TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
APRIL 14, 2016 – 12:00 p.m. – Assembly Room 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Page Nos.	Time Allotted	Requestor/ Presenter
1.	Call To Order/Opening Remarks		2 min.	Chair
2.	Approval of Agenda	1-2	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the March 2016 Meeting	3-10	2 min.	Committee
5.	New Business			
a.	Quality Outcomes Dashboard	11-14	5 min.	Committee
b.	Priority Project Reports		40 min.	Committee
	1. Falls	15		
	2. Pressure Ulcer Prevention	16		
	3. Severe Sepsis Management	17		
	4. Hospital Wide Throughput	18		
c.	Consideration and Possible Approval of Policies and Procedures	19-20		
	Patient Care Services			
	1. Care for Recalcitrant Children Policy	21-27		
	2. Child Passenger Restraint System Education Policy	28-29		
	3. Diluting IV Medication for IV Push Administration Procedure	30		
	4. Immediate Use Sterilization, Intraoperative	31-34		
	5. Micromedex Carenotes Procedure- Tracked Changes	35-38		
	Micromedex Carenotes Procedure- Clean Copy	39-40		
	6. Obstetrical Patients Triage Policy	41-42		
	7. Point of Care New Test/ Method Request and Implementation Policy	43-44		
	8. Point of Care Testing Policy	45-47		
	9. Staffing Requirements, Development of Policy	48		
	10. Sterile Technique	49-51		
	11. Wound Classification During Surgical Intervention	52-53		
	Administrative Policies and Procedures			
	1. Business Visitor Visitation Requirements	54-57		
	Unit Specific Engineering			
	1. Breached Medical Gas Lines 20014.1	58		
	2. Contractors Hazard Communications Program	59		
	3. Contractors Working in the Facility	60-61		
	4. Daily Journal	62-63		
	5. Domestic Hot water 2005	64		
	6. Emergency Generator Test Loads	65-66		

	7. General Personnel Policies 8. Inspection Testing and Maintenance of Fire Alarm Detection and Automatic Extinguishing System 9. Maintenance and Inspection of Electrical Distribution System and Emergency Generator 10. Maintenance and Inspection of Medical Surgical Air and Vacuum System 2004 11. Maintenance and Inspection of Boiler/ Steam System 12. Maintenance Work Request System 13. Managing Biological Agents to Prevent Waterborne Illness 14. Preventative Maintenance 15. Routine Hospital Rounds 16. Scope of Service- Tracked Changes Scope of Service- Clean Copy 17. Staff Meetings 18. Statement of Accountability **Medical Staff** 1. Suspension for Delinquent Medical Records 8710-519 **NICU** 1. Primary Nurse Assignment **Women and Newborn Services** 1. Sterile Processing of WCS Instruments **Formulary Requests** 1. Entresto- Trade Name Sacubitril and Valsartan- Generic Name **Forms** 1. Cardiopulmonary Arrest Record	67-69 70 71-72 73-74 75-76 77-78 79-80 81-84 85 86-87 88 89 90 91-93 94-96 97-98 99-100 101		
6.	Review and Discussion of CLINICAL Contracts (*Discussion/ Possible Action*)	To be distributed	10 min.	Chair
7.	Motion to go into Closed Session		2 min.	Committee
8.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))		30 min.	Chair
9.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair
10.	Comments from Members of the Committee		5 min.	Committee
11.	The next meeting of the Professional Affairs Committee of the Board is on May 12, 2016.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
March 10, 2016

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

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

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Quality, Cli. Risk Mgt. & Patient Safety, Jami Piearson, Director for Regulatory and Compliance, Kathy Topp, Steve Sims, Meggan Mcgraw, Sharon Davies, Isabel Escalle, Mary Diamond, Thomas Moore, Mike Parent, Lisa Mattia, Nancy Myers, Sarah Jayyousi, Priya Joshi, Priscilla Reynolds, Oska Lawrence, Patricia Guerra and Karren Hertz.

Members Absent: Sharon Schultz, CNE/ Sr. VP and Dr. James Johnson.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:05 p.m. in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Schallock and seconded by Director Finnila.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of February 2016.	Director Mitchell called for a motion to approve the minutes from February 11, 2016 meeting.	Minutes ratified. Director Finnila moved and Director Schallock seconded the motion to approve the minutes from February 2016.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	Jami Piearson reported that some of the measures in the current dashboard will be retired. Some measures will be pulled out and sepsis measures will be added. Jami also mentioned that there are six (6) priority projects that are currently ongoing of which quality measures are being tracked by the PI department.	**ACTION:** The Rehab quality report will be updated to reflect all the activities that have been added from the last time it was presented.	Jami Piearson
b. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:**			
1. Code Blue Response Plan Policy	The definition of adult will be taken out on this policy.	**ACTION:** The Patient Care Services policies and procedures were all approved. Director Finnila moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Code Pink Response Plan Policy	There was a quick discussion regarding the existence of the Braslow cart in the unit.		
3. Code Caleb Team Mobilization Policy	The section on outpatient centers should be modified as "Areas out of the hospital but not limited to..:" Also, the Vista Palomar Park will be taken out of the list.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Communicating with Physicians	No discussion on this policy.		Patricia Guerra
5. Interpretation and Translation Services	Isabel Escalle established to the group that there is a separate policy for the hearing impaired (deaf) people.		
6. Massive Transfusion Protocol	Dr. Contardo stated that the massive transfusion protocol also applies to OB patients and procedures.		
7. Patient Safety in Surgical Areas	No discussion on this policy.		
8. Pre, Intra and Post-op Assessment of Fetal heart Rate and Uterine Activity Procedure	The committee made a clear distinction between skilled and regular obstetrical people manning the uterine activity for OB patients.		
Administrative Policies and Procedures			
1. Equipment Transfer, Storage Trade-In, and Disposal 200	The group agreed that this policy is pretty universal so there is no need to make any changes.	**ACTION:** The Administrative policies and procedures were all approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Provision of Education for Pediatrics During Hospitalization	The title was modified to be Provision of Education for Adolescents as pediatrics is only for children up to a certain age.		
3. Storage of Legal Weapons (Moving from Security Manual)	This policy is being pulled out since there were some questions and issues associated with the storage of legal weapons.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific Infection Control 1. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection 2. Management of Patients with MRSA IC 6-3r 3. Management of patients with VRE IC 6-6r	No discussion on these policies. This policy is a combination of Policy #2 and 3 which are being deleted consequently.	**ACTION:** The Infection Control policies and procedures were all approved. Dr. Worman moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
NICU 1. Cue Based Feeding 2. High-Risk Infant Follow-Up Program 3. High-Risk Infant Follow-Up Clinic- Perinatal Data Manager, Role of 4. High-Risk Infant Follow-Up Clinic- Coordinator, Role of 5. High-Risk Infant Follow-Up Clinic- Dietitian, Role of 6. High-Risk Infant Follow-Up Clinic- Physical Therapist, Role of 7. High-Risk Infant Follow-Up Clinic- Registered Nurse, Role of	There is no discussion on this policy. These 7 policies are being broken up so there were no discussion on these policies.	**ACTION:** The NICU policies and procedures were all approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health 1. Co-treatment of Patients 2. Physician Progress Notes	The term Nurse Practitioner (NP) used in this policy will be replaced by Allied Health	**ACTION:** The Outpatient Behavioral Health policies and	Patricia Guerra

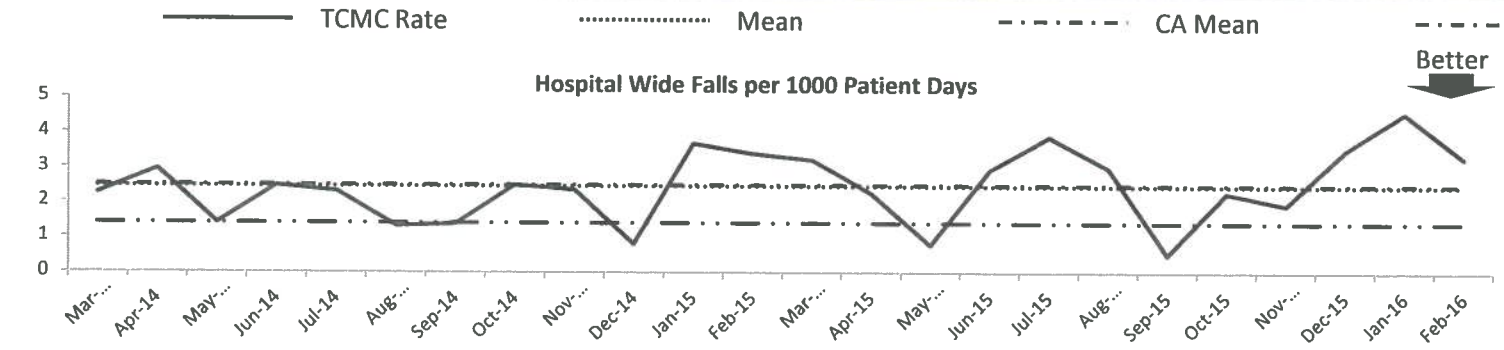
Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	Practitioner (AHP).	procedures were all approved. Dr. Contardo moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	
Patient Care Management			
1. Discharge Planning	There was no discussion on this policy.	**ACTION:** The Patient Care Management policies and procedures were all approved. Dr. Worman moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Rehabilitation			
1. Audiology Services Inpatient Rehab Services 2. Discharge Criteria 3. Documentation of Progress Notes and Discharge Summary 4. Modalities Used Thermal Agents 616 5. NICU Follow-Up High Risk Infant Follow-Up (HRIF) 6. Occupational Therapy Policy 702 7. Patient and Caregiver Education	It was noted that audiology services are being used only for 5-6 times a year only. The audiologist brings the equipment when called in. Even though the need is not that great, it is still beneficial for the hospital to have these services, the group concurred.	**ACTION:** The Rehabilitation policies and procedures were approved and are moving forward for Board approval. Director Finnila moved and Director Schallock seconded the motion to approve these policies.	Patricia Guerra
8. Physical Therapy Department Policy	Dr. Worman added that goals are set up in acute care setting accordingly to each patient's pain level.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Pre-Op Teaching Physical Therapy Occupational Therapy 614 10. Scope of Services 11. Speech Pathology Services Department Policy 12. Swallow Evaluations: Power Outage System Failure 13. Therapeutic Recreation: Acute Care 14. Traction Cervical & Lumbar	Pre-op education is highly encouraged as it aids the patients in achieving good outcomes. This policy has an overlap of neonatal and geriatric. .		
Telemetry			
1. Admission and Discharge Criteria 2. Weighing Telemetry Patient	It was reported that Class 2 or 3 classification is well known by all. This classification criteria is in conjunction with AC report. Director Mitchell asked for clarification that the facility has more than one Hoyer lift; ICU beds have scales; and most newer beds do.	**ACTION:** The Telemetry policies and procedures were approved and are moving forward for Board approval. Dr. Ma moved and Director Schallock seconded the motion to approve these policies.	
Women and Newborn Services			
1. Amnioinfusion 2. Obstetrical Hemorrhage 3. Preeclampsia Care 4. Vibroacoustic Stimulation (VAS) (Fetal Acoustic Stimulation Test- FAST)	No discussion on these policies.	**ACTION:** The Women and newborn Services policies and procedures were approved and are moving forward for Board approval. Dr. Worman moved and Director Schallock seconded the motion to approve these	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Formulary Requests 1. Praxbind- Trade Name- Idarucizumab- Generic Name 2. Tretinoin- Trade Name – All-Trans Retinoic Acid **FORMS:** 1. 7883-1002 High Risk Infant Follow-Up **2.** 8720-1018 Progress Note	This formulary has very low usage and is considered as a drug with no formulary reversal. This commonly used to treat Aneurysm.	policies. **ACTION:** The formulary requests were approved and are moving forward for Board approval. Director Schallock moved and Dr. Worman seconded the motion to approve these policies.	
6. Clinical Contracts	In compliance with CMS as emphasized in the last survey, the clinical contracts that were approved in MEC are being brought forward to this committee.	**ACTION:** The clinical contracts from M to Z were presented and they were all approved by the committee.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Finnila seconded and it was unanimously approved to go into closed session at 1:05 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 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

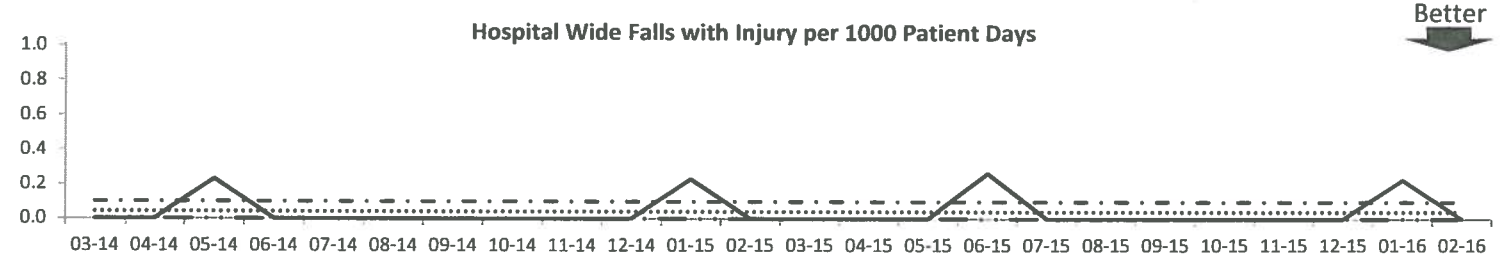
Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Adjournment	Meeting adjourned at 2:24 PM		Director Mitchell

Fall & HAPU's



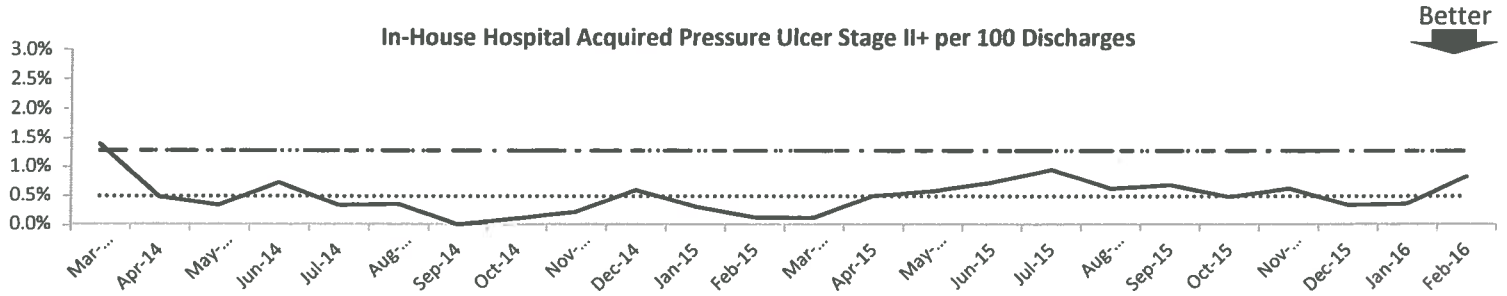
Action Plan

Toileting Pilot: Hourly rounding Using 3P's, At risk assisted to toilet at least every 4-6 hours, Remain with high risk patients at all times during toileting/ showering, Make a commode available if unable to ambulate to BR with assist, Educate patient and family



Action Plan

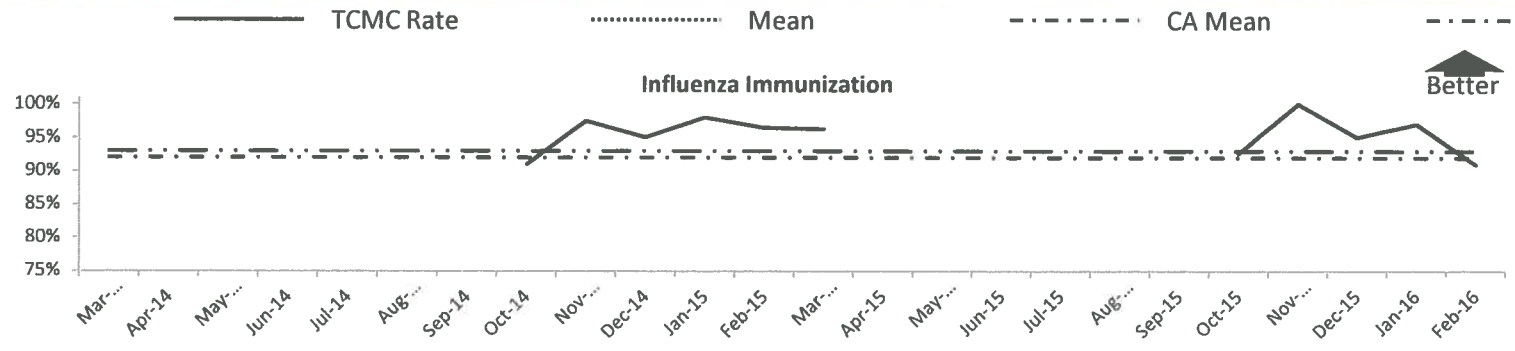
Redesign Fall Risk Identification- "Fresh visibility,"Partnering for Fall Prevention- My Safety Plan- reviewed and signed by patient and RN, No Pass Zone- NEVER walk past room with a call light, New wireless Fall Prevention System, New Avasys Tele Sitter Program



Action Plan

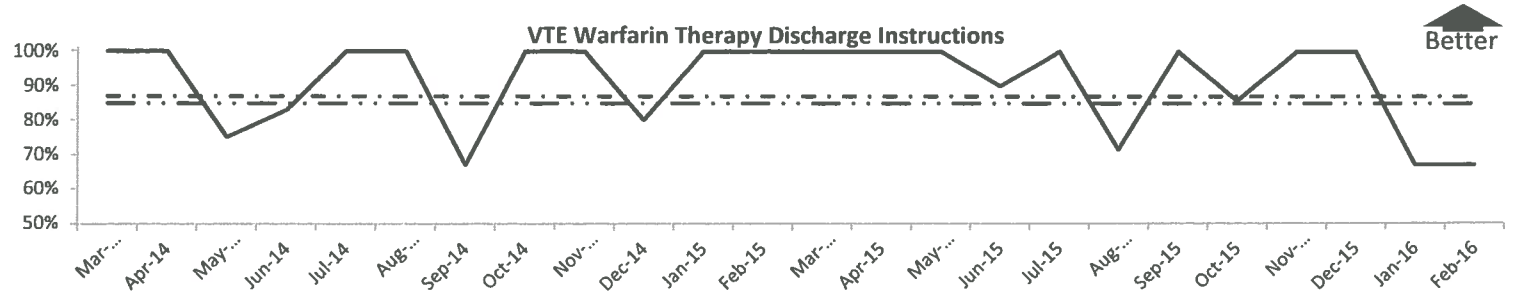
1. Continue Monthly Education for nursing and support staff
2. Continue monitoring discrepencies in risk identification and ulcer existence
3. Improve staff ability to document and photograph easily and consistently
4. Managers to speak to staff whose documentation does not support fact.

Core Measures



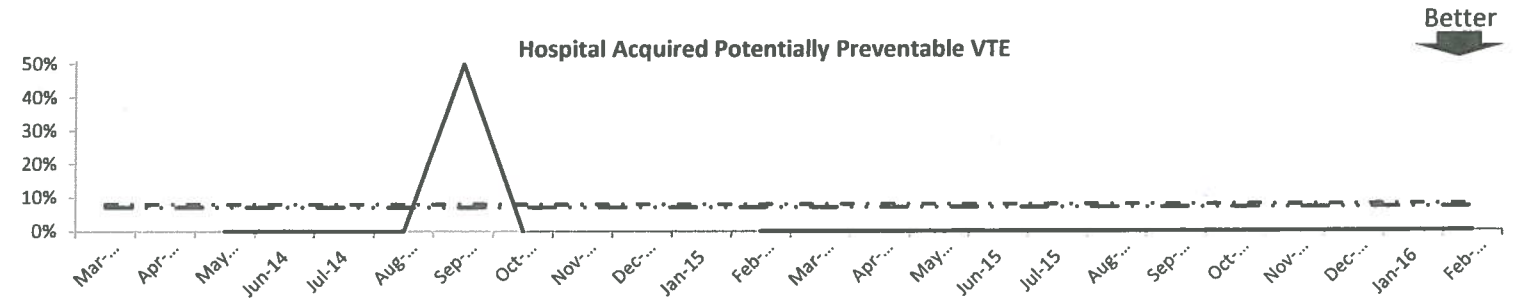
Action Plan

Consistently doing well. February drop being addressed by process change & education on WCS where screening was done on post partum and we were missing women who left without delivering.



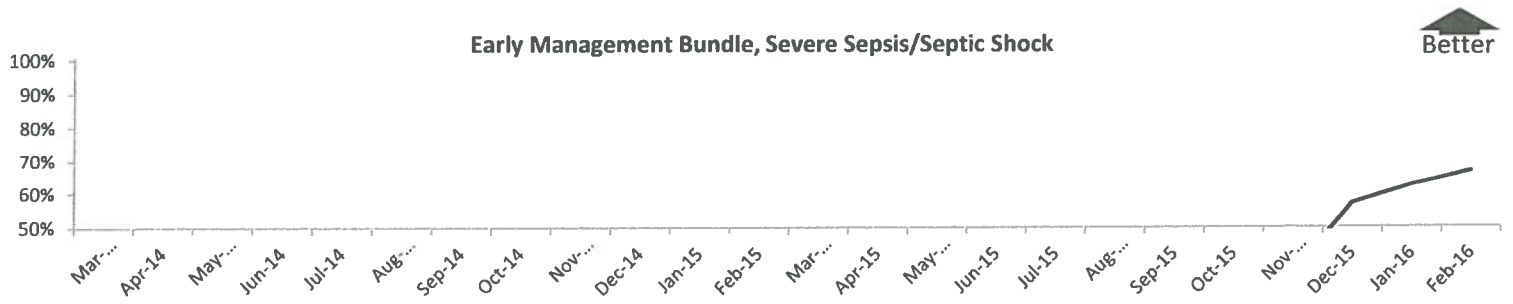
Action Plan

History of doing well on measure. Unexplained drop in Jan & Feb in printing or documenting warfarin pt instructions. Working with unit educators and IT to try to failsafe process. May need additional software to accomplish.



Action Plan

Consistently at 0% fail rate.

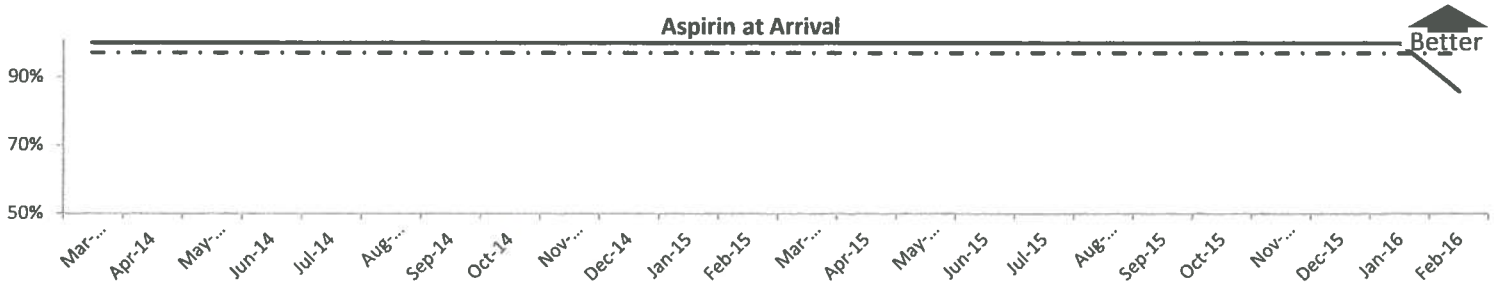


Action Plan

Measure started Oct 2015. We are in line with anacdotal results from other hospitals. We are making significant and linear progress. Meeting monthly with physicians and IT to continue improvement.

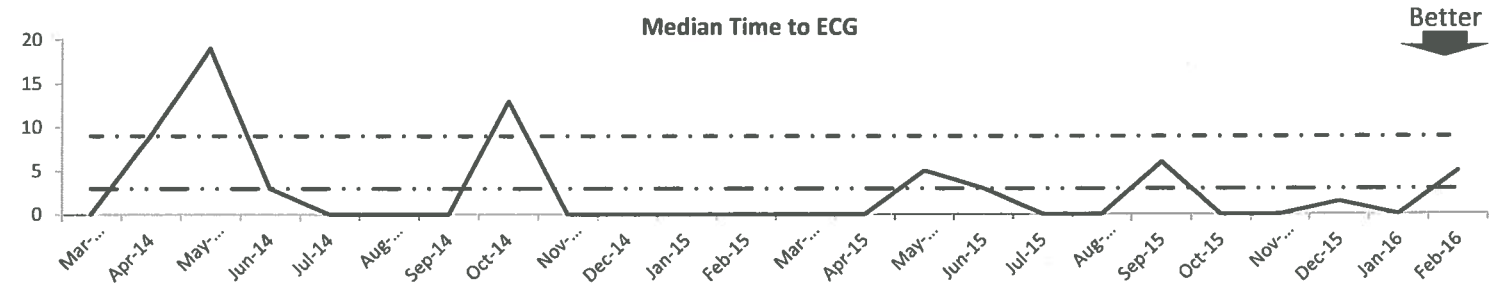
Core Measures

TCMC Rate — Mean — CA Mean — TCMC Target



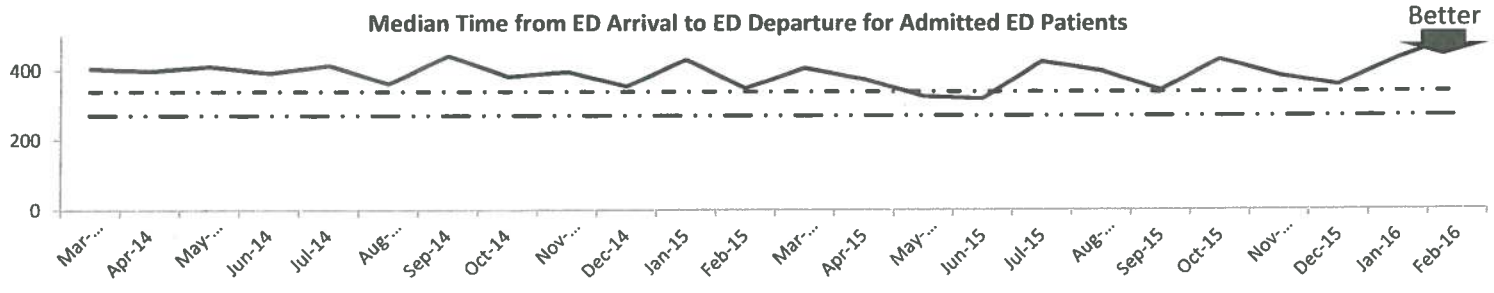
Action Plan

February was 1st fall out in 12 months. Counselling done for physician.



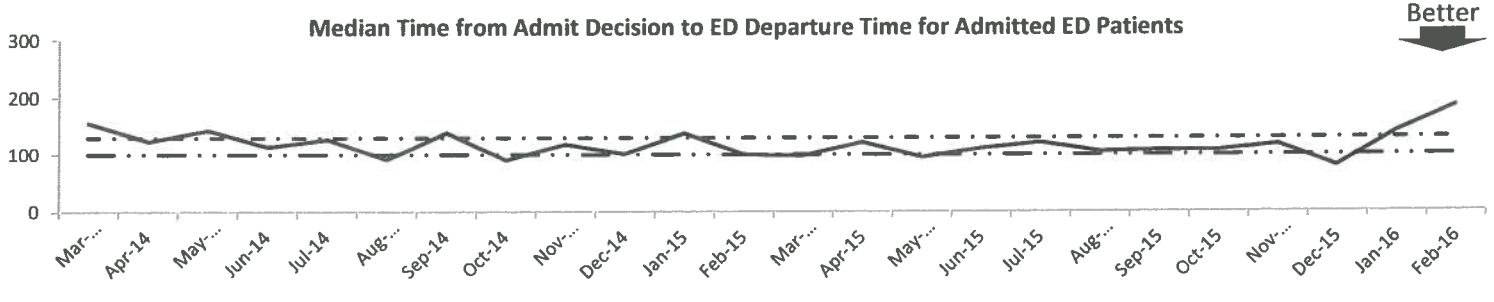
Action Plan

Median Time to ECG for OP Chest Pain patients. Times continue consistently at or below national top 10%.



Action Plan

(Combined with next element)
Current Challenges:
- High census in February
- Staffing challenges for IP beds
- ED Boarder rates went up



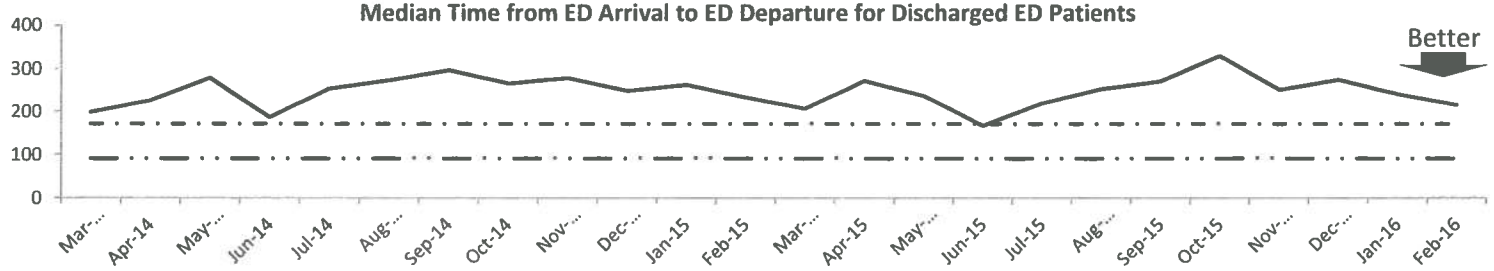
Action Plan

Improvement plans:
- ED Transporter positions still need filling to improve patient transport when bed ready
- Team Triage needs consistent 2nd Reg Clerk

Core Measures

TCMC Rate — Mean — CA Mean — TCMC Target

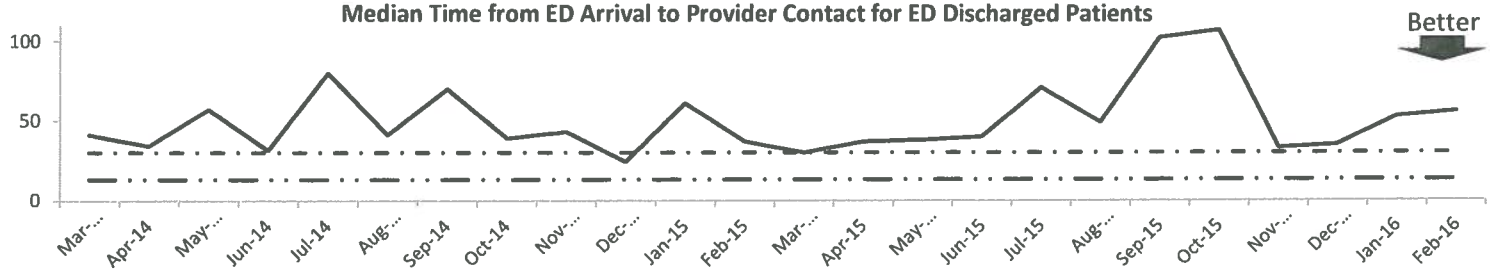
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Dr. Showah to present detailed report to PAC May 2016 meeting.

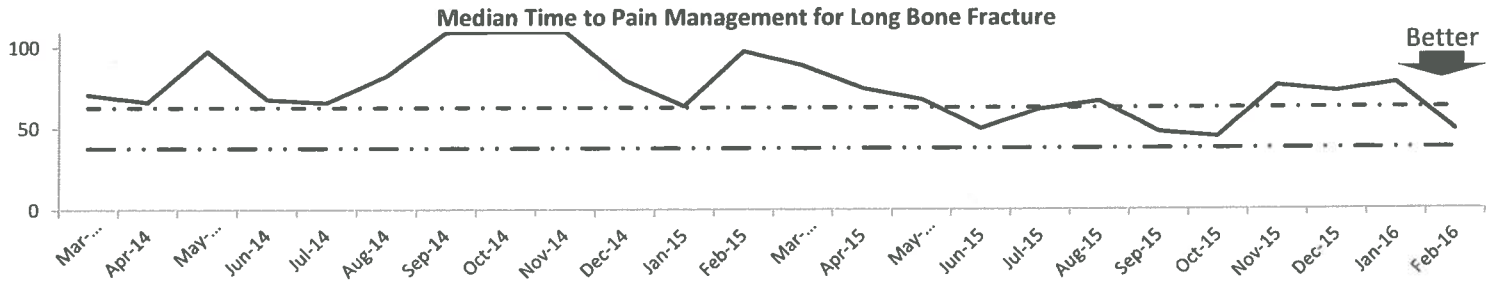
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Dr. Showah to present detailed report to PAC May 2016 meeting.

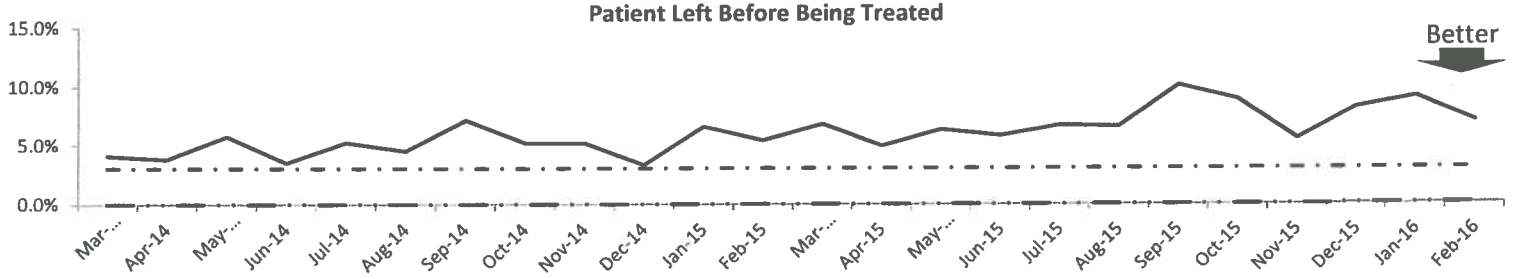
Median Time to Pain Management for Long Bone Fracture



Action Plan

Dr. Showah to present detailed report to PAC May 2016 meeting.

Patient Left Before Being Treated



Action Plan

Dr. Showah to present detailed report to PAC May 2016 meeting.

Targeted Solution Tool: Falls

Michelle Hardin RN, BSN

Self Assessment Score ___2___, (1= Planning; 2= Some Activity; 3 = Some Improvement; 4= Significant Improvement; 5= Outstanding results

Aim Statement

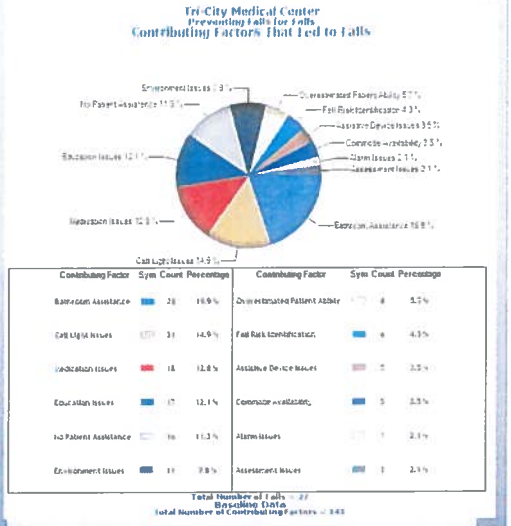
Reduce inpatient falls by 40% in the Acute Care Services and Telemetry units by September 1, 2016.

Changes Being Planned (P) Tested (T), Implemented (I), or Spread (S)

1. New Data Collection Tool for Post Fall Event (T)
2. Toileting Pilot (T)
   - Hourly rounding Using 3P's
   - At risk assisted to toilet at least every 4-6 hours
   - Remain with high risk patients at all times during toileting/ showering
   - Make a commode available if unable to ambulate to BR with assist
   - Educate patient and family
3. Redesign Fall Risk Identification- "Fresh visibility" (T)
4. Partnering for Fall Prevention- My Safety Plan- reviewed and signed by patient and RN (T)
5. No Pass Zone- NEVER walk past room with a call light (P)
6. New wireless Fall Prevention System (P)
7. New Avasys Tele Sitter Program(P)

Top 5 Contributing Factors:

Bathroom Assistance = 19.9%
Call Light issues = 14.9%
Medication Issues = 12.8%
Education Issues = 12.1%
No Patient Assistance = 11.3%



Barriers/ Lessons Learned

1. IT/RL Support for form design- new form is $8,000 to have RL build.
2. Purchasing of new Fall Prevention Products
3. Fall Prevention is everyone's responsibility: No pass zone to include all TCMC employees.
4. Continue to reinforce the proven positive impact of hourly rounding
5. **Feedback on Barriers from staff to toileting project:**
   - Waking patients in the middle of the night
   - Assignments split and not always working with 1 ACT
   - Most patients want to see you every hour, but do not want to be asked the same questions over and over
   - Call light going off while you are assisting another patient
   - Staying in BR when 2 or 3 other people need to use BR
   - Difficult to stay with pt in BR when ACT has 14 pts

Recommendations and Next Steps

1. Utilize the Joint Commission TST Tool to facilitate improvement in selected units
2. Redesign and advertise an entirely new Falls Prevention Program
3. Involve patient and family in the Fall Prevention Program
4. Create a program to include all TCMC staff in Fall prevention program
5. Implement Fall Prevention Alarm System

Team Members

Chair: Michelle Hardin

Co-Chair: Kevin McQueen

Executive Leader: Sharon Schultz

Stake Holders: Marcia Cavanaugh; Kathy Topp; Ingrid Stuiver ; Eva Froyd ; Diane Sikora; Jenessa A. French; Rachel Garcia

Team Members: Linda D. Sprague; Gretel Kovak; Dianne A. Montijo; Lauren S. Nance; Heather Hunter; Deborah K. Deluna; Robert D. Hernandez; Jane Hass; Colleen M. Shoemaker; Laura A. Widmayer; Terri C. Vidals; Bruce S. Bainbridge; Jessica L. Thrift ; Ming Yin; Brandon C. Peer

Pressure Ulcer Prevention 2016

TriCity Medical Center

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

Aim Statement

Aim: Meet and sustain CA Top 10% target which is zero incidence of hospital acquired pressure ulcers by December 31, 2016.

Changes Planned, Tested, Implemented or Spread

- 4 Eyes Skin Audit Tool (S) Relaunch with Education
- Silicone for Prevention Campaign Product Change (S)
- Standardized Procedure for PU Treatment (P)
- Pressure Ulcer Prevention Protocol (P)
- Redesign of EHR Documentation for Hardwiring of Prevention Protocols & PU Treatment Documentation (P)
- Wound Care Monthly Education Classes for CE's (I)
- Wound Care Champions (T)

Relationship of ER and Surgery to Pressure Ulcers

HAPU	Number Reported	Patient was in ER	Patient had Surgery
Dec 15	7	6/7	3/7
Jan 16	18	15/18	6/18
Feb 16	10	10/10	2/10

DETAIL DASHBOARD
% of Patient with Hospital Acquired Pressure Ulcers Stage II+ (In-House Data)

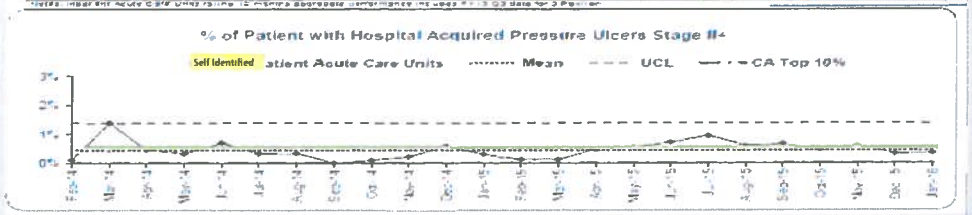
= the target
= the target but = the threshold
= the threshold

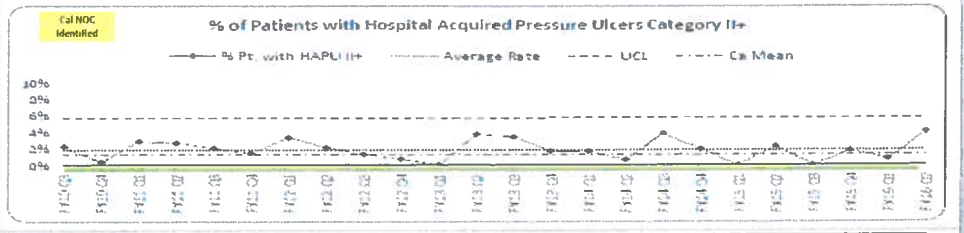
	For Period	Latest Month Performance Num	Stage (II+)	Den	Rate	Rolling 12 Months Performance Num	Den	Rate	Threshold CA Mean	Target CA Top 10%
Inpatient Acute Care Units	Jan-16	3	(s)	947	0.4%	51	10119	0.5%	1.3%	0.0%
1 North Ortho	Jan-16	3	(s)	150	2.0%	10	1910	0.5%	0.7%	0.0%
2 Pavilion Oncology	Jan-16	0	(s)	114	0.0%	2	1914	0.1%	0.7%	0.0%
4 Pavilion	Jan-16	0	(s)	120	0.0%	5	1837	0.3%	0.7%	0.0%
ICU	Jan-16	0	(s)	50	0.0%	17	725	2.3%	3.5%	0.0%
Telemetry	Jan-16	0	(s)	332	0.0%	15	3875	0.4%	1.2%	0.0%
Forensics Unit	Jan-16	0	(s)	75	0.0%	2	795	0.3%	0.7%	0.0%

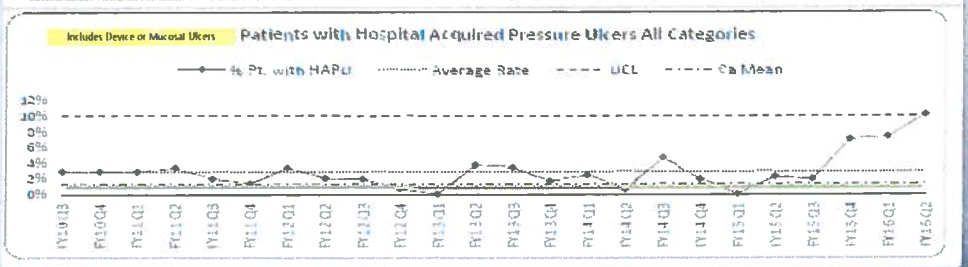
DETAIL DASHBOARD
Percent of Patients with Hospital Acquired Pressure Ulcers Category II+ (Prevalence Study)

= the target
= the target but = the threshold
= the threshold

	For Period	Latest Quarter Performance Num	Den	Rate	Rolling 12 Months Performance Num	Den	Rate	Threshold CA Mean	Target CA Top 10%
Inpatient Acute Care Units	FY16 Q2	6	149	4.0%	9	663	1.8%	1.3%	0.0%
1 North Ortho	FY16 Q2	0	19	0.0%	0	65	0.0%	0.7%	0.0%
2 Pavilion Oncology	FY16 Q2	0	24	0.0%	0	93	0.0%	0.7%	0.0%
4 Pavilion	FY16 Q2	0	23	0.0%	1	86	1.2%	0.7%	0.0%
ICU	FY16 Q2	5	17	29.4%	5	64	7.8%	3.5%	0.0%
Telemetry	FY16 Q2	1	50	2.0%	3	196	1.5%	1.2%	0.0%
Forensics Unit	FY16 Q2	0	17	0.0%	0	46	0.0%	0.7%	0.0%







Lessons Learned

1. **Barrier:** Skin evaluations still not being done consistently in the Emergency Room. If the nurse does not document it, the physician does not document it.

Some staff have suggested that they are too busy, that documenting an ulceration is too difficult. Some staff recommend hiring staff for the ER who only look for pressure ulcers and take the photos.

2. **Barrier:** The Discrepancy report useful if it is followed up by the manager to determine if a discrepancy exists or if the ulcer is changing. Very infrequent feedback if a problem exists with charting or reporting change in status.

3. **Barrier:** Orange forms that are not done or indicate that charting is completed when in fact it is not completed at all.

ANM signing off four eyes without seeing the patient or the documentation because "the staff are too busy".

4.**Barrier:** TIME and Personnel Resources. All of the tracking, investigating and following up on the care of the patient with a pressure ulcer or patients requiring intervention is done by the wound team whose hours were budgeted for wound consults and treatments.

5. Camera availability and Quality of Pictures

Recommendations and Next Steps

- Physician discussion for ER
- Education Tool Remodel
- Education on Measuring

Team Members

Lorena Eckert, WOCN
Emma Hilbourne RN Telemetry
Jenessa French RN Acute Care Educator
Christin Santa Maria, Assistant Nurse Manager
Laura Gipson, RN Quality
Gretel Kovak, ED RN
Linda Inskeep, Oncology RN
Christa Sottile, ICU RN
Michelle Dodson, BSN, RN, Nursing Quality and Outcomes Coordinator
Marcia Cavanaugh, Director of Risk & Quality/ Performance Improvement
Kim Posten, Manager Wound Care Team
Janet Whitney DO Wound Team
Steven Sims NP
Priscilla Reynolds RN Telemetry Educator

SEVERE SEPSIS MANAGEMENT

Bruce Bainbridge

Self Assessment Score 4 , (1= Planning; 2= Some Activity; 3 = Some Improvement; 4= Significant Improvement; 5= Outstanding results

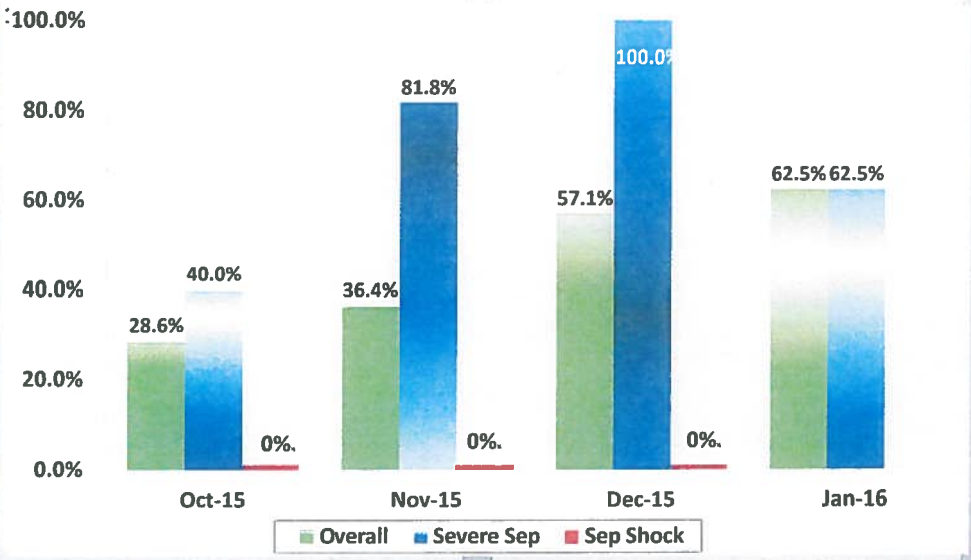
Aim Statement

- The development of screening tools to identify patient in or at risk for severe sepsis or septic shock.
- To provide an efficient and reliable process to initiate appropriate treatment.

Changes Being Tested (T), Implemented (I), or Spread (S)

- T – Create a Real Time sepsis dashboard to provide earlier identification and initiation of treatment
- T – e-Form for physician documentation of a CV Focused Assessment
- T – Implement comprehensive results view in PowerChart
- I – Order Sets to automate timed lab tests
- I – Improve Sepsis Alerts
- I – Implement Sepsis icons to control Sepsis start times
- I – Education of ED staff and MD's

Run Charts/ Data



Barriers/ Lessons Learned

- Most data is retrospective. Maximal progress will rely on creating a real time dashboard utilizing integrating predictive analytics allowing earlier identification and treatment of septic patients.

Recommendations and Next Steps

- Work toward real time data
- Develop predictive analytics

Team Members

Dr Scott Worman
Dr Dorothy Brown
Dr Henry Showah
Sharon Schultz
Jami Piearson
Marcia Cavanaugh
Bruce Bainbridge
Steve Simms
Melanie Bruce
Ingrid Stuiver
Rosemary Mervosh

Hospital Wide Throughput Committee

Update for QAPI

Kathy Topp, RN-BC, BSN, MSM

4/12/16

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Aim Statement

Improve patient flow efficiency from ED arrival to departure or admission.

Overall success is interdependent on the overall patient flow throughout their stay.

Changes Being Tested (T), Implemented (I), or Spread (S)

ED to Inpatient

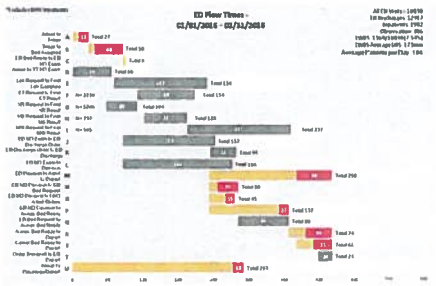
1. **Team Triage**
   - Create improved Triage process with RN, PA and Registration clerk to reduce time and improve throughput
2. **BHU Suite** – Implemented 10/27/15
   - Relocate stable BHU patients that need medication stabilization into separate area to improve turnaround time and discharge of patients
3. **Bed Ready to Depart**
   - Working on maintaining the gain of reduction to 60 min, goal is still 30 min

Inpatient Discharge Process

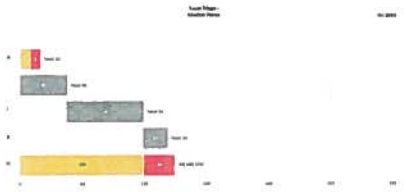
1. **Hospitalist Contract Alignment**
   - Align Hospitalist metrics to increase discharge orders written prior to 1300 and actual time of discharge
2. **Discharge Concierge Service**
   - Utilize services to assist with discharge support for patients without immediate family support
3. **Discharge Lounge**
   - Move stable patients to area if rides are delayed – only used once so far in past few weeks

Run Charts/ Data

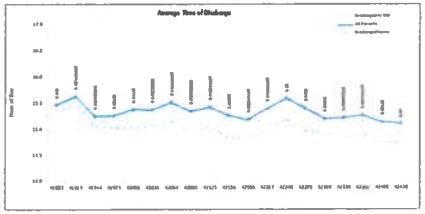
ED Flow Times Report 1/1/16-3/31/16 – Allows Committee to look at metrics for each component of ED visit to analyze ED flow process daily



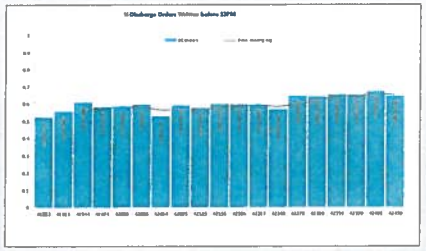
Team Triage – Median Times



Average Time to Discharge



Discharge Orders Written before 12 pm



Barriers/ Lessons Learned

- High variability in issues that effect the efficiency of the admission and discharge process. The physical bed and staffing limitations when census is high is the biggest cause for delays despite solutions that have been implemented. Census was high during February and Staffing was challenging causing longer delays in getting patients moved up to inpatient beds.
- Increased boarding in ED due to limited bed and staff availability.
- Discharge Unit pilot not effective since only opened unit for one day for one patient in past few weeks.
- Discharge Concierge service – had meetings to coordinate ability for when RNs can access this service, should improve access in future.
- Bed Ready to Depart minutes have been increasing due to not being able to transport patients up to the unit in a timely manner due to being down ED transporter positions.
- Need to continue to work to improve metrics despite barriers of bed availability and staffing.

Recommendations and Next Steps

BHU Suite

- ED BHU opened on 10/26/2015: seeing up to 8 BHU Patients, patient throughput has improved for these patients which has opened more beds in the ED for sick medical patients.
- Continue to monitor and adjust criteria as required.

ED Team Triage

- Continue to work with consultant on process improvement with positions and workflow, need to staff another Registration Clerk to optimize process.

Discharge Lounge

- Implement DC lounge on a consistent basis, work out operational issues, monitor utilization.

Discharge Concierge Service

- Promote services, monitor utilization

Team Members

Kathy Topp, Kapua Conley, Rick Sanchez, Sharon A. Schultz; Bruce S. Bainbridge; Candice J. Parras; Carola Hauer; Diane Sikora; Dr. Henry F. Showah; Dr. Mark Obrien; Jenessa A. French; Jessica L. Thrift; Joy M. L. Melhado; Marcia M. Cavanaugh; Merebeth T. Richins; Paula F. White; Rachel Garcia; Steven A. Young; Hope Munoz; Jared Burton; Jessica Ruh; Stephen ChavezMatzel; Mary Canete

Acknowledgments

Rick Sanchez and Jess Thrift – QI/PI Analysts for data graphs

PROFESSIONAL AFFAIRS COMMITTEE
April 14th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Care for Recalcitrant Children Policy	3 year review, practice change	
2. Child Passenger Restraint System Education Policy	3 year review, practice change	
3. Diluting IV Medications for IV Push Administration Procedure	3 year review, practice change	
4. Immediate Use Sterilization, Intraoperative	3 year review, practice change	
5. Micromedex Carenotes Procedure – Tracked Changes 6. Micromedex Carenotes Procedure – Clean Copy	3 year review, practice change	
7. Obstetrical Patients Triage Policy	3 year review, practice change	
8. Point of Care New Test Method Request and Implementation Policy	3 year review, practice change	
9. Point of Care Testing Policy	DELETE	
10. Staffing Requirements, Development of Policy	3 year review, practice change	
11. Sterile Technique	NEW	
12. Wound Classification During Surgical Intervention	NEW	
Administrative Policies & Procedures		
1. Business Visitor Visitation Requirements	3 year review, practice change	
Unit Specific		
Engineering		
1. Breached Medical Gas Lines 2004.1	3 year review, practice change	
2. Outside Contractors Hazard Communications Program	3 year review	
3. Outside Contractors Working in the Facility	3 year review, practice change	
4. Daily Journal	3 year review, practice change	
5. Domestic Hot Water 2005	3 year review, practice change	
6. Emergency Generator Test Loads	3 year review	
7. General Personnel Policies	3 year review, practice change	
8. Inspection Testing And Maintenance of Fire Alarm Detection and Automatic Extinguishing System	3 year review, practice change	
9. Maintenance And Inspection Electrical Distribution System and Emergency Generator	3 year review, practice change	
10. Maintenance And Inspection Medical Surgical Air and Vacuum System 2004	3 year review, practice change	
11. Maintenance And Inspection of Boiler/Steam System	3 year review, practice change	

PROFESSIONAL AFFAIRS COMMITTEE
April 14th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
12. Maintenance Work Request System	3 year review, practice change	
13. Managing Biological Agents to Prevent Waterborne Illness	NEW	
14. Preventative Maintenance	3 year review, practice change	
15. Routine Hospital Rounds	3 year review, practice change	
16. Scope of Service – Tracked Changes 17. Scope of Service – Clean Copy	3 year review, practice change	
18. Staff Meetings	3 year review, practice change	
19. Statement of Accountability	3 year review, practice change	
Medical Staff		
1. Suspension for Delinquent Medical Records 8710-519	Practice Change	
NICU		
1. Primary Nurse Assignment	3 year review, practice change	
Women and Newborn Services		
1. Sterile Processing of WCS Instruments	3 year review, practice change	
Formulary Requests		
2. Entresto – Trade Name Sacubitril and valsartan– Generic Name		
Forms		
1. Cardiopulmonary Arrest Record	Practice Change	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 5/09	**SUBJECT: Care For Recalcitrant Children**
REVISION DATE: 6/12	**POLICY NUMBER: IV.TT**

Clinical Policies & Procedures Committee Approval:	**~~07/12~~12/15**
Nurse Executive Committee:	**~~07/12~~01/16**
Medical Executive Committee Approval:	**~~08/12~~02/16**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. To ensure minor patients are provided with appropriate resources to identify and treat behavioral and psychological challenges.

B. **PROCEDURE:**

1. Every patient ages 0 to 21 years old admitted to Tri-City Medical Center (TCMC) shall be evaluated for persistent behavioral and/or psychological difficulties:
   a. Upon admission, the RN will begin to document any identified problems on the patient admission assessment or patient history form.
   b. Every discipline that interacts with the minor patient is to communicate their findings in the patient's chart upon identification of difficulties.
      i. Nursing
      ii. Physician
      iii. Social Work
      iv. Ancillary Staff: Pulmonary, Rehabilitation, etc.
   c. Each discipline will also take into account the interactions between the minor patient and their parents/guardians.
2. The Social Worker who is a CCS paneled Social Worker will:
   a. Meet with the patient/family and advise regarding the possible eligibility for CCS benefits
   b. Provide the patient/family with the CCS application and assist with completion of the document
   c. Provide the family with a list of the CCS special care centers and assist in making appointments
3. If a child has a condition that warrants a referral to a special care center, a referral should always be made to CCS. If you can get the appointment before discharge (if the child is eligible), then an appointment with a paneled Medical Doctor will be arranged before discharge if possible.
4. Nurses who have determined their minor patient is at high risk for harm to self or others, shall notify the patient's physician immediately.
   a. A psychiatric evaluation may be ordered at any time to be completed by the psychiatric liaison staff, especially where there are:
      i. Threats or warnings about hurting or killing oneself
      ii. Threats or warnings about hurting or killing someone else
   b. For minor patients who need to be transferred to an inpatient child or adolescent psychiatric facility, the psychiatric liaison and social worker will collaborate to expedite the transfer.
5. Persistent and recurrent behavioral and/or other psychiatric difficulties may be identified as needing further assessment and outpatient treatment such as:
   a. General inappropriate or oppositional behavior
   b. Learning disabilities

c. Violent or dangerous behavior
d. Mood changes
e. Depression
f. Complicated grief

6. All treatment disciplines are responsible to review the patient's treatment plan and strive to assist the patient to meet their goals. When caring for minor patients with behavioral and/or psychological difficulties, it is important to remember:
   a. Always build on the positives, give the child praise and positive reinforcement when he/she shows flexibility or cooperation.
   b. Take a time-out break if you are about to make the conflict with your patient worse; not better. This is good modeling.
   c. Support your patient if they decide to take a time-out to prevent overreacting.
   d. Since some children have trouble avoiding power struggles; prioritize the things you want the child to do (choose your battles.)
   e. Set up reasonable age appropriate limits, but know they will be challenged. Be united as a health care team in being consistent with rules and boundaries.
   f. Manage your own stress with patients, recognizing that you are not their parent but their health care advocate.
7. Referrals to approved facilities authorized by the patient's insurance shall be given to the parents and/or guardian for follow-up. This may include either inpatient or outpatient resources.
   a. .

A. **ATTACHMENTS:**

1. Appendix A: Specific Behavioral and/or Psychological Problems Requiring Outpatient Referral
2. Appendix B: Adolescent Substance Abuse Treatment Facilities
3. Rady Children's Hospital – San Diego

B. **REFERENCES:**

1. The American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.W., Washington D.C. 20016-3007, www.aacap.org.

Appendix A
Specific Behavioral and or Psychological Problems Requiring Outpatient Referral

General inappropriate or oppositional behavior

Related to Children

- Marked fall in school performance.
- Poor grades in school despite trying very hard.
- Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child's age.
- Hyperactivity; fidgeting; constant movement beyond regular playing.
- Persistent nightmares.
- Persistent disobedience or aggression (longer than 6 months) and provocative opposition to authority figures.
- Frequent, unexplainable temper tantrums.

Related to Pre-Adolescents and Adolescents

- Marked change in school performance.
- Inability to cope with problems and daily activities.
- Marked changes in sleeping and/or eating habits.
- Frequent physical complaints.
- Sexual acting out.
- Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death.
- Abuse of alcohol and/or drugs.
- Intense fear of becoming obese with no relationship to actual body weight, purging food or restricting eating.
- Persistent nightmares.
- Threats of self-harm or harm to others.
- Self-injury or self-destructive behavior.
- Frequent outbursts of anger, aggression.
- Threats to run away.
- Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism.
- Strange thoughts, beliefs, feelings, or unusual behaviors.

Oppositional Behaviors

- Frequent temper tantrums
- Excessive arguing with adults
- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Mean and hateful talking when upset
- Seeking revenge

Learning disabilities

- Difficulty understanding and following instructions.
- Trouble remembering what someone just told him or her.
- Fails to master reading, spelling, writing, and/or math skills, and thus fails
- Difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").

- Lacks coordination in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- Easily loses or misplaces homework, schoolbooks, or other items.
- Cannot understand the concept of time; is confused by "yesterday, today, tomorrow."

Potentially violent or dangerous behavior

- Threats to run away from home
- Threats to damage or destroy property
- Past violent or aggressive behavior (including uncontrollable angry outbursts)
- Access to guns or other weapons
- Bringing a weapon to school
- Past suicide attempts or threats
- Family history of violent behavior or suicide attempts
- Blaming others and/or unwilling to accept responsibility for one's own actions
- Recent experience of humiliation, shame, loss, or rejection
- Bullying or intimidating peers or younger children
- A pattern of threats
- Being a victim of abuse or neglect (physical, sexual, or emotional)
- Witnessing abuse or violence in the home
- Themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork
- Preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and Internet sites
- Mental illness, such as depression, mania, psychosis, or bipolar disorder
- Use of alcohol or illicit drugs
- Disciplinary problems at school or in the community (delinquent behavior)
- Past destruction of property or vandalism
- Cruelty to animals
- Fire setting behavior
- Poor peer relationships and/or social isolation
- Involvement with cults or gangs
- Little or no supervision or support from parents or other caring adult

Significant mood changes in the pre-adolescent and adolescent

- Severe changes in mood-either unusually happy or silly, or very irritable, angry, agitated or aggressive
- Unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- Great increase in energy and the ability to go with little or no sleep for days without feeling tired
- Increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- Distractibility - the teen's attention moves constantly from one thing to the next
- Repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depression:

- Irritability, depressed mood, persistent sadness, frequent crying
- Thoughts of death or suicide
- Loss of enjoyment in favorite activities
- Frequent complaints of physical illnesses such as headaches or stomach aches
- Low energy level, fatigue, poor concentration, complaints of boredom
- Major change in eating or sleeping patterns, such as oversleeping or overeating
- Frequent sadness, tearfulness, crying

- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

Complicated grief:

- An extended period of depression in which the child loses interest in daily activities and events
- Inability to sleep, loss of appetite, prolonged fear of being alone
- Acting much younger for an extended period
- Excessively imitating the dead person
- Repeated statements of wanting to join the dead person
- Withdrawal from friends, or
- Sharp drop in school performance or refusal to attend school

ADOLESCENT SUBSTANCE ABUSE TREATMENT FACILITIES

PHOENIX HOUSE OF CALIFORNIA
23981 Sherilton Valley Road
Descanso, CA 91916
(619) 445-0405
Both day and residential programs offer treatment, education, family and group therapy.
13 to 17 yrs of age
Variable fees, sliding scale from $15-$2653/mth, and private insurance.

Adolescent Day Program:
684 Requeza Street
Encinitas, CA 92024
(760) 634-7610

Adolescent Residential Program
23981 Sherilton Valley Road
Descanso, CA 91916
(619) 445-0405
12 to 15 months with full-time school program.

McALISTER INSTITUTE
El Cajon and at:
2821 Oceanside Blvd.
Oceanside, CA 92054
(760) 721-2743
Residential program up to 21 days.
12 to 17 yrs of age. Appt needed.
Sliding scale and ability to pay.

MITE (Affiliated with McAlister Inst.)
2964 Oceanside Blvd., Suite G
Oceanside, CA 92054
(760) 754-1393
Outpatient treatment program offers treatment, education, group and individual therapy. They also offer screening for residential program. Program is 3 to 6 months long for youth between 12–17 yrs of age.
Call ahead for appt. Orientation held 2x/week.
Program fees vary and also based on sliding scale.

AA TEEN MEETINGS (adolescents to early 20's)

- ***Young Peoples***
  1430 N. Hwy 101
  Leucadia, CA
  7:30 pm on Fridays
- ***Young Peoples***
  839 2nd Street
  Encinitas, CA
  4pm on Sundays
- ***Tri-City Medical Center***
  4002 Vista Way
  Oceanside, CA
  7:30 pm on Saturdays
  Assembly Rm. 2 & 3

YOUTH TO YOUTH HELPLINE
General Youth Resources
(866) 222-1886 Open Mon-Fri from 3pm-9pm

AURORA SAN DIEGO HOSPITAL
11878 Avenue of Industry
San Diego, CA 92128
(888) 565-4228
Programs include: Outpatient program, 3 days/week. Acute inpatient detox and Partial program offers full time school where student can earn credits.
Private insurance or private pay accepted.

CRASH SOUTH CITY
220 N. Euclid, Suites 120 & 130
San Diego, CA 92114
(619) 263-6663
Outpatient program, county funded, and sliding scale.

SHARP MESA VISTA HOSPITAL
7850 Vista Hill Avenue
San Diego, CA 92123
(858) 278-4110
Outpatient, Partial hospitalization and in-patient programs.
Must call for assessment and program placement.
17 yrs and younger
Medi-cal, private insurance , military and private pay accepted.

SCRIPPS MCDONALD CENTER
9896 Genesee Avenue
La Jolla, CA 92037
(858) 626-4403 for Intake
(800) 382-4357 for information
The outpatient program is a 12-week course of treatment. They meet three days (nine hours) per week. Sessions are conducted after school during the academic year and throughout the day during summer vacation. Program offers education and support to families.
Age: Adolescents to 18 yrs of age.
Please call for program fees.

MIRA MESA TEEN CENTER
10737 Camino Ruiz, Suite 114
San Diego, CA 92126
(858) 578-2492
Outpatient program for 12-17 yr olds.
Appt required.
Sliding scale and ability to pay.

SAN DIEGO YOUTH & COMMUNITY SERVICES/TEEN RECOVERY CENTER
3660 Fairmount Avenue
San Diego, CA 92105
(619) 521-2250
Day treatment program with case management and counseling.
14 to 21 yr olds. Phone and walk-ins accepted.
Variable fee for other services. Med-cal accepted.

Rady Children's Hospital - San Diego
3020 Children's Way
San Diego, CA 92123
(858) 576-1700

Institute of Behavioral Health

The Rady Children's Institute of Behavioral Health is unique because it provides comprehensive mental health and psychosocial services to children and their families within a full-service pediatric medical facility. Its state-of-the-art, cost-effective clinical programs also are available at outpatient clinics throughout the county. Call (858) 966-5832 for more information.

The Institute features:

Therapy/Outpatient Psychiatry
Outpatient psychiatric services at multiple sites including including diagnostic evaluations, medication evaluations and treatment including play therapy, group therapy, family therapy, and parent intervention. The staff is bilingual and bicultural. Emergency and crisis intervention is available 24 hours a day through Rady Children's Emergency Department.

Chemical Dependency and Eating Disorders
Special programs are available for adolescents in areas such as chemical dependency, eating disorders and phobias.

Learning Disabilities and Developmental Delays
The Institute has extensive developmental evaluation programs that include evaluation and referral for:

- *Autism* -- provides developmental/psychological evaluation for children and refers families to appropriate private and public education programs. Parent education and support available through a parent group.
- *Learning Disabilities* -- evaluation of children for problems contributing to poor school performance and helps parents access appropriate education support. Also assesses kindergarten readiness.
- *Developmental Delays* -- evaluates infants and children for significance of developmental delays and helps parents access specific and appropriate intervention services.
- *Attention Deficit Hyperactivity Disorder* -- assesses attentional problems such as inattention, impulsivity, and overactivity as it relates to school difficulties and family stress. Referrals for medical/behavioral management and special school programs when indicated. For more information on ADHD, please see the San Diego ADHD Website.

Mental Health

Mental health services are available at our neighborhood centers in Serra Mesa, Oceanside, El Cajon, San Diego, La Mesa and through the San Diego School System.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 02/2012	**SUBJECT:** Child Passenger Restraint System Education
REVISION DATE:	**POLICY NUMBER:** V.E

Clinical Policies & Procedures Committee Approval:	**~~03/12~~05/15**
Nurse Executive Council Approval:	**~~03/12~~05/15**
Department of Pediatrics Approval	**02/16**
Medical Executive Committee Approval:	**~~04/12~~02/16**
Professional Affairs Committee Approval:	**05/12**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. The purpose is to provide a method for disseminating information to parents/authorized caregivers of infants and young children regarding child passenger safety seats.
2. Prior to the discharge of any child under age 8, regardless of weight, or less than 4 feet 9 inches (regardless of age), the parents or authorized caregiver to whom the child is being released, will be given information regarding current child passenger restraint system. Included are the risks associated with their non-use or misuse. A list of programs offering rental and no or low-cost purchase will be available.

B. **POLICY:**

1. Before an infant or young child is discharged, the parents or authorized caregiver to whom the child is being released, will be verbally informed of the need to have an age-appropriate child passenger safety seat, about Car Seat Safety and the importance that all children under **13** ~~8~~ years of age **ride in the back seat and be properly buckled** ~~should be properly buckled into a car seat or booster in the back seat~~ when being transported.
   a. This information shall be provided to all parents of children receiving care in the ~~Pediatric Unit,~~ Emergency ~~Room~~ Department and ~~all~~ in Women **and Newborn Services.**~~'s and Children's Service's Post-Partum and NICU units with newborn infants and their siblings:~~
      i. Infants must be properly buckled in a rear-facing care seat in the back until they are at least 1 year old **AND 20 pounds**.
         ~~i.~~**1) The American Academy of Pediatrics (AAP) recommends rear facing until the age of 2 or the maximum weight of the car seat for rear facing.**
      ii. If a child is too large for a safety seat, **the AAP recommends children who are 4 feet 9 inches tall or shorter ride in a belt positioning booster seat, regardless of age.** ~~generally around 40 pounds and/or age 4, a booster seat can be used.~~
      iii. **Children who are over 4 feet 9 inches can use a lap/ shoulder belt if:** ~~5 Step Seat Belt Test to determine if a booster is needed for children who are 8 years of age and at least 4 feet 9 inches tall:~~
         1) **T**~~Can t~~he child **can** sit all the way back**/ hips** against the ~~auto~~ seat~~?~~
         2) **The**~~Do t~~he child's knees bend comfortably at the edge of the seat~~?~~
         3) **T**~~Does t~~he **shoulder strap should cross over the shoulder.** ~~best cross over the shoulder between the neck and arm?~~
         4) **T**~~Is t~~he ~~lap~~ belt **fits low and flat on the hips** ~~as low as possible, touching the thighs?~~
         ~~5) Can the child remain seated like this for the entire trip?~~

~~6.~~**5)** If the answer is no to any of the following, then a booster is still required according to the California Law

b. It is illegal for a person to smoke a pipe, cigar or cigarette in a motor vehicle in which there is a minor [Health and Safety Code Section 118948].

c. A parent, legal guardian, or other person responsible for a child who is 6 years of age or younger may not leave that child inside a motor vehicle without being subject to the supervision of a person who is 12 years of age or older, under either of the following circumstances.
   i. Where there are conditions that present a significant risk to the child's health or safety.
   ii. When the vehicle's engine is running or the keys are in the ignition, or both.

d. Other regulatory recommendations:
   i. Toddlers should remain rear-facing until they reach 2 years of age or until they reach the upper weight and height limit of the car seat. Always follow the manufacturer's instructions for proper use and fit.
   ii. Do not buy a used car seat if you do not know if it has been in a crash.
   iii. Do not buy a car seat that is older than 6 years or has been in a crash.
   iv. Children should ride in the back seat until they are 13 years old.
   v. Never allow your child to place the shoulder belt behind his/her back or under the arm.
   vi. Never seat a child in front of an airbag.
   vii. Never leave your child alone in or around cars.

2. Literature available in both English and Spanish will be provided outlining current state laws regarding this issue, proper use of safety seats, and risk of death/injury associated with non-use or misuse, including air-bag issues.

3. Prior to the discharge of the child, parent/conservator or guardian shall provide a signature that this information was reviewed and discussed.
   a. Person receiving information outlining current law requiring child passenger restraint system, will sign the "release of a child under 8 years of age" form. The original will be kept in the medical record and a copy will be given to the person to whom the child is released.

4. Hospitals are required only to provide and discuss information concerning child passenger restraint system laws.
   a. Hospitals are not required to, and should not, attempt to prevent a parent (or other authorized person) from transporting a child in a vehicle which does not have a child passenger system.
   b. Hospitals also should not instruct parents regarding how to install a car seat or help parents install a car seat, for liability reasons. A parent with questions about appropriate car seat installation should be referred to a local police or fire station, a local CHP office or loan program. Parents may also call (866) SEAT-CHECK or visit www.seatcheck.org to locate free car seat inspection facilities.

5. Facilities that provide the required information to the person to whom the child is released cannot be held legally responsible for the failure of that person to use a child passenger restraint system.

C. **REFRENCES:**

~~1. Safely On The Move, 6505 Alvarado Rd. Suite 108, San Diego, CA 92120, Phone: Toll Free 1-866-700-7686 or (619) 594-0784 or http://www.safelyonthemove.sdsu.edu/full/url/~~

~~2.~~**1.** Pacific Safety Council, 9880 Via Pasar, Suite F, San Diego, CA 92126, Phone: 858-621-2313 ~~x15~~ or http://www.safetycouncilonline.com/full/url/

2. www. Kohlscarsafety.org. ~~Safe Kids San Diego, 3 Led by: Children's Hospital & Health Center, Coordinator: Mary Beth Moran 3020 Children's Way, San Diego, CA 92123, Phone: 858-576-1700 or mbmoran@rchsd.org~~

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DILUTING IV MEDICATIONS FOR IV PUSH ADMINISTRATION**
Purpose:	To outline the RNs responsibility when preparing IV push medications that need to be diluted before administration
Supportive Data:	Mosby's Nursing Skills, *Medication Administration: Intravenous Bolus*
Equipment:	1. Blunt tip access canula syringe (3 mL, 5 mL or 10 mL) 2. 10 mL normal saline or sterile water vial 3. Filter needle 4. Alcohol swabs 5. Needle or blunt tip needle

A. **PROCEDURE:**

1. Verify the following against the electronic medication administration record (eMAR):
   a. Patient name
   b. Medication
   c. Route
   d. Dose
   e. Administration time
2. **Medication supplied by the manufacturer in a carpujet does not require dilution.**
3. Verify compatibility of diluent with medication.
4. Check name of medication on vial/ampule label against MAR.
5. Check Expiration date printed on vial or ampule.
6. Perform hand hygiene.
7. Assemble medication and supplies at the admixture workstation.
8. Remove medication from ~~medication~~ **glass** ampule **using a filtered needle or straw.**~~or vial containing the medication.~~
   a. See Mosby's Nursing Skills, *Medication Administration: Intravenous Bolus* ~~http://app44.webinservice.com/NursingSkills/ContentPlayer/SkillContentPlayerIFrame.aspx?KeyId=604&Id=GN_21_8&Section=1&bcp=Index~M~False&IsConnect=False~~
9. Change syringe access needle to a blunt tip access cannula syringe after withdrawing the medication using an ampule or vial preparation method.
10. Insert the blunt tip access cannula syringe into the 10 mL normal saline or sterile water **vial** (per the TCMC IV or medication manufacturer's guidelines) and withdraw the recommended amount of diluent. Never Use Pre-filled Normal Saline Syringes to Dilute or Mix Medications.
11. Discard the 10 mL normal saline or sterile water vial after desired amount of diluent has been removed.
    a. 10 mL normal saline or sterile water vials may not to be used as multidose vials
12. Remove cannula from vial, expel excess air bubbles from tip of syringe, and recap the blunt needle.
13. Administer medication to the patient IV push per the physician orders and the Tri-City Medical Center IV Medication Guidelines or the medication manufacturer guidelines.

~~Revision Dates~~Department Review	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
2/09; **9/15**	06/11, **12/15**	06/11, **01/16**	**03/16**	07/11. **03/16**	08/11	08/11

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**IMMEDIATE USE STERILIZATION, INTRAOPERATIVE**
Purpose:	To ensure safe and effective rapid sterilization of surgical instruments and devices intended for immediate use in an operative procedure. **The effectiveness of the sterilization process is dependent upon effective cleaning. The process of sterilization is negatively affected by the amount of bioburden and the number, type, and inherent resistance of microorganisms, including biofilms, on the items to be sterilized. Soils, oils, and other materials may shield microorganisms on items from contact with the sterilant or combine with and inactivate the sterilant.**

A. **DEFINITIONS:**

1. Decontamination: the process of removing disease-producing microorganisms and rendering the object safe for handling.
2. Immediate Use **Steam** Sterilization (IUSS): rapid steam sterilization of unwrapped instruments and accessories for immediate use in emergencies or when the only instrument available of its kind is contaminated.
3. Implant: tissue or material placed within the body with the intent of permanent or long-term retention. (i.e., over thirty days).
4. Steam Sterilization: saturated steam under pressure in a process that destroys all forms of microbial life including bacteria, viruses, spores, and fungi.
5. Liquid (Peracetic Acid) Sterilization: a method of sterilization used for items that are heat sensitive and can be immersed. Peracetic Acid **(Steris®)** processors are maintained and operated in the Operating Room ~~Clean Utility Area~~**and Sterile Processing Department (SPD)**.

B. **POLICY:**

1. Decontamination and sterilization activities shall be done in compliance with current infection control standards, state and federal regulations and Tri-City Medical Center policies and procedures.
2. All autoclaves will be operated per manufacturer's instructions.
3. All Items will be thoroughly cleaned and rinsed prior to sterilization.
4. A Class V integrator will be placed in every basket/tray of instruments/equipment when performing Immediate Use **Steam** Sterilization.
5. Autoclave doors will be kept closed when not is use.
6. Items processed via IUS shall be used immediately and not stored.
7. Sterilizer function shall be monitored daily with mechanical, chemical, and biological indicators to meet all of the monitoring parameters established for each type of sterilizer.
8. A biological indicator (BI) shall be run with each load containing an implant. The results of the BI are reported to the surgeon as soon as available and documented on the Immediate Use Sterilization Log.
9. **Steris machines shall be tested daily, including both diagnostic and chemical tests.**
~~9.~~**10.** Sterilizer logs shall be kept for a period of seven (7) years.

C. **PROCEDURE:**

1. Thoroughly clean items prior to IUS**, according to manufacturer's instructions**.
2. **Immediate Use Steam Sterilization:**
   a. Place items in an open bottom mesh pan, transfer pan or FlashPak for sterilization.
   b. Place a Class V integrator in all pans.
   c. Obtain two 3M Attest 1292 Rapid Readout Biological Indicators with the same lot number (brown cap, 3-hour readout) when item to be flashed is an implant.
      i. Place one of the Biological Indicators in the load to be sterilized.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/10;8/12; **8/15**	5/10; 8/12, **9/15**	8/12, **09/15**	**03/16**	06/10; 10/12. **03/16**	08/10; 11/12	08/10;12/12

ii. Set aside the second Biological Indicator to use as the control during incubation. This ampule is not run in the autoclave.

d. Select the appropriate sterilization cycle**, according to manufacturer's written instructions for Immediate Use Sterilization**. Follow **autoclave** manufacturer's written instructions to load sterilizer, close door, and select cycle for load contents. Cycles are:
   i. Cycle 1: 4-minute Prevac Cycle (Express): For large amounts of instruments, porous items, instruments with lumens, linen lined pans, surgical implants
   ii. Cycle 2: 4-minute Prevac Cycle (20-minute dry): for wrapped loads; may occasionally be used if manufacturer lists these parameters as necessary for sterilization of a specific item; not usually used by OR staff for IUS.
   iii. Cycle 3: 3-minute Gravity Cycle: For three or fewer single part, non lumened, non-porous instruments
   iv. Cycle 4: 10-minute Gravity Cycle: more than three metal instruments, instruments with lumens, porous items (i.e.., rubber, plastic, glass).
   ~~v. Steris System IE (Peracetic Acid): heat sensitive, immersible items such as endoscopes: 6 minutes at 45.5-60°C with sterilant, concentrations greater than 175ppm. . Power Equipment: IUS per manufacturer's instructions.~~

e. At the end of the sterilization process, the staff member who removes the load shall review and initial the print-con strip. At the end of the day the data strip is taped to the sterilizer log sheet as a permanent record.

f. If any of the parameters (i.e., time, temperature, pressure**, completion of cycle**) are not reached, the load is not sterile.
   i. Circle the parameters that do not meet the acceptable standard.
   ii. Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR Assistant Nurse Manager/Designee of the sterilizer malfunction.
      1) Place tape across the sterilizer door with ~~legend~~**an** "OUT OF SERVICE" **sign**.
      2) Notify Clinical Engineering (Ext. 7711).
      3) Enter a Work Order via TCMC Intranet.
      4) In surgery, make note on the schedule board and pass information at report.
      5) **DO NOT USE** the sterilizer until Clinical Engineering has completed repairs**. ~~AND~~ A major repair requires** three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".
   iii. Remove supplies from sterilizer and reprocess in another sterilizer.
   iv. Document in the sterilizer log book that the load was aborted and reprocessed.

3. Liquid (Peracetic Acid) Sterilization- Steris:

a. Assemble clean instruments in the appropriate Steris tray and tray insert, according to manufacturer's instructions.

b. Obtain appropriate quick connector (matched to manufacturer and equipment identification number) and connect to Steris tray and scope ports, if applicable. Ensure all ports/lumens of the device to be sterilized are attached to a connector.

c. Obtain Steris chemical indicator and attach to orange holder. Place in the Steris tray with the item to be sterilized.
   i. Check expiration date of chemical indicator before use.
   ii. Chemical indicator starts blue and turns pink when passing.

d. Place lid on the Steris tray insert.

e. Place Steris S40 sterilant container in sterilant chamber and insert aspirating probe according to manufacturer's instructions. Ensure tubing is not kinked.
   i. Follow precautions for safe handling of peracetic acid according to manufacturer's instructions and Surgical Services Policy: Peracetic Acid: Disposal of.

f. Close lid of Steris machine and press START to begin cycle.

g. Upon completion of cycle, check printout to ensure the cycle has completed and the following sterilization parameters have been met:
- **i. Temperature (45.5-60°C)**
- **ii. Exposure time (6 minutes)**
- **iii. Concentration (greater than 175)**

~~2.~~**4.** Maintain~~enance of~~ sterility ~~and~~**during** transport to the point of use.~~:~~

a. Immediate Use Steam Sterilization:

i. Avoid ~~traffic in the substerile room when~~ removing sterile items from the autoclave **in the presence of un-masked personnel**.

ii. Open the sterilizer door cautiously, and prepare to remove the sterilizer tray for transport to the operating room.
1) The circulating nurse shall hold the sub-sterile door open for the scrub person.
2) The scrub person, with gown, gloves, and sterile hand towels, shall remove trays from the sterilizer.
3) Drape a ring stand or prep stand with a sterile impervious drape to hold the trays prior to transfer to the sterile field.

iii. At the sterile field (point of use), present or open the tray and inspect the Class V Integrator to ensure parameters have been achieved.
1) The scrub person must also verify the Class V Integrator strip changed color into the "pass" range before removing instruments from the container.
2) The scrub person hands off the Class V Integrator strip to the circulating nurse to affix to the Immediate Use Sterilization log sheet.

iv. If the Integrator did not change color into the "pass" range, the load is not considered sterile and must be run again.
1) If the indicator line has not moved past the "Accept/Reject" mark, on the second load, place the sterilizer "OUT OF SERVICE".
2) Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR Assistant Nurse Manager/Designee of the sterilizer malfunction.
3) Place tape across sterilizer door with ~~legend~~**an "OUT OF SERVICE" sign**.
4) Notify Clinical Engineering (Ext. 7711).
5) Enter a Work Order via TCMC Intranet.
6) In surgery make note on the schedule board and pass information at report.
7) DO NOT USE the sterilizer until Clinical Engineering has completed repairs**. A major repair requires ~~AND~~** three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".

b. Steris:
- **i. Remove the sterilized tray insert from the Steris machine. Instruments that remain in the covered tray insert are sterile and may be delivered to the point of use.**
- **ii. If applicable, ensure connector is still connected to the scope.**
- **~~v.~~iii. Verify chemical indicator changed color into the pink acceptable color range.**

~~3.~~**5.** If the item immediate use sterilized was an implant, the scrub person hands off the Biological Indicator to the circulating nurse, who places it along with the control BI ampule, into the incubator according to manufacturer's written instructions.

a. Results must be read in 3 hours and reported to the implanting surgeon.

b. Implants sterilized via Immediate Use Sterilization shall be quarantined on the sterile field until results of the BI are obtained.

c. If a positive test Biological Indicator occurs, notify the surgeon and the OR Assistant Nurse Manager/Designee.
i. The OR Assistant Nurse Manager/Designee will notify the implanting physician (if not already aware) and the infection control practitioner.
ii. The primary circulator must complete a Quality Review Report

D. **DOCUMENTATION:**

1. Document every load run in the autoclave on the appropriate Immediate Use Sterilization Log sheet. Information recorded from an IUSS cycle shall include:
   a. Sterilizer number
   b. Date
   c. OR suite number
   d. **Name and signature of person starting cycle and removing sterilized items at the end of the cycle**~~Initials of operator~~
   e. Cycle number
   f. Load contents
   g. Identify if load contains implant
   h. Print-Con strip record of cycle parameters (i.e., exposure time, temperature, pressure, vacuum)
   i. Patient Identification label.
   j. Class V integrator for IUS load is affixed to the log sheet
   k. ~~Identify r~~**R**eason for IUS
   l. Biological Indicator ~~Documentation~~**information, if the load contains an implant:**
      i. Incubator well numbers of test ampule and control ampule
      ii. Date/Time/Initials when ampule~~'s;~~ **is** placed in incubator
      iii. Date/Time/Initials when test read/completed (3-hours)
      iv. Test results ("+" or "-")
      v. Control results ("+" or "-")
      vi. Lot # of biological indicators.
2. **Document every load run in the Steris, including:**
   a. Steris machine ID
   b. Date
   c. Patient identification label
   d. Cycle number
   e. OR suite in which item will be used
   f. Item sterilized
   g. Affix processed chemical indicator
   h. Reason for IUS
   i. Initials of person sterilizing item

~~2.~~**3.** Accurate and complete records are required for process verification, infection control monitoring, and sterilizer malfunction analysis.

~~3. Sterilizer logs shall be kept for a period of seven (7) years.~~

E. **REFERENCES:**

1. AORN ~~Preoperative Standards & Recommended practices, 2011.~~**Guidelines for Perioperative Practice (2015).**

~~1.~~**2. Rothrock, Jane. (2015). Alexander's Care of the Patient in Surgery, 15th Edition. Mosby.**

This copy is with TRACKED CHANGES

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MICROMEDEX CARENOTES**
Purpose:	To define the procedure for accessing Micromedex patient and/or family education handouts via Tri-City Medical Center (TCMC) Intranet.
Supportive Data:	CareNotes are patient education instructions accessed via TCMC intranet on a variety of healthcare topics **to provide information to patients and/or their caregivers on individual health care needs. The CareNotes may also be assessed to assist TCMC staff when providing education to patients and/or their caregivers.**. ~~They are used in association with other existing patient education materials. CareNotes may be given to patients and their healthcare providers to provide appropriate information related to individual health care needs.~~
Equipment:	Computer with access to TCMC Intranet Printer linked to computer

A. **POLICY:**

1. Micromedex CareNotes may be used with other printed patient education to provide education information for patients and their family on diseases, surgical procedures, diets, medications laboratory information.~~ throughout their hospital stay and at discharge~~.

B. **DEFINITIONS:**

1. **CareNotes Patient Education Handouts:** Patient education handouts which provide disease, treatment, dietary, medications and laboratory information.
2. **Drug Information:** Patient education medication handouts
3. **Keyword Search Tab:** ~~An option, which~~ allows the user to search disease, medication, treatment, dietary, and laboratory handouts by relevant terminology. Options are limited by the topic selected.
4. **Care and Condition Titles:** ~~An option which allows the users to use~~ an alphabetical **categorized** ~~-~~list **of education** ~~to search for disease and treatment~~ handouts
5. **Drug Titles:** ~~An option, which~~ allows the user to use an alphabetical list to search for medication handouts.
6. **Lab Titles:** ~~An option, which~~ allows the user to use an alphabetical list to search for selected laboratory and diagnostics handouts.
7. **Hot List:** A unit specific department customized lists of Micromedex handouts. The handouts are specific to physician instructions and/or to standards of practice.
8. **Customizing; Allows end users to insert patient specific-text in CareNotes which contain blanks.**
9. **Conversion Calculator: A calculator used by healthcare workers to convert different units of measurements.**

C. **PROCEDURE:**

1. Double click on the TCMC Icon of the main screen of a computer.
2. Select **Micromedex**~~(highlight) Clinical References, located on the left hand side of the page~~.
3. Select **CareNotes** ~~(highlight) Micromedex Healthcare Series~~.
   a. Select **the appropriate Topic tab. The Topic tabs include the following:**
      i. **Keyword Search**
      ii. **Hot Lists**
      iii. **Care & Conditions Titles**
      iv. **Drug Titles**
      v. **Lab Titles**

~~4. (highlight) CareNotes Patient Education Handouts or Drug Information.~~

~~5. Use the five tabs to navigate the system. From left to right, the following tabs are available:~~

~~a. Keyword Search~~

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
8/03; 04/09	12/11, **02/16**	12/11, **02/16**	~~1/12~~n/a	2/12	2/12

~~b. Hot Lists~~
~~c. Care & Conditions Titles~~
~~d. Drug Titles~~
~~e. Lab Titles~~
~~f. Print List~~

~~6.~~**4.** Keyword Search:
- a. Type **a** ~~the~~ key word **of the education topic i.e., disease, diet or condition name, then** ~~and~~ select (click) Search~~.~~
- b. Select the **appropriate** CareNote(s) **from the Care and Condition Titles list then select (click) Select Titles**~~.~~
- **c.** Select the CareNote language **from the Document Type. The Document Types vary based on the topic selected. The available Document Types are as follows:**
  - **i. General Information**
  - **ii. Inpatient Care**
  - ~~c.~~**iii. Ambulatory Care** ~~(i.e. English or Spanish).~~
- ~~d. Select the CareNote instruction type:~~
  - ~~i. PreCare Instructions~~
  - ~~ii. AfterCare Instructions~~
  - ~~iii. Inpatient Care~~
  - ~~iv. Discharge Care~~
  - ~~v. DrugNotes~~
- ~~e.~~**d.** Review the **selected** CareNote(s) **by selecting (clicking) Print or Add to Print List**.
- ~~f.~~**e.** Print the CareNote(s)~~.~~
- ~~g. Department specific procedures may require the use of specific type of document and limits may restrict access to certain document types.~~

5. Care & Conditions~~:~~ **Titles**
- a. Select the Care & Conditions **category**~~topic.~~
- b. Select the desired CareNote ~~(s).~~
- **c.** Select the CareNote language **for the Document Type**~~(i.e. English or Spanish)~~.
- **d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.**
- ~~c.~~**e. Print the CareNote(s)**~~.~~
- ~~d. Select the CareNote instruction type:~~
  - ~~i. PreCare Instruction~~
  - ~~ii. Aftercare Instruction~~
  - ~~iii. Inpatient Care~~
  - ~~iv. Discharge care~~
  - ~~v. DrugNotes~~
- ~~e. Review the CareNote(s).~~
- ~~f. Print the CareNote(s).~~

6. Drug Titles:
- a. Select the alphabet corresponding to the desired **Drug Title i.e.,** medication~~.~~
- b. Select the medication from the ~~d~~**D**rug **Titles** list~~.~~
- **c.** Select the CareNote language **from the Document Type list** ~~(i.e. English or Spanish).~~
- **d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.**
- ~~c.~~**e. Print the CareNote(s)**
- ~~d. Select the CareNote instruction type.~~
- ~~e. Review the CareNote(s).~~
- ~~f. Print the CareNote(s).~~

7. Lab Titles:
- a. Select the lab or diagnostic from the Browse Test**s** List or type the lab or diagnostic in the Jump to: box~~.~~
- b. Click the Select button~~.~~
- **c.** Select the CareNote language **from the Document Type list** ~~(i.e. English or Spanish).~~
- **d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.**

~~c.~~**e. Print the CareNote(s)**
~~d. Select the CareNote instruction type.~~
~~e. Review the CareNote(s).~~
~~f. Print the CareNote(s).~~

8. Hot Lists: Department specific procedures may require the use of a specific type of document and limits may restrict access to certain document types.
   a. Select the Hot List tab~~.~~
   b. Select your **department**~~unit~~**, then select (click) GO**~~.~~
   c. Select the Hot List topic~~.~~
   d. Select the CareNote language from the Document Type list
   e. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   f. Print the CareNote(s)
   ~~d. Review the contents of the selected topic.~~
   ~~e.~~**g.** ~~Print the CareNote(s).~~

9. Customizing:
   ~~9.~~**a. Customizing of CareNotes is not allowed at TCMC.**
   ~~a. Select the CareNote to open the document.~~
   ~~b. Review the full text of the CareNote and type in patient specific information in the "Fill in the Blanks" field.~~
      ~~i. The option to "Fill in the Blanks" may not be available on all units.~~

~~c. Click on the "Print Now" button and proceed to the "Print Set-Up" page or select the "Print Later" button to retain your customization and return to your "Print List" page.~~
   ~~**Update (remove**~~

10. Conversion Calculator:
   a. Select (click) Conversion Calculator
   b. Enter the unit of measure requiring conversion
   c. Select (click) Convert

~~10. Printing CareNotes:~~
   ~~a. Select a CareNote to print form the "Hot List" or any "Search Results" page.~~
   ~~b. Select the check box next to the appropriate CareNote and select Print if only printing one document. Select "Print Later" if multiple documents will be printed.~~
      ~~i. The user is able to select the "Print Later" option while viewing other CareNotes.~~
   ~~c. Print Set-up:~~
      ~~i. Select "Print Now", the user will be directed to the "Print Set-up" page.~~
      ~~ii. The user has the option to further define the patient specific information in the CareNote.~~
         ~~1) Department specific limitations may restrict the following options:~~
            ~~a) Patient Name: Type in the patient's name~~
            ~~b) Caregiver Name: Type in the patient's caregiver's name~~
            ~~c) Special Instructions: The user may type in additional instructions for the patient~~
            ~~d) Signature Line: Space for the patient and the caregiver's signature~~
            ~~e) Patient Education Record: Provides a list of documents given to the patient with special instructions, the patient and caregiver names and the date the document set was printed.~~
      ~~iii. Select "Print Preview" to have an advance look at the CareNotes before printing.~~
      ~~iv. Delete any undesired CareNotes.~~
      ~~v. Print all CareNotes by clicking on the "Print" button on the "Print Set-up" page.~~
      ~~vi. Once the CareNotes are printed, all custom and/or patient specific information is removed.~~
      ~~vii.~~ ~~A separate sheet for the Patient Education record will print~~.

D. **DOCUMENTATION:**
1. Document patient and/or family receipt of the handouts on the Education All Topics powerform.

2. Document as appropriate for Behavioral Health Unit (BHU) or Neonatal Intensive Care Unit (NICU).
3. ~~Place a patient label and make a copy of all CareNotes, which have been customized by filling in the blanks. Place copy in the patient's medical record.~~

E. **LIMITATIONS:**

1. 3000+ CareNotes in several categories are available.
2. Department and/or location may limit limitations on access, customization, and printing. The Department Director has reviewed these limitations.
3. Physicians and Educators may request additions to the unit specific Hot Lists.
4. Educators, Shift Supervisors, and managers may customize CareNotes as needed.

E. **REFERENCES:**

1. ~~Reuters, Thomas. (2002-2009). Thomson micromedex carenotes system. Tri-City Medical Center Intranet. http://www.thomsonhc.com/carenotes/librarian~~**Truven Health Analytics, Inc. (2016). Micromedex carenotes system. Retrieved from Tri-City Medical Center intranet.**

This is a CLEAN COPY

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**MICROMEDEX CARENOTES**
Purpose:	To define the procedure for accessing Micromedex patient and/or family education handouts via Tri-City Medical Center (TCMC) Intranet.
Supportive Data:	CareNotes are patient education instructions accessed via TCMC intranet on a variety of healthcare topics to provide information to patients and/or their caregivers on individual health care needs. The CareNotes may also be assessed to assist TCMC staff when providing education to patients and/or their caregivers..
Equipment:	Computer with access to TCMC Intranet Printer linked to computer

A. **POLICY:**

1. Micromedex CareNotes may be used with other printed patient education to provide education information for patients and their family on diseases, surgical procedures, diets, medications laboratory information.

B. **DEFINITIONS:**

1. **CareNotes Patient Education Handouts:** Patient education handouts which provide disease, treatment, dietary, medications and laboratory information.
2. **Drug Information:** Patient education medication handouts
3. **Keyword Search Tab:** allows the user to search disease, medication, treatment, dietary, and laboratory handouts by relevant terminology. Options are limited by the topic selected.
4. **Care and Condition Titles:** an alphabetical categorized list of education handouts
5. **Drug Titles:** allows the user to use an alphabetical list to search for medication handouts.
6. **Lab Titles:** allows the user to use an alphabetical list to search for selected laboratory and diagnostics handouts.
7. **Hot List:** A unit specific department customized lists of Micromedex handouts. The handouts are specific to physician instructions and/or to standards of practice.
8. **Customizing:** Allows end users to insert patient specific-text in CareNotes which contain blanks.
9. **Conversion Calculator**: A calculator used by healthcare workers to convert different units of measurements.

C. **PROCEDURE:**

1. Double click on the TCMC Icon of the main screen of a computer.
2. Select Micromedex.
3. Select CareNotes.
   a. Select the appropriate Topic tab. The Topic tabs include the following:
      i. Keyword Search
      ii. Hot Lists
      iii. Care & Conditions Titles
      iv. Drug Titles
      v. Lab Titles
4. Keyword Search:
   a. Type a key word of the education topic i.e., disease, diet or condition name, then select (click) Search
   b. Select the appropriate CareNote(s) from the Care and Condition Titles list then select (click) Select Titles
   c. Select the CareNote language from the Document Type. The Document Types vary based on the topic selected. The available Document Types are as follows:
      i. General Information
      ii. Inpatient Care

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
8/03; 04/09	12/11, 02/16	12/11, 02/16	n/a	2/12	2/12

iii. Ambulatory Care

d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
e. Print the CareNote(s)

5. Care & Conditions Titles
   a. Select the Care & Conditions category
   b. Select the desired CareNote
   c. Select the CareNote language for the Document Type.
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   e. Print the CareNote(s)
6. Drug Titles:
   a. Select the alphabet corresponding to the desired Drug Title i.e., medication
   b. Select the medication from the Drug Titles list
   c. Select the CareNote language from the Document Type list
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   e. Print the CareNote(s)
7. Lab Titles:
   a. Select the lab or diagnostic from the Browse Tests List or type the lab or diagnostic in the Jump to: box
   b. Click the Select button
   c. Select the CareNote language from the Document Type list
   d. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List
   e. Print the CareNote(s)
8. Hot Lists: Department specific procedures may require the use of a specific type of document and limits may restrict access to certain document types.
   a. Select the Hot List tab
   b. Select your department, then select (click) GO
   c. Select the Hot List topic
   d. Select the CareNote language from the Document Type list
   e. Review the selected CareNote(s) by selecting (clicking) Print or Add to Print List.
   f. Print the CareNote(s)
   g.).
9. Customizing:
   a. Customizing of CareNotes is not allowed at TCMC.
10. Conversion Calculator:
    a. Select (click) Conversion Calculator
    b. Enter the unit of measure requiring conversion
    c. Select (click) Convert

D. **DOCUMENTATION:**

1. Document patient and/or family receipt of the handouts on the Education All Topics powerform.
2. Document as appropriate for Behavioral Health Unit (BHU) or Neonatal Intensive Care Unit (NICU).

E. **LIMITATIONS:**

1. 3000+ CareNotes in several categories are available.
2. Department and/or location may limit limitations on access, customization, and printing. The Department Director has reviewed these limitations.
3. Physicians and Educators may request additions to the unit specific Hot Lists.
4. Educators, Shift Supervisors, and managers may customize CareNotes as needed.

E. **REFERENCES:**

1. Truven Health Analytics, Inc. (2016). Micromedex carenotes system. Retrieved from Tri-City Medical Center intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/11	**SUBJECT: Obstetrical Patients, Triage**
REVISION DATE: 03/12	**POLICY NUMBER: IV.XX**

Clinical Policies & Procedures Committee Approval:	**~~12/11~~06/15**
Nursing Executive Council Approval:	**~~01/12~~07/15**
Department of OB/GYN Approval:	**12/15**
Department of Emergency Medicine Approval:	**01/16**
Medical Executive Committee Approval:	**~~02/12~~02/16**
Professional Affairs Committee Approval:	**03/12**
Board of Directors Approval:	**03/12**

A. **PURPOSE:**

1. To provide guidelines for determining appropriate disposition and treatment of obstetrical patients at different stages of gestational age who present to Labor and Delivery (L&D) and the Emergency Department (ED).

B. **POLICY:**

1. Obstetrical (OB) patients~~,~~ with gestational age (GA) of greater than or equal to 20 weeks through 40 or more weeks, will be evaluated in L&D for obstetrical issues.
   a. Refer to Patient Care Services (PCS) Standardized Procedure: Medical Screening to Rule Out Labor
   b. Patients 20 weeks or greater presenting to ED for pregnancy related symptoms shall be transferred to L&D via a wheelchair or gurney avoiding supine position during transport.
   ~~b.~~**c. Admission of a 16-20 week gestation pending loss of pregnancy will be considered on a case by case basis by the Charge Nurse in Labor and Delivery.**
2. Pregnant patients **with non-obstetrical complaints/concerns, shall be evaluated and treated in the ED first. These situations** ~~excluded from triage in L&D~~ may include, but are not limited to:
   ~~a. Patients with GA of less than 20 weeks regardless of reason for visit~~
   ~~b. Regardless of GA, the following patients will be evaluated in the ED with collaboration with the OB physician and L&D charge nurse/designee:~~
   a. Major trauma victims
   ~~i.~~**b. Patients involved in a motor vehicle crash with cervical spine precautions in place**
   ~~a.~~**c.** Patients with unstable airway**, difficulty breathing, or painful breathing**
   ~~b.~~**d. Patients with cardiac complaints**
   ~~c.~~**e.** Patients needing surgical procedures
   ~~d.~~**f.** Patients with orthopedic complications or ocular emergencies
   g. Patients with Infectious Perinatal Disease (Varicella, Parvovirus) or suspicious rash which may be contagious to other pregnant patient.
3. **The ED physician may~~can~~ consult and involve the OB physician and L&D Charge nurse at any time to coordinate perinatal evaluation as indicated.**
   ~~ii.~~**a. This can involve a trained L&D Nurse performing external fetal monitoring evaluation in the ED or the stable patient being transported to the L&D unit for monitoring.**

~~3.~~**4.** Patients less than 20 weeks GA will be seen in the ED pursuant to ED protocols. OB consult shall be obtained as deemed necessary by the ED physician.

~~4.~~**5.** Patients who present to the ED whose delivery is imminent or "in the process of delivering" shall be delivered in the ED. If the ED staff **require** ~~need~~ help from an available OB physician/Certified

Nurse Midwife, the Public Branch Exchange (PBX) operator shall be notified to generate a STAT overhead page for "any OB to the ED, Station XX."

a. Refer to the PCS Standardized Procedure: Precipitous Vaginal Delivery

~~5.~~**6.** Patients with a gestational age less than 20 weeks, who present to L&D, will be escorted to the ED for evaluation.

a. The L&D charge nurse/designee shall notify the ED charge nurse/designee of the patient's disposition, including any medical information revealed by the patient or her family

~~6.~~**7.** Evaluation of patients less than 20 weeks gestation may occur in L&D at the joint discretion of the Attending OB Physician and the shift L&D charge nurse/designee; such conditions may include, but are not limited to:

a. Pyelonephritis
b. Diabetes
c. Uncontrolled asthma
d. Pneumonia
e. Incompetent cervix
~~e.~~**f. Inevitable/ Active miscarriage**

~~7.~~**8.** When an obstetrical patient has delivered her newborn outside of the hospital and presents to ED, the ED staff shall:

~~a. Notify L&D and the Neonatal Intensive Care Unit (NICU) assistant nurse managers (ANM)/charge nurses/designee~~
a. Assess mother and newborn **immediately to determine stability**
b. Notify L&D and the Neonatal Intensive Care Unit (NICU) ~~Assistant Nurse Manager (ANM)/~~charge nurses/designee of expected admissions.
~~b.~~
c. Band the mother and newborn before disposition to the appropriate departments
i. Refer to PCS Procedure: Identification of Newborns

~~8.~~**9.** If the patient is being transported by ambulance, and both mother and newborn appear stable, **based on the Paramedic/ field reports,** the ED triage nurse shall:

a. Notify L&D and the NICU ANM/charge nurse/designee **of the expected time of arrival for these direct admissions.**
b. Care of the mother and newborn will be directed by the L&D ANM/charge nurse/designee, including responsibility to:
i. Notify the patient's' OB provider or OB on "unassigned call" **and Pediatrician or Pediatrican on call,** if patient does not have a provider on staff

~~9.~~**10.** If the patient is being transported by ambulance, and mother and/or newborn are not in stable condition, the ED triage nurse shall:

a. Notify L&D ~~and the NICU-~~ ANM/charge nurse/designee, **of the need to have the** ~~so that the NICU team and~~ attending OB provider or OB on "unassigned call"- **and L&D Nurse** ~~can be~~ present in the ED ~~upon arrival of the mother~~**to provide specialty assistance, if indicated. .** ~~and/or newborn.~~
b. Initiate a Code Caleb for the newborn, per ~~patient care services~~ PCS ~~p~~Policy~~,~~: Code Caleb Team Mobilization.

C. **RELATED DOCUMENTS:**

~~a.~~**1. PCS Policy: Code Caleb Team Mobilization**
2. PCS Procedure: Identification of Newborns
3. PCS Standardized Procedure: Medical Screening to Rule Out Labor
4. PCS Standardized Procedure: Precipitous Vaginal Delivery

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/11	**SUBJECT:** Point of Care (POC) New Test/Method Request and Implementation
REVISION DATE:	**POLICY NUMBER:** IV.BB

Department Approval:	**04/15**
Clinical Policies & Procedures Committee Approval:	**~~12/11~~05/15**
Nurse Executive Council Approval:	**~~01/12~~05/15**
Department of Pathology Approval:	**~~03/12~~03/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval:	**05/12**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. To ensure that:
   a. POC testing meets the needs of the patients served, is performed correctly by non-laboratory staff, and is cost effective.
   b. POC testing is approved by the appropriate committees at a hospital level before implementation.
2. Devices, tests, and analytes available as POC testing are continually improving and expanding. However, POC testing is not appropriate for use in all situations. New test and method requests must be evaluated before implementation.

B. **POLICY:**

1. POC testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Medical Director.
2. Any patient testing, including testing that is performed outside of the clinical laboratory by non-clinical personnel, must conform to state and federal regulations. The Clinical Value Analysis Team (CVAT) reviews all requests for new testing. Once approved by the CVAT, the laboratory and POC Department will establish standards for POC testing, evaluate POC devices or tests before implementation, and monitor all POC testing sites for compliance.
3. Requestors must complete and submit the form "Request for Approval of New POC Test/Method" to POC Coordinator (POCC) and/or Lab Leadership Team.
   a. The front of the form explains the extent and use of desired testing, and must be filled out in full by the requesting department.
   b. The back of the form evaluates the financial impact of testing. This can be completed with assistance from the POCC, but the requesting department must be fully aware of all costs involved.
4. Requestors must then submit to the Clinical Value Analysis Team according to current CVAT policies. CVAT reviews all requests for new POC testing taking into consideration the following aspects
   a. Medical need for decreased turn around time
   b. Procedure complexity
   c. Regulatory compliance
   d. Ongoing competency
   e. Cost
5. Following approval for consideration, the POCC and Lab Leadership Team assigns oversight to the appropriate personnel who will

a. Assess available technology for the requested test by contacting vendors.
b. Evaluate and make recommendation to the POC Committee.
c. Perform test method validation according to regulatory requirements and obtain approval by the Laboratory Medical Director.
d. Create written policies/ procedures that are clear to users and meet all regulatory requirements.
e. Establish quality control policy to be followed by testing personnel with regular review of data by responsible staff.
f. Enroll in appropriate proficiency testing or establish alternative proficiency testing if needed.
g. Ensure testing personnel are trained and demonstrate competency prior to performing patient testing.
h. Request **Lab Information System** or **Information System** input, if needed.
i. Communicate to physicians new test availability.
j. The Laboratory Medical Director and POCC review and approve all data for test implementation prior to patient testing. The Lab Medical Director is involved in the selection of all equipment and supplies, in accordance with College of American Pathology (CAP) regulations.

6. CAP requirements for POC testing include the following general items. Refer to the POCC and current CAP POC testing checklist for specific requirements.
   a. Proficiency testing is performed at intervals determined by the subscribed survey, in a timely manner, as similar to patient testing as possible, by personnel who perform patient tests, and rotated among all testing personnel.
   b. Testing Personnel must adhere to manufacturer instructions and written procedure.
   c. Results are reported in the medical record. Critical Results are handled appropriately.
   d. Reagents are stored properly. New lots and shipments are evaluated appropriately before use.
   e. Equipment maintenance is performed and documented to meet manufacturer requirements.
   f. Personnel must be trained and competency assessed **according to the current Point of Care Testing Competency Assessment Policy** ~~upon hire, 6-months after hire, 12-months after hire, and annually thereafter. Depending on test complexity, 2 to 6 elements of complexity must be evaluated.~~
   g. Quality Controls are performed and documented at required intervals.
7. Managers overseeing departments performing POC testing must understand and support the Federal/ State/ Agency/ and Organizational standards. The following statement must be read and agreed to, and signed on the form 'Request for Approval of New POC Test/Method' :
   a. I have read and understand the "POC New Test/Method Implementation" Policy and the CAP requirements for POC testing. I am qualified as a manager and will assume responsibility for testing, including all aspects of training and certification of personnel, quality controls, proficiency testing, competency checks, routine instrument maintenance, recording of all test results and all other required documentation. I also understand that all supplies are the responsibility of the performing department. The privilege to perform testing will be removed if requirements are not met and maintained.

C. **REFERENCES:**

1. College of American Pathology. CAP Accreditation Program. Point of Care Testing Checklist Tri-City Medical Center, CAP Number: 2317601. Version: ~~06.17.2010~~**04.21.2014**.
2. College of American Pathology. CAP Accreditation Program. Team Leader Assessment of Director and Quality Checklist Tri-City Medical Center, CAP Number: 2317601. Version: ~~06.17.2010~~**04.21.14**.

D. **ATTACHMENTS:**

1. Request for Approval of New Point of Care Test/Method
2. Refer to current forms required by CVAT.

Tri-City Medical Center
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DELETE – Duplicate to PCS Point of Care New Test Method Request and Implementation Policy

PATIENT CARE SERVICES ~~POLICY MANUAL~~

~~ISSUE DATE: 12/01~~ ~~SUBJECT: Point of Care Testing~~

~~REVISION DATE: 6/03, 8/05, 11/06, 7/08, 5/10, 3/12~~ ~~POLICY NUMBER: IV.K~~

Department Approval:	04/15
Clinical Policies & Procedures Committee Approval:	~~04/12~~05/15
Nursing Executive Council Approval	~~04/12~~05/15
Department of Pathology Approval:	03/16
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval:	07/12
Board of Directors Approval:	07/12

~~A. **POLICY:**~~

~~1. Point-of-Care Testing (POCT) refers to analytical patient-testing activities provided by Tri-City Medical Center (TCMC), but performed outside the physical facilities and by personnel other than those of the main clinical laboratory.~~
~~a. Synonyms for POCT include alternate-site testing, waived testing, near-patient testing, bedside testing, and decentralized testing.~~
~~b. POCT may be classified by the FDA and CLIA as waived or moderate complexity.~~
~~2. All POCT procedures are under the direction, authority, jurisdiction, and responsibility of the Laboratory Medical Director.~~
~~3. Responsibilities of the Medical Director to review quality control records on a periodic basis may be delegated to lab supervisory staff.~~
~~4. The use of POCT procedures and waived testing will be assessed by the Laboratory Medical Director to determine the extent to which the tests will be used for diagnosis, treatment or screening and whether follow-up confirmation is required.~~
~~5. See Attachment A for the POCT procedures approved by the Medical Director for testing under the TCMC Laboratory Clinical Laboratory Improvement Amendments (CLIA) license.~~
~~6. The Laboratory POCT Coordinator has the authority to oversee the training and quality of all POCT procedures.~~
~~7. Clinical POCT Personnel must meet all regulatory requirements of the Laboratory's accrediting agency (College of American Pathologists).~~
~~8. Clinical Managers, Assistant Nurse Managers/designee, and testing personnel shall be responsible for the day-to-day operational activities of POCT procedures including the performance and recording of quality control, any necessary corrective action, occasional mandatory proficiency testing assigned by the lab, and routine maintenance procedures.~~
~~9. POCT procedures may be performed by a clinical practice professional with appropriate orientation, training, and competency validation. Competency shall be evaluated upon hire, 6 months after hire, 12 months after hire and annually thereafter. Competency must be documented and records retained in the personnel file.~~
~~10. Review skills, major procedural changes, and problem prone areas annually through skills lab, as needed through department or hospital wide notices or trainings, or on an individual basis.~~
~~11. Each unit is responsible for maintaining the supplies/equipment necessary for POC testing.~~
~~12. Written policies and procedures for each POCT will be current and will include the following components:~~
~~a. Principle and clinical significance~~
~~b. Patient identification and preparation~~

c. Specimen type, collection, identification (ID), labeling, preservation
d. Test procedure, step by step
e. Reagent storage, preparation, and use, including not using after expiration
f. Calibration and calibration verification
g. Quality control and corrective action
h. Reference range
i. Critical values
j. Need for confirmatory testing or follow-up
k. How to report and document results, including not reporting unless Quality Control (QC) is acceptable and documented
l. Limitations, interfering substances
m. Instrument maintenance and calibration
n. What to do if the system becomes inoperable
o. Equipment performance evaluation
p. Applicable literature references

B. **CROSS REFERENCES: [Find procedures on the TCMC intranet> Policies and Procedures>Patient Care Services or Point of Care]**

1. Patient Care Services Procedures:
   a. ACT Testing using Medtronics ACT Plus
   b. Hemoglobin using the HemoCue HB 201 Analyzer
   c. Measuring Occult Blood in Stool and Gastric Contents
   d. Nitrazine Test on Vaginal Fluid
   e. Urine Chemistry Using a Dipstick, Measuring
   f. Urine Dipstick Analysis using Bayer Clinitek Status
   g. Whole Blood Glucose Testing Using the Sure Step Flexx Meter
   h. Siemens Rapidpoint 405
   i. Quality control Procedures for POC Waived Testing
2. Point of Care Procedures
   a. Ferning Test Examination of Vaginal Fluid
   b. HMS Plus Hemostasis Management System: Activated Clotting Time, Heparin Assay, Heparin Dose Response
   c. Whole Blood PT/INR using the Roche CoaguChek XS Plus Meter
   d. Urine Pregnancy/HCG test: Beckman Coulter Icon 25

Attachment A

POC Test:	FDA / CLIA Complexity:	Test used for Screening/Diagnosis*/ Treament	Lab Confirmation/Follow up Required?	Procedure:
Activated Clotting Time, Heparin Dose Response, Heparin Assay	Moderate	T	No.	ACT Testing using Medtronics ACT Plus HMS Plus Hemostasis Management Stystem: Activated Clotting Time, Heparin Assay, Heparin Dose Response
Blood Gas	Moderate	T	No.	Siemens Rapidpoint 405
Ferning	Moderate	S D T	No.	Ferning Test Examination of Vaginal Fluid
Glucose, whole blood	Waived	T	Yes. For critical results	Whole Blood Glucose Testing using the SureStep Flexx Meter
HCG, urine	Waived	SDT	No.	Urine HCG Analysis using the Siemens Clinitek Status
Hemoglobin	Waived	T	Yes. For critical results	Hemoglobin using the HemoCue HB 201 Analyzer
INR, whole blood	Waived	T	Yes. For high results	Whole Blood PT/INR using the Roche CoaguChek XS Plus Meter
Nitrazine	Waived	S D T	No.	Nitrazine Test on Vaginal Fluid
Occult Blood; Gastric, Fecal	Waived	S	No	Measuring Occult Blood in Stool and Gastric Contents
Rupture of Membranes, Amnisure	Moderate	D T	No.	Placental Alpha-1Microglobulin (PAMG1) – Amnisure test for Rupture of Fetal Membranes (ROM)
Urine Dipstick	Waived	S D T	No.	Urine Chemistry using a Dipstick, Measuring Urine Dipstick Analysis using Siemens Clinitek Status

* Diagnosis in conjunction with other clinical and laboratory findings.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**3/02**	**SUBJECT:**	**Staffing Requirement, Development of**
REVISION DATE:	**6/03, 12/03, 6/05, 7/06, 8/08, 03/11, 3/12**	**POLICY NUMBER:**	**VIII.B**
Clinical Policies & Procedures Committee Approval:		**~~04/12~~03/16**	
Nursing Executive Committee Approval:		**~~04/12~~03/16**	
Professional Affairs Committee Approval:		**07/12**	
Board of Directors Approval:		**07/12**	

A. **POLICY:**

1. Staffing Grid requirements shall be developed for each nursing unit ~~by the Directors and Clinical/Operations Managers~~ and approved by the Chief Nurse Executive annually during the budgetary process.
2. Budgeted staffing requirements shall be based on hours of nursing care to be delivered per patient day, patient delivery system, patient care requirements, minimum staffing requirements, average acuity, ratios, and projected average daily census.
3. Budgeted staffing requirements shall be reviewed at least once per year by the Directors and Clinical Operations Managers at the time of the budget process and revised if indicated by the staffing plan evaluation process.
4. Once staffing requirements are determined, master staffing plans are developed **with Finance** ~~by the Staffing Resource Office~~ in collaboration with management and approved by the Chief Nurse Executive.
5. Master staffing plans shall include the following elements:
   a. Department
   b. Staffing Summary required by census level or volume
   c. Projected skill mix requirements
6. Productive hours worked per patient day shall include: Assistant Nurse Managers, RNs, ACTs, Techs, Unit Secretaries, Clinical/Operations Managers, Clinical Educators, and Directors. Non-productive hours worked per calendar day shall include: orientation, education time, jury duty, Paid Time Off (PTO), and bereavement and are tracked in the budgets.
7. Current Staffing Grids are ~~published~~ **available on the intranet.** ~~in the Staffing Reference Manual available in the Staffing Resource Center.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT:** Sterile ~~Aseptic~~ Technique

REVISION DATE(S):

Department Approval Date(s):	06/15
Clinical Policies and Procedures Approval Date(s):	09/15
Nurse Executive Committee Approval Date(s):	09/15
Operating Room Committee Approval Date(s):	01/16
Infection Control Committee Approval Date(s):	03/16
Pharmacy and Therapeutics Approval Date(s):	03/16
Medical Executive Committee Approval Date(s):	
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To provide guidelines for establishing and maintaining a sterile field.

B. DEFINITIONS:
1. **Sterile: The absence of all living microorganisms. Synonym: aseptic.**
2. **Sterile field: The area surrounding the site of the incision or perforation into tissue, or the site of introduction of an instrument into a body orifice that has been prepared for an invasive procedure. The area includes all working areas, furniture, and equipment covered with sterile drapes and drape accessories, and all personnel in sterile attire.**
3. **Sterile technique: The use of specific actions and activities to prevent contamination and maintain sterility of identified areas during operative or other invasive procedures.**

~~B.~~**C. STERILE FIELD:**
1. A sterile field shall be constantly monitored and maintained.
   a. Sterile fields shall be prepared as close as possible to the time of use.
   b. The sterile field should be prepared as ~~close~~ **near** as possible to the location where it will be used.
   c. Sterile fields may be covered with a sterile drape if there is an unanticipated delay, or during periods of increased activity.
      i. When sterile fields are covered, they shall be covered in a manner that allows the cover to be removed without bringing the part of the cover that falls below the sterile field above the sterile field.
   d. Unguarded sterile fields shall be considered contaminated.
   e. Every team member shall observe for events that may contaminate the sterile field and initiate corrective action.
   f. Conversation shall be minimal in the ~~operating room~~ **presence of a sterile field**.
   g. Non-perforating devices shall be used to secure equipment to the sterile field.
   h. Non-sterile equipment brought into or over the sterile field shall be draped with sterile material.
   ~~i. Isolation technique should be used during bowel surgery and during procedures involving resection of metastatic tumors.~~
2. Sterile drapes shall be used to establish a sterile field.
   a. Surgical drapes shall be selected according to Association of ~~p~~**P**eri~~O~~**o**perative Registered Nurses (AORN) recommended practices for protective barrier materials.

b. Sterile drapes shall be placed on the patient and on all furniture and equipment to be included in the sterile field.
c. Sterile drapes shall be handled as little as possible.
d. During draping, the draping material shall be compact, held higher than the ~~Operating Room (OR) bed~~**surface to be draped** and draped from the operative**/procedural** site to the periphery.
e. During draping, sterile gloves shall be protected by cuffing the draping material back over the hand.
f. Once the sterile drape is placed in position, it shall not be moved.

3. Items used within the sterile field shall be sterile.
   a. Packaging materials shall meet AORN recommended practices for selection and use of packaging systems.
   b. Methods of sterilization, storage and handling of sterile items shall meet AORN recommended practices for disinfection, storage and handling.
   c. All items presented to the sterile field shall be checked for expiration date, correct size/style, proper packaging, processing, moisture, seal integrity, package integrity, and appearance of sterilization indicator.
4. All items introduced onto the sterile field shall be opened, dispensed and transferred by methods that maintain sterility and integrity.
   a. Vendors/Industry Representatives are not allowed to ~~pass~~ **open** sterile implants**, instruments** or supplies onto the sterile field.
   b. When opening wrapped supplies, unscrubbed persons shall open the wrapper flap farthest away from them first, then the side flaps, and the nearest flap last.
   c. Wrapper edges shall be secured when supplies are presented to the sterile field.
   d. Sterile items shall be presented to the scrubbed person or placed securely on the sterile field.
   e. Sharp or heavy objects shall be presented to the scrubbed person or opened on a separate surface, to avoid making a hole in the sterile barrier.
   f. If organic material (eg blood, hair, tissue, bone) or other debris is found on an instrument or item in a sterile set, the entire set is considered contaminated and personnel should take corrective actions immediately, including, at a minimum, removing the entire set and any other items that may have come into contact with the contaminated item from the sterile field and changing gloves of any team members for may have touched the contaminated items.
   g. When dispensing solutions to the sterile field, the entire bottle contents shall be poured into the receptacle and/or the remainder discarded.
      i. **Solutions and medications shall be labeled on the sterile field per Patient Care Services Procedure: Labeling Medication/Solutions On and Off a Sterile Field.**
      ii. Solution receptacles shall be placed near the edge of the table, or held by the scrubbed person.
      iii. Solutions shall be poured slowly to avoid splashing.
      iv. Sterile transfer devices (i.e., sterile vial spike) shall be used when transferring medications or solutions to the sterile field.
      v. Stoppers shall not be removed from vials for the purpose of pouring medications unless specifically designed for removing and pouring by the manufacturer.
      vi. The edge of the container should be considered contaminated after the contents have been poured.
5. All persons moving within or around a sterile field shall do so in a manner to maintain the integrity of the sterile field.
   a. Scrubbed persons shall remain close to the sterile field and shall not leave the room.
   b. Scrubbed persons shall keep arms and hands at or above the level of the sterile field.
   c. Scrubbed persons shall avoid changing levels and shall be seated only when the entire surgical procedure will be performed at this level.

d. Scrubbed persons shall change positions by moving face-to-face or back-to-back, maintaining a safe distance between each other.
e. Scrubbed persons shall always face the sterile field.
f. Unscrubbed persons shall face sterile areas, maintaining an awareness of distance so as to avoid contacts with sterile areas.

~~C.~~D. SURGERY/INVASIVE PROCEDURE AREAS

1. All members of the surgical team shall demonstrate competence in understanding the basic principles and practices of aseptic technique.
2. All personnel entering the Operating Room (OR) or invasive procedure room for any reason shall wear clean scrub attire and head cover according to Patient Care Services Policy Surgical Attire.
3. Personnel shall perform hand hygiene before entering the OR or invasive procedure room where sterile supplies have been opened.
4. Personnel shall wear a clean surgical mask that covers the mouth and nose and is secured in a manner to prevent venting when open sterile supplies are present and when preparing, performing, or assisting with surgery or invasive procedures.
5. Scrubbed persons shall wear sterile gowns and gloves.
   a. Materials for gowns shall be selected according to recommended practices for protective barrier materials.
   b. Surgical hand scrubs/surgical hand asepsis shall be performed before donning sterile gown and gloves.
   c. The scrubbed person shall don sterile gown and sterile gloves from a sterile field away from the main instrument table.
   d. Sterile gowns shall be considered:
      i. Sterile from the chest to the level of the sterile field on the front of the gown
      ii. Sterile sleeves from two inches above the elbow to the cuff, circumferentially
      iii. Unsterile at the neckline, shoulders, underarm, back and sleeve cuff
   e. The scrubbed person shall inspect gloves for integrity after donning them.
      i. The preferred method for changing contaminated gloves is for one member of the sterile team to glove the other.
      ii. The alternative method for changing contaminated gloves is by the open-glove method.
   f. Surgical gloves worn during invasive surgical procedures should be changed:
      i. After each patient procedure
      ii. When suspected or actual contamination occurs
      iii. After touching surgical helmet system hood or visor
      iv. After adjusting optic eyepieces on the operative microscope
      v. Immediately after direct contact with methyl methacrylate
      vi. When gloves begin to swell, expand, and become loose on the hands as a result of the material's absorption of fluids and fats
      vii. When a visible defect or perforation is noted or when a suspected or actual perforation from a needle, suture, bone, or other object occurs
      viii. Every 90 to 150 minutes
6. **Isolation technique should be used during bowel surgery and during procedures involving resection of metastatic tumors.**

E. RELATED DOCUMENTS:

1. **Patient Care Services Procedure: Labeling Medication/Solutions On and Off a Sterile Field**
2. **Patient Care Services Policy: Surgical Attire**

~~D.~~F. REFERENCES:

1. AORN Guidelines for Perioperative Practice, 2015 Edition.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Wound Classification During Surgical Intervention

REVISION DATE(S):

Department Approval Date(s):	**06/15**
Clinical Policies and Procedures Approval Date(s):	**07/15**
Nurse Executive Committee Approval Date(s):	**07/15**
Operating Room Committee Approval Date(s):	**01/16**
Infection Control Committee Approval Date(s):	**03/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**03/16**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To classify all wounds according to the likelihood and degree of wound contamination at the time of surgical intervention.

B. **SUPPORTIVE DATA:**

1. The American College of Surgeons' definitions of Surgical Wound Infections (SWI) should be used for routine surveillance because of their current widespread acceptance and reproducibility.
2. A wound can be considered infected if purulent material drains from it, even if a culture is negative or not taken.
3. A positive culture does not necessarily indicate infection since many wounds, infected or not, are colonized by bacteria.
4. Infected wounds may not yield pathogens by culture because the pathogens are fastidious, culture techniques are inadequate, or the patient has been treated.
5. **Wound classification shall be addressed at the end of the case as it may have changed since the start of the case.**

C. **CLASSIFICATIONS:**

1. Clean Wound, Class I
   a. Uninfected operative wounds in which no inflammation is encountered, and neither respiratory, alimentary, genitourinary tracts, nor oropharyngeal cavity is entered.
   b. Cases are elective, primarily closed, and if necessary, drained with closed drainage.
   c. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.
2. Clean-Contaminated Wound, Class II
   a. Operative wounds in which the respiratory, alimentary, or genitourinary tract is entered under controlled conditions and without unusual contamination.
   b. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in sterile technique is encountered.
   c. All clean returns to surgery.
   d. Any tube that involves a skin incision.
3. Contaminated Wounds, Class III
   a. Include open, fresh, accidental wounds, a chest tube, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which

acute, non-purulent inflammation is encountered~~.~~ **Including necrotic tissue without evidence of purulent drainage (ie: dry gangrene).**

4. Dirty And Infected Wounds, Class Iv
   a. These include old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.

~~5. Unknown~~
~~a. This classification will be used when the status of a wound cannot be determined utilizing the above criteria.~~

~~6.~~**5.** Not Applicable
   a. When there is no wound, i.e. for such procedures as:
      i. Closed reductions (where there is no break in the skin)
      ii. Examination Under Anesthesia (EUA)
      iii. Esophageal Dilatation

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 9/07

SUBJECT: BUSINESS VISITOR VISITATION REQUIREMENTS

REVISION DATE: 01/08; 07/11

POLICY NUMBER: 8610-203

Department Approval Date(s)	**11/15**
Administrative Policies & Procedures Committee Approval:	**~~04/12~~01/16**
~~Executive Council Approval:~~	**~~06/11~~**
Professional Affairs Committee Approval:	**05/12**
Board of Directors Approval:	**05/12**

A. **PURPOSE:**

1. To outline expectations for business visitors at Tri-City Health Care District (TCHD)
2. To ensure all business visitors are pre-authorized to visit with appropriate identification; understand all practices as they relate to contracts, products, loaner instrumentation, new/borrowed equipment, dress code, conduct while in the hospital, and confidentiality in the hospital setting.

B. **DEFINITIONS:**

1. Business visitors: Any non-credentialed supplier, vendor, community liaison or clinical research personnel
2. Suppliers: A person who provides sales or sales support of products or services to TCHD. Examples of suppliers include but are not limited to representatives of equipment, supply, or medical materials.
3. Vendors: A person who provides contracted services to departments or patients at TCHD. Examples of vendors include but are not limited to dialysis services, ~~registry and supplemental staff,~~ or equipment repair or installation technicians.
4. Community liaisons: Community Liaisons may include, but not be limited to providers of Home Health, Hospice, **Chaplains,** and Skilled Nursing & Acute Rehabilitation Services who may present to ~~TCMC~~**TCHD** upon invitation from patient or family or Case Manager/Social Worker staff for purposes of assessing patient for appropriate admission to their service.

C. **POLICY:**

1. TCHD's selection of contractors and business visitors shall be made on the basis of objective criteria including:
   a. **Group Purchasing Organization**~~National contract~~ affiliation
   b. Quality
   c. Technical excellence
   d. Price
   e. Delivery
   f. Service
2. TCHD's purchasing decisions shall be made based on the business visitor's ability to meet our needs.
3. ~~**Prior to entering any patient care area, all Registry staff must meet all established requirements in ShiftWise as determined by TCHD Leadership.**~~
4. **~~3.~~** Prior to entering any patient care area, all business visitors must meet all established requirements in Reptrax as determined by ~~TCMC~~**TCHD** Leadership.
5. **~~4.~~** Business visitor visitation within the hospital shall be by appointment only.
6. **~~5.~~** All business visitors must sign in at the Reptrax kiosk in the main lobby.

a. Business visitors visiting the Surgical Services division are required to ~~register~~ **check in** at the front desk of the Main Operating Room (OR) or the Sterile Processing Department (SPD), and must always be identifiable by badge.

b. Business visitors denied access in Reptrax must report immediately to ~~Purchasing~~**Supply Chain Management~~.~~ to receive a temporary badge** before visiting any areas.

~~7.~~**6.** Business visitors must wear the Reptrax printed badge **or other appropriate TCHD vendor identification** and check in with the charge nurse prior to entering any clinical area.

~~8.~~**7.** Business visitors whose product competes with products covered by a sole or multiple source contracts **already in use at TCHD** shall not be seen unless the hospital is in the process of re-negotiating for these items and has requested representation.

~~9.~~**8.** Business visitors who are awarded national contracts with the hospital's affiliated Group Purchasing Organization may only discuss those products covered under the agreement.

a. These discussions shall only take place after the Supply Chain Management department has completed the initial review and the business visitor has received authorization to proceed.

~~10.~~**9.** No products shall be left in hospital departments without approval from Clinical Values Analysis Team. ~~(Refer to Administrative Policy, *Product Standardization Evaluation*)~~

~~11.~~**10.** TCHD employees and business visitors are expected to employ the highest ethical standards in business practices regarding source selection, negotiation, determination of contract awards, and administration of all purchasing activities to foster public confidence in the integrity of the procurement process.

a. Neither party shall disclose third party confidential information including contract pricing, information to any outside party, or use of confidential information for actual or anticipated personal gain without express consent by the other party **or as required by law**.

11. Any business visitor not complying with these rules shall be issued a ~~verbal~~ warning **in Reptrax**. If a second offense occurs, TCHD reserves the right to ban that particular business visitor representative from doing business with TCHD~~. for a period of five years.~~

12. **TCHD employees are prohibited from being vendors or suppliers of any product or service at TCHD.**

D. **PRODUCT REMOVAL AND REPAIRS:**

1. No TCHD owned equipment or instrumentation shall be removed from the Hospital unless accompanied by authorized paperwork.

~~1.~~**2. No instruments or trays (hospital or vendor owned), will be removed from SPD without SPD staff's knowledge and consent.**

E. **PRODUCTS ANF REPLACEMENT PRODUCTS:**

1. All products being brought into the hospital for review/evaluation must be 501**K**/FDA approved and at no cost to TCHD. All products for review, replacement, and/or evaluation must be submitted through the Supply Chain Management Department or Supply Chain Director in advance.

2. No in-service or product demonstration shall occur without the prior knowledge of the Unit Manager **and**~~or~~ Supply Chain Management.

a. Under no circumstances are products used on patients without in-service/education for Medical Staff and Health Care providers prior to use of the product/equipment.

F. **DRESS CODE:**

1. All business visitors conducting business must dress according to unit policy.

i. If the business visitor representative is required to wear scrubs~~:~~, ~~H~~his/her temporary identification badge shall be clearly visible on the front left pocket of the scrub shirt.

ii. Scrub tops shall be tucked in at all times.

iii. All ~~TCMC~~**TCHD** owned surgical scrubs must be returned before leaving the hospital.

2. Hair covers must be worn properly. **All head and facial hair, including sideburns and necklines shall be covered** (all hair enclosed), and masks must be worn whenever entering an area where sterile supplies are open.
3. No open toed shoes are allowed.

G. **PRICING:**

1. All business visitors must submit pricing to Supply Chain Management Director and receive approval prior to bringing the product to ~~TCMC~~**TCHD** regardless of who request**ed** the product to be brought in.
2. Product brought in without **TCHD Supply Chain Director** previously agree**ing**~~d~~ upon pricing ~~to TCMC~~**TCHD** ~~Supply Chain Director~~ will be considered a "donation" to ~~TCMC~~**TCHD** and will not be paid for.
3. All business visitors and vendors with an on-going relationship with TC**HD**~~MC~~ must have a **current and approved** pricing **agreement on**~~contraction~~ file.
   a. List pricing is n~~o~~**ever** accept**ed**~~able.~~

H. **LOANER INSTRUMENTS:**

1. All loaner trays must be delivered to SPD no less than 24 hours prior to the procedure start time to allow for proper inventory and sterilization.
   a. All loaner trays shall include up-to-date count sheets listing all contents.
   b. All loaner trays must be labeled accurately with the name of the tray, physician intending to use the tray, and date and time of procedure.
   c. Trays must be checked in and picked up at SPD.
      i. When picking up loaner instrumentation, business visitors shall visually inspect all items and request additional cleaning if items do not meet cleanliness standards.
      ii. Missing instruments must be identified at the time of pick-up and verified with a sterile processing technician.
      iii. No replacements shall be made for instrument loss identified after the loaner instruments have left SPD.
      iv. Loaner instruments and trays must be picked up within 24 hours after the use.
      v. ~~TCMC~~**TCHD** is not ~~longer~~ responsible for any loaner trays and instruments left over ~~that~~ 24 hour**s** ~~period.~~

I. **CONDUCT IN SURGICAL SERVICES AREAS:**

1. A distance of three feet shall be maintained from all sterile fields. Laser pointers may be used to identify items on the sterile field
2. Business visitors NEVER scrub in or assist in the surgical procedure.
3. Business visitors are not to open any sterile supplies onto a sterile field.
4. Business visitors shall not operate autoclaves or assist with any patient care.
5. All pagers and mobile phones must be placed on vibrate while in the operating suites.
6. At no time shall a business visitor operate a surgical suite phone, **copier or fax machine**.
7. Business visitor representatives may not operate any patient care equipment except under the following circumstances:
   a. Contracted service with TCHD (i.e., laser, lithotripter)
   b. Demonstrated evidence of specialized training (i.e., pacemaker, AICD) shall be allowed to adjust devices to surgeon specifications.
8. Business visitor representatives may not market products in the **OR department to include physician lounges and surgical suites**~~surgical suites~~. Only pre-approved products may be demonstrated. All physician sales calls must be arranged through the physician's office.
9. ~~TCMC~~**TCHD** will not pay for any product opened by a business visitor or vendor during surgical procedures. Only ~~TCMC~~**TCHD** staff will open product.
10. Business visitors and vendors must remain present during surgical procedures to support use of their product.
11. Once the patient has entered the OR, the business visitor representative is not allowed in the OR until surgical drapes are applied and the procedure is ready to commence. The business visitor is

allowed in the OR ONLY for the portion of the procedures related to use of the business visitor's product. Business visitor representatives shall ~~limit to a minimum~~**minimize** the number of times they enter/exit an operating suite once a procedure has started. ~~to a minimum.~~

a. Only one business visitor shall be permitted in the OR, Catheterization Lab, and/or Interventional Radiology Room during a procedure unless authorized by the department **D**~~d~~irector or designee.

b. Business visitor names/information is recorded on the intraoperative record.

J. **TRIAL EQUIPMENT:**

1. All non-TCHD owned equipment for trial must be pre-approved by Supply Chain Management and Clinical Engineering prior to the day of use.
2. All equipment must be safety checked by the Clinical Engineering department prior to being brought into clinical areas.
3. Any consumable supplies required for use during the trial of equipment must be FDA approved and at "no cost" to TCHD.
4. The business visitor/vendor must obtain a "no cost" purchase order from Purchasing before the product can be left for trial **and complete a vendor trial agreement form**.

K. **CONFIDENTIALITY:**

1. All business visitors with access to patient health information must read and follow all **TCHD policies**~~TC health care districts and~~**,** sign a confidentiality agreement and submit to TC**HD**~~MC~~ **contracting** ~~legal~~ for file.
2. Access to specific health data and information shall be limited to the medical record number.
3. Discussion of patient medical information must be limited to work or patient care related discussions and must take place in a private area.
   a. Discussions in public areas (i.e., elevators, restrooms, lounges, and cafeteria) are strictly prohibited.
4. Business visitor representatives shall only enter an operating suite after the patient is under the effect of anesthesia and draped for surgery.
5. Business visitor representatives shall not be granted access to the surgical schedule.
6. Photographs are prohibited.
7. **PHI will only be possessed and transported by TCHD staff only.**
~~6.~~**8. Patients should be informed and provide consent of the possibility of business visitors being present during their procedure to support the equipment and/or products used during the case.**

L. **COURTESIES:**

1. TCHD employees may not accept gifts, entertainment, or anything else of value from current or potential business visitors of goods and services or from consultants to the organization except for items that are clearly promotional in nature, mass produced, or nominal in value.
   a. Perishable or consumable gifts may be accepted from business visitors currently providing supplies or services.
2. Cash or cash equivalents such as gift c**ards**~~ertificates~~ shall not be given to staff.
   a. Business meals and/or nominally valued sporting tickets are permissible by business visitors currently providing supplies or services. (Refer to Administrative Policy, ~~*Acceptance of Gifts or Gratuities*~~ ***Conflict of Interest Acceptance of Gifts***)
3. Items presented to TCHD employees/staff shall not be intended to evoke any form of reciprocation.

M. **REFERENCES**:

1. **Administrative Policy #483 Conflict of Interest Acceptance of Gifts**

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

SUBJECT: Breached Medical Gas Lines

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. Any medical gas lines that are repaired, added or replaced shall be tested for purity and contamination before being allowed for patient usage.
2. This policy includes oxygen, nitrous oxide and medical air.
3. All documentation of testing will be retained in the Engineering Department ~~and a copy to Administration. A copy will also be forwarded to the department that the repair, replacement or addition was made in.~~
4. All testing will be **scheduled by Projects Department and** performed by a Certified Medical Gas Testing Company.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Outside Contractors - Hazard Communications Program~~ ~~Policy Number: 1009 Page 1 of 1~~
~~Department: Engineering Department~~	~~EFFECTIVE: 9/94~~ ~~REVISED: 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: ~~Outside~~ Contractors- Hazard Communications Program

ISSUE DATE: 9/94
REVIEW DATE(S):
REVISION DATE(S): 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **POLICY:**

1. It is the responsibility of the contracting engineer to provide on-site contractors with the following information:
   a. Hazardous chemicals to which they may be exposed while on the job site.
   b. Precautions the contractor and his/her employees may take to lessen the possibility of exposure by usage of appropriate protective measures.
2. It is the responsibility of the contracting engineer to contact each contractor before work is started to gather and disseminate information concerning hazards which the contractor will bring into the workplace.
3. Compliance with the OSHA Hazard Communications Standard is certified by:

   _____
   Name, Title

   _____
   Date

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Outside Contractors Working in the Facility~~ ~~Policy Number: 1008 Page 1 of 2~~
~~Department: Engineering~~	~~EFFECTIVE: 9/94~~ ~~REVISED: 1/97; 5/00; 5/03; 10/05; 6/09, 8/11, 6/12~~

SUBJECT: ~~Outside~~ Contractors Working in the Facility

ISSUE DATE: 9/94
REVIEW DATE(S):
REVISION DATE(S): 1/97, 5/00, 5/03, 10/05, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **POLICY:**

1. All ~~outside~~ contractors will coordinate all work within Tri-City ~~Medical Center~~**Healthcare District Facilities** with the Engineering before beginning work.

B. **PROCEDURE:**

1. Before beginning work, all ~~outside~~ contractors shall check in at the Engineering office to obtain ID badges. The outside contractor will supply the following information: ~~-~~scope of work, authorization, duration and any pertinent information that is required.
2. All contractors who need to be in the hospital for more than fours hours are required to view the ~~safety tapes~~**infection control video** and take **hospital orientation.** ~~the test.~~
3. All contractors shall follow the hospital infection control policy.
4. All contractors shall work as professionally as possible so as not to aggravate patients, staff and visitors.
5. All contractors shall follow the hospital smoking policy.
6. If special parking is required, permission shall be granted and coordinated through Engineering.
7. All contractors are to maintain their work area as clean as possible while working and clean up thoroughly when finished.
8. If any utilities or critical systems are to be interrupted, notification of Engineering personnel is mandatory. Engineering personnel will in turn assist.
9. All contractors are asked to use competent subcontractors on hospital projects. Poor work practice will not be tolerated.
10. All contractors are expected to use courtesy. Loud and abusive language will not be tolerated.
11. Contractors must provide assurance not to block corridors and fire exits.
12. Any life safety code violations incurred during construction or renovation will result in close

coordination with Engineering's interim life safety measures. ~~These measures are required by JCAHO.~~

13. All contractors working above the ceiling are required to replace all disturbed ceiling tile.
14. Any work involving penetration of firewalls needs to obtain Fire Wall Penetration Permit from Engineering Department. All penetrations in fire/smoke partitions are to be sealed with fire caulk and inspected by Engineering staff before final payment is made.
~~14.~~**15. Any hot work requires a Hot Work Permit that can be obtained at Engineering.**
~~15.~~**16.** Upon completion of daily activities contractors are asked to check out and report progress to Engineering.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Daily Journal~~ ~~Policy Number: 1010 Page 1 of 1~~
~~Department: Engineering~~	~~EFFECTIVE: 11/87~~ ~~REVISED: 10/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Daily Journal

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 10/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. The purpose of this instruction is to develop and execute a standard procedure to record and maintain a permanent record of significant occurrences within Engineering **Department**. The journal will be kept in the **P**~~p~~lant ~~o~~**O**perations division of Engineering.

B. **PROCEDURE:**

1. The journal contains a log sheet for each day of the year.
2. The following procedures and information will be included in the journal:
   - ~~a. Record of daily routine inspection and notes from the Engineering Log.~~
   - ~~b.~~**a.** **All equipment**~~Major machinery inoperative due to~~ failure, estimate of time for completion of repairs and when the ~~major~~ piece of **equipment**~~machinery~~ has been repaired ~~or the maintenance completed~~.
   - ~~c.~~**b.** Major ~~machinery~~ **equipment** in operation or shifted.
   - ~~d. Entry of weekly tests and inspections conducted should correspond with the daily weekly test inspections schedule.~~
   - ~~e.~~**c.** ~~Entry of the status of~~ **T**~~t~~est**s and**~~or~~ inspection**s.**~~, satisfactory or unsatisfactory (State reason for unsatisfactory test, etc.).~~
   - ~~f.~~**d.** Report of injury and cause to personnel in the Engineering.
   - ~~3.~~**e.** Safety hazards ~~shall be entered in the journal~~ and the appropriate corrective action taken.
   - ~~4.~~**f.** ~~Record in journal major~~ Service calls or inspections by contract insurance **company and**~~or other~~ regulatory agencies that are visiting the hospital.
3. ~~5.~~**3.** Journal will start with the beginning of each shift.
4. ~~6.~~**4.** All department personnel will coordinate with "duty engineer" the entries of significance that

should be recorded in the journal at the end of the working shift.

~~7.~~**5.** Entries shall be made in ink - no erasures. If a change is to be made, draw a line through the item and put your initials beside it.

~~8.~~**6.** The journal will be reviewed by ~~Engineering Manager~~ **Facilities Manager or** ~~on a regular basis to insure all significant problems, safety hazards or recommendations have~~**his/her designee on a regular basis to insure all significant problems, safety hazards or recommendations have** been properly resolved.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Domestic Water Temperature~~ ~~Policy Number: 2005 Page 1 of 1~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Domestic **Hot** Water Temperature

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To define the acceptable range in temperature of domestic hot water through-out the facility.

B. **POLICY:**
1. The temperature of hot water ~~used by patients~~ (domestic hot water) in this facility shall be maintained between 105 and 120 degrees Fahrenheit.
2. Any taps delivering water at a temperature exceeding 125 degrees Fahrenheit will be prominently marked.

C. **PROCEDURE:**
1. The temperature of domestic hot water is tested ~~as part of the minor mechanical instruction during environmental maintenance checks. (See Environmental Maintenance Policy 2000).~~**on regular basis by the Plant Operators.**
2. ~~Culturing for L~~legionella **testing** is **scheduled by the Facilities Manager or his/her designee on as needed basis and performed**~~performed whenever it is suspected that the ventilation or water distribution system may be carrying such bacteria~~**by a qualified Contractor**.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Emergency Generator Test Loads~~ ~~Policy Number: 2001.1 Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/94~~ ~~REVISED: 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Emergency Generator Test Loads

ISSUE DATE: 11/94
REVIEW DATE(S):
REVISION DATE(S): 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. POLICY:

1. Required test loads for the emergency generators have been calculated by the following method as set forth by NFPA 110.
2. All transfer switches are identified as to which generator with they were associated.
3. Each transfer switch actual load was recorded on each phase for 72 hours while being supplied by SDG&E. Recordings were made in amps.
4. Recorded actual loads were then totaled for each phase per generator.
5. Required test load is 30% of name plate rating in amps.

#1 GENERATOR NAME PLATE DATA: 400KW 500KVA 1384A				
	PHASE			
ACTUAL LOAD:	A	B	C	Average
	685.5	672.3	600.6AMPS	652.8A
Required load = 30% of name plate amps = 415 amps				
#2 GENERATOR NAME PLATE DATA: 400KW 500KVA 1388A				
	PHASE			
ACTUAL LOAD:	A	B	C	Average
	331.1	300.0	504.2AMPS	378.4A
Required load = 30% of name plate amps = 417 amps				

	234.4	189.8	206.0AMPS	210A
Required load = 30% of name plate amps = 625 amps				
#4 GENERATOR NAME PLATE DATA: 1000KW 1250KVA 1503A				
	PHASE			
ACTUAL LOAD:	A	B	C	Average
	312.1	327.3	302.2AMPS	313.8A
Required load = 30% of name plate amps = 451 amps				
CENTRAL PLANT GENERATOR NAME PLATE DATA: 800KW 1000KVA 1203A				
	PHASE			
ACTUAL LOAD:	A	B	C	Average
	41.1	46.2	41.6AMPS	42.9A
Required load = 30% of name plate amps = 361 amps				

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: General Personnel Policies~~ ~~Policy Number: 1003 Page 1 of 4~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06,2/09,8/11, 6/12~~

SUBJECT: General Personnel Policies

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 2/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To define personnel policies relating to the Engineering Department:

B. **POLICY:**
1. Selection of Employees:
   a. All department employees are selected on the basis of their qualification to fulfill established specifications for the job. General criteria include experience, mental capacity, physical ability, and willingness to work in the specific environment.
   b. No person is discriminated against in employment, placement, or promotion because of race, religion, citizenship, national origin, marital status, liability for service in the Armed Forces, or age.
   c. **Per policies and procedures, the Director of Facilities will make** ~~Once~~ the decision ~~is made~~ **to hire an individual based on available budget and personnel needs and will submit for approval to Administration. Once approved Human Resources will present an offer to** ~~, the Department Director/Manager concerning salary range, personnel policies, and the responsibilities of the position informs~~ the candidate. In addition, a physical examination is conducted as part of the screening.
   d. Employees will be terminated for making false statements on the application or for concealing information on the medical history.
2. Probationary Period:
   a. All employees of this department are employed for a probationary period of 90 days. In this period, the employee has an opportunity to accustom him or herself to the job, and the supervisor has an opportunity to see how well the employee has fitted to the job. At anytime during this period, the **S**~~s~~upervisor may determine ~~that the~~ employee to be unsatisfactory for the job; this would necessitate termination before completion of the 90-day probationary period. At the end of the third month of the probationary period, the

Ssupervisor will review the employee's work performance and forward a written evaluation to the Director of the Department. This provides an opportunity for the employee to express his/hers views and to learn of ways in which the employee can improve their performance. After the probationary period, employees begin**s** to acquire seniority in the **D**~~d~~epartment from the date of their employment. After an employee has served his/hers probationary period, he/she will be entitled to all benefits of a regular full-time employee, such as sick leave, vacations, etc.

b. An employee may also be placed on probationary status if he/she has committed a violation of organizational rules or regulations for which he/she could be discharged.

3. Hours of Work:
   a. Employees will be expected to work evenings, nights, holidays, and weekends as needed.
   b. It is expected that employees work additional hours or days as required by absenteeism, etc., but only with the consent of the immediate supervisor.
   c. The determination of the daily and weekly work schedule is left to the different department **S**supervisors. It is expected that all employees will follow the schedule as set forth by their immediate **S**supervisor. If the employee has any questions concerning the schedule or a problem that the **S**supervisor cannot handle, feel free to contact the Director / Manager of the Department.
4. Starting Time:
   a. Your starting time means just that, starting time. It means that you are ready to work.
5. Overtime:
   a. All personnel are expected to work overtime, as needed, to provide necessary service.
   b. All overtime must have prior approval of your immediate **S**supervisor. On the PM Shift, the cost center **S**supervisor or duty **E**engineer on-call will approve.
6. Record of Warning:
   a. An employee may receive a warning for inefficiency, improper conduct or violation of organizational or departmental policies. Such a warning will be written in triplicate by the **S**supervisor, countersigned by the employee and placed in his/her personnel file. One copy will go to Human Resources, one in the employee's department file and one to the employee.
   b. Written warnings are issued to insure important correction of employee performance and attitude. A total of three warnings; verbal, counseling session and written warning may mean immediate dismissal. Warnings may be issued for any of the following:
      i. Incompetence
      ii. Inefficiency
      iii. Discourtesy
      iv. Disregard of established organization and department procedures
      v. Disregard of personal appearance, uniforms, dress, and hygiene
      vi. Frequent tardiness or absenteeism
      vii. Violation of organization or department safety rules.
7. Smoking:
   a. Hospital policy does not allow smoking ~~within the hospital~~**anywhere on campus**.
8. Department Head, Manager and Supervisor Responsibilities:
   a. Each department has a ~~Department Head / Manager~~**Supervisor** that is responsible for the work of that department. ~~In turn, within some departments, the work there is further subdivided, with a supervisor responsible to the department head/Manager for each such part of the work in the department~~. The **S**supervisor will see that the employee is acquainted with their fellow employees, with the duties of their job and with other matters connected with the job. He/she is available to answer your questions, to offer guidance and direction, to discuss opportunities for advancement, and to inform the employee about their progress in their work.
9. Performance Evaluation:
   a. Supervisor will be required to evaluate the employees work performance at the end of ~~the employees first year of work and on each anniversary of employment thereafter~~**each year**. However, the **S**supervisor may decide to evaluate the employee at anytime. These evaluations were designed to help the employee understand what is expected of them,

and how the employee can improve their job performance. Each evaluation will be explained to the employee, and the employee will be asked to sign the evaluation form.

10. Rest Breaks:
    a. Employees are allowed two 15-minute work breaks within each working period. The breaks are not to be taken other than in designated areas at the designated times.
    b. All personnel working an eight-hour shift are allowed a 30-minute meal break included in their work shift. All personnel working six hours or more, but less than eight hours, must take a 30-minute meal break.
11. Reporting an Absence:
    a. Daily attendance is vitally important in order for the department to provide complete and efficient service. Excessive absenteeism, for any reason, places a severe hardship on coworkers and **S**supervisor whenever a replacement must be called in to perform duties.
    b. If it is necessary that the employee be absent from their duties, call the **Supervisor** ~~Plant Operations area~~ two hours prior to your shift.~~ and notify your supervisor of absence~~. The employee must continue to report their absence each day if their return date is undetermined. ~~Any Engineering Department employee taking a call for reporting an absence will fill out the Unscheduled Absence/Tardiness Form completely, including a specific reason, length of absence, and their signature. Monday through Friday, 0750 to 1600, notify your Department (cost center) Supervisor, or if unavailable, the Engineering Manager. For all other hours, notify the duty engineer on-call. The duty engineer on-call is responsible for calling the telephone roster for additional coverage. If additional coverage cannot be met, then that individual will notify the Engineering Manager, or if unavailable, the Sr. Director of Support Services.~~
    c. Unreported absences may result in automatic termination.~~ of the employee's employment.~~
12. Tardiness:
    a. If for some reason the employee will be late for work, they should notify their supervisor that they will be late and what time they expect to arrive. Excessive tardiness could result in termination. Tardiness is defined as anytime later than 7 minutes of the employees defined start time.
13. Personal Phone Calls:
    a. Personal phone calls are to be made on the employee's breaks.~~ and using the public pay phones. Excessive personal phone calls can result in disciplinary action.~~
14. Scheduled Time Off (Vacation, Holidays, Excused Time Off, etc.):
    a. Due to the necessity of providing coverage for patient care 24 hours/day, seven days/week, it is necessary to set guidelines for submission of Paid Time Off (PTO) requests. These are guidelines only and special circumstances will be handled on an individual basis as they arise~~. Pay in lieu of vacation is contrary to the basic principles for which vacations are given. Vacations will not be cumulative, and if not taken will be forfeited~~. Your preference for vacation time will be granted whenever possible, if it does not conflict with the functioning of the department or cause disruption of service. ~~Submit~~ PTO requests **must be submitted at least 2 weeks prior to the requested time off unless an emergency exists.**~~by the 15th of the month prior to your request. Requests after the 15th of the month may or may not be considered at the discretion of the scheduler. PTO requests will be accepted up to three months in advance from the day it is submitted. Requests submitted past the three-month date will be rejected~~. All PTO requests are contingent on the ability ~~of the scheduler~~ to arrange appropriate coverage.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Inspection Testing And Maintenance of Fire Alarm Detection And Automatic Extinguishing System~~ ~~Policy Number: 2000 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 5/14/91~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Inspection Testing and Maintenance of Fire Alarm Detection and Automatic Extinguishing System

ISSUE DATE: 5/91
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To describe the process by which the Fire Alarm ~~,~~ Detection and Automatic Extinguishing System will be inspected, tested and maintained.

B. **GENERAL INFORMATION:**
1. Computerized Maintenance Management System (CMMS) - A computerized information system **to be** used to facilitate the scheduling, maintenance and documentation of equipment testing and inspection.

C. **PROCEDURE:**
1. A qualified service company is contracted to inspect and test the Fire Alarm ~~,~~ Detection and Automatic Extinguishing Systems **to ensure compliance with Authorities Having Jurisdiction (AHJ)**~~on a quarterly basis~~. Inspections and tests are conducted in compliance with NFPA regulations.
2. Maintenance of **these** systems is performed by ~~-~~**Engineering**~~Plant~~ Engineers **and/**or qualified service company, as necessary, in compliance with NFPA regulations.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Maintenance And Inspection Electrical Distribution System And Emergency Generator~~ ~~Policy Number: 2001~~ ~~Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Maintenance and Inspection Electrical Distribution System and Emergency Generator

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To describe the process by which the electrical distribution system is maintained and inspected.

B. **GENERAL INFORMATION:**
1. Computerized Maintenance Management System (CMMS) - A computerized information system used to facilitate the scheduling, monitoring, and documentation of equipment and environmental maintenance.

C. **PROCEDURE:**
1. ~~A~~ **B**~~b~~uilding **E**engineer**s** check~~s~~ electrical receptacles in accordance with a scheduled work order produced ~~for each environmental unit~~ by the CMMS and indicating the established time frame and **maintenance** instruction~~s set for the maintenance of that environmental unit~~.
2. Work orders for other components of the electrical distribution system, are produced on a~~pre-determined and~~ pre-programmed scheduled by CMMS.
3. Each work order is assigned by the ~~Engineering Supervisor~~**Facilities Manager or his/her designee** to a qualified **E**engineer.
4. The **E**engineer performs preventive maintenance (and corrective maintenance if needed), inspects the system, and conducts testing: as specified in the CMMS instruction set printed on the work order.

5. The **Ee**engineer prepares and submits to the Engineering Department a work order for any repair work which will take more than thirty minutes to complete or for which he does not have tools or parts readily available.
6. The **Ee**engineer completes the Preventative Maintenance Work Order, indicating specific preventive or corrective actions he has taken and noting the date the scheduled maintenance was complete. Th**is information to be entered** ~~e work order is submitted to the Engineering Administrative Coordinator for entry~~ in the CMMS.
7. The Plant Operations **Ee**engineer inspects the ~~generator set (and batteries) monthly~~**generators monthly** and tests **them**~~it~~ under actual load and operating temperature conditions for at least 30 minutes. The tests are documented and the Supervisor reviews these test~~s~~ results ~~weekly~~ to be certain the generator**s**~~r set~~ **are**~~is~~ performing in a reliable manner.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Maintenance And Inspection Medical/Surgical Air And Vacuum System~~ ~~Policy Number: 2004~~ ~~Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Maintenance and Inspection Medical/Surgical Air and Vacuum System

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE**:
1. To describe the process by which the medical/surgical and vacuum system is maintained and inspected.

B. **GENERAL INFORMATION**:
1. Computerized Maintenance Management System (CMMS): A computerized information system used to facilitate the scheduling monitoring and documentation of equipment and environmental maintenance.

C. **PROCEDURE**:
1. A work order for preventive maintenance, and /or inspection testing of each component of the medical/surgical air and vacuum system is produced on a ~~pre-determined and~~ pre-programmed schedule by the CMMS.
2. The work is assigned by the **Facilities Manager or his/her designee** ~~Engineering Supervisor~~to an **E**engineer to complete.
3. The **E**engineer performs preventive maintenance (and corrective maintenance if needed), inspects the system and conducts testing as specified in the CMMS instruction set printed on the work order.
4. The **E**engineer prepares and submits to the Engineering Department a work order for any repair work which will take more than thirty minutes to complete or for which he does not have tools or parts readily available.
5. The **E**engineer completes the Preventative Maintenance Work Order, indicating specific

preventive or corrective actions he has taken and noting the date the scheduled maintenance was completed. ~~The work order is submitted to the Engineering Department Office for entry in the~~**This information is entered into** CMMS.

6. Respiratory Therapy Department personnel check**s** system flow rates before each procedure and report**s** malfunctions to the Engineering Department.

~~**An outside**~~ **qualified vendor is contracted annually to perform an inspection of all master signals, area alarms, automatic pressure switches, shut off valves, flexible connections, outlets and purity from source in accordance with NFPA ~~and Joint Commission standards~~to ensure compliance with Authorities Having Jurisdiction (AHJs).**

~~7. All medical gas systems shall be labeled per NFPA 99, chapter 4. Zone valve labeling shall include the exact rooms or areas that are served by the load side of the zone valve(s). The accessibility of all shut-off valves, as well as the main control valves shall undergo regular monitoring during hazard surveillance and SOC™ updates to ensure no obstructions exist and a minimum 36-inch clearance is adhered to.~~

~~D. **DISTRIBUTION**:~~

~~1.~~**7.** ~~Respiratory Therapy Department, Engineering Manager, Engineering Supervisor.~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Maintenance And Inspection Boiler/Steam System~~ ~~Policy Number: 2002 Page 1 of 1~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Maintenance and Inspection Boiler/Steam System

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

~~A. REFERENCE:~~
~~1. Engineering Maintenance Manual~~

~~B.~~**A. PURPOSE:**
1. To describe the process by which the boiler/steam system is maintained and inspected.

~~C.~~**B. GENERAL INFORMATION:**
1. Computerized Maintenance Management System (CMMS) - A computerized information system used to facilitate the scheduling monitoring and documentation of equipment and environmental maintenance.

~~D.~~**C. PROCEDURE:**
1. A work order for preventive maintenance, inspection, and/or testing of each component part to the boiler/steam system is produced a**t** ~~pre-determined and~~ pre-programmed schedule by the CMMS.
2. The work is assigned by the ~~Engineering Supervisor~~**Facilities Manager and/or his designee** to an E~~e~~ngineer **or a Qualified Contractor**.
3. The E~~e~~ngineer **or a Qualified Contractor** performs preventive maintenance (and corrective maintenance, if needed), inspects the system and conducts testing as specified in the CMMS instruction set printed on the work order.
4. The E~~e~~ngineer prepares and submits to the Engineering Department a Corrective Maintenance form for any repair work which will take more than thirty minutes to complete or for which he**/she** does not have tools or parts readily available.
5. The E~~e~~ngineer **or Qualified Contractor** completes the Scheduled Maintenance Work Order,

indicate**s** specific preventive or corrective actions ~~he has~~ taken and not**es**~~ing~~ the date the scheduled maintenance was completed**. This information to be entered into** ~~, and submits the work order to the Engineering Administrative Coordinator for entry in~~ the CMMS.

6. The engineer checks the alternative fuel supply daily and replenishes it when at 12,500 gallons to maintain at least a 72 hour supply.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Maintenance Work Request System~~ ~~Policy Number: 1012~~ ~~Page 1 of 1~~
~~Department: Engineering~~	~~EFFECTIVE: 11/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Maintenance Work Request System

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 10/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish an effective means of requesting, coordinating and completing maintenance ~~of a corrective nature~~**work orders**.

B. **PROCEDURE:**
1. Corrective maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and to operate as designed. The following ~~procedures are established to initiate and carry out an effective program and is~~**procedures are established to initiate and carry out an effective program and are** considered ~~a~~ normal means for obtaining maintenance action.
2. The Maintenance Work Request System will be divided by the~~Engineering Manager~~ **Building Maintenance Supervisor or his/her designee** into three major categories which are defined as follows:
   a. URGENT: These are corrective actions of such a nature that the failure to take immediate action or actions will jeopardize the ~~operation of the hospital with respect to it's primary mission and service~~**safety of patients, visitors and staff**. ~~Procedures for URGENT corrective action is by far the fastest means.~~
   b. ROUTINE: These are corrective actions which should be performed at the first opportunity, but their nature is such that the primary function of the hospital is not significantly affected. Work **orders**~~requests~~ will be picked up on a daily basis by Engineering personnel.~~ during their normal rounds~~.
   c. DEFERRED: Some routine ~~requests~~ **work orders** may be deferred based on priority.
~~3. Ultimate priority assigned to the Work Request will normally be determined by the Engineering Manager upon review of the written requisition.~~
~~4.~~**3.** For the Maintenance Work Request System to operate efficiently, it is mandatory that the

telephone and paging for Engineering be used only in cases of urgent requirements or emergencies (**safety,** flood, fire, power loss, etc.).~~, since it is impossible to assign priorities and schedule phone calls and pages~~

~~5.~~**4.** On a daily basis, the ~~Engineering~~ **Building Maintenance** Supervisor **or his/her designee** will assign **w**~~W~~ork **orders**~~Requests~~ to personnel and review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance.

Tri-City Medical Center
Oceanside, California

ENGINEERING
INFECTION CONTROL

SUBJECT: **Managing Biological Agents to Prevent Waterborne Illness**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Infection Control Committee Approval Date(s):	**03/16**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) Engineering Department to maintain, treat and test open water and potable water systems to minimize pathogenic biological agents.

B. **PURPOSE:**

1. Equipment that operates with water that can be aerosolized (e. g., cooling towers, faucets, showers, fountains, pools, spas) may become contaminated with potentially infectious biological agents even though the equipment is operated within the manufacturer's guidelines. Regular maintenance and cleaning of the equipment and proper treatment of the water will be performed to ensure that the risks of hazards are minimized to the staff, patients and visitors of TCHD.
2. Treatment & General Cleaning
   a. Cooling towers, water display fountains, spas, pools, and other open water systems that can generate aerosols shall have a maintenance program that includes routine cleaning of the water reservoir and piping systems. The maintenance shall be conducted in accordance with the manufacturer's recommendations and appropriate cleaning instructions. When necessary, make up water should be provided from the normal water service system. Open-water systems that have been out of service for an extended period of time shall be thoroughly cleaned before being returned to service.
   b. Systems that generate or utilize aerosolized potable tap water (showers, drinking fountains, ice machines, tap water faucets) shall be properly cleaned and maintained to control the contamination from potentially infectious biological agents if out of service for a period of time. Water storage tanks (hot water systems, reserve storage tanks) that are not continually utilized should be routinely cleaned and decontaminated.
   c. During maintenance and cleaning procedures, the appropriate personnel protection equipment (PPE) shall be worn to prevent exposure to potentially infectious biological agents, such as Legionella, Mycobacterium, and Pseudomonas.
3. Treatment
   a. The water treatment program should include the routine application of the appropriate biocide treatment agents designed to eliminate and control biological agents and other contaminates that can accumulate from exposure to the open atmosphere. During the application of treatment and cleaning agents, the appropriate PPE shall be worn.
4. Documentation

a. Routine maintenance and treatment procedures of open water and potable water systems shall be recorded. Date of service, service and treatment activity, and personnel conducting the service shall be recorded. Maintenance and cleaning of open water and potable water systems that have been out of service for an extended period of time shall also be documented.

5. Preventative Maintenance
   a. In frequencies determined by Director of Engineering or his/her designee a qualified testing agency will be scheduled to perform testing and validation reports to determine the effectiveness of the Water Safety Management Plan.
   b. Ice Machines and Cooling Towers are to be maintained per Manufacturer's Recommendations or Alternative Equipment Maintenance program.
   c. Decorative fountains to be placed on a chemical treatment program or put out of service.
   d. Cooling Towers to be on a continuous chemical treatment program.
   e. Hot Water Tanks and Storage Tanks to be blowdown in frequencies determined by Director of Engineering or his/her designee.
   f. Disinfect Hot Water Storage Tanks and Cooling Towers in frequencies determined by the Director of Engineering or his/her designee.
   g. Disinfect high risk Air Handling Unit Coils and Drain Pans in frequencies determined by the Director of Engineering or his/her designee.
   h. In frequencies determined by Director of Engineering or his/her designee flush taps in vacant/low use areas.
   i. In frequencies determined by Director of Engineering or his/her designees flush emergency eyewash and shower stations.

6. Staff Training
   a. Staff members responsible for the water treatment program will be trained regarding proper cleaning and maintenance procedures, and the safe handling and proper application of water treatment and cleaning chemicals. All guidelines for handling hazardous materials and the recommendations for proper use of PPE will be presented.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Preventive Maintenance~~ ~~Policy Number: 1004 Page 1 of 3~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03; 6/06;2/09, 8/11, 6/12~~

SUBJECT: Preventive Maintenance

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 2/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To describe the process by which preventative maintenance **(PM)** work within ~~defined environmental units~~ **Tri-City Healthcare District (TCHD) facilities** is assigned, performed and documented.

B. **GENERAL INFORMATION:**
~~1. Environmental Unit: A space of manageable size in terms of square footage or work intensity classified by the principal activity which takes place within it. See Attachment 1 for environmental unit classifications.~~
~~2.~~**1.** Preventative Maintenance **(PM)**: Those regularly scheduled activities performed to ensure that each ~~environmental unit~~**facility**, and the individual items classified as part of it, are maintained in a safe, functional and aesthetically acceptable condition. See Attachment ~~1~~**2** for items generally maintained as part of an environmental unit.
~~3.~~**2.** Computerized Maintenance Management System (CMMS): A computerized Information system used to facilitate the scheduling, monitoring, documentation and instructions on performing **PMs**~~preventative maintenance~~ of equipment and environmental maintenance.

C. **POLICY:**
1. **TCHD**~~The hospital~~ will maintain its ~~physical plant~~**facilities** in a manner and in accordance with a schedule that will serve to provide a safe, functional, and aesthetically pleasing environment.
2. ~~Preventative maintenance~~**PMs** will be scheduled, performed and documented in accordance with ~~environmental unit instruction~~**PM procedures** set ~~incorporated~~ in the CMMS.

D. **PROCEDURE:**
1. Each month, ~~the Engineering Administrative Coordinator issues to the engineering departments the scheduled maintenance work orders produced by the CMMS~~**each Engineer will receive a**

list of PMs that he is responsible to complete by assigned due dates.

2. The **E**engineer conducts ~~an inspection of~~ each ~~environmental unit~~**PM** scheduled ~~for~~ **by the due date and in accordance with the procedure listed in CMMS**~~maintenance~~.

3. ~~The engineer performs preventive and corrective maintenance and conducts functional and safety testing as specified in the task set~~**Once the PM is completed, an Engineer logs the results in the CMMS and notifies the Supervisor in case an issue had be~~**n**~~**en identified.**

~~3.~~**4. In case of failure, the Supervisor will assess the situation and if necessary will enforce and document Interim Life Safety Measure (ILSM) or Interim Utility Safety Measure (IUSM) to keep the occupants safe.**

E. **ATTACHMENTS:**

1. **Attachment 1 – Items Generally Included in Preventative Maintenance But Not Limited To.**

~~ENVIRONMENTAL MAINTENANCE~~

~~ATTACHMENT 1~~

~~ENVIRONMENTAL UNIT CLASSIFICATIONS~~

~~1. Non-Flammable Anesthetizing Location:~~
~~Area in which inhalant anesthetic agents are administered and which is so designated by a hospital policy.~~

~~2. Critical Care Area:~~
~~Area in which patients may be subjected to invasive procedures and/or directly connected to line operated medical devices (other than nonflammable anesthetizing locations).~~

~~3. Wet Location:~~
~~Patient care area which normally operates under wet conditions, Including standing water or flushing of the work area.~~

~~4. General Care Area:~~
~~Area in which patients come in contact with ordinary electrical appliances (lamps, beds, televisions, etc.) or may be connected to medical devices.~~

~~5. Non-Patient Care Area:~~
~~Area in which patients are not normally cared for or treated, such as administrative offices, laboratories, nursing stations, storage areas or kitchens.~~

~~6. Mechanical Area of restricted access containing plant equipment.~~

~~7. Grounds:~~
~~Area surrounding hospital buildings, including driveways, walkways, parking lots, lawns and gardens, to which the public normally has access.~~

ATTACHMENT ~~12~~ –
ITEMS GENERALLY INCLUDED IN PREVENTATIVE MAINTENANCE BUT NOT LIMITED TO:

Automatic Transfer Switches – Emergency Power
Baby cribs
Bassinets
~~Ceilings~~
Central Plant Equipment
Door latch tensions
Doors (manually operated & auto)
Drinking fountains
Electrical outlets / system
Electrical Beds
~~Electrocautery~~
Elevators
Enzyme treatment drains
Exam tables
Exit lighting
Eye washers
Fire Alarm Systems
Fire Sprinkler Systems
~~Floor coverings~~
Floor and roof drains
General lighting
Generators
Gurneys
Heaters
HVAC
Ice Machines
Mechanical beds
Medical gas outlets
Medical vacuum outlets
Motorized tables
Morgue table
Non-electrical food carts (and electrical)
Nurse-call system
OR lamps
Patient lifts
Patient scales
Plaster traps
Portable exam lamp
Portable heat lamps
Refrigerators (medical & non-medical storage)
~~Room furniture~~
Room grounding
~~Sewers~~
~~Showers~~
Signs and lighting
~~Sinks~~
~~Toasters~~
~~Ultrasonic cleaners (small)~~
~~Walls~~
Warming cabinets
Water temperatures
Wheel/chairs
X-ray view boxes

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Routine Hospital Rounds~~ ~~Policy Number: 1011 Page 1 of 1~~
~~Department: Engineering~~	~~EFFECTIVE: 11/87~~ ~~REVISED: 10/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Routine Hospital Rounds

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 10/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **POLICY:**

1. Routine rounds will be made at the beginning of each shift, by the Plant ~~Operator of Engineering on~~**Operator on** shift.
2. Commence tour of hospital.
3. Make a visual check of boiler room. Check the water level in the condensate return tank. Normal operating level should be maintained. Check boiler feed pumps noting any unusual conditions. Check the water level of each boiler. Conduct an operational check test of low-water cut off. Record the steam pressure of operating boiler. Test and record the boiler water softener to assure make-up water is soft.
4. ~~Check mechanical equipment (kitchen exhaust fan, domestic circ. water pump, tank float, hot water tank) and record temperature.~~
5. **4.** Check mechanical equipment.~~ space~~ **Operation of exhaust f**~~F~~ans~~ operation~~, chiller**s, domestic and heating hot water circulating pumps**~~pumps~~, cooling tower**s, air compressors,**~~ and~~ air handlers **and record any discrepancies**.
6. **5.** Return to Engineering office with a list of any discrepancies noted ~~or received~~ during your inspection. Make proper entries in the Daily Journal~~ and on the operation log~~.
7. ~~Proceed with maintenance work orders or other assigned jobs.~~

Tri-City Medical Center
Oceanside, California

This copy of the procedure is with TRACKED CHANGES.

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Scope of Service~~ ~~Policy Number: 1005 Page 1 of 3~~
~~Department: Engineering~~	~~EFFECTIVE: 11/87~~ ~~REVISED: 9/94; 1/97: 5/00; 5/03; 6/06;2/09, 8/11, 6/12~~

SUBJECT: Scope of Service

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 2/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To define the scope of services provided by the Engineering Department in an effort to create a safe and quality environment for patient care, visitors and employees.

B. **POLICY**:

1. In an effort to comply with all regulatory agencies while ensuring ~~minimal risk environment to the patient~~ **safe and quality environment,** the Engineering –Department will be responsible for the condition and function of ~~the~~**all of the** hospitals~~ physical plant~~ **facilities**, including all utilities and **Engineering** equipment. All ~~areas~~ of the ~~hospital~~facilities and equipment therein, are inspected and maintained ~~as Environmental Units,~~ in accordance with the Computerized Maintenance Management System (CMMS).

~~1. , with the following exceptions:~~
~~2. Equipment and utilities:~~
~~i. considered essential for the comfort and safety of the patient~~
~~ii. considered essential for life support, infection control, environmental support, equipment support as well as communication support~~
~~iii. associated with higher than normal incident risk during routine operation~~
~~iv. requiring, by reason of its complexity, a more intensive maintenance schedule~~
~~v. Supplied or maintained by an outside vendor; will be inventoried, inspected, maintained and recorded on an individual basis within the system. Documentation of outside vendors will also be maintained as part of CMMS.~~
~~3. Arrangements for the inspection, maintenance and repair of the following categories of equipment, and documentation thereof, will be the responsibility of the department Indicated:~~
~~a. Imaging equipment, Radiology or Nuclear Medicine, as appropriate~~

~~b. Laboratory testing equipment - Clinical Laboratories~~
~~c. Anesthetic delivery equipment (including analyzers) - Anesthesia~~
~~d. Pharmacy computers, 3M computers,~~
~~i. all IBM or Telex equipment connected to the Regional mainframe computer- INFORMATION TECHNOLOGIES~~
~~e. Communication Lines dedicated to:~~
~~i. Equipment listed in 2d - COMMUNICATIONS~~
~~ii. Computer Systems - INFORMATION S TECHNOLOGIES~~
~~iii. Telecommunications equipment - COMMUNICATIONS~~

~~4. The following services will be provided by outside vendors or as requested and arranged by the Engineering Department but not limited to:~~
~~a. Inspection, maintenance and repair of elevators~~
~~b. Maintenance and repair of the grounds~~
~~c. Maintenance and repair of driveways, parking lots and walkways.~~

~~5.~~**2.** ~~The following services will be provided by outside vendors as requested and arranged by each user department,~~**Equipment maintained by the Engineering Department includes** but **is** not limited to **the following**:

~~a. Maintenance and repair of Cat Scan, MRI~~
a. Central Plant Equipment~~Maintenance and repair of Colter, A.C.A~~
b. Generators and Automatic Transfer Switches
c. Fire Alarm and Fire Suppression Equipment
d. Elevators
e. HVAC
f. Steam Equipment
g. Ice Machines
h. Water Fountains
i. Eye Wash Stations
j. Drench Showers
k. Exit Lights
l. Lighting
m. Power Distribution Equipment
n. Domestic Water Equipment
o. Other Engineering/Building equipment not listed here. Full list of equipment is available at the Engineering Department.

~~b.~~

~~6.~~**3.** Movement of furniture and equipment is provided as follows:
a. Performed by the Environmental Services Department.

~~7.~~**4.** Key and lock services are provided by Engineering.

~~8.~~**5.** Service manuals for patient care and other equipment maintained by Engineering are kept on file in the~~is~~ **Engineering D**~~d~~epartment.

6. User/Operator instructions are on file in the department in which the equipment is used and by Engineering.

~~9.~~**7. Construction Projects Services are provided by the Engineering Department.**

Tri-City Medical Center
Oceanside, California

CLEAN COPY OF THIS PROCEDURE.

ENGINEERING
GENERAL ADMINISTRATIVE

SUBJECT: Scope of Service

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 2/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To define the scope of services provided by the Engineering Department in an effort to create a safe and quality environment for patient care, visitors and employees.

B. **POLICY**:
1. In an effort to comply with all regulatory agencies while ensuring safe and quality environment, the Engineering Department will be responsible for the condition and function of all of the hospital facilities, including all utilities and Engineering equipment. All of the facilities and equipment therein, are inspected and maintained in accordance with the Computerized Maintenance Management System (CMMS).
2. Equipment maintained by the Engineering Department includes but is not limited to the following:
   a. Central Plant Equipment
   b. Generators and Automatic Transfer Switches
   c. Fire Alarm and Fire Suppression Equipment
   d. Elevators
   e. HVAC
   f. Steam Equipment
   g. Ice Machines
   h. Water Fountains
   i. Eye Wash Stations
   j. Drench Showers
   k. Exit Lights
   l. Lighting
   m. Power Distribution Equipment
   n. Domestic Water Equipment
   o. Other Engineering/Building equipment not listed here. Full list of equipment is available at the Engineering Department.
3. Movement of furniture and equipment is provided as follows:
   a. Performed by the Environmental Services Department.
4. Key and lock services are provided by Engineering.
5. Service manuals for patient care and other equipment maintained by Engineering are kept on file in the Engineering Department.
6. User/Operator instructions are on file in the department in which the equipment is used and by Engineering.
7. Construction Projects Services are provided by the Engineering Department.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Staff Meetings~~ ~~Policy Number: 1007 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 4/16/90~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 6/12~~

SUBJECT: Staff Meetings

ISSUE DATE: 4/90
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 6/12

Department Approval Date(s): 03/16
Environmental Health and Safety Committee Approval Date(s): 03/16
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish time and attendance requirements for staff meetings.

B. **PROCEDURE:**
1. Departmental meetings will be as follows:
   a. Supervisors on an as needed basis.
   b. All department meetings will be conducted monthly.
2. Division meetings will be as follows (or on ~~an~~ as needed basis):
   a. Projects - Weekly.
   b. Building Engineering - ~~Plan of the Day (POD) - twice W~~weekly.
   c. Plant Engineering - ~~Plan of the Day (POD) - twice W~~weekly.

C. **POLICY:**
1. Departmental staff meetings will be held, as posted monthly, in the Division Shops or designated class room.
2. All staff on duty at TCMC will be expected to attend. -Copies of the meeting minutes will be ~~placed in memo book for review~~**emailed for review** and **it** is the responsibility of all personnel to review **and comment on any discrepancies by the given deadline**~~and sign~~. **After the deadline the meeting minutes will be considered as archived.**
3. The agenda of the meetings will be determined by input from all employees.
4. The meeting will be conducted by the appropriate individual or his designee.

Tri-City Medical Center
Oceanside, California

ENGINEERING
GENERAL ADMINISTRATIVE

~~TRI-CITY MEDICAL CENTER~~ ~~Facilities Policy & Procedure~~	~~Section: Engineering Department~~ ~~Subject: Statement of Accountability And Responsibility~~ ~~Policy Number:~~ 1002 ~~Page: 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE:~~ 11/87 ~~REVISED:~~ 9/94; 1/97; 5/00; 5/03;6/06;2/09, 8/11, 6/12

SUBJECT: Statement of Accountability and Responsibility

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 2/09, 8/11, 6/12

Department Approval Date(s): **3/16**
Environmental Health and Safety Committee Approval Date(s): **3/16**
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To describe the hierarchy of accountability and responsibility within the Engineering Department and that between the department and hospital administration.

B. **POLICY:**
1. The Engineering Department inclusive of Building Engineering, Plant Operations and Projects is the responsibility of the **Director of** Facilities. ~~Manager of Engineering Department.~~ It is the responsibility of this individual to ensure that all the divisions of **the** Engineering Department operate as efficiently and effectively as practicable, work cooperatively with other hospital departments toward achieving its goals and objectives and meets the applicable standards and regulations of the accrediting and licensing bodies.
2. In carrying out these responsibilities, the Facilities ~~Manger~~ **Director** ~~of Engineering Department~~ is directly accountable to the Chief Operating Officer. ~~through a reporting relationship with the Sr. Director of Support Services.~~

Tri-City Medical Center
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MEDICAL STAFF POLICY MANUAL

ISSUE DATE:	**7/01**	**SUBJECT:**	**Suspension for Delinquent Medical Records & Fine Process**
REVISION DATE:	**3/05, 4/06, 3/07, 7/07, 3/08, 9/09, 10/14; 3/15; 2/16**	**POLICY NUMBER:**	**8710 – 519**

Medical Executive Committee Approval: **02/16**
~~**Governance Committee Approval:** **04/15**~~
Professional Affairs Committee Approval:
Board of Directors Approval: **04/15**

A. **POLICY:**

1. It is the policy of Tri-City Medical Center and its Medical Staff that all medical records are completed in a timely manner, in accordance with Medical Staff Policy 8710-518, Medical Record Documentation Requirements, applicable laws, and accreditation standards.

B. **PROCEDURE:**

1. Applicable TCMC departments shall enforce pre-procedure requirements for History and Physical exam, as outlined in Medical Staff Policy 8710-518, Medical Record Documentation Requirements.
2. In order to facilitate timely medical record completion and appropriate practitioner notification, the TCMC IT Department shall develop and implement such automated notification mechanisms as requested by the Medical Records/HIM Department.
3. The Medical Records/HIM Department is responsible for reviewing medical records and identifying deficiencies of dictations and signatures, as outlined in Medical Record Documentation Requirements.
4. The practitioner is responsible for identifying any error(s) in assigned dictations/signatures by "refusing" the item within the Cerner Message Center, and indicating the appropriate practitioner if possible.
5. The Medical Records/HIM Department will run a weekly report to identify dictations and signatures that are not complete following patient discharge.
   a. A letter under the Chief of Staff's signature will be initiated to each practitioner weekly when the practitioner has any deficiencies aged 7 days from discharge. A second communication will be sent at 10 days post discharge.
6. Each week the Medical Records/HIM Department will submit to the Chief of Staff (via the Medical Staff Office) a list of verified deficiencies.
7. The Medical Staff Office shall:
   a. Call the physician to give verbal notice of the impending suspension.
   b. Prepare and send a written Notice of Automatic Limited Suspension to the physician.
8. Limited suspension shall apply to the practitioner's right to admit, treat or to provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the practitioner has already admitted or has scheduled to treat or to perform any invasive procedure. Obligations to fulfill ED On-Call duties as per existing schedule shall remain in effect.
9. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life threatening situations, when no other physician of the appropriate specialty is available.
10. In the case of a patient care emergency, the suspension may be lifted by the Chief of Staff or his/her designee, otherwise the suspension shall continue until the medical records are complete.

11. If the physician is on vacation or has an illness when his or her records become delinquent, with Chief of Staff approval, such physician shall have five (5) days of returning to practice from vacation or illness to complete the records.

C. **MEDICAL STAFF FINES FOR DELINQUENT MEDICAL RECORD DICTATION**

1. **Purpose:**
   a. **To provide a Policy and Procedure for implementation and ongoing enforcement of fines for Medical Staff members with delinquent medical record dictation.**
2. **Definition Of Terms For Fine Process:**
   a. **Delinquent Dictation: A medical record is considered "delinquent" 14 calendar days after discharge, however, for this purpose fines will only be imposed for "dictations only", i.e. H&P, Op Reports, ~~Discharge~~and Discharge Summary.**
   b. **Limited Suspension: A Limited Suspension permits the practitioner to continue to care for a patient he/she is already treating in the hospital or has scheduled to treat prior to the date of the imposed suspension.**
   c. **Fines: A fine of $10.00 will be imposed and billed to any practitioner who appears on the suspension list for each delinquent dictation. The $10.00 fine will be compounded weekly if not completed.**
3. **Policy And Procedure:**
   a. **Each Monday, prior to suspension, Medical Records sends Medical Staff office a list of physicians with delinquent dictation(s). Medical Staff office notifies the practitioner of the delinquent dictations indicating that the delinquent dictation(s) must be completed by the following Wednesday or a $10 per each delinquent dictation will be assessed.**
   b. **Medical Staff suspends each Wednesday. Physicians with delinquent dictation(s) will be billed $10 per delinquent report via the Medical Staff Department.**
   c. **Fines are due and payable when the practitioner receives a bill. (Physicians must notify Medical Records prior to leaving on vacation in order to be considered "exempt" from the fining process during their absence from the facility.)**
   d. **Loss of privileges/membership will result in the following circumstances:**
      i. **If, at the time of reappointment, the practitioner is found to owe outstanding fines, the application for reappointment will be considered "incomplete";**
      ii. **If the physician is found owing a fine for delinquent medical records for a period of 6 months or more;**
         1) **The practitioner will be sent a certified letter, including a copy of this Policy/ Procedure, which states that "failure to pay the outstanding fine, within twenty-one days of the date of the final notice, will result in the automatic relinquishment of his/her membership".**
         2) **The letter will give the practitioner an opportunity to forward a written response, within seven days of the date of the final notice, to be considered at the Medical Executive Committee meeting.**
         3) **The outcome of the deliberations/decision determined at the Medical Executive Committee meeting will be forwarded to the practitioner in question via certified mail. Should the practitioner fail to submit a letter for consideration at the Medical Executive Committee meeting or after consideration of such a letter, if it is determined at the Medical Executive Committee meeting that the practitioner does owe the fine, the payment of such fine is due and payable on the date identified in the first notice. A practitioner who has failed to pay the outstanding fine will be considered to have automatically relinquished his/her medical staff privileges and membership at Tri-City Medical Center. If the practitioner wishes to reapply to the staff he/she will be required to pay the full application fee plus the total of any outstanding fines owed for delinquent medical record dictation.**

e. The monies collected from this process will be added to the Medical Staff Checking account and used as determined by the Medical Executive Committee on behalf and in support of the Medical Staff.

~~C.~~D. MEDICAL STAFF SUSPENSION MONITORING:

1. The Medical Staff Office shall notify Medical Records/HIM, IT, Surgery, Administration, Admitting, Cardiology and Radiology of the automatic suspension.
   a. Each of these departments is responsible for enforcing the suspension.
   b. Any questions shall be directed to the Chief of Staff via the Medical Staff Office.
2. The Medical Records/HIM Department shall notify the Medical Staff Office when a suspended practitioner has completed all deficiencies.
3. The Medical Staff Office shall notify the practitioner and applicable departments that the suspension has been lifted.
4. Days on suspension shall be tracked in the Medical Staff's credentialing database and considered at the time of OPPE and reappointment.
5. The Medical Executive Committee will serve as the intermediary in resolving suspension/delinquency status questions from physicians and will assist the Medical Records Department in communications with practitioners who have disputes regarding the actions of this policy.
6. Practitioners indicating an intent to resign will be advised to complete all outstanding dictations and signatures before departure, as failure to do so will make them ineligible for "good standing" affiliation verifications.

~~D.~~E. REFERENCES:

1. Medical Staff P&P 8710-518: Medical Record Documentation Requirements
2. Medical Staff Bylaws: Article VI, § 6.4-4

Tri-City Medical Center	Women's and **Newborn**~~Children's~~ Services Manual - NICU
PROCEDURE:	**PRIMARY NURSE ASSIGNMENT**
Purpose:	1. To promote continuity and efficiency of care in order to optimize outcomes for the patient and their family. 2. To promote developmentally age appropriate, individualized, family-centered care for the NICU infant and family. 3. To promote and increase family satisfaction and enhance morale of the NICU **Registered Nurse**.
~~Issue Date: 9/10~~	~~Revision Date(s): 6/11, 8/12~~

~~**SUBJECT: PRIMARY NURSE ASSIGNMENT**~~

~~**ISSUE DATE: 9/10 REVISION DATE: 6/11, 8/12**~~

A. **STANDARD OF PRACTICE:**

1. Nurses shall provide care in a manner that is developmentally age appropriate, individualized, and family centered.
2. Nurses shall provide care in a manner which maximizes continuity, efficiency and optimal outcomes.

~~B. **PURPOSE:**~~

~~1. To promote continuity and efficiency of care in order to optimize outcomes for the patient and their family.~~
~~2. To promote developmentally age appropriate, individualized, family-centered care for the NICU infant and family.~~
~~3. To promote and increase family satisfaction and enhance morale of the NICU RN.~~

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

1. All infants with an expected stay greater than 7 days may be assigned a **primary nurse**.
2. Any qualified **Neonatal Intensive Care Unit** (NICU) **Registered Nurse** (RN) may volunteer to serve as primary nurse to any unassigned, primary-qualified infant who does not have a primary nurse within the first 48-hours of stay.
3. During the 48 hours after admission of the primary-qualified infant, any qualified NICU RN may sign up to be primary nurse to the infant, unless that RN is already serving as primary nurse to another patient.
4. At 48 hours of stay, if no qualified NICU RN has volunteered to serve as primary nurse for the infant, the **Supervisor or designee**~~Assistant Nurse Manager (ANM)~~ will facilitate the assignment of a primary nurse to the patient. The following criteria will serve as guidelines in the assignment of a primary nurse to a specific patient:
   - **a. Must work a minimum of 5 shifts in a pay period on a regular basis (FTE ≥ 0.8).**
   - **b. Must have a minimum of six month's experience as a NICU RN.**
   - **c. Must be a Tri-City Medical Center staff member.**
   - ~~a. The RN must meet the qualifications stated in C: 5, below.~~
   - ~~b.~~**d.** The RN must not currently be serving as primary nurse to another patient.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/15	n/a	n/a	n/a		6/11; 8/12

~~c.~~**e.** The assignment will be rotated, with the qualified NICU RN who has had the longest break from serving as a primary nurse preferentially assigned to the next infant qualifying for primary nursing, unless another qualified NICU RN voluntarily chooses to serve within 48 hours after the infant's admission.

~~d.~~**f.** If the NICU RN who is first in the rotation is not on duty, and is to be off from work for more than three days following the assignment, the next NICU RN in the rotation will be assigned to the patient.

~~e.~~**g.** It is acceptable to "pass over" an RN under special circumstances with the consent of the **supervisor**~~ANM~~/nurse manager.

~~5. The primary nurse:~~

~~a. Must work a minimum of 5 shifts in a pay period on a regular basis (FTE ≥ 0.8).~~

~~b. Must have a minimum of six month's experience as a NICU RN.~~

~~c. Must be a Tri-City Medical Center staff member.~~

~~6.~~**5.** It is the responsibility of the primary nurse to:

a. Evaluate the needs of the infant and family, including teaching/learning issues.

b. Formulate, in conjunction with the multidisciplinary team and the family, **an** individualized **plan of care, inclusive of** short-term and discharge goals, for the infant and family.

~~c. Formulate, in conjunction with the multidisciplinary team and the family, an individualized plan of care for the infant and family.~~

~~d.~~**c.** Communicate plan **of care** to other caregivers; ensure plan is carried out.

~~e.~~**d.** Evaluate effectiveness of plan of care in achieving goals **and alter plan of care as needed**.

~~f. Alter plans as indicated.~~

~~g.~~**e.** Evaluate the need for family conferences at least every two weeks and prn. These are to include at a minimum, one of the parents and/or primary caregiver, the attending physician, the primary or associate nurse, and the infant's social worker.

~~7.~~**6.** The primary nurse serves as primary to only one patient at the time, unless she/he chooses to serve as primary nurse to two infants of a multiple birth.

~~8.~~**7.** The primary nurse may serve as associate nurse to one infant in addition to the infant for whom they serve as primary nurse.

~~9.~~**8.** It is optimal that each infant who qualifies for primary nursing care will also have an associate nurse on the shift opposite of the shift worked by the primary nurse (additional associate nurses may also serve on the team as available and indicated).

~~10.~~**9.** The associate nurse is a NICU RN who has successfully completed the NICU orientation period.

~~11. A primary nurse may serve as associate nurse to one infant in addition to the infant for whom they serve as primary nurse.~~

~~12.~~**10.** The responsibilities of the associate nurse(s) are to:

a. Continue identification of problems and potential interventions.

b. Aid in evaluating the effectiveness of the plan.

c. Communicate the above to the primary nurse.

d. Carry out plan of care, including family teaching.

e. Support the plan of care with the family and other team members.

f. Serve as the primary nurse if the original primary nurse is not available for ≥ 4 days.

~~13.~~**11. Any RN caring for any patient in the NICU at any time is responsible for performing the duties of an associate nurse except for that of consistently caring for a specific patient.**

~~14.~~**12.** The primary nurse and the associate nurse(s), in this order, will be preferentially staffed with the infant on whose team they are serving unless safe staffing of the NICU requires otherwise. A further exception may occur either when the team member requests a brief break from caring for the infant or the primary nurse is assigned as relief charge.

~~D.~~C. PROCEDURE:

1. **Supervisor and/or designee**~~Assistant Nurse Manager~~:

a. As each patient is admitted, determine the expected stay of the infant. If the expected stay is greater than seven days:

i. Ask the admitting RN (if qualified), if they wish to be assigned as primary nurse to the infant. If so, place the admitting RN's name in the Kardex **and primary nurse board** as primary nurse.

b. If at 48-hours after admission the patient does not yet have a primary nurse signed up, facilitate the assignment of a primary nurse to the patient.
c. Post the primary nurse's name in the patient kardex **and primary nurse board**.
d. Ensure that the primary nurse is preferentially assigned to bedside care of their primary patient whenever safe unit staffing needs allow.
e. **The newly assigned primary nurse should be assigned to bedside care of the primary patient on the first working day after being designated as primary nurse.**

2. Bedside/Relief Nurse:
   a. Explain the concept of primary nursing to the family if not already done and tell them the day when the primary nurse will be back to work.
3. Primary Nurse:
   a. Review the infant's chart, discuss the case with the team, and initiate contact with the parents no later than the first day on duty after being assigned the infant as primary.
   b. Formulate an initial plan of care in conjunction with the team and the family.
   c. Continue duties as outlined **above**~~in C. 5 above~~.

~~E. EXTERNAL LINKS:~~

~~F.~~D. REFERENCES:

1. Miles, M.S. & Holditch-Davis, D. (1997). Parenting the prematurely born child: Pathways of influence. *Seminars in perinatology*, 21 (3), 254-266.
2. Scharer, K. & Brooks, G. (1994). Mothers of chronically ill neonates and primary nurses in the NICU: Transfer of care. *Neonatal Network,* 13 (5), 37-46.
3. Smith, S.J. (1987). Primary nursing in the NICU: A parent's perspective. *Neonatal Network,* February, 25-27.

~~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	Women and Newborn Services (WNS)
PROCEDURE:	**INSTRUMENT CLEANING ~~STERILE~~ PROCESS AND TRANSPORT TO STERILE PROCESSING DEPARTMENT (SPD)~~ING OF WCS INSTRUMENTS-~~**
Purpose:	To outline **the** procedure and individuals responsible ~~for~~**for the** ~~instrument~~**initial instrumentation** ~~tion~~ cleaning **process and transport to SPD. Instrument decontamination, final cleaning and sterilization occur in SPD and not at the unit level. Once sterilized, instrument packs and instrument trays are picked up in SPD for unit use.** ~~, sterilizing~~ ~~and packing cesarean section packs, vaginal delivery packs, tubal ligation packs and singles.~~
Equipment:	1. **An identified enclosed case cart to transport dirty instruments to SPD** **2. An identified case cart to transport sterilized instrument packs and trays from SPD to the unit.** **3. Appropriate sized containers and/or basins, with lids to transport dirty instruments to SPD.** **4. Appropriate enzymatic cleaning product** **5. Protective personal equipment** ~~Two case carts, containers for singles and dirty instruments~~

A. **PROCEDURE:**

1. All instruments from the Women~~'s~~ and **Newborn**~~Children's~~ Services **(WNS)** unit will be **initially** cleaned **on the unit but then transported to SPD for further decontainment, packaging, and sterilization**, ~~sterilized and packaged by SPD.~~
2. ~~Sterile Instrument packs will be delivered by SPD at 0600, 1200, 1800, and 0000.~~
2. **WNS staff shall adhere to standard universal precautions, to include eye protection as indicated.**
3. **WNS staff is responsible for the initial instrument cleaning process which includes transferring the instruments to the biohazard room for initial cleaning, as soon as possible after use, and coating the instruments generously with an approved enzymatic gel or spray while in a basin or container that can be securely covered.**
   a. **For grossly contaminated instruments, the staff shall remove tissue, clots, and/or gross blood, with gauze or rinse lightly with water before applying the enzymatic product.**
4. **The containers with the dirty instruments will be placed into a case cart, located in the biohazard room in the Labor and Delivery (L&D) Operating Room spaces and transported to SPD in an enclosed case cart, with a biohazard label on the outside, for eventual processing at least once a shift, at a minimum.**
   a. **If dirty instrument sets become more than four in number, efforts shall be made by the L&D staff to transport the case cart to SPD immediately, so the instrument kits/ trays are cleaned, processed, sterilized, and returned in a timely manner.**
5. **The L&D Techs/ staff will pick up clean/sterilized, packaged instruments and trays from SPD at least once a shift, or more often if needed, and transport the sterile gear back to the unit in a "clean" case cart**
6. **The sterilized trays and instrument packs will be stored in a clean supply room until utilized for patient care.**
7. **The SPD manager shall be notified for any problems encountered related to the instrument cleaning, packaging, and/or sterilization process by calling 760-908-3367. related**

~~3. Dirty instruments will be rinsed by the OB tech, placed in clearly marked containers marked "dirty" and transported by the OB techs at 1000, 1400, 2200, and 0200.~~

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/16	n/a	n/a	n/a	03/16	n/a		

~~4.~~**8.** ~~A moist towel will be placed over rinsed instruments awaiting transport with container sealed~~.

~~5. Dirty case cart will be located in the dishwashing OR area on labor and delivery.~~

~~6. SPD will deliver sterilized, packaged instruments on cart labeled "clean" which will be located in L&D OR supply station.~~

~~7. OB techs should call extension 7288 SPD storage equipment for additional packs when necessary.~~

~~8. SPD techs are to call extension 7453 and notify shift supervisors of any potential delays in process.~~

B. REFERENCES:

1. **AORN (2015). Guidelines for Perioperative Practice, 2015 Edition, Denver, CO.**
2. **ACOG & AAP (2012). Guidelines for Perinatal Care, 7th Edition, Washington DC.**

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion { }**

Date: 09/02/2015 **Requestor:** Dr. David Spiegel

Trade Name: Entresto **Generic Name:** Sacubitril/Valsartan

Dosage form(s): Tablet, Oral: 24/26mg, 49/51mg, 97/103mg

Indications:

1. Reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction.

Efficacy:

Sacubitril/valsartan was superior to enalapril in reducing the risk of the combined endpoint cardiovascular death or hospitalization for heart failure, based on a time-to-event analysis (hazard ratio [HR]: 0.80, 95% confidence interval [CI], 0.73, 0.87, p<0.0001). The treatment effect reflected a reduction in both cardiovascular death and heart failure hospitalization. Sudden death accounted for 45% of cardiovascular deaths, followed by pump failure, which accounted for 26%. Sacubitril/valsartan also improved overall survival (HR 0.84; 95% CI [0.76, 0.93], p=0.0009). This finding was driven entirely by a lower incidence of cardiovascular mortality in sacubitril/valsartan.

Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:

1) **Angioedema**: In the double-blind period of PARADIGM-HF, 0.5% of patients treated with sacubitril/valsartan had angioedema
2) **Hypotension:** . In the double-blind period of PARADIGM-HF, 18% of patients treated with sacubitril/valsartan reported hypotension as an adverse events, with hypotension reported as a serious adverse event in approximately 1.5% of patients in both treatment arms
3) **Impaired Renal Function:** In the double-blind period of PARADIGM-HF, 5% of patients in both the sacubitril/valsartan and enalapril groups reported renal failure as an adverse event
4) **Hyperkalemia:** In the double-blind period of PARADIGM-HF, 12% of patients treated with sacubitril/valsartan reported hyperkalemia as an adverse event

Cost comparison with similar Formulary products: N/A

Other considerations:
Combined inhibition of the renin-angiotensin system and neprilysin provides for a novel class of agents with potential for therapeutic benefit in patients with HFrEF. Sacubitril/valsartan was found to be superior to enalapril in reducing the risk of death and hospitalization for heart failure. Additionally sacubitril/valsartan was well tolerated, however given the run-in study design, the adverse reaction rates reported are likely lower than expected in practice.

Recommendation:

1. Add sacubitril/valsartan to TCMC formulary for the indication of reducing the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction
2. Restrict prescribing of this agent to the Cardiology Service for both new and established patients

Process/Plan to monitor Patient Response:

1) Monitor blood pressure and electrolytes at baseline throughout therapy
2) Patients to be primarily monitored on an outpatient basis by a cardiologist (heart failure functional status assessment)

References:

1. Sacubitril/valsartan (EntrestoTM) [package insert]. East Hanover, NJ. Novartis Pharmaceuticals Corp. 2015.
2. Solomon SD, Zile M, Pieske B, et al. The angiotensin receptor neprilysin inhibitor LCZ696 in heart failure with preserved ejection fraction: a phase 2 double-blind randomized controlled trial. Lancet 2012; 380:387-95
3. Iso S, Stoh M, Tamaki Y, et al. Safety and efficacy of LCZ696, a first-in-class angiotensin receptor neprilysin inhibitor, in Japanese patients with hypertension and renal dysfunction. Hypertension Research 2105; 38:269-275
4. McMurray JJ, Packer M, Desai AS, Gong J, Lefkowitz MP, Riskala AR, et al. Angiotensin neprilysin inhibition versus enalapril in heart failure. N Engl J Med. 2014 Sept 11;371: 993-1004.

Date:_____ Time event recognized:_____ Time Code Blue Team arrived:_____ Location:_____

Pre code Events:_____

Time	Resp			Pulse			Rhythm			Bolus / Dose / Route								Code status: Full Code ☐ No Code ☐
	Spontaneous Rate	Assisted Breaths (✓)	$ETCO_2$ mmHg	Spontaneous Rate	Compressions (✓)	B/P	Rhythm	Defib/Cardiover Joules	AED? (✓)	Amiodarone /mg	Atropine /mg	Epinephrine /mg	Etomidate /mg	Neuromuscular Block (_____)	Fluid Bolus: /mLs			ED Physician arrival time:_____ Comments:
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Time compressions started:_____ Time of first defibrillation:_____ Time of first assisted breath:_____

Time of intubation: _____ ETT size/depth:_____ $ETCO_2$ confirmation of ETT placement ☐

Debriefing/Eval completed? ☐ Emergency Event form completed by RN and RCP? ☐

Recorder's Name/Initials:_____ / _____

1st Code Team RN's Name/Initials:_____ / _____

2nd Code Team RN's Name/Initials:_____ / _____

Primary RN Name/Initials: _____ / _____

RCP's Printed Name/Initials:_____ / _____

Responding Physician's Printed Name:_____

Responding Physician's Signature:_____

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

CARDIOPULMONARY ARREST RECORD

6010-1005

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