelines to Perinatal Nursing* **(7th ed.)**. Washington DC, ~~2012.~~

2. Simpson, K.~~,~~**&**~~-~~ Cree**h**an, P.**(2014)** *Perinatal Nursing (4th ed).* Philadelphia, PA: Wolters/Kluwer/Lippincott Williams & Wilkins~~; 2014.~~

~~D.~~E. RELATED DOCUMENT(S):

1. Women and Newborn Services Procedure: Group B Strep Prevention and Treatment in Labor and Newborn follow-up.
2. Patient Care Services Standardized Procedure: **Blood Glucose Newborn Monitoring**~~Hypoglycemia Management in the Newborn~~

Epidural Administration of Corticosteroids by Interventional Radiology at TCMC

Situation: The epidural administration of corticosteroids including, but not limited to methylprednisolone, triamcinolone, and betamethasone is not approved by the FDA. Concerns were raised by pharmacists regarding verification of orders for steroids intended for epidural injection.

Background: Injection of corticosteroids into the epidural space has been commonplace for several decades, however the safety and effectiveness have not been established and thus has never been approved by the FDA. Concerns were raised in the medical community regarding the risk of serious neurologic adverse events secondary to epidural administration of corticosteroids. As a result, the FDA commissioned an expert panel to investigate this issue.

The conclusion of this investigation in November 2014 resulted in changes to the package inserts for all injectable corticosteroids indicating that epidural administration is not recommended. This recommendation was independent of the presence or absence of preservatives in the drug solution.

An FDA expert panel also produced clinical considerations in February of 2015 to provide guidance on appropriate epidural administration if corticosteroids if they are used in this off-label setting.

Assessment: In June of 2016, the Pharmacy Service issued concerns regarding the safety epidural administration of corticosteroids by IR physicians at TCMC. Clarification was requested from Risk Management to determine if pharmacists may approve these medication orders for this indication and/or if patient's needed an updated consent form addressing the risks associated with this specific procedure given the changes in the Package Insert for these agents.

A meeting between IR, Risk Management, and Pharmacy was held on August11th, 2016 to address these issues. IR has addressed the issue internally and currently follows all of of the FDA Expert Panel recommendations on best injection practices to minimize the risk of neurologic injury. Given that IR is following currently accepted best practice and has an extensive history of performing this procedure without incident, Risk Management felt that it was reasonable to continue this practice without changes. Furthermore, Risk Management has asked that the details of this meeting be discussed with the P&T Committee and Medical Executive Committee for informational purposes.

Recommendation(s):

- Epidural administration of corticosteroids may be performed by IR physicians following FDA recommended best-practice
- Details of meeting held between IR, Pharmacy, and Risk Management to be reviewed by P&T and MEC

References:

Rathmell JP, Benzon HT, Dreyfuss P, et al. Safeguards to prevent neurologic complications after epidural steroid injections: Consensus opinions from a multidisciplinary working group and national organizations. Anesthesiology. 2015;122:974-984

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:
Gadobutrol (Gadavist) **Admission { x }** **Deletion { }**

Date: 09/13/2016 **Requestor:** Dr. Donald Ponec

Trade Name: Gadavist **Generic Name:** Gadobutrol

Dosage form(s): 1 mmol/mL (2 mL, 7.5 mL, 10 mL, 15 mL, 30mL, 65mL vials), 1mmol/mL (7.5mL, 10mL, 15mL pre-filled syringes)

Indications:

1. Diagnostic imaging (Breast malignancy, CNS, supra-aortic, or renal artery angiography)

Efficacy:

Study	Study Design	Intervention	Outcomes
N=336 MRI of the CNS	Double-blind, cross-over Phase III study	Single dose of gadobutrol 0.1 mmol/kg then a single dose of gadoteridol 0.1 mmol/kg in randomized sequence 24 hours apart	Superiority seen in contrast enhancement, border delineation, internal morphology Non-inferiority demonstrated for gadobutrol vs gadoteridol for exact match diagnosis

Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:
Anaphylactic and other hypersensitivity reactions with cardiovascular, respiratory or cutaneous manifestations, ranging from mild to severe, including death, have occurred. Monitor patients closely during and after administration of Gadavist.

Cost comparison with similar Formulary products:

Gadoversetamide (Optimark)	Gadobutrol (Gadavist)
15 mL syringe ($26)	7.5 mL ($63)
20 mL syringe ($33)	10 mL ($84)

Recommendation:
Gadobutrol (Gadavist) as compared to the currently utilized contrast gadoversetamide (Optimark) may have reduced risk of NSF due to its macrocyclic structure. Gadoversitamide is among a small group of agents associated with the highest number of NSF cases historically speaking. As compared to the macrocyclic product gadobenate (MultiHance), gadobutrol is nonionic which in theory may pose less risk of tissue injury in the rare but serious event of extravasation. Another macrocylic product gadoteridol (ProHance) has lower relaxivity as compared to gadobutrol and in studies some evidence of this difference was apparent as gadobutrol produced improved image enhancement and border delineation. Of all the macrocyclic gadolinium agents, gadobutrol has the most FDA labeled indications demonstrating efficacy in breast, CNS, aortic, and renal artery imaging.

Whereas the current formulary product gadoversitamide is contraindicated in those patients with severe kidney disease (GFR <30 ml/min/1.73 m^2), the macrocyclic agents including gadobutrol are not, although this does not obviate the risk of NSF. Among the macrocyclic agents, costs are comparable however gadobutrol is the only product among this class which comes packaged as a pre-filled syringe.

The TCMC Pharmacy and Therapeutics Committee recommends the addition of gadobutrol (Gadavist) to the TCMC Formulary to replace gadoversetamide (Optimark). This recommendation is secondary to an improved safety profile with newer macrocyclic gadolinium-based contrast agents, comparable pricing against other macrocyclic agents, and compatibility with existing equipment and protocols.

References:

1. ACR Manual on Contrast media Version 10.2, 2016. ACR Committee on Drugs and Contrast Media
2. Gadavist™. Full Prescribing Information (Package insert). Bayer Health Care Pharmaceuticals, Inc. April 2016
3. Kanal, E, Maravilla K, Rowley, HA. Gadolinium Contrast Agents for CNS Imaging: Current Concepts and Clinical Evidence. American Journal of Neuroradiology, 2014;35(12):2215-26

Formulary Line Item Additions/Deletions

Additions:

- **Capsaicin 0.025% topical cream**
- **Ticagrelor 60mg tablets**

Deletions:

- **Capsaicin 0.075% topical cream**
- **Albuterol oral solution**
- **Potassium chloride 40 meq/30mL unit dose cups**
- **Vitamin K 5mg oral tablets**

Capsaicin 0.025% topical cream: Capsaicin 0.075% cream on formulary no longer available from local distributor. **P&T Committee recommends addition of capsaicin 0.025% cream to formulary. Capsaicin 0.075% cream will be removed as a line item from the formulary.**

Ticagrelor 60mg tablet: Ticagrelor 90mg tablets are currently on formulary. In 2015, a 60mg tablet strength was developed following approval for new dosing regimen of 60mg twice daily after 1 year of therapy on ticagrelor 90 mg twice daily. **The P&T Committee recommends adding the 60mg tablet strength as a formulary line item to facilitate continuity of outpatient care.**

Albuterol oral solution: Oral formulation is not the preferred route of therapy for this agent. The recommended route of administration is via metered-dose inhaler (MDI) or nebulizer for all indications. This recommendation is supported by the National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines (2007). Due to the lack of orders for this agent, the bulk bottle routinely expires on the shelf. **The P&T Committee recommends deletion from the TCMC formulary given lack of use and availability of the recommended dosage forms (MDI, nebs).**

Potassium chloride 40 meq/30 ml unit dose cups: Ambiguous labeling by the manufacturer lead the Pharmacy Service to pull this dosage strength from all Pyxis machines in August 2016. The label read "20meq per 15mL" which could easily be misconstrued as 20meq total in the unit dose when in reality the nurse would be giving 40 meq. ISMP has been notified of this issue and the manufacturer is planning to correct their product label in the future. **The P&T Committee recommends removing this as a formulary line item. The 20 meq/15mL unit dose cups will remain available.**

Vitamin K 5 mg tablets: Tablets significantly increased in price, tripling over the last several years (currently $55 per tablet). Given this dramatic cost increase, several institutions have begun compounding an oral solution using the intravenous dosage form. The stability of a vitamin K oral preparation (1mg/mL) using intravenous vitamin K (10mg/mL) and sterile water for injection has been well documented. A compounded 5mg dose of vitamin K using this preparation will cost TCMC approximately $16 per dose (~$40 cost savings per dose). Oral ingestion of the intravenous solution is considered equivalent to oral tablets. **The P&T Committee has approved the deletion of vitamin K 5mg tablets from the formulary and approved the change in practice to provide oral doses using an oral solution compounded using the intravenous solution.**

Governance & Legislative Committee
(No meeting held in October, 2016)

Tri-City Medical Center
Audit, Compliance & Ethics Committee
October 20, 2016
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director Education & Clinical Informatics

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Finnila.		
2. Approval of Agenda	**It was moved by Director Mitchell and seconded by Ms. Kathryn Fitzwilliam to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – September 15, 2016	It was noted on page 5 C. the word "laborers" should be revised to read "regulators". **It was moved by Director Schallock and seconded by Director Mitchell to approve the minutes as amended. The motion passed unanimously.**	**Amended Minutes ratified.**	Ms. Donnellan
5. New Business			
A) Review and Discussion of Policies & Procedures:	Director Finnila stated several policies on today's agenda are listed as "deletions". She encouraged committee	**Recommendation to be sent to the Board of**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1) 8750-537 – Hiring and Employment; Definitions (DELETE)	members to speak up if they have any questions as to whether information contained in a deleted policy has been addressed elsewhere. Ms. Fitzwilliam stated going forward it would be productive to attach the policies that have the deleted language incorporated to ensure the language has been captured to the committee's satisfaction. Ms. Kathy Topp stated typically the new policy is brought to the committee at the same time as the deleted policy however in this instance that did not occur.	**Directors to delete Policy 8750-537 – Hiring and Employment; Definitions.**	
2) 8750-560 – Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation	The committee had extensive discussion related to Policy 8750-560 – Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation. Suggestions included formatting changes in section A . as well as a modification to the title of the policy. A question was raised regarding whether the District has a Whistle Blower policy. Ms. Bernard-Shaw stated many organizations do not have a specific Whistle Blower Policy as it is counterproductive for the organization, however the policy before the committee today clearly addresses non-retaliation. She stated the purpose of the policy is to be consistent with federal and state law which prohibits retaliation. Ms. Racicot also provided a detailed explanation of the False Claims Act and Deficit Reduction Act. Director Schallock commented on the importance of insuring the Board is informed when those individuals hired by the Board including the CEO, Chief Compliance Officer and General Counsel are being investigated. Ms. Racicot suggested this issue be addressed in Policy 8750-561 as that policy speaks to the process and investigation of suspected misconduct. **It was moved by Ms. Kathryn Fitzwilliam to recommend approval of Policy 8750-561 with amendments as described. Director Mitchell seconded the motion. The**	**Recommendation to be sent to the Board of Directors to Approve Policy**	Ms. Donnellan

	motion passed unanimously.	**8750-561 as described.**	
3) 8750-561 – Responding to Compliance Issues – Reports of Suspected Misconduct; Investigation	The committee had extensive discussion on Policy 8750-561 related to how and when the Board is informed of compliance issues related to those individuals hired by the Board (CEO, CCO and General Counsel). Ms. Bernard-Shaw explained the Compliance Officer also makes judgments as to other compliance issues and investigations that should be brought to the attention of the Board. Minor grammatical revisions were also suggested. Ms. Racicot stated in her opinion the policy is not well written and should be tabled to address the issues described.	**Policy 8750-561 – Responding to Compliance Issues – Reports of Suspected Misconduct; Investigation to be revised and brought back to the committee for consideration.**	CCO
4) 8750-563 – Development and Revision of Code of Conduct and Policies – Introduction (DELETE)	Ms. Kathy Topp explained Policy 8750-563 – Development and Revision of Code of Conduct and Policies – Introduction has been deleted and its content has been incorporated into Policy 8750-564.	**Recommendation to be sent to the Board of Directors to delete Policy 8750-563.**	Ms. Donnellan
5) 8750-564 – Development and Revision of Code of Conduct and Policies	The committee reviewed Policy 8750-564 and recommended the following revisions: ➢ Section C. 1. Last line strike the word "Compliance" and replace with the word "Committee". ➢ Section C. 1. Last line insert the words "related compliance" policies, as … ➢ Strike Section D in its entirety. **It was moved by Director Mitchell to recommend approval of Policy 8750-564 – Development and Revision of Code of Conduct and Policies with amendments as described. Mr. Leslie Schwartz seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8750-564 as described.**	Ms. Donnellan
6) 8750-565 – Revision of Conduct and Compliance Policies (DELETE)	It was noted Policy 8750-565 – Revision of Conduct and Compliance Policies has been deleted.	**Recommendation to be sent to the Board of Directors to delete Policy 8750-565.**	Ms. Donnellan
7) 8750-568 – Development and Revision of Code of Conduct and Policies – Dissemination of New or Revised Code of Conduct and Policies (DELETE)	It was noted Policy 8750-568 – Development and Revision of Code of Conduct and Policies – Dissemination of new or Revised Code of Conduct and Policies has been deleted. *Ms. Topp left the meeting at 9:09 a.m.*	**Recommendation to be sent to the Board of Directors to delete Policy 8750-568.**	Ms. Donnellan

B) Consideration to appoint Ms. Kathryn Fitzwilliam to an additional two-year term on the Audit, Compliance & Ethics Committee	**It was moved by Director Schallock to recommend Ms. Kathryn Fitzwilliam be appointed to an additional two-year term on the Audit, Compliance & Ethics Committee. Director Mitchell seconded the motion. The motion passed unanimously.** Chairperson Finnila expressed her appreciation to Ms. Fitzwilliam for her willingness to serve. Chairperson Finnila reported Mr. Barton Sharp's term is also expiring, however he has not expressed an interest in serving an additional term.	**Recommendation to be sent to the Board of Directors to appoint Ms. Kathryn Fitzwilliam to an additional two-year term on the Committee.**	Ms. Donnellan
6. Old Business - None			
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes.		
8. Motion to go Into closed session	**It was moved by Mr. Jack Cunning and seconded by Director Schallock to go into closed session at 9:10 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 9:15 a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
11. Comments from Committee Members	Director Mitchell expressed her appreciation to Ms. Fitzwilliam for her willingness to serve an additional term.	None	Chairperson
12. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting is tentatively scheduled for November 17, 2016. Director Schallock commented that the committee should consider cancelling the December 15th meeting due to the Board meeting holiday schedule.	**The committee's next meeting is tentative scheduled November 17, 2016.** **The December 15th meeting will be cancelled.**	
13. Adjournment	Chairperson Finnila adjourned the meeting at 9:15 a.m.		

AUDIT AND COMPLIANCE COMMITTEE
October 20th, 2016

Administrative Policies & Procedures	Policy #	Reason	Recommendations
Compliance			
1. Hiring and Employment; Definitions -	537	DELETE	Pulled – submit with 539 & 541
2. Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct Policy	560	3 year review, practice change	Forward to BOD for approval with revisions
3. Responding to Compliance Issues - Reports of Suspected Misconduct Investigation	561	3 year review, practice change	Pulled for further review
4. Development and Revision of Code of Conduct and Policies - Introduction	563	DELETE	Forward to BOD for approval
5. Development and Revision of Code of Conduct and Policies	564	3 year review, practice change	Forward to BOD for approval with revisions
6. Revision of Code of Conduct and Compliance Policies	565	DELETE	Forward to BOD for approval
7. Development and Revision of Code of Conduct and Policies - Dissemination of New or Revised Code of Conduct and Policies 568	568	DELETE	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 12/12

SUBJECT: Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct ~~Policy~~

REVISION DATE(S):

POLICY NUMBER: 8750-560

Department Approval Date(s):	**01/16**
Administrative Policies and Procedures Approval Date(s):	**08/16**
Organizational Compliance Committee Approval Dates (s):	**08/16**
Medical Executive Committee Approval Date(s):	**~~02/16~~09/16**
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	**12/12**

A. **PURPOSE:**

1. ~~This policy~~ **To** provide~~s~~ a statement of Tri-City Healthcare District's (TCHD**'s**) non-retaliation policy relating to reports of suspected misconduct and potential compliance irregularities. It is the District's intent that ~~any~~**no** person reporting a compliance concern ~~not~~ **be subjected to** ~~suffer~~ retaliation in any form**. This**~~which~~ is consistent with applicable **Federal and state** laws and regulations, the District's Compliance Program Policies, and ~~the District's~~**TCHD's** Code of Conduct.~~o encourage employees and contractors to report potential misconduct.~~

B. **NON-RETALIATION; ~~POLicySITIVE CITATION~~:**

1. When a ~~District~~ **TCHD** employee or contractor has made a good faith report of an activity, practice, or arrangement that the employee believes violates or may violate applicable laws and regulations, ~~the District's~~**TCHD's** Compliance Program Policies, or the TCHD's Code of Conduct:
   a. TCHD shall not in any manner harass or engage in retaliation or retribution against the **person, whether a board member,** employee **or** /contractor for making a report, provided the **Board member,** employee/contractor was not involved in the misconduct at issue.
   b. TCHD shall take appropriate corrective and/or disciplinary action against any **individual**~~employee/contractor~~ who either commits or condones any act of retaliation, retribution, or harassment against a person who reports a compliance concern. Disciplinary action **for employees engaging in retaliation** can be up to and including termination of employment or affiliation with the District.

C. **REPORTING EMPLOYEE'S PARTICIPATION IN MISCONDUCT:**

1. TCHD shall take appropriate corrective and/or disciplinary action against any employee who violates any laws, regulations, policies and/or TCHD's Code of Conduct, whether or not that employee reported such violation.
2. As set forth in Policy 8750-562, the fact that the employee reported his or her own misconduct, and the truthfulness and completeness of that self-disclosure, can be a factor in reducing the severity of any corrective and/or disciplinary action.
3. No corrective and/or disciplinary action shall be taken against any **individual** ~~employee/contractor~~ who mistakenly but in good faith reported an act reasonably believed **to be** a compliance violation or other misconduct. **Individuals** ~~Employees/contractors~~ may be subject to corrective and/or disciplinary action **(if appropriate)** if it is determined that a report of wrongdoing or suspected violation of the Compliance Program was not made in good faith (e.g.,

was knowingly fabricated, distorted, exaggerated or minimized in order to injure someone else, protect himself/herself, or for any other reason).

4. Any **individual**~~employee/contractor~~ who misuses the Confidential Reporting Line (Values Line) or attempts to interfere with efforts to investigate or address a possible compliance issue is subject to corrective and/or disciplinary action up to and including termination of employment or affiliation with TCHD.

D. **DOCUMENTATION:**

1. TCHD shall document compliance with this policy and maintain such documentation consistent with the document retention policies.

E. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-562 – Responding to Compliance Issues; Remedial Action.
2. TCHD Code of Conduct.
~~1.~~**3. TCHD Employee Handbook.**

F. **REFERENCES:**

1. **"False Claims Act" – 31 U.S.C. Sections 3723-3733, a.k.a. "The Lincoln Law"**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – This policy has been incorporated into Policy 8750-564- Development and Revision of Code of Conduct and Policies.

ISSUE DATE: 05/12

SUBJECT: Development and Revision of Code of Conduct and Policies; Introduction

REVISION DATE(S):

POLICY NUMBER: 8750-563

Department Approval Date(s):	01/16
Administrative Policies and Procedures Approval Date(s):	08/16
Organizational Compliance Committee Approval Date(s):	08/16
Medical Executive Committee Approval Date(s):	09/16
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	10/16
Board of Directors Approval Date(s):	05/12

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

~~1.~~ ~~Policy 8750-563 establishes (1)~~**~~To establish~~** ~~policies for the development, review, revision, approval, retirement and dissemination of Tri-City Healthcare District's Code of Conduct and Policies and Procedures, and (2) to ensure that the District's~~**~~Tri-City Healthcare District's (TCHD)'s~~** ~~practices are consistent with its stated policies~~

~~B.~~ ~~**QUESTIONS RELATED TO DRP POLICIES AND PROCEDURES:**~~

~~1.~~ ~~Any questions concerning the Development and Revision of Code of Conduct Policies (8750-563 through 8750-568), or questions that are not specifically addressed in the Development and Revision of Code of Conduct Policies, shall be directed to the District's~~ **~~TCHD's~~** ~~Chief Compliance Officer.~~

~~C.~~ ~~**AUDIT AND DOCUMENTATION:**~~

~~1.~~ **~~TCHD~~**~~District shall and document compliance with the Development and Revision of Conduct Policies (8750-563 through 8750-568). Such audit shall be conducted pursuant to Policy 8750-553. Relevant documentation shall be maintained in the District's~~ **~~TCHD's~~** ~~Compliance Program files, consistent with its document retention policies~~

~~D.~~ ~~**REFERENCES:**~~

~~1. **Administrative Policy 8750-553 – Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits**~~
~~2. **Administrative Policy 8750-563 – Development and Revision of Code of Conduct and Policies; Introduction and General Policies**~~
~~3. **Administrative Policy 8750-564 – Development and Revision of Code of Conduct and Policies**~~
~~4. **Administrative Policy 8750-565 – Revision of Code of Conduct and Compliance Policies**~~
~~5. **Administrative Policy 8750-567 – Development and Revision of Code of Conduct and Policies – Retiring Code of Conduct and/or Policies**~~
~~6. **Administrative Policy 8750-568 – Development and Revision of Code of Conduct and Policies – Dissemination of New or Revised Code of Conduct and Policies**~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: **Development and Revision of Code of Conduct and Policies**

REVISION DATE(S):

POLICY NUMBER: 8750-564

Department Approval Date:	**08/16**
Administrative Policies and Procedures Approval Date:	**08/16**
Organizational Compliance Committee Date (s):	**08/16**
Medical Executive Committee Approval Date(s):	**09/16**
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	**05/12**

A. **PURPOSE:**

1. ~~This policy explains~~**To provide a statement of** Tri-City Healthcare District's (TCHD**'s**) policy regarding the development, **review and revision** of the Code of Conduct and Policies implementing TCHD's Compliance Program, and helps ensure TCHD's practices are consistent with its stated policies.

B. **DEVELOPMENT OF SPECIFIC POLICIES AND PROCEDURES:**

1. The **Chief** Compliance Officer, in conjunction with the ~~Internal~~ **Organizational** Compliance Committee (and legal counsel and others, as appropriate), shall develop TCHD's Code of Conduct and identify and develop the Policies necessary to ensure the effectiveness of TCHD's Compliance Program for recommendation to the Board of Directors.
2. The Compliance Program Policies shall specifically address the seven factors identified by the OIG, as fundamental to an effective compliance program. Specifically, the Policies shall address:
   a. Implementing written standards, policies;
   b. Designating a **Chief** Compliance Officer and compliance committee;
   c. Conducting effective training and education;
   d. Developing effective lines of communication;
   e. Conducting internal monitoring and auditing;
   f. Enforcing standards through well-publicized disciplinary guidelines; and
   g. Responding promptly to detected problems and undertaking corrective action.
3. The Policies shall specifically address "risk" areas identified by OIG, in applicable compliance program guidance or otherwise, as well as risk areas identified by other agencies of the federal government, or which the **Chief** Compliance Officer determines are relevant to TCHD.
4. All Policies shall be clear and concise and follow the same general format
5. New Policies, while in development, shall be discussed with the appropriate persons in the affected department(s). If a department proposes a policy, it must provide any supporting documents, for evaluation by the **Chief** Compliance Officer.

C. **REVIEW OF CODE OF CONDUCT AND POLICIES:**

1. **The Chief Compliance Officer, in conjunction with the Organizational Compliance ~~Internal Compliance~~Committee, shall review the Code of Conduct and all related**

compliance policies, as necessary, but at a minimum, once every twelve (12) months.

2. The Chief Compliance Officer shall propose modifications and amendments to the Code of Conduct and/or policies, as appropriate, to reflect:
   a. Changes in applicable laws and regulations, including changes in applicable coverage and reimbursement laws, regulations and decisions.
   b. Changes in the nature or scope of ~~the District's~~ TCHD's business (including TCHD's ~~the District's~~ contractual obligations), and
   c. Indications that existing policies have been ineffective in preventing compliance violations or new or additional policies would be more effective in preventing or avoiding the recurrence of misconduct.
3. Where appropriate, the Chief Compliance Officer, in conjunction with the Organizational ~~Internal~~ Compliance Committee, shall propose revisions to TCHD's ~~the District's~~ Code of Conduct policies.
4. Proposed revisions shall be discussed with appropriate persons in the affected department before implementing changes.
5. Any revision must be approved by the Board of Directors.

~~D. QUESTIONS RELATED TO POLICIES AND PROCEDURES:~~

~~1.~~6. ~~Any questions concerning the Development and Revision of Code of Conduct Policies (8750-563 through 8750-568 8750-564 and 8750-567), or questions that are not specifically addressed in the Development and Revision of Code of Conduct Policies, shall be directed to the District's TCHD's Chief Compliance Officer. Program files will be maintained, consistent with its document retention policies.~~

~~E.~~D. AUDIT AND DOCUMENTATION:

1. TCHD ~~District~~ shall document compliance with the Development and Revision of Conduct Policies (~~8750-563 through 8750-568~~ 8750-564 and 8750-567). Such audit shall be conducted pursuant to Policy 8750-553. Relevant documentation shall be maintained in ~~the Districts~~ TCHD's Compliance Program Files, consistent with its documentation retention policies.

~~F.~~E. DOCUMENTATION:

1. The Chief Compliance Officer shall maintain copies in the Compliance Program Files of:
   a. All final versions of the Code of Conduct.
   b. All final versions of compliance policies.

~~G.~~F. REFERENCES:

1. Administrative Policy 8750-553 – Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits.
2. Administrative Policy 8750-564 – Development and Revision of Code of Conduct and Policies.
3. Administrative Policy 8750-567 – Development and Revision of Code of Conduct and Policies; Retiring Code of Conduct and/or Policies.

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – This policy has been incorporated into Policy 8750-564- Development and Revision of Code of Conduct and Policies.

ISSUE DATE: 05/12

SUBJECT: Revision of Code of Conduct and Compliance Policies

REVISION DATE(S):

POLICY NUMBER: 8750-565

Department Approval Date(s):	**01/16**
Administrative Policies and Procedures Approval Date(s):	**08/16**
Organizational Compliance Committee Approval Date(s):	**08/16**
Medical Executive Committee Approval Date(s):	**09/16**
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	**10/16**
Board of Directors Approval Date(s):	**05/12**

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

~~1. This policy provides (1)**To provide** a statement of Tri-City Healthcare District's policy regarding the review and revision of the District's Code of Conduct and policies implementing the District's Compliance Program, and (2) to ensure that the District's practices are consistent with its stated policies.~~

~~B. **REVIEW OF CODE OF CONDUCT AND POLICIES:**~~

~~1. The Compliance Officer, in conjunction with the Internal **Organizational** Compliance, shall review the Code of Conduct and all policies, as necessary, but, at a minimum, once every twelve (12) months.~~

~~2. The Compliance Officer shall propose modifications and amendments to the Code of Conduct and/or policies, as appropriate, to reflect: (1) changes in applicable laws and regulations, including changes in applicable coverage and reimbursement laws, regulations and decisions, (2) changes in the nature or scope of the District's business (including the District's contractual obligations), and (3) indications that existing policies have been ineffective in preventing compliance violations or that new or additional Policies would be more effective in preventing or avoiding the recurrence of misconduct.~~

~~3. Where appropriate, the Compliance Officer, in conjunction with the Internal **Organizational** Compliance Committee, shall propose revisions to District's Code of Conduct and policies.~~

~~4. Proposed revisions shall be discussed with appropriate persons in the affected department before implementing changes.~~

~~5. Any revision must be approved by the Board of Directors.~~

~~C. **DOCUMENTATION:**~~

~~1. The Compliance Officer shall maintain copies in the Compliance Program Files of:~~

~~a. All final versions of the Code of Conduct.~~

~~b. All final versions of compliance policies.~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – This policy has been incorporated into Policy 8750-564- Development and Revision of Code of Conduct and Policies.

ISSUE DATE: 05/12

SUBJECT: Development and Revision of Code of Conduct and Policies; Dissemination of New or Revised Code of Conduct and Policies

REVISION DATE(S):

POLICY NUMBER: 8750-568

Department Approval Date(s):	01/16
Administrative Policies and Procedures Approval Date(s):	08/16
Organizational Compliance Committee Approval Dates (s):	08/16
Medical Executive Committee Approval Date(s):	09/16
Audit, ~~and~~ Compliance and Ethics Committee Approval Date(s):	10/16
Board of Directors Approval Date(s):	05/12

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

~~1. This Policy provides a statement of Tri-City Healthcare District's policy regarding dissemination of a new or revised Standard of Conduct and/or Policies, and ensures that the District's practices are consistent with its stated policies.~~

~~B. **DISSEMINATION OF NEW OR REVISED CODE OF CONDUCT AND POLICIES:**~~

~~1. TCHD shall disseminate any new or revised Standard of Conduct and Policies pursuant to Policy 8750-546 – Education and Training; Distribution/Certification of Code of Conduct and Policies, within 30 days of such Code of Conduct and Policies being approved.~~

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

September 29, 2016 – 1:30 o'clock p.m.
Classroom 6 – 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 September 29, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director RoseMarie V. Reno
Director Larry Schallock

Absent was Director Julie Nygaard

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Ray Rivas, Acting Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Chairman Dagostino noted New Business item 16 c) Recruitment Agreement with Dr. Anton M. Kushnaryov and North County Ear, Nose, Throat and Head & Neck Surgery has been pulled pending additional information.

   Chairman Dagostino also requested that an item be added to Closed Session 6 f) Conference with Legal Counsel – Existing Litigation to provide an update on the Patricia Jenkins vs. Tri-City Health Care District litigation matter.

It was moved by Director Kellett to approve the agenda as amended. Director Finnila seconded the motion. The motion passed (6-0-1) with Director Nygaard absent.

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the September 26, 2016 Regular Board of Directors Meeting 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. Greg Moser made an oral announcement of the items listed on the September 26, 2016 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; one Report Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding two (2) matters of Existing Litigation; three (3) matters of Potential Litigation and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Schallock to go into closed session at 1:35 p.m. The motion passed (6-0-1) with Director Nygaard absent.

6. The Board adjourned to Closed Session at 1:35 p.m.

7. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Julie Nygaard

Also present were:

Greg Moser, General Legal Counsel
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
Cheryle Bernard-Shaw, Chief Compliance Officer

Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

8. Chairman Dagostino reported no action was taken in open session.

9. Director Dagostino led the Pledge of Allegiance.

10. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

Chairman Dagostino reported a special guest has joined us today, our Sacramento Representative, Assemblyman Rocky Chavez, who has requested the opportunity to address our Board of Directors.

Assemblyman Chavez stated he has the honor of representing the cities of Carlsbad, Oceanside and Vista which incidentally is the same district as Tri-City Medical Center. He commented that in the past few years he has been extremely impressed with this Board and is here today to express his appreciation for the Board's hard work and their ability to focus on what matters and the residents of this District.

Assemblyman Chavez stated that he recently learned that through the efforts of this Board and CEO Tri-City will be applying for a funding mechanism from HUD which he believes is an outstanding idea and has provided a letter of support on our behalf. He stated that with a favorable result from HUD, the issue of finances will be put it in our history and allow the District to move forward.

Assemblyman Chavez stated the two messages he would like to relay today is he is hopeful that through the fall Tri-City will continue to have this strong leadership in place focusing on what is best for the community and he strongly supports us in our efforts with HUD.

In closing, Assemblyman Chavez stated his office stands by to do anything that is needed to ensure we move forward for our community.

On behalf of the Board, Chairman Dagostino stated he is honored with Assemblyman Chavez's presence and expressed his appreciation for recognizing our Board.

12. Special Presentations –

(1) Clinical Equipment Update – Dr. Donald Ponec

Dr. Ponec presented a comprehensive review of major medical equipment that included a description of devices that have been purchased in the time period FY2013 – FY2016. Dr. Ponec explained Tri-City Healthcare District has invested approximately $57.8 million in medical equipment technology over the past seven (7) years. He commented that the Radiology Department is State of the Art in many areas and is at or above the Community Standard in all areas.

Dr. Ponec also included in his review the technical classification and regulatory agencies that routinely inspect or certify the devices.

Dr. Ponec stated he wanted to reassure both the public and the Board that we are very much aware of all the latest and greatest technology and due diligence is done in selecting what makes the most sense for the hospital in terms of equipment.

Directors asked questions which Dr. Ponec responded to.

Mr. Steve Young, Senior Director of Ancillary Services also presented an update on state of the art Cardiology equipment that has been purchased as well as FY2017 pending equipment projects.

Director Reno stated she very much appreciates today's educational presentation on our medical equipment and technology and she feels more comfortable that we have this fine equipment. Director Reno suggested the Board receive an educational session once a year on the hospital's Medical Equipment and Technology. Director Reno also expressed her appreciation to the Foundation and Auxiliary for their assistance in purchasing some of our equipment.

No action was taken.

(2) Information Related to Quality – Sharon Schultz, CNE

Ms. Sharon Schultz presented a report related to Quality. She reported on the various agencies that report out data and noted no two agencies report out in the same way. For example, Leap Frog measures by outcomes and CMS takes into account HCAP scores and claims data. Ms. Schultz stated the fact that we have a large number of "double rooms" is an issue as "quiet at night" is the score that brought us down the most. Ms. Schultz emphasized that Tri-City Medical Center provides the highest quality of care and it is our mission to provide patients with help and healing for a safe passage. She stated we truly believe our patients come first!

Ms. Schultz described the Falls Program that has created safe units where rounding is conducted every 15 minutes to make sure patients at risk for falls are safe and in their beds.

Another program Ms. Schultz commented on was the Code Sepsis Team in which our team responds 24/7 to codes. She noted Tri-City was the first hospital in San Diego County to implement a Code Sepsis Team and it has made a big impact on the wellbeing of our patients.

Lastly, Ms. Schultz described the benefits of the Wound Care Team who conducts rounds to assess breakdown of skin.

Ms. Schultz stated a new service will be implemented next month, the Palliative Care Program and she looks forward to discussing this program at a future meeting.

No action was taken.

(3) Marketing Report – David Bennett, CMO

Mr. David Bennett provided a Marketing Update on activities for the time period January - September, reviewing the following:

- There have been a total of 18 Press Releases and the one he is most proud of is our Sixth Consecutive "A" Rating in Patient Safety;

- There are four commercials that run on NBC and CBS that feature some of our fine physicians;

- Wellness Center Memberships ending September 2016 totaled 3,608 which includes 1,023 new members. Cancellation of membership continues to be a problem with 1,086 cancellations during this time period, however Corporate Memberships are six ahead of last year;

- There have been a total of six Bill Boards with the latest one announcing our Affiliation with UCSD;

- Primary Care Physician Print Ad Campaigns in the Union Tribune, Coast News and Inland Edition total 54 during this time period;

- The Marketing Department also provides internal hospital support through brochures, flyers, entryway posters, etc.;

- Tri-City sponsored or participated in 89 community events and Grand Openings;

- 12 Lectures were given by TCMC affiliated physicians;

- 11 TV and radio appearances were given by TCMC affiliated physicians; and

- 6 print articles were provided by TCMC affiliated physicians.

Mr. Bennett introduced Mr. Brian Greenwald, Website Content Specialist who provided a review of our digital and social media. Mr. Greenwald reported there have been over 3.5 million "impressions" across the internet with Oceanside being our largest follower.

Campaigns include "I Am Tri-City", "Tri-City Docs", as well as posts related to our recent affiliation with UCSD, announcement of IORT, CT scanner dedication and NICU reunion, to name a few.

Lastly, Mr. Greenwald provided an updated on our new Website Redesign which went live in May and will highlight Breast Cancer Awareness during the month of October.

In closing, Mr. Bennett presented a three minute video highlighting our Marketing Campaign.

No action was taken.

13. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart provided a presentation on the 30th NICU Reunion that was held on September 10th. He introduced Dr. Hamid Movahhedian, Ms. Nancy Myers, Manager, NICU and Ms. Sharon Davies, Director of Women's & Children's Services.

Dr. Movahhedian stated he was extremely pleased with the attendance at the NICU reunion in which over 1,000 family members attended and shared their stories. Members of the Board and the Executive Team also attended the event.

Ms. Myers commented on her jubilation and pride to see these individuals thriving and the immense emotion that staff felt in caring for the tiniest members of our community.

Mr. Newhart shared some messages from families before and after the event that reflected their immense gratitude.

Director Finnila also commented on the event and expressed her appreciation to the Foundation volunteers for hosting such a beautiful meaningful occasion.

Mr. Newhart also provided an update on the Diamond Ball which is scheduled for November 12th at the Omni La Costa Resort and is very close to a sellout.

Lastly, Mr. Newhart reported on the recent Golf Tournament that was oversold and generated double the net revenue of years past. He noted both the Diamond Ball and Golf Tournament proceeds benefit the renovation of Women's Services.

Directors recognized the Foundation Staff and volunteers for their efforts in organizing the NICU Reunion and noted the sincere outpouring of support from the community.

No action was taken.

14. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO reported he attended the 30th NICU union in which 1,000 people chose to come and celebrate this facility. He commented on the true outpouring of support from the community. Mr. Dietlin expressed his appreciation to the Foundation, Dr. Movahhedian, Ms. Sharon Davies, Director of Women's Service, Nancy Myers, NICU Manager and the entire Foundation for their support.

Mr. Dietlin also expressed his appreciation to Dr. Donald Ponec for his Clinical Medical Equipment update. He commented on how great it is to hear from a clinician's standpoint exactly what the equipment is used for. Mr. Dietlin stated Dr. Ponec has been recognized as a Top Doctor for his clinical excellence, along with many other of our physicians.

Mr. Dietlin also recognized Director Larry Schallock for being the recipient of the 2016 University of Arizona College Pharmacy's Distinguished Alumni Award for providing leadership in the profession and in the community as recommended from our local mayors.

Mr. Dietlin stated he is pleased to report we have been invited to submit an application with HUD, and if successful that would release $51 million of liquidity to the District. Mr. Dietlin explained long term financers are looking for stability and clean financial statement audits. He noted a Resolution is coming forward for consideration related to submission of the HUD application.

No action was taken.

15. Report from Acting Chief Financial Officer

Mr. Rivas reported on the second month of FY 2017 as follows (Dollars in Thousands):

- Operating Revenue – $55,899
- Operating Expense – $56,239
- EROE - $499
- EBITDA - $3,079

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 185
- Adjusted Patient Days – 19,511
- Surgery Cases – 1,102
- Deliveries – 462
- ED Visits – 11,271

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $28,134
- Operating Expense – $28,345
- EROE - $211
- EBITDA - $1,496

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 192
- Adjusted Patient Days – 10,196
- Surgery Cases – 557
- Deliveries – 239
- ED Visits – 5,544

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.6
- Days in Net Accounts Receivable – 51.0

Mr. Rivas presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

Director Reno commented on the slight dip in Emergency Department visits. Dr. Ma stated typically there will be a drop in Emergency Department visits in the summer and a significant rise in November.

No action was taken.

16. New Business

a. Consideration to accept the FY2016 Financial Statement Audit

Mr. Blakey stated Moss Adams was engaged to conduct an audit of the consolidated financial statements for year end June 30, 2016. He stated the audit was conducted in accordance with generally accepted audit standards which consist of obtaining reasonable assurance about whether the financial statements are stated fairly in all material respects. Mr. Blakey explained that during the course of the audit they perform their own testing of the transactional data and based on this evidence draw their conclusions. In addition, the auditors look at the internal control structures that the organizations have put in place to make sure the financial statements are accurate. Mr. Blakey noted that during the course of our audit the auditors were not limited in any way, all of their requests were complied with by management, all questions were answered in a transparent way and their scope was not limited in any way. Mr. Blakey reported that based on the results of their test work, it is their opinion that the financial statements for year end June 30, 2016 are materially accurate and are presented fairly and thus they have issued an unmodified (clean) opinion of the Financial Statements. In addition, the auditors did not note any internal deficiencies or weaknesses or adjustments that they would consider to be significant.

Director Finnila stated that the Audit Committee had recommended a partner rotation change this year to get a fresh set of eyes on the financials. Mr. Blakey stated this this is his first year as the Engagement Partner serving Tri-City Medical Center and it is best practice for those charged with governance to request a rotation of the audit partner as it allows for an increased level of objectivity when the audit is conducted.

Director Reno stated she appreciated that the audit was performed in a timely manner.

Director Schallock commented that there are some expenses that were recorded for this year only related to the OIG settlement. He explained that this event occurred 4-5 years ago however the final settlement occurred this year and was thus recorded in this fiscal year. Director Schallock stated there are also legal expenses recorded this fiscal year due to events that took place 4-5 years ago. Director Schallock stated it is gratifying that we have three years of unequivocal clean audits.

Director Kellett thanked Mr. Blakey for his frank and honest discussion and stated through Mr. Dietlin and Mr. Rivas's efforts, they have produced the best documents this hospital has seen.

Director Reno clarified the OIG matter occurred prior to 2009 and with the assistance of Mr. Rivas and Mr. Dietlin this matter has concluded.

Director Finnila expressed her appreciation to the Audit Committee community members who have a long history of working in the financial arena and stated their comments and suggestions have been greatly appreciated.

It was moved by Director Finnila to accept the FY2016 Financial Statement Audit as presented and approved by the Audit, Compliance & Ethics Committee. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

Chairman Dagostino questioned if Mr. Blakey would consider this institution a solvent institution. Mr. Blakey responded that yes, as part of the auditor procedure the audit standards require that the independent auditor evaluate the organization's ability to satisfy their obligations as they become due for a reasonable time and that is reflected in their opinion.

Chairman Dagostino called for the question.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

b. Consideration of Resolution No. 779 Authorizing the District to submit HUD application

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors adopt Resolution 779 relating to the authorizing of filing of an application to the Federal Housing Authority (FHA). Director Kellett seconded the motion.

Director Kellett congratulated Mr. Dietlin and the team who met with HUD in Washington, D.C. He stated the team obviously did an outstanding job and he is thrilled the District has been invited to submit an application.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

Chairman Dagostino reported the Board authorized the hiring of Bond Counsel in Closed Session pending approval of Resolution No. 779.

c. Approval of a Physician Recruitment Agreement with Dr. Anton M. Kushnaryov, and North County Ear, Nose, Throat, Head and Neck Surgery

Chairman Dagostino reported the Physician Recruitment Agreement with Dr. Anton Kushnaryov was pulled at the beginning of today's meeting pending additional information.

17. Old Business

Report from Ad Hoc Committee on Electronic Board Portal

Director Mitchell reported she had nothing new to report at this time.

No action was taken.

18. Chief of Staff

a. Consideration of September 2016 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on September 26, 2016.

It was moved by Director Mitchell to approve the September 2016 Credentialing Actions involving the Medical Staff, and October 2016 Time Limited Reappointments as recommended by the Medical Executive Committee at their meeting on September 26, 2016. Director Schallock seconded the motion.

Dr. Ma noted there was an amendment as previously advised in closed session to remove the Fluoroscopy restriction for Dr. Grant Seiden.

The maker and the second of the motion agreed to consider approving the amended Credentialing Reports.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

19. Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Mitchell seconded the motion.

It was moved by Director Finnila to pull item 19 (1) A. 1) h. Policy 8610-485 – Hiring & Employment; Screening Current Employees. Director Kellett seconded the motion.

It was moved by Director Finnila to pull 19(1) C. Community Healthcare & Alliance Committee minutes. Director Kellett seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

Director Reno requested that the minutes reflect that she is voting "no" on the August 25, 2016 Regular Meeting Minutes.

20. Discussion of items pulled from Consent Agenda

Director Finnila who pulled item 19(1) A. 1) h Policy 8610-485 – Hiring & Employment Screening Current Employees stated the Policy does not reflect who conducts the actual screenings. Ms. Norma Braun, CHRO explained the screening is conducted by a Human Resources staff member who is designated by the Chief Human Resources Officer. Director Finnila requested that language be reflected in the policy.

It was moved by Director Finnila to approve Policy 8610-485 – Hiring & Employment Screening Current Employees with the additional language as described. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Schallock and Reno**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

Director Finnila who pulled item 19(1) C. Community Healthcare & Alliance Committee minutes requested that Mr. Conley discuss the SANDAG award grant that was discussed at this month's Community Healthcare & Alliance Committee meeting.

Mr. Conley reported approximately six (6) months ago we entered into a partnership with FACT (Facilitating Access to Coordinating Transportation), a not for profit group out of Oceanside and SANDAG to apply for federal grant funds under FTAs "Rides to Wellness" Medical Initiative. Mr. Conley stated we have been notified that we are a recipient of this grant and will be awarded $200,000 over an 18 month period. Mr. Conley explained this is significant in that we are the only hospital based institution participating in this grant and funds will be utilized to implement a discharge lounge and provide transportation to our patients back home at a level of their care. In addition, we will perform safety wellness checks at the home and will be offering door to door service. Mr. Conley stated he is confident this service will help with ER throughput, readmission initiatives and the wellness and goodness of the community.

Mr. Conley clarified this information was presented to the Community Healthcare & Alliance Committee rather than the Governance Committee and we became aware of the grant opportunity through our relationship with FACT and SANDAG.

21. Reports (Discussion by exception only)

With regard to the Reimbursement Report, Director Finnila reminded Directors of the need to have a current Ethics Training Certificate on file in order to be eligible to receive reimbursement.

22. Legislative Update

Director Schallock commented on the importance of supporting Proposition 52 in the November election. He explained Proposition 52 is supported by all parties and will continue to maximize federal funds available for Medi-Cal patients.

23. Comments by members of the Public

Chairman Dagostino recognized Mr. Kevin Stotmeister, former Chair of the Tri-City Hospital Foundation.

Mr. Stotmeister stated he and his wife Ellen are long-time volunteers and fundraisers of the hospital dating back to the late 1990's. He commented that some of the issues in the past negatively impacted the ability of the Foundation to secure donations and it was difficult to recruit and engage Board members in the Foundation. However, he has observed a positive change that he attributes to the collaborative effort of the Board, staff and the Medical Staff. Mr. Stotmeister expressed his appreciation for a job well done and stated due to these collaborative efforts, we now enjoy a strong Foundation staff and have over 20 Board members actively involved in raising funds for our hospital.

Mr. Stotmeister stated the Diamond Ball gala tickets are going fast with over 90% sold. He noted this will be the largest Diamond Ball to date!

24. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

25. Board Communications

Director Schallock reported Saturday, October 27th is Prescription Take Back Day. He encouraged everyone to drop off their unwanted and outdated medications in the Hospital parking lot between the hours of 10:00 a.m. and 2:00 p.m.

Secondly, Director Schallock reported last Saturday, he, along with Chairman Dagostino and Mr. Dietlin attended a tour of the UCSD Jacobs Medical Center in which there is an impressive Women's Center, NICU and Cancer Center. Director Schallock stated he took the opportunity to "tout" our IORT.

Lastly, Director Schallock expressed his satisfaction with Mr. Dietlin's leadership and commented on how fortunate we are to have him as our CEO. Director Schallock stated he looks forward to seeing the hospital move forward under his leadership.

Director Mitchell expressed her appreciation to Mr. Dietlin and his entire team for getting us through some difficult times and clearing a path to a bright future.

Director Reno also expressed her appreciation to Mr. Dietlin and his diligent and loyal staff for leading the hospital toward a good future.

Director Reno commented on the delicate balance between the purchase of equipment and the fiscal ability to purchase high tech equipment. She expressed her appreciation to the Foundation and the Auxiliary who assist in the funding of high tech equipment.

Director Finnila provided a public service announcement related to the HPV virus which can be dangerous to young men and women. She stated inoculation (HPV vaccine) is recommended for boys and girls age 11 on up to ward off cervical and other types of cancers.

Director Finnila commented on the positive financial solvency of the District which was demonstrated today by the Audit. She also commented on our alliance with UCSD as well as other groups in the community such as SANDAG which was described today.

Director Finnila commented on Ms. Schultz's quality presentation and the importance of recognizing that data is measured in multiple different ways.

Lastly, Director Finnila expressed her appreciation to the staff and committees and all who have worked together to make a difference in the community.

Director Kellett expressed his condolences to the immediate family of Dr. Victor Avedian who passed away recently. Director Kellett stated Dr. Avedian was very devoted to Tri-City Hospital and delivered high quality care. In addition, he was one of the first Board Certified Surgeons in North County.

26. Report from Chairperson

Chairman Dagostino stated he is amazed at what has transpired in this community over the past several months. He commented that we have secured our clinical and healthcare quality future by partnering with UCSD, a world class medical institution and we are now close to partnering with the United States Government and HUD to secure our financial future.

Chairman Dagostino expressed his appreciation to the community for entrusting their care to us.

31. There being no further business Chairman Dagostino adjourned the meeting at 5:45 p.m.

_____
James J Dagostino, DPT
Chairman

ATTEST:

_____
Ramona Finnila, Secretary

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending September 30, 2016

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.85	(a)	10,098.32	2/1/2015	10/31/18	**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	$2.56	(a)	19,672.00	2/1/2015	10/31/18	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,265.25	12/01/15	12/31/20	**PCP Clinic** 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	09/30/16	**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)	9,965.94	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	$1.37	(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	$3.88	(a)	24,931.00	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	$2.11	(a)	4,984.83	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		7,789.71	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		12,361.10	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056
Tri City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	246,428.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009
Total				**$358,995.31**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Education & Travel Expense
Month Ending 9/30/16

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171	ACHSA CONFERENCE	91516	200.00	82419	LORI ROACH
6340	BH SYMPOSIUM - REGISTRATION	9202016	495.00	14365	JOY MELHADO
7010	MICN TRAINING	90816	800.00	62089	J CONSTANTINO-S OLSON
7010	MICN TRAINING	62216	1,500.00	31263	TINGLE-WESTRA-WESTERNBERGER
7680	ACLS-BLS COURSE	80316	220.00	82786	HEATHER TARDY
7893	WOUND CARE - BILLING COMPIANCE	91216	300.00	33292	ARCHIE LLORCA
7893	WOUND CARE - BILLING COMPIANCE	91216	300.00	33292	KIM POSTEN
8010	FDA WEBINAR	91516	189.00	80273	INGRID STUIVER
8390	CHA QTR SAFETY	90116	207.96	81328	THERESA VIDALS
8390	NCCP CONFERENCE	51016	468.07	10894	LAURA BALL
8610	PRIME PROJECT-SECURE TEXTING	82916	229.00	80739	SCOTT LIVINGSTONE
8610	HUD MEETING - EXPENSES	90216	320.36	78648	GENE MA
8610	DHLF BOARD MEETING	82916	601.56	81508	STEVEN DIETLIN
8610	HOSPITAL ASSOC 2016 ANNUAL MTG	91316	875.00	34627	DIETLIN-CONLEY-SCHULTZ-BENNETT-KNIGHT
8610	HUD MEETING - FLIGHT	83116	1,033.02	81163	EUGENE MA
8610	HUD MEETING - FLIGHT	83116	985.03	81163	STEVEN DIETLIN
8610	HUD MEETING - FLIGHT	83116	842.20	81163	PHILLIP SOULE
8610	HUD MEETING - FLIGHT	83116	931.82	81163	RAY RIVAS
8620	HUD MEETING - HOTEL/EXPENSES	90816	264.33	81515	JAMES DAGOSTINO
8620	HUD MEETING - HOTEL/EXPENSES	90816EXP	305.37	78591	LARRY W. SCHALLOCK
8620	HUD MEETING - FLIGHT	83116	1,033.02	81163	JAMES DAGOSTINO
8620	HUD MEETING - FLIGHT	83116	842.20	81163	LARRY W. SCHALLOCK
8650	SEXUAL HARASSMENT TRAINING	82616	250.00	82746	NORMA BRAUN
8700	ICD 10 EXPERT 2017 TEXTBOOK	80011891545	1,055.52	82236	HOSPITAL STAFF
8720	2016 HQI CONFERENCE	90916SCHULTZ	685.00	82808	SHARON SCHULTZ
8730	BH SYMPOSIUM - REGISTRATION	92016	495.00	14365	CAROLA HAUER, PHD
8730	BH SYMPOSIUM - HOTEL EXPENSE	28514212	586.36	82530	J MELHADO, C HAUER,PHD
8740	RNC RE-CERTIFICATION	90616	100.00	81979	SUSAN AZARIAN
8740	ACLS COURSE	82516	189.00	81295	LORRAINE BULLA
8740	NUCLEAR MEDICINE COURSE	82516	200.00	77784	HAMID WALEH
8740	ACLS COURSE	81816	200.00	79318	NATALIE ALONZO
8740	ACLS RENEWAL COURSE	90116	200.00	82312	STEVEN ALDEN
8740	ADVANCED FETAL	91516	200.00	82314	JACQUELYN COBBS
8740	PERIOPERATED TEXT BOOK	825499	580.00	9999	HOSPITAL STAFF
8740	RN TO BSN	90816	2,500.00	82011	LAURA GIPSON
8750	CA SOCIETY FOR HEALTHCARE ATTY	81216	413.33	82462	CHERYLE BERNARD-SHAW
8750	COMPLIANCE CERTIFICATION	82916	1,293.65	82462	CHERYLE BERNARD-SHAW
8764	INTRO TO HYPERBERIC	BST11137	13,000.00	82795	HOSPITAL STAFF

**This report shows payments and/or 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.