TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
July 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 June 2016 Meeting	3-7	2 min.	Committee
5.	New Business			
a.	Priority Project Dashboard			
	1. Falls	8		J. Piearson
	2. Patient Throughput (*Hand-out to Be Distributed During Meeting)*	9		J. Piearson
b.	Quality Outcomes Dashboard	10-13		
c.	Consideration and Possible Approval of Policies and Procedures	14		All
	Patient Care Services			
	1. Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS)	15-28		
	2. Alcohol Withdrawal Symptom Management	29-31		
	3. Chain of Command Policy	32-33		
	4. Emergency Cart, Cardiopulmonary Arrest	34-37		
	5. Family Presence During Resuscitation	38-40		
	6. Postural (Orthostatic) Vital Signs, Obtaining	41-42		
	7. Stool Management (Rectal Tube) Dignicare Stool Management	43-47		
	Unit Specific **Medical Staff**			
	1. Credentialing Policy, Processing Medical Staff Reappointments	48-51		
	Formulary Requests			
	1. Bridion- Trade Name/ Sugammadex- Generic Name	52-53		
	2. Emend- Trade Name/ Aprepitant- Generic Name	54-55		
	3. Veltassa- Trade Name/ Patiromar Sorbitex Calcium- Generic Name	56-57		
6.	Review and Discussion of CLINICAL Contracts- NO Contracts To Review (*Discussion/ Possible Action*)		10 min.	Chair
7	Review and Discussion of PAC Charter	58-60	10 min.	Cheryle Bernard-Shaw
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 August 11, 2016.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
June 9, 2016

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

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conlery, COO/ Exe. VP, Sharon Schultz, CNE/ Sr. VP, and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Kathy Topp, Sharon Davies, Jessica Ruh, Mary Diamond, Kathy R. Topp, Priya Joshi, Tom Moore, Board Chair Director Dagostino, Patricia Guerra and Karren Hertz.

Members Absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:07 p.m. in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications. Director Mitchell made a note to omit Item number 6 in the agenda as there is no contracts to be reviewed at this month's meeting.	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	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
committee's consideration of the item.			
4. Ratification of minutes of May 2016.	Director Mitchell called for a motion to approve the minutes from May 12, 2016 meeting.	Minutes ratified. Director Finnila moved and Director Schallock seconded the motion to approve the minutes from May 2016.	Karren Hertz
5. New Business a. Priority Project Dashboard	Severe sepsis management is the priority project discussed for this month's meeting. Jami reported that the Sepsis measure is a is doing considerably good even though it is a brand new measure. The Power Plan contains the severe sepsis gudelines and they were created way back in 2004. With the guidelines and order sets being used, Jami reported that these attributes helped the hospital in doing better than the national average. There is currently a challenge in identifying patients and also there is a need to adjust indicators to improve mortality. Once these process improvement take place to improve the issues taking place, the data will be improved in future tracking.	Informational	Jami Piearson
b. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Accounting of	It was noted that after a patient fills out the	**ACTION:** The Patient Care	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Disclosure of Patient Information (PHI) Procedure	PHI form, this form needs to be a part of the medical record.	Services policies and procedures were approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	
2. Release of Deceased Procedure	A sample of the mortuary form needs to be attached to this policy. It was also noted that the loss counselor (or whatever they may be called) mentioned that the staff in NICU is appropriately trained in sensitive situations like these.		
3. Infant Baptism Procedure (Spiritual Care for Family of Critically Ill or deceased Infant)	The Christian/ Catholic staff in the unit is well trained on dealing with patients who have preferences on how to deal with infants that are deceased.		
Administrative Policies and Procedures			
1. Business Visitor Visitation Requirements 8610-203	Tom Moore clarified some issues associated with this policy. He clearly defined the processes for new vendors and how they need to adhere to the hospital guidelines when they go to the hospital. He mentioned that these vendors also sign the HIPAA and BAA form. As an addition, he also stated that vendors train TCHD staff as we do not pay outside vendors to be in the hospital to do the demo for staff. TCHD staff cannot be in any way selling any item or products that is in use at the hospital.	**ACTION:** The Administrative policy and procedure was approved as moved by Director Finnila and seconded by Dr. Worman.	Patricia Guerra
Unit Specific			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Surgical Services 1. Admission/Discharge Criteria	There was a brief discussion on this policy and it was noted that this is not yet in the EHR.	**ACTION:** The Surgical Services policy and procedure was approved as moved by Director Schallock and seconded by Dr. Johnson.	Patricia Guerra
Forms 1. High Risk Infant Follow-Up Standard Visit Form 7883-1002	This form is done in consistent with the way CCS does it. The assessment is done but not necessarily the treatment This form is scanned into CERNER.	**ACTION:** The Forms were approved as moved by Dr. Contardo and seconded by Director Finnila.	Patricia Guerra
2. Progress Record	It was discussed that the paper form needs to be revised every 5 years.		
6. Clinical Contracts	No contracts were reviewd for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Directir Finnila moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 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

Targeted Solution Tool: Falls

Michelle Hardin RN, BSN

Self Assessment Score ___3__ , (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)

Active Ortho/ Telemetry Pilot

1. 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
2. Redesign Fall Risk Identification- "Fresh visibility" (T)
3. Partnering for Fall Prevention- My Safety Plan- reviewed and signed by patient and RN (T)
4. No Pass Zone- NEVER walk past room with a call light (P)
5. New wireless Fall Prevention System (P)
6. 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%

Ortho & Telemetry Falls Data

June 2016 Falls

1 North = 0 Hurray!!

Telemetry= 6

Barriers/ Lessons Learned

1. Tele staff want more concrete instructions
2. Tele staff feel like they are already doing most of the new tests of change
3. Continue to reinforce the proven positive impact of hourly rounding

Recommendations and Next Steps

1. Re-open Safe Units on 2 & 4 Pavilion
2. Patient Observer Room Assessment
3. Extend to 2p & 4P
4. Work with Tele ANMs and educator to overcome barriers

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

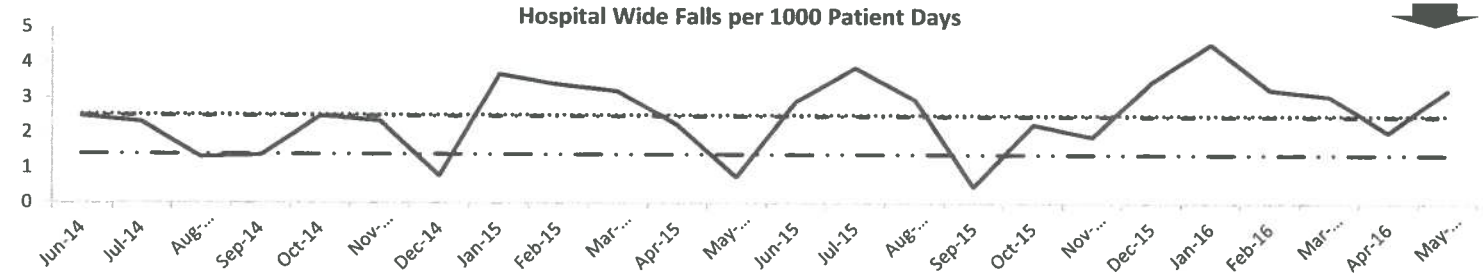
PRIORITY PROJECT:

Patient Throughput (*Hand-Out to be Distributed During the Meeting*)

Fall & HAPU's

TCMC Rate Mean CA Mean TCMC Target

Better

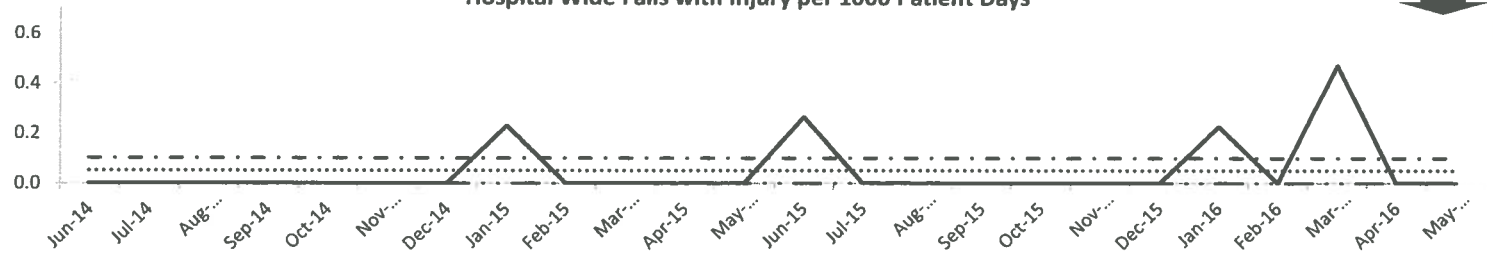


Action Plan

Falls Pilot started 6/1/16 Ortho and Telemetry to include: Active toileting, new fall signage, hourly rounding, & partnering with patients for prevention.

June 2015 Falls
Ortho= 0
Telemtry= 6

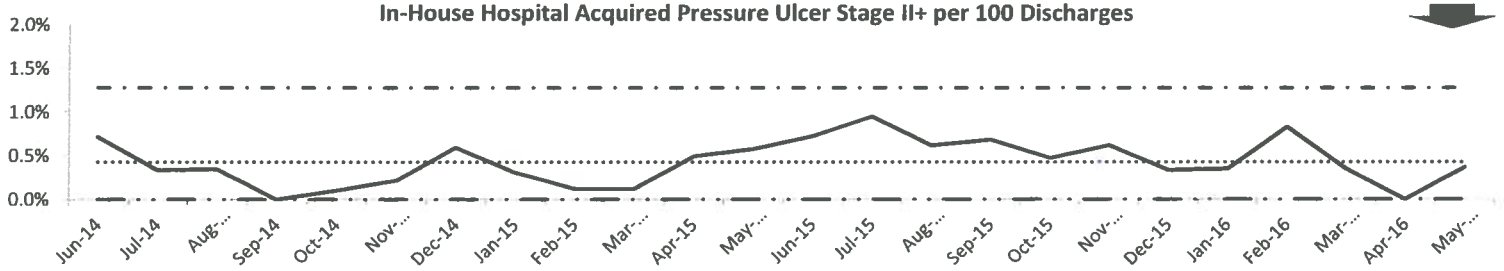
Better



Action Plan

Telemetry Barriers: Staff want more concrete instructions, Staff feel process is vague, Staff don't see what is different from what they are currently doing.
Action Plan: Work with tele ANMs to assist with reinforcement of Pilot stategies.
Try to engage more Telemetry front line users in project to create buy-in.

Better



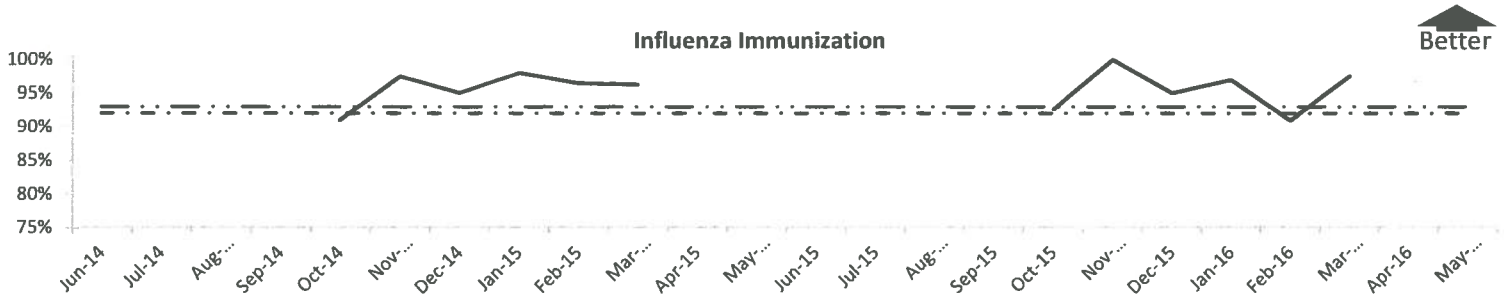
Action Plan

Increase # of expert staff & divided hospital into zones for more focused education and review.
Redesign of EHR documentation to hardwire prevention protocols & treatment documentation.
Wound Care monthly education classes.

Core Measures

TCMC Rate | Mean | CA Mean | TCMC Target

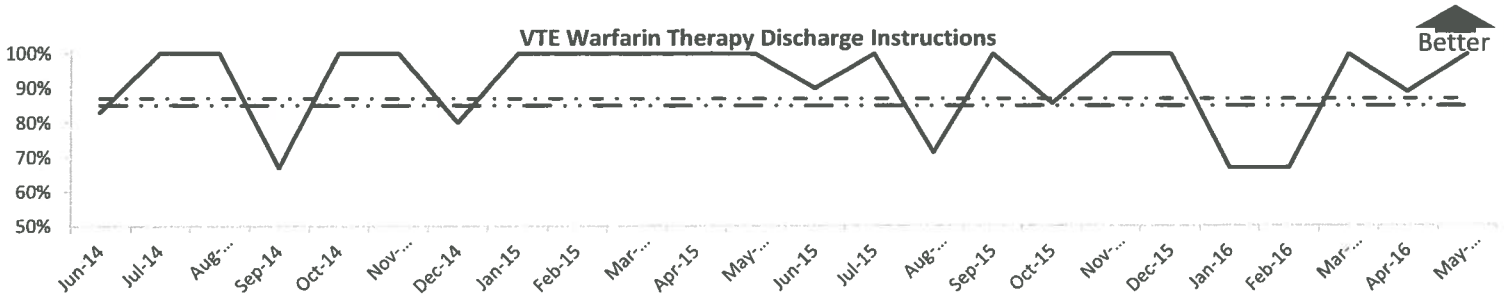
Influenza Immunization



Action Plan

IMM monitoring done for the year. Last Flu season consistently above goal results.

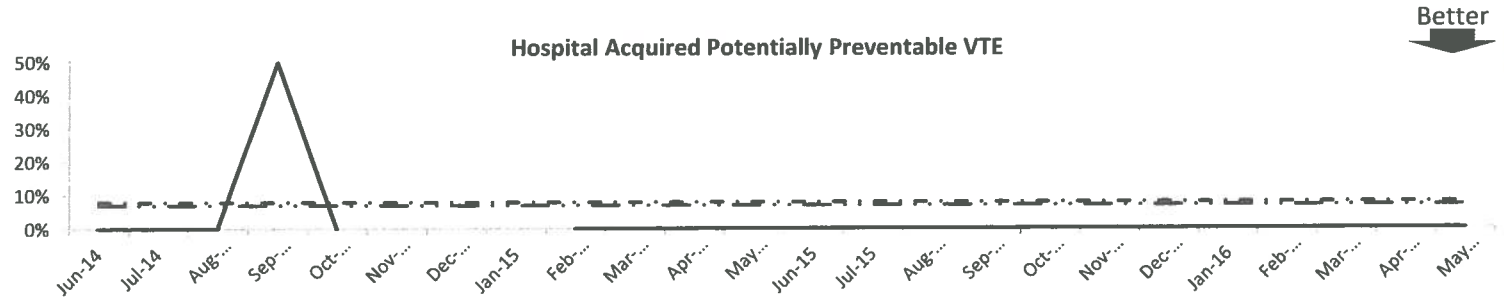
VTE Warfarin Therapy Discharge Instructions



Action Plan

January and February were below goal. Some nurses were not providing warfarin education if patient was on warfarin prior to admission. Staff education and redesign of the documentation forms seem to have corrected the problem.

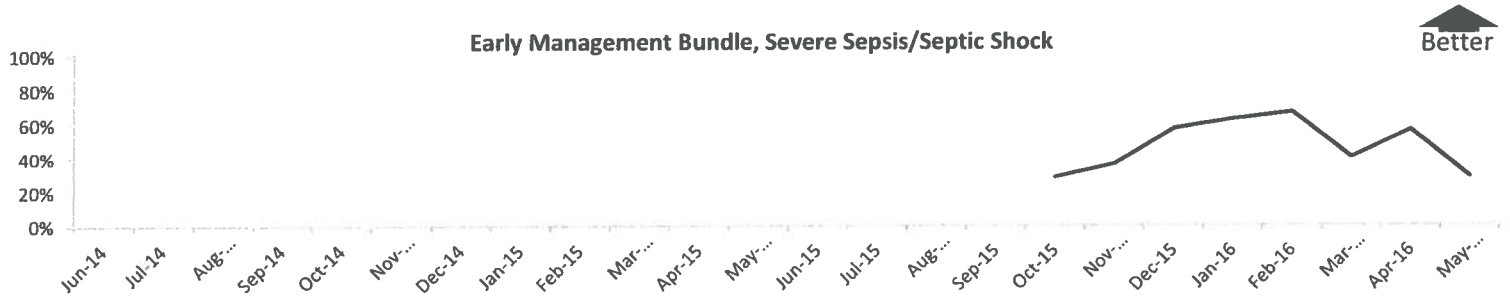
Hospital Acquired Potentially Preventable VTE



Action Plan

Consistently passing at 100%. (patients were receiving VTE prophylaxis prior to event.)

Early Management Bundle, Severe Sepsis/Septic Shock

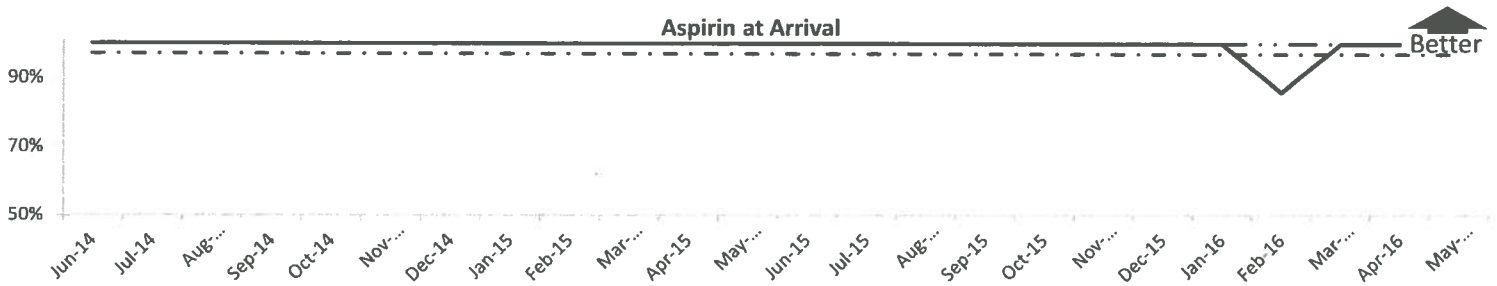


Action Plan

Small case #'s. 7 in May. No comparative data. Unofficial polling shows about 55% pass rate nationwide. Better data when MDs use Sepsis Order sets and Focused CV Assessment template used. Encouraging physician use.

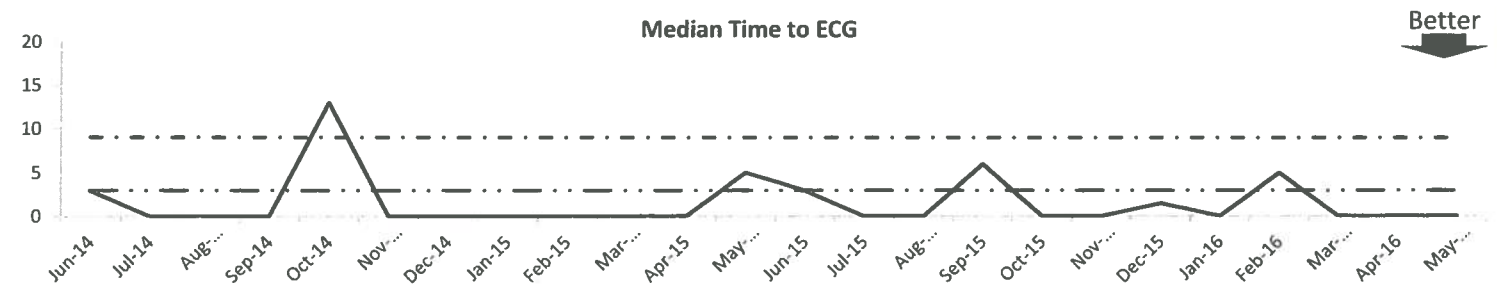
Core Measures

TCMC Rate — Mean — CA Mean — TCMC Target



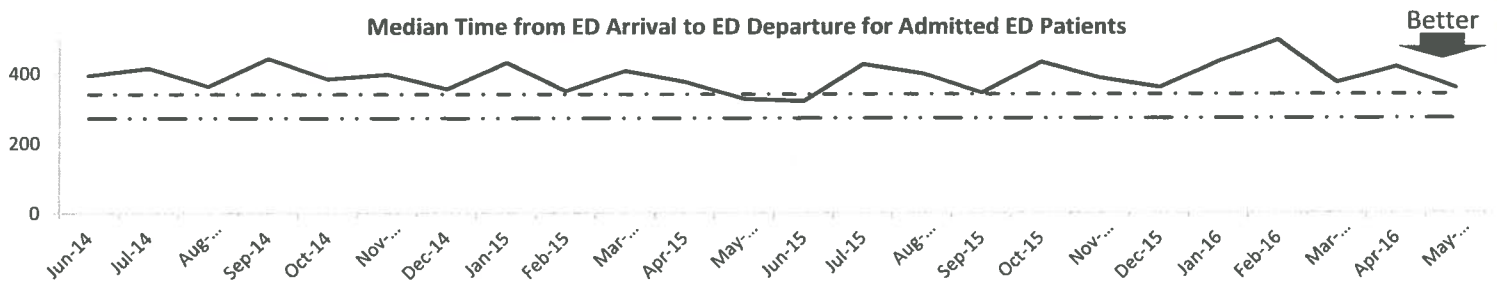
Action Plan

Consistently at 100%. Single miss in February, physician notified of fall out by Dr Showah.



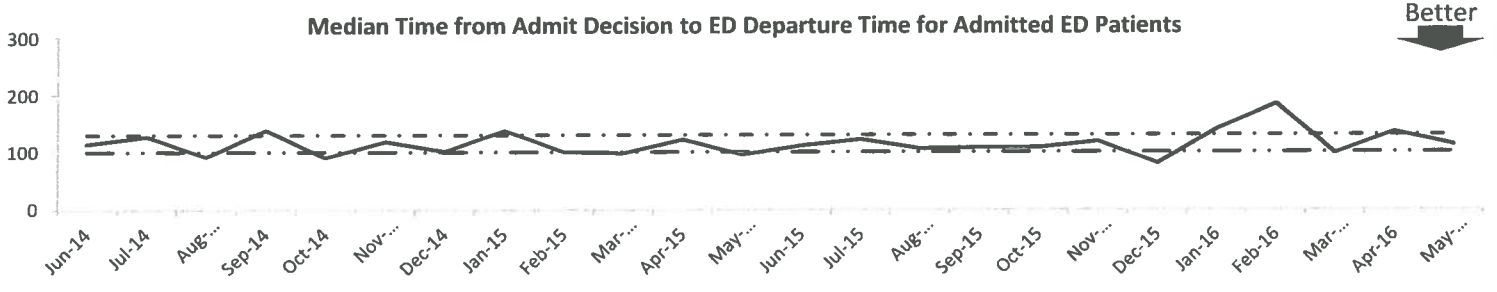
Action Plan

Consistently below top 10% hospital rate due to frequent EMS ECG's prior to arrival.



Action Plan

New Hospital Compare data comparing hospitals of comarable (very high) volume we are better (379 min) than both CA mean (423 min) and National mean (344).



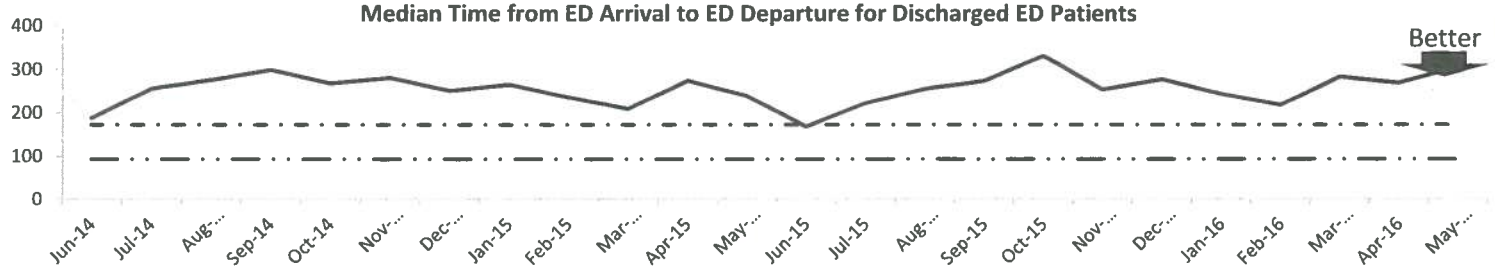
Action Plan

New Hospital Compare data comparing hospitals of comarable (very high) volume we are better (108 min) than both CA mean (180 min) and National mean (134 min).

Core Measures

TCMC Rate Mean CA Mean TCMC Target

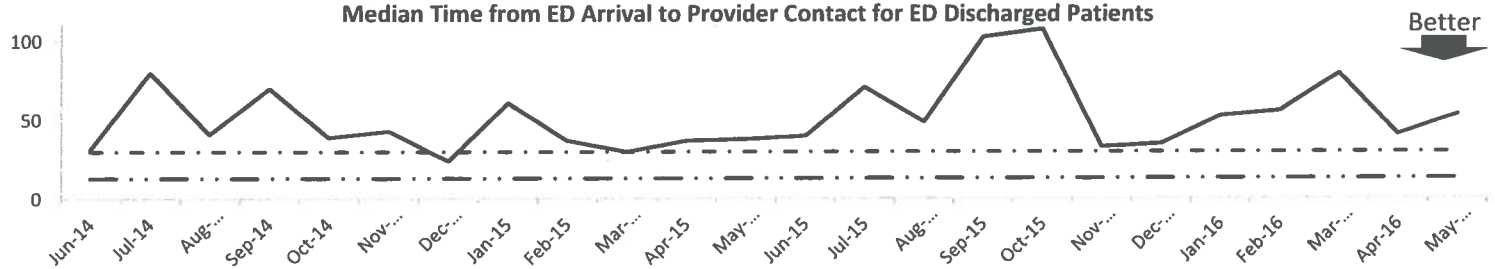
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to work on Team Triage for Level 4 and 5 pts which has seen an overall Improvement in throughput for these pts.

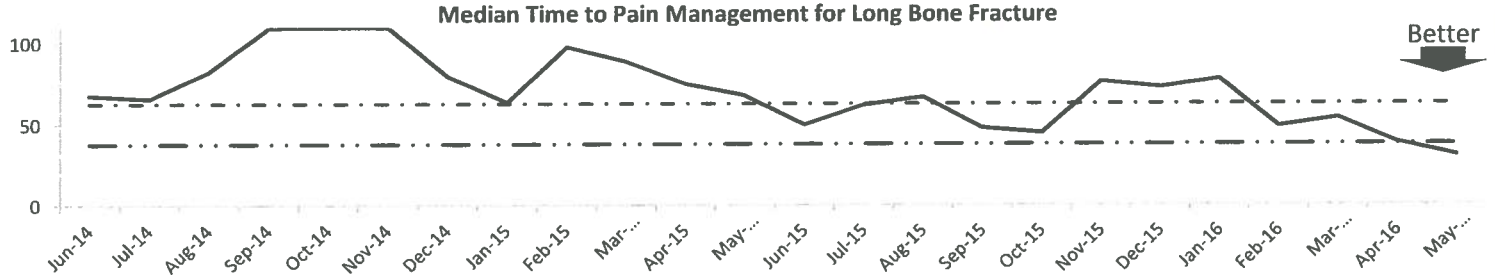
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Working on Medical Screen Exam (MSE) icon triggers to improve timeliness of MD screening and registration of ED patients. Working to expand hours of Team Triage.

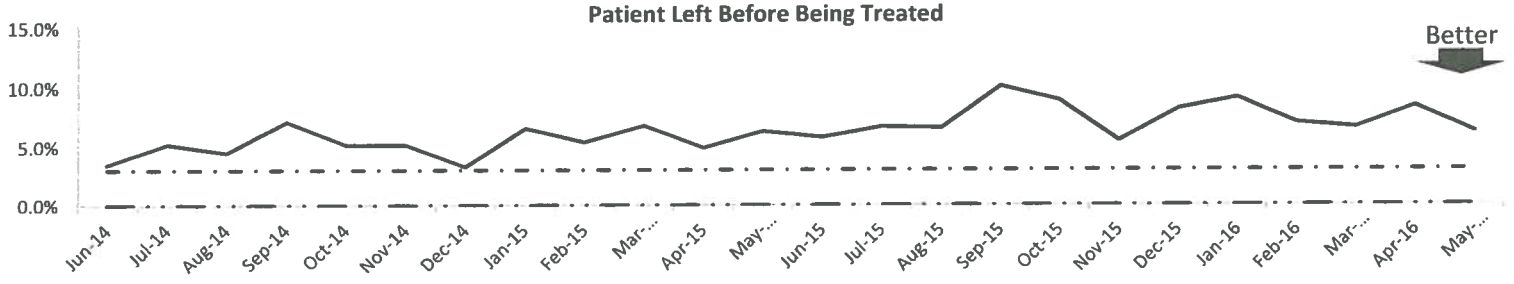
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continued improvement finally passing goal of 40 min mean time to pain administration. Working to maintain.

Patient Left Before Being Treated



Action Plan

Correlation seen between higher ED volume and pt census in August which causes increased LWBS for patients. Working to expand Team Triage hours.

PROFESSIONAL AFFAIRS COMMITTEE
July 14th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS)	Practice change	
Alcohol Withdrawal Symptom Management	NEW	
Chain of Command Policy	3 year review	
Emergency Cart, Cardiopulmonary Arrest	3 year review, practice change	
Family Presence During Resuscitation	3 year review, practice change	
Postural (Orthostatic) Vital Signs, Obtaining	3 year review, practice change	
Stool Management (Rectal Tube) Dignicare Stool Management System	3 year review	
Unit Specific		
Medical Staff		
Credentialing Policy, Processing Medical Staff Reappointments	3 year review, practice change	
Formulary Requests		
Bridion – Trade Name Sugammadex – Generic Name	NEW	
Emend – Trade Name Aprepitant – Generic Name	NEW	
Veltassa – Trade Name Patiromer sorbitex calcium – Generic Name	NEW	

ISSUE DATE:

SUBJECT: Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS)

REVISION DATE(S): 4/14

Clinical Policies & Procedures Committee Approval:	**~~02/14~~10/15**
Nursing Executive Committee Approval:	**~~02/14~~10/15**
Medical Executive Committee Approval:	**06/16**
Professional Affairs Committee Approval:	**04/14**
Board of Directors Approval:	**04/14**

A. **PURPOSE:**

1. To outline the Advanced Care Technician's shift assignments, routines, tasks, vital sign, intake and output, and weight assignment.
2. Acute Care Services (ACS) ACT's, Telemetry ACTs, resource ACTs, and registry Certified Nursing Assistants (CNA) shall use the Handoff Tool for their assigned unit to communicate shift handoff.

B. **POLICY:**

1. ACTs shall assist with patient care needs of all patients' on their assigned units as delegated by the Registered Nurse (RN) and the Assistant Nurse Manager (ANM)/relief charge nurse.
2. Assignments shall be made every shift by the ANM or relief charge nurse.
3. Assignments may not be changed without the approval of the ANM/relief charge nurse
4. Breaks Telemetry & ACS
   a. One ACT shall be available on each unit at all times
   b. ACTs shall sign up for break times at the beginning of their shift.
   c. Break times will be determined by the management team and listed on the break sheet.
      i. Sitter break coverage shall be arranged by the ACTs assigned to the unit or ANM
   d. The ACT break sheet will be posted on every unit to inform RNs of the ACT break times.
   e. ACTs are expected to take the allotted time for breaks.
      i. ACT's must initial on the break form to confirm break time.
5. Hand-off
   a. Shift handoff is mandatory and shall be conducted for a maximum of 10 minutes from 0700-0710 and 1900-1910.
      i. After reviewing the ACT/CNA Report Sheet, start answering call lights and phones, pass or pick up meal trays, and start A.M. or P.M. care while the nurses are completing report.
   b. Hand Off Tool
      i. Telemetry Hand Off Tool - The Nursing Unit Census shall be used as the Telemetry ACT Hand-off tool.
      ii. Acute Care Services Hand Off Tool (ACT Report) - The ACS ACT Hand Off Tool shall be used when giving and receiving report
   c. Shift hand-off shall consist of a verbal hand-off and rounds on assigned patients
   d. The following information shall be documented on the ACT Hand-off tool:
      i. Code Status
      ii. Isolation Status
      iii. Patient's orientation i.e. alert, confused
      iv. Oxygen requirements i.e. nasal cannula, number of liters
      v. Mobility i.e., with assist, lift team assist, turn every 2 hours

vi. Toileting needs i.e., voids, foley catheter, rectal tube, incontinent
vii. Hygiene needs i.e., (shower bed bath, or minimum assistance)
viii. Oral care
ix. Tubes, drains, and other patient care equipment
x. Daily weight
xi. Diet
1) Aspiration precautions
2) Level of assistance required during meals
xii. Intravenous (IV) type and location [i.e. peripheral (saline lock) vs. central venous catheter (CVP), or peripherally inserted central catheter (PICC)].
xiii. Special considerations
1) Hard of Hearing
2) Legally Blind
3) No Blood Pressure (BP) on Left or Right Arm
4) Restraints
5) Dialysis fistula/graft
6) Mastectomy
xiv. Admitting diagnosis
xv. Safety Falls Risk status
xvi. Braden Scale

e. Note tasks not completed on previous shift and ensure incomplete tasks are completed prior to the end of the shift. Task not completed shall be communicated to RN and oncoming ACT.
f. After the RN (s) complete their bedside report, check for any additional patient information or changes in patient care for assigned patients.
g. Discuss with the lift team member patients needing their assistance.

6. Vitals Signs
a. Vital signs shall be taken on all patients per unit policy and as directed by the RN
i. Telemetry vitals signs every 4 hours while patient is awake and as needed
ii. ACS vital signs every 8 hours and as needed
b. Vital signs shall be taken on all patients scheduled for discharge at least one hour prior to discharge per Patient Care Services Discharge of Patients – Discharge AMA Policy.
c. The heart rate/pulse will be obtained using the patient's radial pulse per Mosby's Radial Pulse Procedure.
d. Vital signs shall be initially documented on the Vital Signs Worksheet and then charted in the medical record after they are reviewed by the primary RN.
e. After obtaining vital signs complete the following:
i. Make copies of the Vital Signs Worksheet for each RN
ii. Give each RN a copy of the Vital Signs Worksheet
iii. Document the results of the vital signs in the medical record after the primary RN reviews the results and provides instructions to document
f. Report the following findings to the primary RN immediately or as instructed by the primary RN:
i. Temperature greater than 38.6 or less than 36
ii. Heart Rate (HR) greater than 100 or less than 60
iii. Systolic Blood Pressure (SBP) greater than 150 and less than 100
iv. Diastolic Blood Pressure (DBP) greater than 90
v. Respiratory Rate (RR) greater than 24 and less than 10 breaths per minute
1) Post-op patients RR less than 14 breaths per minute
vi. SPO2 less than 92%

7. Intake and Output (I & O)
a. Intake

i. ACTs are responsible for measuring and documenting oral intake on all patients on their assigned unit in a timely manner
ii. ACTs are responsible for refilling the water pitchers every 8 hours or as directed by the primary RN.

b. Output
i. ACTs are responsible for measuring and discarding urine and stool for all patients on their assigned unit, and documenting the results in a timely manner.
1) Check urine output every 4 hours and notify the primary RN if low or no output. Notify the primary RN if less than 240 mLs of urine is obtained within 8 hours or patient has not voided.
2) Check stool output once a shift and notify the primary RN of any complaints of constipation or diarrhea
ii. Output from tubes and drain is limited to Foley catheters, rectal tubes, and colostomies canisters and will be measured and discarded at the end of the shift or as directed by RN.
iii. Nasogastric canisters will be emptied as directed by RN. .

c. Intake and output will be completed and documented in a timely manner and prior to the end of each shift.
d. Intake and outputs not completed by the end of the shift shall be communicated to the oncoming ACT/CNA and primary RN.

8. Weights
a. Admission
i. All patients shall be weighed on admission
1) All patients transferred to Telemetry shall be weighed as directed by the RN.
ii. The patient's weight and the type of scale used to weigh the patient shall be documented in the medical record.

b. Daily
i. Nightshift ACTs shall receive a daily weight assignment from the RNs on their assigned units.
ii. All daily weights shall be completed and documented by nightshift ACTs
iii. Weights not completed shall be communicated to the RN and the oncoming shift ACT.
1) The oncoming shift ACT shall weigh the patient(s) and document the weight

c. Please review Patient Care Services Weighing Patients for additional information

9. Bath Assignments
a. Document bath assignments on the Bath Board. Draw a line through the assignment when the bath is completed.
i. Place the letter "R" near the assignment if the patient refuses and inform the primary RN.
ii. ACTs are responsible for documenting completion of the baths in the medical record.
iii. Dayshift ACTs are responsible for complete assist baths or ensuring showers are taken, if ordered, on their assigned patients.
1) Baths not completed on the dayshift shall be communicated during shift hand-off and completed by the nightshift ACT.
iv. Nightshift: Each ACT is responsible to complete up to 4 baths on confused or total care patients. If these patients are not on the unit, ask each primary RN for at least two patient bath assignments.
1) Baths not completed on the nightshift shall be communicated during shift hand-off and completed by the dayshift ACT

b. Electrodes shall be replaced with each bath if needed and PRN.

c. Ventilator patients (Core Telemetry ACTs only may be assigned to these patients:
   i. Ventilator patients that are not weaning shall receive a bath daily on nightshift and as directed by the RN.
   ii. Ventilator patients and patients with artificial airways that are weaning shall receive their baths on the nightshift between 1800 and midnight or as directed by the primary RN.

d. Confused, disoriented, or patients that are awake shall be offered a bath during the PM and night time frames or as directed by the RN

10. Meals
   a. Patients shall sit in chair for all meals unless instructed to remain in bed by the primary RN
   b. Diabetic patients should not receive their trays until checking with primary RN to ensure the point of care blood glucose (finger stick) is completed
   c. Distribute bedtime snacks as directed by the RN
      i. Restock refrigerator when supplies are received for dietary
   d. Document percentage of meal intake in the medical record.
   e. Ensure trays are removed from patient's room after completion of the meal
11. Infection Control
   a. Infection control manual must be followed at all times.
   b. Always check with the RN if unsure of the patient's isolation status or if unclear on what isolation precautions need to be taken.
   c. Infection Control Caddys or baskets must be kept stocked throughout the shift by both the day and night shift ACTs.
   d. Gloves and masks must be disposed of when exiting the room of a patient that is on isolation precautions.
   e. Perform hand hygiene and clean equipment use for all patients prior to leaving patient's room.
   f. Do not use masks multiple times. Masks are one time use only.

C. **PROCEDURE:**
1. Duties and Responsibilities of all ACT's
   a. Document all interventions performed.
   b. Answer telephones and patient call lights during RN shift hand-off and PRN
   c. Sitter relief as directed by the RN and/or ANM/relief charge nurse
   d. Weights (daily, admission, transfer and as directed by the RN)
   e. Pre-operative shower/baths for patients as directed by RN per PCS Pre-Operative Patient Preparation
      i. Cardiovascular surgery (CVS) ~~patients~~**patients** pre-operative clipper prep and showers/bath should be performed by Telemetry ACTs hired for the Telemetry Unit.
   f. Distribute and assist with meal trays and bedtime snacks as directed by RN
   g. Ambulate patients as directed by RN
      i. Documentation should include the patient's distance and tolerance of the activity
   h. Assist with passive Range of Motion (ROM) as directed by the RN
   i. Assist with pressure ulcer reduction by completing the following:
      i. Assist with and/or ensure the lift team repositions patients requiring assistance every 2 (two) hours and more often as directed by the RN
      ii. Offer toileting and hygiene care to incontinent patients every hour
      iii. Offer hydration as directed by the RN
      iv. Discuss any skin abnormalities with the primary RN
   j. Discontinue foley catheters and saline locks as directed by the RN and document in the medical record. Notify RN immediately if unable to manage bleeding, redden skin, patient complaint of pain not related to removal of tape, drainage other blood.

k. Apply Falls Risk bands as directed by RN or as indicated from the information obtained from the hand-off tool per PCS Fall Risk Procedure and Scoring Tool
l. Check and restock patient room supply baskets and remove inappropriate supplies every shift
m. Document vital signs, weights, intake and output, and Activity of Daily Living (ADL)s
n. Other duties as assigned by RN and/or ANM/relief charge nurse

2. Hourly Rounding ACT Standard Work
   a. ACTs shall round on the odd hours and as direct by RNs.
   b. Introduce yourself to patient and explain your role
   c. Inform patient of the task(s) that you plan to perform prior to performing the tasks(s)
   d. Address the four (4) P's i.e., Potty, Pain, Position and Possession
   e. Address comfort needs
   f. Ask patient prior to leaving room if there is anything else you may do for them
   g. Document completed task in the medical record
3. Patient Safety
   a. Prior to leaving a patient's room ensure the following:
      i. Patient's room is clean and uncluttered
      ii. Bedside tray is clean, clear of clutter and within patient's reach
      iii. Call button, television remote control and patient's other personal items are within patient's reach
      iv. Water pitcher is filled per RN instructions and/or per unit specific policy
      v. Patient's bed is in low position with upper side rails in up position
      vi. Appropriate patient signs are posted as directed by RN
      vii. Ensure each room has appropriate urine or stool graduated collection containers.
      viii. Ensure graduated container is clearly marked with patient's name and bed location. For example:
         1) Mr. Doe
         2) Room 232
   b. Assist the lift team when they are in the room turning patients or ambulating patients
4. Equipment
   a. Ensure all patient care equipment is placed or returned to the appropriate location
   b. Ensure equipment that requires charging is plugged in a socket when not in use
   c. Ensure equipment is cleaned per TCMC policy or manufacturers recommendation after each patient use
   d. Ensure remote monitoring unit and remote monitoring cables are cleaned when patient are transferred or discharged
5. Admissions and/or Transfers
   a. Assist with admission and transfers to unit by completing the following:
      i. Set up room with hygiene items, water pitcher, cup and urine collection container (label container with patient's name and room number)
      ii. Ensure chair scale is available, zeroed, and near patient room; use the chair scale to weigh ambulatory patients.
         1) If a bed with a scale is needed, ensure the bed is zeroed per unit specific policy.
      iii. Assist patient into a gown if needed.
      iv. If abnormal skin findings are observed, notify the RN.
   b. Orient patient on the use of bed controls, call button, television (TV) remote, telephone, meals times, and use of light controls
   c. Provide rationale for using urine collection container
   d. Document patient's belongings, vital signs, admission weight, height, and ADLs in the medical record
      i. Notify primary RN of abnormal vital signs, patient questions, concerns, complaints, and other abnormal findings.

e. Monitored units:
   i. Telemetry Unit
      1) Place clean Telemetry box with batteries inserted and leadwires in room
      2) Attach patient to Telemetry box, or DASH if needed, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor
      3) Ensure Telemetry box is placed in a plastic protective cover
   ii. Medically Monitored Unit
      1) Place clean remote monitoring unit with batteries inserted and leadwires in room
      2) Attach patient to remote monitoring unit, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor

6. Post-Operative Transfers – set-up room before patient arrives
   a. Bed available with linen pulled down and scale zeroed
   b. Equipment available:
      i. Vital sign machine
      ii. Remote monitoring device appropriate to unit
      iii. Oxygen regulator with tubing connector
      iv. Suction set-up including regulator, tubing and container
      v. Infusion pump
      vi. Sequential compression pump
      vii. Emesis basin
7. Discharges, transfers to non-monitored units, or rate monitoring discontinuation
   a. For monitored patients, remove remote Telemetry box/ remote monitoring unit immediately after notification by the RN or ANM/relief charge nurse
      i. Clean Telemetry box/remote monitoring unit and leadwires with appropriate cleaning solution and store in the appropriate location
   b. Place all patient belongings in a "Patient Belonging Bag"
      i. Check room cabinets, drawers, and bedside table for patient's belongings
      ii. Inform RN if patient/or their family reports personal items are missing, notify RN immediately.
   c. Assist patient with discharge by performing the following as directed by the RN:
      i. Removal of saline lock
      ii. Removal of foley catheter
      iii. Assist patient with applying clothing
   d. Ensure vital signs including pulse oximetry are obtained at least one hour prior to discharge. Inform RN of the results immediately.
   e. Assist with discharge transfer via wheelchair as directed by the RN

~~A.~~D. SPECIALTY PATIENT POPULATIONS:

~~8.~~**1.** Status Post Cardiac Catheterization
   a. Non-core Telemetry ACT will receive additional instructions from primary RN
   b. Do not reposition patient without instructions from the primary RN
   c. Ensure a procedure vital sign sheet is placed in patient's room
   d. Program vital sign machine to take vital signs every 15 minutes or as directed by an RN

~~9.~~**2.** Cardiovascular Surgery (CVS) Patients – shall be assigned to core Telemetry ACTs
   a. Pre-operative Care
      i. All AM showers should be completed 2 (two) hours prior to the surgery. Verify the time of AM shower with the RN.
      ii. Perform the following task as outlined below and/or as directed by the RN
         1) Obtain urine for urinalysis
         2) Set up DVD player with the appropriate education DVD as directed

3) Assist patient with PM shower/bed bath
   a) Change linen prior to patient returning from bath or after completion of bed bath
4) Complete AM clipper prep
   a) Use surgical clippers only. Do not use disposable razors.
   b) Change clipper blade frequently as needed do not allow the clipper blades to become dull.
5) Change patient's electrodes and place patient on Telemetry box
6) Do not place electrodes on or near the sternum.
7) Notify the primary nurse of abnormal skin findings.
8) Weigh patient if more than 3 (three) days has passed since admission or as directed by the RN
9) Document shower or bed bath, clipper prep, weight and vitals in the medical record

b. Post-operative Care Prior to Shower/Bath
   i. All CVS patients shall shower unless contraindicated, i.e., shortness of breath, attached to a pacemakers, attached to infusion pump, and/or abnormal vital signs as directed by the primary RN.
   ii. If a patient does not shower or receive a bed bath on the day shift, the patient shall have a shower/bed bath on the PM shift with the assistance of the ACT.
   iii. All patients must receive a shower or bed bath daily and/or as directed by the RN.
   iv. Perform the following task as outlined below and/or as directed by the RN:
      1) Verify with the RN patient may be escorted to shower. Remain with patient during first shower and/or until the primary RN states it is safe for the patient to be alone during their shower.
      2) Report the following to the primary RN; patient complaints of dizziness, headache, light-headedness shortness of breath, increased pain, and/or drainage from incision sites.
      3) Remove and discard dressing and assist patient to the shower using the necessary equipment directed by the RN
      4) Do not remove the patient's oxygen during the shower unless instructed by the RN
      5) Cover peripheral IV access or central line IV access with water proof barrier or glove. Secure the water proof barrier or glove with waterproof plastic tape
      6) Remove ted hose, if applied prior to going to the shower
      7) Report patient's refusal of shower or bath to primary RN

c. Post-operative Care After Shower/Bath
   i. Assist patient back to their room, remove water proof barrier from peripheral IV site or central IV site. Notify RN immediately if the central line dressing is wet or loose
   ii. Ensure incisions are dry. Do not apply lotion, ointments, betadine, iodine, or creams to incisions.
   iii. Re-apply ted hose if ordered
   iv. Assist patient to bed or chair
   v. Document patient's bath/shower and ambulation to shower in the medical record.
   vi. Ensure all patient equipment is within reach i.e., call button, water cup, tissue, telephone, and Incentive Spirometer (IS).

d. Post-Operative Ambulation
   i. Ambulate patients as ordered or at least 3-4 times a day.
      1) Examples: ambulate patient after breakfast, before lunch or dinner, and after dinner or prior to the patient's bedtime.
   ii. Patient's first ambulation shall be with oxygen, if ordered, and with a nursing staff and thereafter as directed by RN.

iii. Check patient's oxygen saturation during ambulation.
iv. Notify the primary RN if patient appears short of breath, patient complains of shortness of breath, has a decrease on oxygen saturations, and/or complains of discomfort. Assist patient back to their room or to nearest chair.
v. Ambulation post-op CVS with patient pushing a wheelchair and oxygen until informed by an RN patient may ambulate independently
vi. Encourage patients with steady gaits to ambulate ad lib, or as directed by RN.
vii. Document patient's ambulation distance and tolerance in the medical record

3. Seizure monitored patients on Medically Monitored unit
a. Non-core 4 Pavilion ACTs will receive additional instructions from primary RN

~~10.~~**4.** Orthopedic patient population
a. Non-core 1 North ACTs will receive additional instructions from primary RN

~~11.~~**5.** Oncology patient population
a. Non-core 2 Pavilion ACTs will receive additional instructions from primary RN

6. Progressive Care Unit
a. ACTs assigned to the Progressive Care Unit will follow the guidelines identified within the Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS) with the following exceptions:
i. ACTs will be staffed based on unit census
ii. Handoff-tool
1) ACTs will use Progressive Care Unit identified hand-off tool
iii. Vital signs will be obtained as outlined for ACS and Telemetry and as ordered
iv. Showers
1) A Correctional Officer (CO) or Deputy will escort patients to and from the showers. Patients will be showered as outlined below:
a) Occupational Therapy (OT) Patients
i) Occupational Therapist will assist with showers
b) Post Cardiac Surgery Patients
i) Patients will be showered daily as order; preferred time prior to 0700
c) California Department of Correction and Rehabilitation (CDCR)
i) Patients will be showered on Monday, Wednesday, and Friday
d) San Diego Department of Correction
i) Patients will be showered on Tuesday, Thursday, and Saturday
v. Baths (Bed Bath)
1) Patients will receive a bed bath only if a shower is contraindicated
~~1.~~2) If patient requires a bed bath, allow patient to bath self and provide assistance as needed
vi. Electrode Care – electrodes will be changed daily with AM vitals and scheduled baths/showers as identified in 6.v.
vii. Additional task and responsibilities are outlined in the Progressive Care Unit ACT Shift Task List

~~2. Seizure monitored patients on Medically Monitored unit – need to add information~~
~~Non-core 4 Pavilion ACTs will receive additional instructions from primary RN~~

~~D.~~E. FORMS:

1. Acute Care Services Hand-Off Tool (ACT Report) **- SAMPLE**
2. ~~Telemetry~~ **ACT** Hand-Off Tool **- SAMPLE**
3. ACT Task List
4. ACT Shift Helpful Hints
~~3.~~5. Progressive Care Unit ACT Shift Task

Sample Acute Care Services Hand Off Tool (ACT Report)

ACT REPORT

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

PATIENT NAME:			ROOM
AGE:	SEX:	CODE:	FALL RISK: Y N
DIAGNOSIS:		ALERT	OXYGEN
ISOLATION: STANDARD MRSA ESBL C-DIFF AIRBORNE VRE SITE:			
ACTIVITY:	OUTPUT:		V/S:
DIET:		ACCU CHECK: Y N	
NOTES:			

Sample~~Telemetry~~ ACT Hand-Off Tool

SAMPLE

TRI-CITY MEDICAL CENTER
NURSING UNIT CENSUS
NURSING UNIT 2E
MON Current Date

ROOM / DIAGNOSIS / PRIMARY INSURANCE	PATIENT NAME / CORE MEAS / URINARY CATHETER	AGE / ADMIT PHYSICIAN	SEX	ADMIT DATE / FALL RISK	LOS	MRUN / BRADEN	TYPE / CENTRAL LINE	SERVICE / ACCOMMODATION
227-01 afib flutter Medicare A and B	Patient's Name NPO up with assist, BPR, 2L NC, Daily WT, IV on pump Bath	79 Y	M	Date of Admission Admitting Physician FR: 35		Inpatient BS 17		DOU DOU
227-02 Sepsis Hypothermia Medi-Cal	Patient's Name up Ad lib, gait steady, Indwelling catheter RA Family at bedside	57 Y	M	Date of Admission Admitting Physician FR: 85		Inpatient BS 14 CL Triple		DOU DOU
228-01 pneumonia	Patient's Name NO Code 6Lt NC	93 Y CM P	F	Date of Admission Admitting Physician FR: 35		Inpatient BS 15		DOU DOU

The following information shall be documented on the ACT Hand-off tool

i. **Code Status**
ii. **Isolation Status**
iii. **Patient's orientation i.e. alert, confused**
iv. **Oxygen requirements**
v. **Mobility i.e. with assist, lift team assist, turn every 2 hours**
vi. **Toileting needs i.e. voids, foley catheter, rectal tube, incontinent**
vii. **Tubes and drains**
viii. **Daily weight**
ix. **Equipment in use**

Review the handoff tool for the information listed above and the following:

x. **Admitting diagnosis**
xi. **Safety Falls Risk status**
xii. **Braden Scale**

ACT Task List

Beginning of the Shift Checklist

- ❑ Receive hand-off tool for the following:
  - ✓ Diet
  - ✓ Ambulatory needs
  - ✓ Code Status
  - ✓ Isolation Precautions
  - ✓ Special Considerations
    - ➢ Hard of Hearing
    - ➢ Legally Blind
    - ➢ No BP on Left or Right Arm
    - ➢ Restraints
    - ➢ Fall Risk
    - ➢ Pressure Ulcers
- ❑ Vitals Signs
  - Write your name and date on patient's board
  - Make sure all patients have an identification band or a risk for fall band. If the allergy band is missing, notify RN
- ❑ After completing vitals, if AM
  - Prepare patients for breakfast
  - Offer washcloth for hands and face

Before Meal Trays Arrive

- ❑ Document vitals and assist with answering call lights and telephones
- ❑ Document bath assignments on the bath board

Arrival of Meal Trays

- ❑ Pass trays and assist with answering lights
- ❑ Pass HS snacks as directed by RN
- ❑ Assist feeders, if no feeders, go to break or document VSS and I & O's

Vital Signs AM Shift

- ❑ Begin AM vitals 0730-0900
- ❑ Begin Noon vitals at 1100-1200
- ❑ Begin Evening vitals at 1600 & 1930
- ❑ Begin Midnight vitals at 2200-0100
- ❑ Begin Night Shift AM vitals 0400-0600
- ❑ Documented vital signs as soon as possible

After meal times

- ❑ Complete documentation
- ❑ Ambulate patients

Intake and Output

- ❑ Document output after completing task
- ❑ Document intake as soon as possible

Hourly Rounding

Assist with hourly rounding as directed

HS Snack

Pass HS as directed by RN. Document intake in the medical record

HS Care

Assist patients with HS care

End of Shift Checklist

- ❑ I/Os documented
- ❑ Vital Signs documented
- ❑ Hand-off tool updated
- ❑ Patient's room clean, call button within reach
- ❑ Upper side rails up
- ❑ Water pitcher refilled per unit policy and/or as directed by RN
- ❑ Patient information signs posted above head of bed

Admission Checklist

- ✓ Assist ED staff by helping to transfer patient from gurney to their room
- ✓ If patient is ambulatory, use chair scale
- ✓ Ask patient for their height or estimate (verify with RN)
- ✓ Assist patient to bed
- ✓ Assist patient with removal of their clothes
- ✓ Assist patient into a hospital gown
- ✓ Obtain admission vital signs
- ✓ Provide the patient with the following:
  - ➢ Pitcher of water and cup, if not NPO
  - ➢ Box of tissue
  - ➢ Bedside trash bag
  - ➢ Toothbrush and toothpaste
  - ➢ Plastic comb
  - ➢ Slippers
  - ➢ Place a urinal or "hat" in the bathroom
  - ➢ Label urinal or hat with pt's name and room number
- ✓ Before leaving the room complete the following:
  - ➢ Instruct patient how to use the call button and place it near the patient
  - ➢ Instruct patient how to use to the bedside lights, TV remote, and bed controls
  - ➢ Place bedside table within reach of patient
- ✓ Document the patient's WT, HT, and vital signs

Transfer /Discharge Checklist

- ✓ Assist with discharges and transfers as directed by RN and/or ANM/relief charge nurse
- ✓ Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge

Telemetry 2/08, Revised 11/10;5/11. 5/12, 3/13 PFR

ACT Shift Helpful Hints

TIME	TASK	HELPFUL HINTS
0700-0800	Provide/receive hand-off and round with off-going ACT. Identify sitters and arrange break coverage. Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water Assist with answering phones and calls lights Receive update from RNs Offer washcloth for hand/face	Document any special task on your vital signs' worksheet Ask patients the following prior to leaving their rooms: 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Check incontinent patients
0805-1100	Prepare patients for breakfast and pass trays Take vital signs, make copies of the vital signs' worksheet for the primary nurses, and receive approval of vitals before documenting. Document vitals, outputs, and ADLS Assist with answering phones and calls lights Start AM bath assignments Assist with answering call lights and answering telephone calls, reposition patients and Complete oral care as needed. Pick up trays, and Document breakfast intake	Bath assignments: Note the patients who will need oral care, baths, or require assistance with repositioning or ambulating. Assist patients with feeding as needed Take a few purple fall bands and keep them in your pocket. Put them on patients as needed while you are taking vital signs, answering calls lights, assisting with baths.
Until lunch trays arrive	Start Noon Vital signs Check incontinent patients; assist patients to the bathroom, and check urine collection containers. Sign falls log Document vitals, output, and ADLs prior to leaving for the next unit. Assist with answering call lights and answering phones. Assist with passing lunch trays and assist patients with feeding as needed	Note the patients who will require assistance with repositioning or ambulating. Ask patients the following prior to leaving their rooms: 1. Would you like to be repositioned? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? 3. Would you like to take a walk before or after lunch? Can I get you anything before I leave?
Breaks	Take morning break as assigned. Breaks shall not exceed 30 minutes	Inform ACTs and primary RNs you are leaving the floor for break
Until lunch trays arrive -1330	Go to lunch after patient lunch trays are passed (Breaks shall not exceed 30 minutes) Pick up lunch trays Document intake and complete documentation of noon vital signs. Complete AM Care and reposition patients Assist with answering call lights.	Inform primary nursing that you are leaving the floor for break Assist with discharges, transfers, and admissions
1331-until arrival of dinner trays	Round: Check incontinent patients; assist patients to the bathroom, check urine collection containers and empty foley catheters, and other drainage collection containers. Refill water pitchers Assist with answering call lights and telephones Complete charting. Ambulate patients Set up room (s) for new admissions	Assist with discharges, transfers, and admissions Prepare patient's for dinner (assist to chair, raise head of bed) Complete baths. Inform primary nursing that you are leaving the floor for break After ambulating patients offer the chair instead of returning them to bed. (This will prepare the patient for dinner). Call the lift team to assist as needed. Consider documenting any I & Os or ADLS that you have not completed. Do not restock supply baskets before you complete your documentation. Remember: an empty room will be filled and you will be expected to assist.

TIME	TASK	HELPFUL HINTS
until dinner trays arrive	Prepare for break Take evening break as assigned. Breaks shall not exceed 30 minutes Assist with answering telephones and call lights	Inform ACTs and primary RNs you are leaving the floor for break
1700-1830 (Dinner Trays Arrive)	Pass trays Assist with patients as needed	Once trays are passed and you have assisted patients requiring assistance with feeding, go to break.
1831-1900	Prepare for hand-off Review documentation Round on all patients	Complete task as needed
1901-2000	Provide/receive hand-off, round with off-going ACT. Assist with answering call lights and telephones Receive update for task to perform from primary RNs	
1931-2000	Pick up dinner trays Start vitals Make copies of the vital signs' worksheet for the primary nurses. Document vitals, intakes, outputs, and ADLS Get an update and sitters you may need to relieve for breaks. Check incontinent patients Place bedside table, with water pitcher, call button, and telephone within patient's reach. (Check to ensure the previous shift provided patients not NPO with a fresh pitcher of water). Assist with answering phones and calls lights Identify patients requiring baths, ambulation, repositioning every two hours	Consider documenting intakes before starting vitals If you cannot complete your documentation, do not worry, chart as much information as you can and continue to assist as the primary nurses as needed. Assist with transfers, discharges, or admissions
2001-2230	Take dinner break (breaks shall not exceed 30 minutes) Assist primary RNs Continue to complete charting Offer PM oral and hygiene care Check supply baskets and restock as needed Assist with answering call lights Refill water pitchers, place NPO signs as needed, document I & Os and ADLs. Assist with night vital signs as directed Pass HS snack as directed by nursing Assist with answering call lights and complete unfinished documentation. Update primary nurse of any task not completed	Complete your charting before checking or restocking the supply baskets. If working with weaning ventilator patients, began PM bath. Complete baths assigned by RN or not completed by dayshift
2231-0030	Vital signs	
0031-0400	Complete task as assigned by RNs, Round on all patients, Check complete baths assigned by RNs	Assist with admissions, Complete at least two baths on patients defined in this policy
0401-0659	Complete end of shift task i.e., vital signs, daily weights, intake and output, refill water pitchers, Task assigned by primary RNs	
	Provide/receive hand-off and round with off-going ACT. Identify sitters and arrange break coverage. Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water Assist with answering phones and calls lights Receive update from RNs Offer washcloth for hand/face	
0700-0800	Review 0700-0800 previously stated	

PROGRESSIVE CARE UNIT ACT TASK LIST

Beginning of the Shift Checklist

- ❑ Print Census, receive hand-off from RNs
- ❑ Obtain the following from RNs
  - ✓ Diet
  - ✓ Ambulatory needs
  - ✓ Code Status
  - ✓ Isolation Precautions
  - ✓ Bath Assignment
    - ❖ Check with RN if patient requires a shower or assistance
  - ✓ Special Considerations
    - ➢ Hard of Hearing
    - ➢ Legally Blind
    - ➢ No BP on Left or Right Arm
    - ➢ Restraints
    - ➢ Fall Risk
    - ➢ Pressure Ulcers

Vital Signs

- ❑ Vitals Signs
  - Complete vital signs as directed by RN
  - Document results on VSS worksheet
  - Give a copy to each RN to review prior to documenting
  - Routine VSS
    - ❖ Tele patients every 4 hours while awake
    - ❖ Med/Surg patients every 8 or once a shift as directed by RN

Before Meal Trays Arrive

- ❑ Document vitals and assist with answering call lights and the telephone
- ❑ Perform additional duties as directed by RN

Arrival of Meal Trays

- ❑ Ensure unapproved items are removed from tray as directed by Correctional Officers
- ❑ Pass trays and assist with answering lights
- ❑ Assist feeders as directed, if no feeders, go to break or document VSS and I & O's

After meal times

- ❑ Complete documentation
- ❑ Ambulate patients
- ❑ Answer call lights and the telephone
- ❑ Assist RNs as directed

Intake and Output

- ❑ Document output after completing task
- ❑ Document intake as soon as possible

Prior to Leaving Patient Rooms

- ❑ Remove all items taken in room
- ❑ Discarded items in proper container
- ❑ Patient's room clean, call button within reach
- ❑ Upper side rails up
- ❑ Water pitcher refilled per unit policy and/or as directed by RN
- ❑ Patient information signs posted per RN

End of Shift Checklist

- ❑ Inform RNs of task not completed as soon as possible
- ❑ I/Os documented
- ❑ Vital Signs documented
- ❑ Activity of Daily Living documented

Admission Checklist

- ✓ Assist RN as directed
- ✓ If patient is ambulatory, use chair scale
- ✓ Ask patient for their height or estimate (verify with RN)
- ✓ Obtain admission vital signs as directed by RN
- ✓ Verify with RN or Correctional Officers items to place in patient's room (see the suggested item list below):
  - ➢ Pitcher of water and cup, if not NPO
  - ➢ Box of tissue
  - ➢ Toothbrush and toothpaste
  - ➢ Plastic comb
  - ➢ Slippers
  - ➢ Place a urinal or "hat" in the bathroom
  - ➢ Label urinal or hat with patient's name and room number, if not contraindicated
- ✓ Before leaving the room complete the following as directed by the RN:
  - ➢ Instruct patient how to use the call button and place it near the patient
  - ➢ Instruct patient how to use to the bedside lights, TV remote, and bed controls
  - ➢ Place bedside table within reach of patient
- ✓ Document the patient's WT, HT, and vital signs

Discharge Checklist

- ✓ Do not discuss discharge plans or expected time of discharge with patient.
- ✓ Assist with discharges directed by RN, ANM, or Correctional Officers
- ✓ Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge
- ✓ Inform RN of VSS results after completing the task

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Alcohol Withdrawal Symptom Management

REVISION DATE(S):

Department Approval Date(s):	04/16
Clinical Policies and Procedures Approval Date(s):	05/16
Nurse Executive Committee Approval Date(s):	05/16
Medical Staff Department/Division Approval Date(s):	n/a
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	06/16
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **DEFINITION(S):**

1. **Alcohol Use Disorders Identification Test** (Audit-C): is a 3-item alcohol screen that can help identify person who are hazardous drinkers or have active alcohol use disorders. **Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting their health and safety.**
2. Clinical Institute Withdrawal Assessment Scale for Alcohol Revised (CIWA-Ar): at 10-item scale for assessment and management of alcohol withdrawal. A summation of the scores correlates to the severity of alcohol withdrawal.

B. **POLICY:**

1. All patients shall be screened for alcohol use on admission
   a. If a patient is identified on admission as currently consuming alcohol which puts them at risk for experiencing alcohol withdrawal symptoms during hospitalization the nurse will discuss with physician and obtain orders for management of withdrawal symptoms.
2. Patients shall be assessed each shift for signs/symptoms of alcohol withdrawal
   a. If patient exhibits signs/symptoms of alcohol withdrawal, the patient will be assessed using the CIWA-Ar scale.
      i. Based on the CIWA-Ar score, the nurse will contact physician and obtain orders for management of withdrawal symptoms.
3. If a patient has a CIWA score of greater than or equal to 8, the patient requires a more frequent monitoring and a higher level of care (ie: Telemetry or Intensive Care Unit).

C. **PROCEDURE:**

1. **Screen the patient for alcohol use by completing the Audit–C screen in the electronic health record (EHR) upon admission.**
   a. **If a patient scores less than 5, monitor patient for signs and symptoms of alcohol withdrawal with shift assessments and reassessments.**
   b. **If a patient scores greater than or equal to 5:~~, the results are positive.~~**
      i. **Ask 3 additional screening questions.**
      ii. **Initiate the Adult Alcohol Withdrawal Interdisciplinary Plan of Care (IPOC).**
      iii. **Complete the CIWA–Ar in the EHR.**
2. **CIWA-Ar scores upon admission or during shift assessment,**
   a. **If the CIWA- Ar is less than 8:**
      i. **Notify the MD of the positive Audit-C and or CIWA-Ar scores within 24 hours.**

ii. **Continue CIWA-Ar reassessment every 4 hours times 72 hours.**

~~3.~~iii. **If the patient has 3 consecutive CIWA-Ar scores less than 8, monitor every shift for signs and symptoms of alcohol withdrawal.**

~~a.~~b. **If the CIWA-Ar score is greater than or equal to 8:**

i. **Request a higher level of care (i.e. Telemetry or Intensive Care Unit) bed.**

ii. **Contact MD to request treatment plan if none present.**

iii. **Monitor CIWA-Ar every 2 hours times 72 hours.**

iv. **Additional requirements for Intravenous (IV) Lorazepam**

1) **Assess prior to and 1 hour after administration**

a) **CIWA-Ar**

b) **Vital signs**

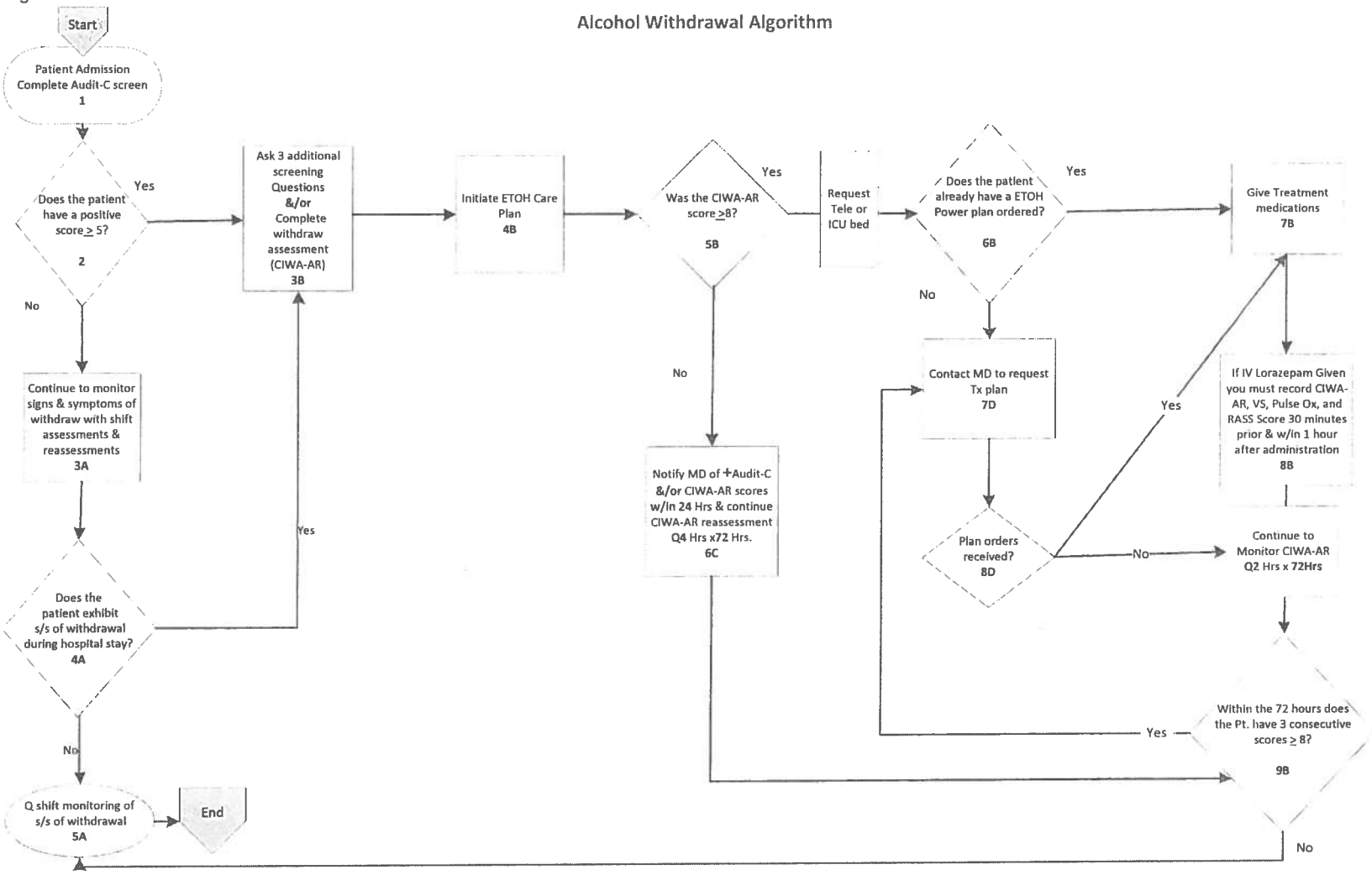
c) **Oxygen saturation per Pulse Oximetry**

d) **Richmond Agitation Scale Score (RASS)**

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

1. Alcohol Withdrawal Algorithm

Alcohol Withdrawal Algorithm



Notify MD if:
1) Vital Signs or RASS score are out of range
2) Patient exhibits signs/ symptoms of DT's

(Rev. 04/2016)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01 **SUBJECT:** Chain of Command

REVISION DATE: 6/03; 12/04; 10/05, 3/10; 6/13 **POLICY NUMBER:** I.J

Department Approval Date(s):	**04/16**
Clinical Policies & Procedures Committee Approval:	**~~03/13~~05/16**
Nurse Executive Council Approval:	**~~03/13~~05/16**
Medical Executive Committee Approval:	**~~05/13~~06/16**
Professional Affairs Committee Approval:	**06/13**
Board of Directors Approval:	**06/13**

A. **PURPOSE:**

1. Chain of Command provides employees an expeditious process to resolve administrative, clinical, or other patient safety or service issues in order to provide safe patient care. All employees are encouraged to use the chain of command to present an issue of concern and pass it up the lines of authority until a resolution is reached. In situations where the safety of the patient or of employees, visitors, and others does not allow time for use of the chain of command, employees shall take the concern to the highest level he/she deems necessary.

B. **POLICY:**

1. Tri-City Medical Center will not tolerate any acts of reprisal against those who raise issues concerning quality patient care.
2. All health care providers (HCP) are responsible for ensuring that patients receive quality care and should implement chain of command to obtain necessary patient care interventions when the quality of care or safety of a patient is in question.
3. Examples of when to implement the chain of command may include but are not limited to the following:
   a. A conflict exists concerning the plan of care/physician orders for the patient.
   b. The plan of care is unclear and caregiver is unable to get clarification from physician.
   c. Qualified care professional providers are unavailable: **Registered Nurses** (RNs), physicians, and other essential care providers.
   d. Unprofessional behavior by or impairment of the healthcare providers that jeopardize patient care.
   e. Instances where a physician has not responded in a timely manner to a deteriorating patient condition.
   f. The RNs assessment of the patient varies significantly from physician's assessment.
   g. In clinical situations where the RN believes the physician has not responded in a manner to fully address the issues raised that may present an immediate risk to the patient.
4. The next level of authority shall be contacted if issues are not resolved in an appropriate time frame. Progression continues through the levels of authority until the issue is resolved.
   a. In some instances, one or more levels may be passed over due to extremely sensitive subjects or when the higher level of authority may be the individual involved.
5. For conflicts that cannot be resolved between employees related to patient care/safety issues, the order in which the lines of authority shall be contacted are as follows:
   a. The employees shall attempt to address and resolve conflict outside of the patient care area.
   b. If unresolved, then the Assistant Nurse Manager is notified.
   c. If unresolved, then the Clinical Manager and/or Administrative Supervisor is notified.

d. If unresolved, then the Director is notified.
e. If unresolved, then the Senior Director is notified.
f. If unresolved, then the Chief Nurse Executive (CNE) is notified.

6. For conflicts involving physicians/**Allied Health Professionals**, the order in which the lines of authority shall be contacted upon initiation of chain of command is as follows:
   a. The HCP shall contact the Assistant Nurse Manager in a confidential manner to express concerns.
   b. If unresolved, the Clinical Manager and/or Administrative Supervisor is notified.
   c. If unresolved, the Director is notified.
   d. If unresolved, the Senior Director is notified.
   e. If unresolved, the Senior Executive, or if unavailable the Administrator on-call is notified.
   f. If unresolved, the Medical Director of the identified department is notified.
   g. If unresolved, the Chief Of Medical Staff is notified
   h. If unresolved, the President/Chief Executive Officer is notified.
7. The Administrative Supervisor is available as a resource when contacting all levels of authority.

C. **DOCUMENTATION:**

1. The HCP shall document the following in the medical record under clinical notes without including personal opinions:
   a. Date, time, and name of person contacted
   b. Events and observations objectively as they occur
   c. Specific facts and accurate times
2. Quality review report (QRR) shall be completed and submitted to Risk Management.

D. **RELATED DOCUMENTS:**

~~2.~~**1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions 396**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**12/01**	**SUBJECT:**	**Emergency Cart, Cardiopulmonary Arrest**
REVISION DATE:	**6/03, 10/04, 11/06, 10/07; 6/08; 8/09; 8/12**	**POLICY NUMBER:**	**IV.O**

Department Approval Date(s)	**03/16**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~05/16**
Nursing Executive Council Approval:	**~~06/12~~05/16**
Medical Executive Committee Approval:	**~~07/12~~06/16**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **POLICY:**

1. Emergency Carts shall be checked at least daily for integrity and expiring products by a licensed healthcare provider or **designee**~~emergency technician~~ on the unit. This is documented by date, shift, and signatures in a logbook kept on top of the cart.
   - **a.** ~~All documentation of cart checks is completed on the specific Emergency Equipment/Supplies Checklist. (See attachments).~~
   - **b. The licensed healthcare provider or designee checking cart will ensure ~~that~~ missing items are replaced immediately. If items cannot be replaced in a timely manner, the cart should be replaced by the Sterile Processing Department (SPD).**
2. **Emergency Carts shall be stored in a visible or secure location.**
3. SPD shall immediately replace any cart used during a Code Blue, Code Caleb or Code Pink.
   - a. After a code, one **(1)** ~~green~~ lock is used to lock the cart before it is returned to SPD for cleaning.
   - b. The used crash cart shall remain ~~outside of the patient's room,~~ locked and monitored until it is returned to the SPD.
4. The Code Blue Committee shall make recommendations for content changes based on code evaluations and recommendations from the American Heart Association.

B. **PROCEDURE FOR CHECKING CODE BLUE, CODE PINK AND CODE CALEB EMERGENCY CARTS:**

1. All documentation of cart checks is completed on the department specific Emergency Equipment/Supplies Checklist. All fields must be completed and the document signed.

~~1. For Adult Code Blue Carts: Check and document the following:~~

- **a. Check ~~T~~t**he integrity **of all locks/tags**~~and~~. If **any**~~the~~ lock**/tag** is broken, call SPD to replace the cart.
  - **i. Adult cart document:**
    - **1) ~~the~~Lock** number ~~of the red lock~~ on the locking bar on the Emergency Cart.
  - ~~i.~~**ii. Pediatric cart document:**
    - **1) Medication drawer expiration date and lock number**
    - **2) IV drawer expiration date and lock number**
    - **~~b.~~3) Red Airway Bag expiration date and lock number**
  - **iii. Neonatal Crash Cart**
    - **1) Medication drawer expiration date and lock number**
    - **~~c.~~2) IV drawer expiration date and lock number**

~~d.~~**b.** **Check** ~~T~~the **medication** sticker ~~for~~**and document medication expiration date**~~outdated medications~~**.**
   i. Notify Pharmacy of expired medications.

~~e.~~**c.** **Check non-medication supply sticker(s) and document the** ~~The SPD sticker for~~ expiration dates.
   i. Notify SPD if **any supplies are** expired.

~~f.~~**d.** Presence and function of suction equipment **(except for Neonatal Crash Cart).**

e. Presence of **Resuscitation Code** ~~Cardiopulmonary Arrest~~ Record **and Evaluation/Debriefing form** on clipboard **appropriate to type of cart (adult, pediatric, neonatal).**

~~g.~~**f.** **Resuscitation algorithms appropriate for type of cart (adult, pediatric, neonatal).**

g. The inventory lists ~~and ACLS algorithms~~ attached to side of cart.
   i. The list is maintained and updated by SPD.

h. **One pack of ECG electrodes (three pack).**

~~h.~~**i.** **Defibrillator or AED pads appropriate for type of cart (except for Neonatal Crash Cart), Ensure pads are not expired.**

~~i.~~**j.** Presence of resuscitation bag (Ambu) and supplies **appropriate for type of cart (adult, pediatric, neonatal).**
   i. Check the mask to ~~i~~ensure the seal is sufficiently inflated.

~~j.~~**k.** Presence of oxygen **tank (except for Neonatal Crash Cart).**
   i. Replace tank if gauge reads 1000 p.s.i. or less.

~~k.~~**l.** Presence of extension cord**/multi-outlet cord.**

m. Presence of backboard **(except for Neonatal Crash Cart).**

n. **For Pediatric/Broselow Cart only:**
   i. Scissors
   ~~l.~~**ii. Two (2) Alaris Pumps**

~~m. Sign your name in the signature column~~

2. For units with defibrillators, check defibrillator for proper functioning.

a. **Check unit cleanliness and inspect cables and connectors for integrity.**
   i. ECG electrodes should not be pre-attached to the leads.

b. **Ensure that you have a charged battery in the unit – testing will be performed with the unit unplugged from the power supply.**

~~a.~~**c.** Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit.

~~b.~~**d.** Ensure the Multi-Function Cable is plugged into the unit.
   i. The Multi-**Function** Cable ~~Function~~ should not be plugged into the test connector.

e. **Switch to monitor, listen for four beep tone. The message *MONITOR* should display.**
   i. If you need to adjust the time or date on the unit, depress the softkey on the far right prior to switching to *MONITOR* and adjust as needed (this should be performed every two weeks).

f. **Switch to *PACER* and set to a rate of 150 per minute.**

g. **Press recorder button.**

h. **Pacer pulses occur every two large divisions.**

i. **Press 4:1 button, pulses occur every 8 large divisions.**

j. **Stop recorder**
   i. Note that signing, dating and retaining the recorder output is not a requirement.

k. **Set *PACER OUTPUT* to 0 mA and ensure that there is no *CHECK PADS* message.**

l. **Set *PACER OUTPUT* to 16 mA and ensure that there is a *CHECK PADS* message and alarm.**

m. **Connect multifunction cable to test connector,**

n. **Press Clear Pace Alarm softkey; *CHECK PADS* message will disappear and pace alarm stops.**

~~i.~~**o.** **Disconnect multifunction cable from test connector,**

~~c.~~**p.** Switch unit to *DEFIB* and set energy to 30 joules

i. The messages *CHECK PADS* and *POOR PAD CONTACTS* will alternately display.

~~d.~~**q.** Plug the Multi-Function Cable into its test connector.

i. The message *DEFIB PAD SHORT* will display.

~~e.~~**r.** Press the *CHARGE* button on the front panel or on the apex paddle handle.

~~f.~~**s.** Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules.

i. The message will read *DEFIB 30J READY*

ii. The strip chart recorder will print a short strip indicating *TEST OK* energy delivered if the unit delivered energy within specifications. **. Note that signing, dating and retaining the recorder output is not a requirement.**

~~1)~~**iii.** During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules.

iv. If *TEST FAILED* appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.

~~iii.~~**t.** **Plug device back into the electrical socket after testing is complete.**

3. For units with Automatic External Defibrillators (AED):

a. Check unit for flashing hourglass

i. If hourglass is not visible or not flashing, notify Clinical Engineering immediately.

b. HouseWide AED's are checked daily by Security Staff.

~~c. Check unit for flashing hourglass~~

~~d. If hourglass is not visible or not flashing, notify Clinical Engineering immediately.~~

4. ~~The Emergency Cart Contents List shall be kept on each cart. The list is maintained and updated by SPD.~~

~~5. Additional Emergency Carts checked daily using cart specific checklist include:~~

~~a. Rapid Response Cart: Kept in ICU Staff shall check Rapid Response Team cart for supplies and test defibrillation for proper functioning as noted above.~~

~~b. Neonatal Crash Cart: Kept in L&D, NICU and ED.~~

~~c. OB Hemorrhage Cart: Kept on L&D and Couplet Care Units~~

~~6. Braslow Pediatric Carts with Airway Bags: Kept in PACU, ED and 3 Pavilion and HouseWide.~~

C. **RELATED DOCUMENTS**~~Forms available on the Intranet~~:

1. ~~Adult~~ Emergency **Equipment/Supplies (Crash Cart) Checklist Sample**~~Cart – Unit Specific~~

~~2. Braslow Cart~~

2. Patient Care Services (PCS) Policy: Rapid Response Team

3. PCS Procedure: Malignant Hyperthermia Management

~~3.~~**4. Women & Newborn Procedure: Obstetrical (OB) Hemorrhage**

SHIFT:_____

TRI-CITY MEDICAL CENTER CRASH CART CHECKLIST - SAMPLE

MONTH/YR _____

GENERAL	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
~~RED~~-LOCK # (check mark if unchanged from previous day)																															
MEDICATION DRAWER EXPIRATION DATE																															
CART EXPIRATION DATE																															
SUCTION UNIT TESTED																															
CARDIOPULMONARY ARREST RECORDS & EVALS																															
RESUSCITATION ALGORITHMS																															
CART INVENTORY LISTS																															
ECG Electrodes (3 Pack)																															
AMBUBAGS/SUPPLIES																															
O_2 TANKS (PSI >1000)																															
EXTENSION/OUTLET CORD																															
BACKBOARD																															
2 WEST																															
DEFIB TESTED PLUGGED UNPLUGGED (DC 30J)																															
DEFIB BATTERY CHECKED																															
MULTIFUNCTION PADS x3 (Check exp date)																															
PACEMAKER (on top of cart) Check Battery																															
Suction Supplies (tubing and Yankauer with suction unit)																															
SUPPLEMENTAL INTUBATION TRAY																															
SIGNATURE OF PERSON CHECKING CART Legend: ✓ = Present																															

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 03/09	**SUBJECT:** Family Presence During Resuscitation
REVISION DATE: 01/12	**POLICY NUMBER:** IV.PP

Department Approval Date(s):	**04/16**
Clinical Policies & Procedures Committee Approval:	**~~09/11~~05/16**
Nursing Executive Council Approval:	**~~10/11~~05/16**
Medical Executive Committee Approval:	**~~11/11~~06/16**
Professional Affairs Committee Approval:	**01/12**
Board of Directors Approval:	**01/12**

A. **DEFINITIONS:**

1. Family Presence: The presence of family in the patient care area in a location that affords visual or physical contact with the patient during resuscitation events.
2. Resuscitation: A sequence of events, which are initiated to sustain life or prevent further deterioration of the patient's condition.
3. Family: A relative of the patient or any significant other with whom the patient shares an established relationship.
4. Family Support Person **Tri-City Healthcare District (TCHD) employees including:**
   a. Assistant Nurse Manager (ANM)
   b. Staff Registered Nurse (RN)
   c. Chaplain
   d. Social Worker
   e. Administrative Supervisor or other designee who is assigned to the family of a patient during a resuscitation event and assumes no direct care responsibilities for the patient. During day shift hours the Family Support Person role will be fulfilled by a chaplain or social worker, or if unavailable, the ANM or his/her designee. During night shift hours the Family Support Person role will be fulfilled by the Administrative Supervisor, ANM, or his/her designee.

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

1. To assure patient and families are provided care consistent with the philosophy of patient/family-centered care and established emergency care standards.
   a. Supportive data:
      i. The family is a constant in the patient's life. Family participation and involvement in the patient's health care promotes collaborative relationships among the patient, family and health care professionals. The strengths and coping strategies of the family are supported and incorporated into the care of the patient.

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

1. Patient & Family Assessment
   a. Family members shall be assessed by the primary **Registered Nurse** (RN) or designee for the appropriate levels of coping, desires and needs.
      i. In addition, family members should demonstrate the absence of combative or threatening behavior, extreme emotional volatility, and behaviors consistent with an altered mental status related to drugs or alcohol.
         1) Family members demonstrating such behavior are not candidates for family presence.

ii. Children must have an adult caregiver present to be allowed at the bedside.

b. Cultural customs shall be considered and assessed. Healthcare providers shall maintain an awareness of cultural variations and be sensitive to these factors and family needs.

c. Decision to initiate family presence is dependent upon criteria consisting of three components:
   i. Patient's desire to have family with them
   ii. Family's desire to be present
   iii. Agreement of the direct care providers

d. Family members who do not wish to participate shall be supported in their decision without judgment and the family support person shall remain with them.

e. When a resuscitation event is ~~called~~ **announced a Family Support Person shall be determined.** ~~the ANM, Staff RN, Chaplain, Social Worker or Administrative Supervisor responsible for that unit shall respond to act as family support.~~

f. The family support person shall identify the primary RN and ask if the family can be present.

2. Preparation/Participation of Family Presence

a. The family support person shall explain the patient's appearance, treatments and equipment used in layman's language and shall prepare the family for entering the patient's room**, including:**~~.~~
   i. Communicating that the patient is the priority.
   ii. Explaining how many family members may enter the room safely, where they may stand initially, when they shall be able to move to the bedside and what not to touch to prevent injury.
   iii. **Explaining and adhering to appropriate infection control measures if the**~~If~~ patient is in isolation or contact precautions~~, the appropriate measures shall be explained and applied~~.
   iv. Prepar**inge** ~~the~~ family members for the sights and sounds of resuscitation.
   v. **Clearly informing the** family ~~shall be clearly informed~~ of the status of their loved one at all times.
   vi. Explain**ing** why **the family** ~~they~~ may be asked to step out of the room and when they can leave the room.
   vii. **Informing**~~The family support person shall inform~~ the health care providers of the presence of the family.
   viii. **Remaining**~~The family support person must remain~~ with the family at all times during the resuscitation.
   ix. **Escorting the family**~~The health care providers can retain the option to request that the family be escorted~~ from the bedside and/or out of the room if deemed necessary **by the health care providers**.

3. Post-Code Follow-Up

a. Immediately following the resuscitation event, **the** Family Support Person shall meet with and debrief the family regarding circumstances of the resuscitation event and the outcome.

b. Patient survives resuscitation efforts with good prognosis
   i. Patient/family orientation to the Intensive Care Unit (ICU)
   ii. Procedures/test fully explained and all parties updated per primary care RN/Primary physician on an on-going basis.
   iii. Transfer to ICU

c. Patient survives with poor prognosis
   i. Discussion initiated with family regarding comfort measures, hospice, etc.
      1) Hospitality cart ordered for family
      2) Chaplain Services as appropriate
      3) Open Visitation
   ii. Life sharing referral initiated

d. Patient Expires

i. End of Life process explained to family per primary care RN/ancillary staff (i.e., Chaplain, Social Worker, **and** Administrative Supervisor).
ii. Life-Sharing notified of expiration.
iii. Family allowed private time in room.
iv. Required ~~paper work~~**documentation** completed; patient representative phone number given when necessary.
v. Grieving pamphlet offered to family.
i. Sympathy card mailed to family within 24-48 hours of expiration.
ii. Follow-up phone call/survey completed regarding family who witnessed the resuscitation event.

D. **REFERENCES:**

1. American Association of Critical Care Nurses (AACN). (~~2004~~**2016**). Practice alert: Family ~~p~~**P**resence ~~d~~**D**uring **Resuscitation** ~~CPR~~ and ~~i~~**I**nvasive ~~p~~**P**rocedures. Retrieved **May 9,2016** ~~March 31, 2007~~, from ~~http://www.aacn.org/_88256667005a14f.nsf/0/8ca0ac929815ee788256f2e0057df2e?OpenDocument#alert~~ **http://www.aacn.org/wd/practice/docs/practicealerts/family-presence-during-resusitation-and-invasive-procedures-pa-2015.pdf**
~~2. Clark, A. P., Aldridge, M. D., Guzzetta, C. E., Nyquist-Heise, P., Norris, M., Loper, P., et al. (2005). Family presence during cardiopulmonary resuscitation. Critical Care Nursing Clinics of North America, 17(1), 23-32.~~
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~~5.~~**3.** Emergency Nurses Association (2007). Presenting the Option for Family Presence (3rd Edition).
~~6.~~**4.** Guzzetta, C. E., Clark, A. P., & Halm, M. A. (2008). Family presence facilitation. In E. Ackley, G. Ladwid, B. A. Swan, & S. Tucker (Eds.), Evidence-based nursing care guidelines. Philadelphia: Elsevier.
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~~8.~~**5.** Mian, P., Warchal, S., Whitney, S., Fitzmaurice, J., & Tancredi, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' behaviors toward family presence during resuscitation. Critical Care Nurse, 27(1), 52-61.
~~9.~~**6.** **Oczkowski, S.J.W., Mazzetti, I., Cupido, C., Fox-Robichaud, A. E. (July/August 2015). Family Presence During Resuscitation: A Canadian Critical Care Society Position Paper. Canadian Respiratory Journal, 22(4), 201-205.**
~~10.~~**7.** **Porter, J. E., Cooper, S. J., Sellick, K. (2014). Family Presence During Resuscitation (FPDR): Perceived Benefits, Barriers and Enablers to Implementation and Practice. International Emergency Nursing, 22(2), 69-74.**
~~11.~~**8.** **Beesley, S.J., Hopkins, R. O., Francis, L., Chapman, D., Johnson, N., & Brown, S. M. (April 2016). Let Them In: Family Presence During Intensive Care Unit Procedures. American Thoracic Society.**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**POSTURAL (ORTHOSTATIC) VITAL SIGNS, OBTAINING**
Purpose:	To outline the nursing responsibilities when obtaining postural (orthostatic) vital signs.
Supportive Data:	Abnormal postural vital signs may indicate intravascular volume depletion, fluid loss, inadequate vasoconstriction, cardiac dysrhythmias or autonomic insufficiency secondary to the administration of pharmacological agents.
Equipment:	Manual blood pressure cuff and stethoscope or automatic blood pressure machine

A. **DEFINITIONS:**

1. **Postural (o~~O~~rthostatic) h~~H~~ypotension:** occurs when the **systolic blood pressure (S-**BP**) or blood pressure (BP)** drops after **a change in position from supine posture to** upright posture. ~~is assumed.~~ Orthostatic instability usually takes place within one (1) minute. **Heart rate** (HR) may increase with a fall in BP.
   a. Normal postural changes include the following:
      i. HR increases by 5 to 20 beats per minute transiently
      ii. Systolic BP (SBP) drops 10 mm Hg
      iii. Diastolic BP (DBP) drops 5 mm Hg
      iv. Patient has no presenting symptoms
   b. Positive **postural** (orthosta**sis)**~~tic~~ changes include the following:
      i. Drop in SBP by more than 20 mm Hg
      ii. Drop in DBP by more than 10 mm Hg within 3 minutes
      iii. HR may increase by 15-30 beats per minute with a fall in BP
      iv. Patient presents or complains of one or more of the following symptoms:
         1) Dizziness
         2) Lightheadedness
         3) Cardiac rhythm changes
         4) Syncope

B. **POLICY:**

1. Postural (orthostatic) vital signs shall be obtained with the patient in the following three positions; supine, sitting and standing unless contraindicated.
   a. For pregnant patients, ensure lateral hip wedge is used.
2. Postural (orthostatic) vital signs shall consist of ~~three blood pressure~~ **BP** readings and ~~three~~ heart rates taken in ~~each of the~~ three positions **i.e., supine, sitting, and standing**.
3. ~~2.~~ It is important to obtain a complete set of postural vital signs before changing the patient's position.
4. ~~3.~~ The blood pressure cuff shall not be removed between position changes.
5. **Obtaining accurate BP readings includes the following:**
   a. Compare right and left measurements
   b. Position the extremity at the level of the heart
   c. Document the position of the patient
   d. Ensure proper cuff size
   ~~4.~~ **e. Measure readings at eye level at the top of the meniscus for manual readings.**

C. **PROCEDURE:**

1. Select appropriate blood pressure cuff size.
   a. A cuff that is too small may result in a false high result.
   b. A cuff that is too large may result in a false low result.
2. At any time during procedure, if patient exhibits positive orthostatic changes, return patient to supine position and notify physician.
3. Perform hand hygiene and don gloves as needed.

Department Review	Clinical Policies & Procedures	~~Patient Quality Care~~Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/94, 6/09;6/12; **11/15**	7/12; **12/15**	8/12, **01/16**	8/12, **6/16**	9/12	9/12

4. ~~Ask patient to lie~~ **Position patient** in the supine position **(flat)** for 10 minutes before taking initial vital signs.
   a. If the patient cannot tolerate a supine position, lower the head of bed per patient's tolerance.
   ~~5.~~**b.** Obtain supine BP and HR measurements.
   ~~a.~~**c.** This reading is considered the initial baseline measurement.
5. Position patient in the sitting position with legs hanging. ~~and~~
   ~~6.~~**a.** **O**~~o~~btain BP and HR measurement immediately and after 2 minutes.
6. Assist patient to standing position. ~~and~~
   ~~7.~~**a.** ~~o~~**O**btain BP and HR measurements immediately and after 2 minutes.
   ~~a.~~**b.** If BP and HR are stable but orthostasis is suspected, repeat BP and HR in 2 minutes.
~~8.~~**7.** The physician should be notified if patient has positive orthostatic changes.
   a. On cardiac monitoring units, notify physician of patient's cardiac rhythm

D. **DOCUMENTATION:**

1. Document the following on ~~the Cerner Vital Signs Powerform or on the appropriate form in~~ the medical record.
   a. Patient's position
   b. BP and HR in each position
      i. Cardiac rhythm on cardiac monitoring units
   c. Patient's associated signs and symptoms
2. Document physician/**Allied Health Professional** notification of any positive orthostatic changes.

E. **REFERENCES:**

~~1. Irvin, D.J. & White, M. (2004, May 28). The importance of accurately assessing orthostatic hypotension. *Geriatric Nursing*. Retrieved May 20, 2009 from http://www.medscape.com.~~

1. Urden, L.D., Stacy, K. M., & Lough M, E. (201~~406~~). **Critical care nursing: Diagnosis and management. (7th ed). Cardiovascular Clinical Assessment, Chapter 13 Elsevier. St. Louis, MO.**~~Thelan's critical care nursing: Diagnosis and management. (5th ed). Cardiovascular Clinical Assessment. Chapter 16. Elsevier. St. Louis:MO.~~

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**STOOL MANAGEMENT (RECTAL TUBE) DIGNICARE STOOL MANAGEMENT SYSTEM**
Purpose:	To define the appropriate use, initiation and management of the DigniCare® Stool Management System (SMS). The DigniCare® "is intended for fecal management by diverting and collecting liquid or semi-liquid stool to minimize skin contact in bedridden patients. This may help to reduce patient's risk of skin breakdown, minimize exposure to infectious microorganisms and save nursing time and hospital costs associated with bed linen changes and cleanup" (Bard), 2009)
Equipment:	1. Gloves 2. 45 mL tap water 3. Cavilon Skin Barrier 4. Cavilion Skin Sealant 5. Collection Bag 6. DigniCare®SMS Insertion Tray a. Rectal tube assembly (closed system), self-locking collection bag with drainage plug b. 60 mL syringe c. Underpad d. 10 mL water-soluble lubricating jelly syringe e. 1 oz MEDI-AIRE® biological odor eliminator f. Instructions for use

A. **CONTRAINDICATIONS:**

1. Do not use for more than 29 consecutive days.
2. Do not use on patients known to be sensitive to or allergic to any components within the system.
3. Do not use on patients who have large bowel or rectal surgery within the last year.
4. Do not use on patients with any rectal or anal injury, severe rectal or anal stricture or stenosis (or on any patient if the distal rectum cannot accommodate the inflated cuff), confirmed rectal or anal tumor, severe hemorrhoids, or fecal impaction.
5. Not for use in patients with suspected or confirmed rectal mucosa impairment (i.e. severe proctitis, ischemic proctitis, mucosal ulcerations).
6. Not for use in patients with indwelling rectal or anal devices (i.e. thermometer) or delivery mechanism (i.e. suppositories) or enemas in place.
7. Not for use in neutropenic patients with absolute neutrophil count (ANC) less than 500.
8. Do not use for patients with solid or soft-formed stool.

B. **POLICY:**

1. A physician's order is required for initiation of the DigniCare® SMS.
2. A Registered Nurse (RN) shall be responsible for initiation and managing the DigniCare SMS.
3. Product is for single use only.
4. Indications for use include the following:
   a. Critically ill patient
   b. Functional rectal sphincter
   c. Frequent episodes of liquid to semi-liquid stool
   d. Protection of medical devices or wound dressing which will become compromised by fecal contact
   e. Management of infectious or potentially infectious stool
   f. Collection of liquid to semi-solid stool in the medical/surgical patient who requires stool containment for:

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/11, 04/16	11/11, 05/16	11/11, 05/16	1/12, 6/16	2/12	2/12

i. Protection of skin and prevention of pressure ulcers in the incontinent patient
ii. Stool control and diversion

5. Discontinue SMS when the patient's bowel control, consistency and frequency of stool begin to return to normal.
6. Care should be used in patients with the following diseases or conditions:
   a. Inflammatory Bowel Disease
      i. The physician shall determine the degree and location of the acute inflammation prior to use of the device.
   b. Anti-coagulant/anti-platelet therapy
   c. Colon or rectal surgery of anastomosis prior to initiation
      i. Consider site of anastomosis prior to initiation
   d. Hemorrhoids
7. Do not insert devices such as thermometers or suppositories into the anal canal while the device is in place.
8. Do not connect mechanical pumping devices to catheter irrigation port.
9. Rectal bleeding should be investigated to ensure no evidence of pressure necrosis from the device, discontinuation of the device is recommended if evident.
10. Abdominal distention that occurs while using the device should be investigated.
11. Excessive prolonged traction on the catheter may result in the retention cuff migrating into the anal canal which may result in temporary or permanent clinical sphincter dysfunction, or catheter expulsion.
12. Notify a physician if any of the following occur:
    a. Rectal pain
    b. Rectal bleeding
    c. Abdominal symptoms such as distension or pain

C. **PROCEDURE:**

1. The DIGNICARE® SMS has three drainage tube ports which are labeled as outlined below:

Label	Port Color	Label Definition
INF (45mL)	**Green (matches the cuff color)**	**Inflation port for retention cuff specifies recommended inflation volume and inflation medium.** • **The green inflation port is used for cuff inflation to ensure proper cuff seating in the rectal vault.**
FLUSH	**Purple**	**Flush port for clearance of drain tube only** • **The purple flush port is designed to flush the rectal tubing via the 8 outlet tubes (located throughout the main tubing) for irrigation (as needed) throughout the stool management system's use.**
IRRG	**Clear**	**Irrigation port infuses water into rectum** • **The clear irrigation port is used to irrigate the patient's bowel to break-up stool (as needed)** • **To verify proper cuff placement during initial insertion, as well as throughout the stool management system's use.**

2. Insertion of the DigniCare® SMS
   a. Perform hand hygiene and don gloves.

b. Explain the procedure to patient.
c. Open DIGNICARE® SMS Insertion Tray. Identify cuff end. Identify ball valve end.
d. Ensure green "door" on ball valve is in closed position with the green latch pointed back towards the hanger. Connect collection bag to catheter as follows:
    i. Holding collar on collection bag upright with non-dominant hand, align the valve latch with the groove on bag collar and insert.
    ii. Turn ball valve clockwise until fully (snaps into place) engaged.
e. Locate green inflation port and align with the tubing to ensure patency. Connect syringe (included) to port and pull back slowly on plunger to remove all air from DIGNICARE® SMS inflation cuff. Remove syringe.
    i. Ensure cuff is fully deflated.
f. Draw 45 mL of tap water into 60 mL syringe and connect to inflation port. DO NOT INSTILL!
g. Unfold and Position tubing of catheter lengthwise on bed, extending collection bag towards the foot of the bed, and assure tubing is not coiled or kinked.
h. Attach 60 mL syringe with 45 mL tap water to the inflation port but do not inflate.
i. Position patient (left side lying) and place absorbent pad under patient.
    i. The preferred patient position for catheter insertion is the left lateral knee-chest position, to maximize sphincter relaxation to ease catheter insertion.
    ii. Position patient based on their clinical situation.
j. Perform a digital rectal exam to assess for fecal impaction.
    i. If fecal impaction is present, patient should be disimpacted before insertion of the DigniCare® SMS.
k. Lubricate patient's anus (lubricant included in tray).
l. Insert the inflation cuff as follows:
    i. Squeeze the inflation cuff to ensure all air has been removed and hold the cuff flat in order to fold for insertion.
    ii. Holding the left point of the cuff between the thumb and index finger, fold the top right point of the cuff down and to the left in a 45 degree angle (this creates a conical shape with a leading edge for easy insertion).
    iii. Generously coat the cuff end on the catheter with the lubricating jelly.
    iv. Gently insert the cuff end through the anal sphincter until the cuff is beyond the external orifice and well inside the rectal vault.
m. Slowly instill 45 mL of tap water (previously drawn up) into cuff and disconnect syringe.
    i. Do not over inflate.
    ii. Use the external pilot balloon as a guide to determine proper inflation.
        1) The pilot balloon indicates over or under inflation.
        2) Use the syringe to withdraw the fluid from the cuff, reposition the cuff in rectal vault and re-inflate.
        3) Ensure the inflation port remains parallel to the catheter in order to prevent kinking of the inflation lumen and blockage of injected fluid.
n. Gently tug on the tubing to "seat" cuff completely in rectal vault.
o. Note where black position indicator line is in relation to the rectum.
p. Locate irrigation port. Irrigate with tap water to determine patency.
q. Locate purple flush port. This port is designed to flush and clear tubing only. Flush tubing at least twice per shift and as needed.
r. Hang the collection bag by the hanger and secure to bed (lower than patient) and position rectal tubing alongside patient. Do not place collection bag on the floor.

3. Care and Maintenance of the DigniCare® SMS
    a. Assess patient every shift and PRN for indications to continue DigniCare® SMS.
    b. Verify proper cuff placement every shift and PRN.
    c. Assess cuff volume every shift and PRN to ensure proper inflation.
    d. Assess the position indicator band after repositioning the patient and PRN to ensure the device is positioned properly against the rectal floor every shift and PRN.

e. Assess the catheter tubing and collection bag ensure the tubing is not twisted or kinked and collection bag is in properly position.
f. Irrigation of patient's bowel (through the clear port) may be performed to break up stool.
g. Flush tubing at least twice per shift and as needed.
h. Monitor output per the Standards of Patient Care.
i. The collection bag should be changed and disposed of as needed, and/or when full.
   i. Grab ball valve connector, gently push in catheter, and twist counterclockwise.
   ii. Remove bag, insert bag plug into socket connector, and dispose of bag.
j. Remove/replace when clinically indicated, at least every twenty nine days per manufacturer's recommendation.

4. Obtaining a Fecal Sample
   a. Disconnect the ball valve connector from the bag by turning counterclockwise.
   b. Obtain a sample from the drainage bag by pouring specimen into a specimen container.
   c. Re-attach current bag or new bag to ball valve by turning clockwise.
5. Troubleshooting the DigniCare® SMS
   a. If the retention cuff area becomes obstructed with fecal matter and the catheter may require irrigation of flushing with tap water and/or the patient may be lying on catheter drain tube.
   b. Use only gravity or slow manual irrigation.
   c. Do not irrigate patient with compromised intestinal wall integrity.
   d. Ensure the appropriate port irrigation or flush port remains parallel to the catheter in order to prevent kinking in the tubing and blockage of the injected liquid.
   e. Irrigate the catheter as follows and repeat the procedure as often as necessary to maintain proper functioning of the device.
      i. Fill syringe with tap water
      ii. Attach to irrigation port
      iii. Depress plunger
   f. Flush the catheter if the drainage tube becomes obstructed with fecal matter and repeat the process as needed. If repeated flushing with water does not return the flow of stool through the catheter, the device should be inspected to determine if there is an external obstruction i.e. pressure from a body part or piece of equipment) if no source of obstruction of the device is detected, use of the device should be discontinues.
      i. Fill syringe with tap water
      ii. Attach to flush port
      iii. Depress plunger
6. Replacement/Removal of the Collection Bag
   a. Grab the collection bag
   b. Grab the ball valve connector
   c. Gently push the catheter in and twist the catheter in a counter-clockwise direction.
      i. Rotate the ball valve connector 90 degrees to ensure the ball valve is closed prior to removal of the collection bag.
   d. Once the bag is remove, insert bag plug into the socket connector and dispose.
   e. Replace the collection bag by securely snapping a new bag to the connector.
7. Removal of DigniCare® SMS
   a. Explain procedure to patient.
   b. Deflate cuff by attaching syringe to inflation port and slowly withdraw all water.
      i. If less than 45 mL is removed, reposition patient and repeat as needed.
      ii. Disconnect the syringe and discard.
      iii. Grasp the rectal tubing as close to the patient as possible, have patient bear down, and slowly pull cuff out of the anus.
      iv. Dispose **of** the device
8. Documentation
   a. The RN inserting the DigniCare® SMS is responsible for entering the following in the patient's medical record:

i. Date and time of insertion.
ii. Patient's response to insertion.
iii. Volume of stool every shift and PRN.
iv. Education provided and follow-up education.
v. Flushing and irrigation, if performed.

b. Document presences of the DigniCare ® SMS every shift and PRN in the medical record.
c. Document discontinuation of the DigniCare® SMS in the medical record.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 04/08	**SUBJECT:** Credentialing Policy, Processing Medical Staff Reappointments
REVISION DATE: 04/08; 04/10; 01/12;~~3/11, 12/11, 8/12~~	**POLICY NUMBER:** 8710 – 548
Credentials Committee Approval:	~~08/12~~4/16
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~08/12~~4/16
Professional Affairs Committee Approval:	
Board of Directors Approval:	~~04/08; 04/10; 01/12;~~ 08/12

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership renewal are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaws requirements.
2. The Medical Staff shall consider each application for reappointment using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and Rules and Regulations appropriate for each department. The Medical Staff shall perform this function also for reappointment of privileges for Allied Health Professionals. The Medical Staff shall investigate each application for reappointment and make an objective, evidence-based decision based upon assessment of the applicant's general competencies before recommending action to the Board of Directors. The Board of Directors shall ultimately be responsible for granting membership and privileges. By applying to the Medical Staff for reappointment, the applicant agrees that regardless of whether he/she is reappointed or granted the requested privileges, he/she will comply with the responsibilities of Medical Staff membership and the Medical Staff Bylaws and Rules as they exist and as they may be modified from time-to-time.

B. **REAPPOINTMENT PROCESS:**

1. **Schedule for Reappointment**
   a. As described in the Medical Staff Bylaws Article IV, §4.6, at least 90 days prior to the expiration date of each staff member's term of appointment, the Medical Staff office shall provide the member with a reappointment application form . Completed reappointment application forms shall be returned to the Medical Staff office at least sixty (60) days prior to the expiration date. Failure, without good cause, to return the form within the specified timeframe shall result in termination of privileges and prerogatives at the end of the current staff membership.
2. **Content of Reappointment Form**
   a. The reappointment application shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the application shall request an update of all of the information and certifications requested in the appointment application form with the exception of that information which cannot change over time; such as information regarding the member's premedical and medical education, date of birth, and so forth. The application shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.
      i. If the staff member's level of clinical activity at this hospital is not sufficient to permit evaluation of his or her competence to exercise the clinical privileges requested,

the staff member shall have the burden of providing evidence of clinical performance at another institution in whatever form the Medical Staff may require.

b. In addition to completing the information requested on the reappointment form, the staff member shall submit his or her Medical Staff dues as described in the Medical Staff Bylaws Article XIII, §13.2. Application for reappointment will be considered incomplete if dues (or other fine or assessments) are not paid within the time frame as described in §4.6 of the Medical Staff Bylaws and the member is deemed to be voluntarily resigned without the rights to a hearing as described in Article VII §7.2 of the Bylaws.

3. **Verification and Collection of Information** (Medical Staff Bylaws §4.6)

a. The Medical Staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Department/Division Chair, Credentials Committee, Medical Executive Committee, or Board of Directors. The information shall address without limitation:

i. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

ii. Participation in relevant continuing education activities.

iii. Level/amount of clinical activity (patient care contacts) at the hospital. Patient care activities include:

1) Inpatients:
   a) Admitting
   b) Attending
   c) Assisting at Surgery
   d) Consulting
   e) Operative and other procedures

2) Outpatients:
   a) Assisting at Surgery
   b) Operative and other procedures
   c) Emergency Room visits

iv. Sanctions imposed or pending including, but not limited to, previously successful or currently pending challenges to any licensure or registration (State or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

v. Confirmation of the applicant's health status, both physical and mental, or substance abuse that could affect his or her ability to exercise the clinical privileges requested, or whether the applicant required any type of accommodation in order to exercise the requested privileges safely and competently.

vi. Attendance at Medical Staff Department/Division and committee meetings.

vii. Participation as a staff officer and committee member/chair.

viii. Timely and accurate completion and preparation of medical records as outlined in **Medical Staff** Policy: ~~and Procedure 8710-518~~ Medical Record Documentation Requirements **8710-518**.

ix. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel, and patients as described in the **Medical Staff Policy:** Professional Behavior ~~Policy~~ 8710-~~511.1~~**570**.

x. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

xi. Compliance with all applicable Medical Staff and hospital bylaws, rules, and policies.

xii. **Two** Professional references **are required and** ~~from~~ at least one (1) practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.

xiii. Any other pertinent information, which may include, the staff member's activities at other hospitals and his or her medical practice outside the hospital.
xiv. Teleradiologists - Hospital affiliations shall be selected for 5 institutions and verified.
xv. Information concerning the member from the State licensing board and the Federal National Practitioner Data Bank.
xvi. Information from other relevant sources.

4. **Department Action**
   a. The Department/Division Chair shall review the application and all other relevant available information. The Department/Division Chair will then forward his or her written recommendations to the Credentials Committee.
5. **Credentials Committee Action**
   a. The Credentials Committee shall review the application, all other relevant available information and the Department /Division Chair's recommendations. The committee shall transmit to the Medical Executive Committee its written recommendations.
6. **Medical Executive Committee Action**
   a. The Medical Executive Committee shall review the Department/Division Chair's and the Credentials Committee's recommendations and all other relevant information available and shall forward recommendations to the Board of Directors.
7. **Board Closure**
   a. To ensure the Medical Staff reappointment credentialing process is completed; upon Board of Directors approval of the reappointments, board closure process shall be initiated to include notifying the practitioner of the decision regarding privilege(s) and/or Medical Staff membership.
8. **Reappointment Recommendations**
   a. Reappointment recommendations shall be written and shall specify whether the member's appointment should be renewed; renewed with modified membership category and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described.
   b. The Medical Staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

C. **SPECIAL CONSIDERATIONS:**

1. **Extension of Appointment:** As provided in Bylaws, Article 4, §4.6-4.
2. **Failure to File Reappointment Application:** As provided in Bylaws, Article 4, §4.5.10
   a. Members who automatically resign under this rule shall be processed as new applicants should they wish to reapply.
3. **Reapplication After Adverse Appointment:** As provided in Bylaws, Article 4, §4.5.10
4. **Relinquishment of Privileges**
   a. A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall notify the Credentials Committee identifying the particular privileges to be relinquished or limited.
5. **Additional Privilege Requests**
   a. Whenever a member desires to increase his/her clinical privileges, he/she shall indicate additional requested privileges on a privilege request form and submit the completed form to the Credentials Committee. The member's request must include documentation of training and/or experience as required by the Rules and Regulations. The request shall be processed in the same manner as an application for initial clinical privileges.
   b. Prior to the consideration or granting of any privilege not currently delineated on the Delineation of Privileges it shall be determined, by the Department/Division Chair whether the resources necessary to support the requested privilege are currently available or are available within a specified time frame as stated in the **Medical Staff Policy: Requests**

for New Privileges/Technologies New to TCMC ~~Determination for Organizational Resource Availability Policy~~ 8710-526.

6. **Leave of Absence**
   a. During any period of leave of absence, the requirement for reappointment as specified in the Bylaws, Article 4.4, shall continue unless waived by the Medical Executive Committee (MEC).

D. **RELATED DOCUMENTS:**
1. **Medical Staff Policy: Medical Record Documentation Requirements 8710-518**
2. **Medical Staff Policy: Professional Behavior Policy 8710-570**
3. **Medical Staff Policy: Requests for New Privileges/Technologies New to TCMC 8710-526**

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion** { }

Date: 03/17/2016 **Requestor:** Dr. Dandy Lee

Trade Name: Bridion **Generic Name:** Sugammadex

Dosage form(s): 200 mg/2 mL or 500 mg/5 mL single dose vials

Indications:

1. Reversal of neuromuscular blockade caused by rocuronium bromide or vecuronium bromide in adults undergoing surgery

Efficacy:

Comprehensive summary and assessment of eleven Phase III trials: The total number of patients in each study ranged from 30 to 137. Included patients were greater than 18 years of age, unless otherwise specified in table three. Trials also included patients of varying American Society of Anesthesiologists (ASA) physical status.. The ASA physical status classification system identifies the risk of complications in surgical patients. All 11 trials found sugammadex to be associated with quicker recovery of TOF to 0.9, and no serious adverse reactions were reported related to the study drug.

Safety:

Propensity for medication error: Moderate

Abuse potential: None

Sentinel event potential:

1) Bradycardia observed in clinical trials
2) Hypersensitivity reactions (flushing, urticarial, rash, hypotension) observed in patients without prior exposure to sugammades

Cost comparison with similar Formulary products: N/A

70 kg patient	Neostigmine (max 5 mg) + Glycopyrrolate	Sugammadex
Standard reversal	$65 +$6=$71	2 mg/kg (140 mg) $90 (1 vial)
Deep reversal	$65 +$6=$71	4 mg/kg (280 mg) $180 (2 vials)
Emergency reversal	$65 +$6=$71	16 mg/kg (1,120 mg) $537 (6 vials)

Recommendation:
Recommend the addition of suggamadex 200mg/2mL to the TCMC formulary. Sugammadex will be restricted to the Anesthesia Service strictly for indications outlined in the Criteria For Use listed below. Neostigmine/glycopyrrolate will remain the first line option for reversal of neuromuscular blockade by

rocuronium or vecuronium. Use of suggamadex will be monitored and a Medication Use Evaluation (MUE) will be conducted after a period of no later than 1 year to ensure adherence to established criteria.

Criteria For Use:

Inclusion (patient should receive if one of the following is selected)

Rescue therapy in a rare but life-threatening "cannot intubate, cannot ventilate" situation with rocuronium only

Emergency reversal needed (premature procedure termination) soon after induction of profound depth of neuromuscular blockade with rocuronium or vecuronium

Rapid reversal necessary for neurologic function monitoring during spine-related surgery in cases where degree of paralysis cannot be adequately reversed in a timely fashion with neostigmine/glycopyrrolate

Exclusion (patient should not receive sugammadex of one of these is selected)

Patient did not receive rocuronium or vecuronium as neuromuscular blocking agent

Patient has a known hypersensitivity to the active substance or to any of the excipients

Process/Plan to monitor Patient Response:

1. Monitor HR, respiratory rate, oxygen saturation after administration
2. Monitor for signs of hypersensitivity

References:

Sugammadex® package insert. Merk & Co.Inc., Kenilworth, NJ. 2015.

McGrath C, Hunter J. Monitoring of neuromuscular block. Contin Educ Anaesth Crit Care Pain. 2006 Feb; 6(1):7-12.

Srivastava A, Hunter J. Reversal of neuromuscular block. British Journal of Anaesthesia. 2009 May 24; 103(1):115-29.

FDA approves Bridion to reverse effects of neuromuscular blocking drugs used during surgery. Food and Drug Administration. Silver Spring, MD. 2015. Available from: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm477512.htm

ASA physical status classification system. American Society of Anesthesiologiest. 2014, Oct 15. Available from: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system

Rahe-Meyer N, Berger C, Wittmann M, Solomon C, Abels E, Rietbergen H, Reuter D. Recovery from prolonged deep rocuronium-induced neuromuscular blockade: A randomized comparison of sugammadex reversal with spontaneous recovery. Anaesthesist. 2015 Jul;64(7):506-12.

Amao R, Zornow M, Cowan R, Cheng D, Morte J, Allard M. Use of sugammadex in patients with a history of pulmonary disease. Journal of Clinical Anesthesia. 2011 Sept 9; 24:289-97.

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion** { }

Date: 05/01/2016

Requestor: Dr. Oska Lawrence/Dr. Navneet Boddu

Trade Name: Emend

Generic Name: Aprepitant

Dosage form(s): 40mg, 80mg, 125mg capsules.150mg single dose vial for injection
Indications:

1. For prevention of acute and delayed nausea/vomiting associated with initial and repeat courses of highly emetogenic chemotherapy regimens, including high-dose cisplatin

2. For postoperative nausea/vomiting (PONV) prophylaxis

Efficacy:
Chemotherapy associated nausea/vomiting

Herrstedt et al (2005) conducted a randomized, double-blind study comparing efficacy and tolerability of aprepitant (APR), ondansetron and dexamethasone to a serotonin receptor antagonist and dexamethasone in 866 breast cancer patients receiving a cyclophosphamide-based regimen. Patients randomized to the APR regimen received: Day 1 (aprepitant 125 mg, ondansetron 8 mg and dexamethasone 12 mg) before chemotherapy and ondansetron 8 mg 8 hours later; Day 2-3 (aprepitant 80 mg every day). Patients randomized to the control regimen received: Day 1 (ondansetron 8 mg twice a day and dexamethasone 20 mg before chemotherapy); Day 2-3 (ondansetron 8 mg twice daily). Each treatment repeated for ≤ 3 more cycles for a total of 4 cycles. In cycle 1, 50.8% of the APR patients achieved a complete response compared to 42.5% in the control group. Over the 4 cycles, the investigators reported that the percentage of patients achieving a complete response (CR) in Cycle 1 and who sustained a CR over cycles 2-4 was greater with the APR group compared to the control group ($p=0.017$). Both treatment groups were reported to be well tolerated. The incidence of adverse effects was similar for both treatment arms.

Post-operative nausea and vomiting
Gan et al (2007) conducted a randomized, double-blind trial comparing the efficacy and tolerability of aprepirtant and ondansetron for the prevention of postoperative nausea and vomiting in 805 patients receiving general anesthesia for open abdominal surgery. Patients were randomized to receive a preoperative dose of aprepitant 40mg orally, aprepitant 125mg orally, or ondansetron 4mg intravenously. The incidence of vomiting, nausea, and use of rescue therapy were assessed over 48 hours after surgery.

For the primary end point (complete response [no vomiting and no use of rescue agents] there was no difference between aprepitant and ondansetron (45% with aprepiatnt 40mg, 43% with aprepitant 125mg, and 42% with ondansetron). The incidence of no vomiting in the first 24 hours was significantly higher with aprepitant 40mg (90%) and aprepitant 125mg (95%) versus ondansetron (74%), ($p<0.001$ for both comparisons). The rates of nausea control and use of rescue therapy however did not significantly differ between the treatment groups. Side effects appeared to be similar amongst patients in all treatment arms.

Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:

1) Neutropenia (Risk <3% in adults)

Cost comparison with similar Formulary products: N/A

Other considerations:

Aprepitatant has been used for several years at TCMC's Outpatient Infusion Center. It has been used as a non-formulary agent for inpatients as part of oncologic treatment regimens proposed by national guidelines. The purpose of this request is to formally add this drug to the TCMC formulary. Aprepitant also represents a new treatment approach for the prevention of post-operative nausea and vomiting and may prevent catastrophic events in patients who are at high risk of aspiration in this setting.

Recommendation:

Recommend the addition of aprepitant 40mg and 125mg capsules in addition to fosaprepitant 150mg vials for injection. For the indication of chemotherapy associated nausea/vomiting, aprepitant will be utilized as recommended for moderate-highly emetogenic regimens as outlined in accepted practice guidelines.

With regard to post-operative nausea/vomiting prophylaxis, we recommend allowing use in the **pre-operative setting** for high-risk patients only as identified by anesthesiologist pre-op screening

Process/Plan to monitor Patient Response:

1) Monitor patient for signs/symptoms of nausea/vomiting

References:

Gan TJ, Apfel CC, Kovac A, et al. A randomized, double-blind comparison of the NK1 antagonist, aprepitant, versus ondansetron for the prevention of postoperative nausea and vomiting. Anesth Analg 2007; 104:1082.

Herrstedt J, Muss H, Warr D, Hesketh P, Eisenberg P, Raftopoulos H, Grunberg S, Gabriel M, Rodgers A, Hustad C, Horgan K, Skobieranda F. Efficacy and Tolerability of Aprepitant for the Prevention of Chemotherapy-Induced Nausea and Emesis over Multiple Cycles of Moderately Emetogenic Chemotherapy. Cancer 2005; 104(7):1548-55.

Lasseter KC, Gambale J et al. Tolerability of Fosaprepitant and Bioequivalency to Aprepitant in Healthy Subjects. J Clin Pharmacol 2007; 47:834-40.

War D, Grunber S, Gralla R, Hesketh P, Roila F, de Wit R, Carides A, Talyor A, Evans J, Horgan K. The oral NK1 antagonist aprepitant for the prevention of acute and delayed chemotherapy-induced nausea and vomiting: Pooled data from 2 randomised, double-blind, placebo controlled trials.

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion** { }

Date: 4/1/2016 **Requestor:** Dr. Richard Barager

Trade Name: Veltassa **Generic Name:** Patiromer sorbitex calcium

Dosage form(s): Powder – 8.4, 16.8 and 25.2 grams packets

Indications:

1. Treatment of hyperkalemia

Efficacy:

[CHF Patients] PEARL – HF Trial - Patiromer decreased potassium and increased the proportion of subjects able to proceed with spironolactone dose titration. Compared with placebo, the patiromer group had significantly lower potassium (mean difference _0.45 mEq/L, p50.001) and a lower incidence of hyperkalemia (7.3% patiromer vs. 24.5% placebo, p=0.015). At the end of the treatment period, 91% vs. 74% of subjects were able to increase their spironolactone dose in the patiromer and placebo groups, respectively (p=0.019). Hypokalemia occurred in 6% and 0% of the patiromer and placebo groups, respectively (p=0.094).

[CKD Patients] AMETHYST-DN Trial - The mean reduction from baseline in serum potassium level at week 4 or time of first dose titration in patients with mild hyperkalemia was 0.35 (95% CI, 0.22-0.48) mEq/L for the 4.2 g twice daily starting-dose group, 0.51 (95% CI, 0.38-0.64) mEq/L for the 8.4 g twice daily starting-dose group, and 0.55 (95% CI, 0.42-0.68) mEq/L for the 12.6 g twice daily starting-dose group. In those with moderate hyperkalemia, the reduction was 0.87 (95% CI, 0.60-1.14) mEq/L for the 8.4 g twice daily starting-dose group, 0.97 (95% CI, 0.70-1.23) mEq/L for the 12.6 g twice daily starting-dose group, and 0.92 (95% CI, 0.67-1.17) mEq/L for the 16.8 g twice daily starting-dose group ($P < .001$ for all changes vs baseline by hyperkalemia starting-dose groups within strata).

Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:

1) **Bowel obstruction** – use should be avoided in patients with severe constipation, bowel obstruction as it may worsen GI conditions
2) **Hypomagnesemia** – drug may bind to magnesium in the colon and cause low magnesium levels

Cost comparison with similar Formulary products:

Drug	Cost per dose	Cost per Day
Sodium polystyrene sulfate (15g/60mL)	$7	$7-28 (Dosed 1-4x daily)
Patiromer (8.4g)	$30	$30

Other considerations:

Based on the published studies reviewed in this monograph, patiromer may be good alternative to SPS in management of hyperkalemia. It appears to be better tolerated and likely has greater safety margin in patients with CKD and HF due to reduced sodium load. In addition, RAAS inhibition has been shown to benefit renal and cardiac function, and the ability to continue uninterrupted therapy in patients with heart failure is important. Patiromer, not unlike SPS, is not ideal agent for treatment of acute hyperkalemia due to delayed onset of action and its use will likely be most appropriate in patients with chronic or medication-induced hyperkalemia.

Recommendation:

We recommend the addition of patiromer to the TCMC Formulary as an alternative to sodium polystyrene sulfate for the management of hyperkalemia in patients with chronic kidney disease (CDK) or heart failure (HF). For patients with hyperkalemia who can otherwise tolerate sodium polysterene sulfate, this will remain the first-line treatment option for this indication.

Process/Plan to monitor Patient Response:

1) Monitor serum potassium and magnesium levels while on therapy

References:

Veltassa™. Full Prescribing Information (Package insert). Relypsa, Inc. Oct 2015

Pitt B, Anker SD, Bushinski DA et al. Evaluation of the efficacy and safety of RLY5016, a polymeric potassium binder, in a double-blind, placebo-controlled study in patients with chronic heart failure (the PEARL-HF trial). Eur Heart J 2011; 32:820-828

Weir MR, Barkis GL, Bushinski DA et al. Patiromer in patients with kidney disease and hyperkalemia receiving RAAS inhibitors. N Engl J Med 2015; 372:211-221

Barkis GL, Pitt B, Weir MR et al. Effect of patiromer on serum potassium level in patients with hyperkalemia and diabetic kidney disease: the AMETHYST-DN randomized clinical trial. JAMA 2015; 314:151-161

TRI-CITY HEALTHCARE DISTRICT

PROFESSIONAL AFFAIRS COMMITTEE CHARTER

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

I. Purpose

The Committee is to provide governance oversight and make recommendations to the Tri-City Healthcare District Board of Directors ("Board") regarding quality, patient safety, performance improvement, and risk management policies; oversee development and implementation of the Quality Assurance, Quality Improvement, and Patient Safety (QA/QI/PS) Programs; and provide oversight of processes relating to the reporting, monitoring, investigation, and appropriate responsive/corrective actions taken in connection with any issues identified at the meetings, including the following:

1. Quality. The Committee will review reports regarding quality of patient care, including:

    a. Hospital operating unit and quality intervention programs;

    b. Core measures and performance measures;

    c. Medical staff and contracted hospital-based physicians' reports.

2. Patient Safety. The Committee will review reports regarding patient safety, including:

    a. Patient safety improvement programs;

    b. Incidents reported to the California Department of Public Health (CDPH) including any findings;

    c. Surveys from The Joint Commission, Center for Medicare and Medicaid Services, and other regulatory agencies.

3. Performance Improvement. The Committee will review the following reports:

    a. Operating unit performance improvements;

    b. Performance of clinical service providers.

4. Risk Management. The Committee will review the District's risk management program, including:

    a. Summaries of incident reports;

b. Compliments and complaints;

c. Surveys from Joint Commission, CMS, and CDPH visits;

d. Sentinel Events/Root Cause Analyses;

e. Professional liability claims and lawsuits.

5. Oversight Duties and Responsibilities. In addition, the Committee will:

a. Review and reassess the adequacy of this charter annually, recommend any proposed changes to the Board for approval, and publish this charter in accordance with applicable regulatory authorities;

b. Review significant reports prepared by any individual performing significant quality assurance functions together with management's response and follow-up to these reports;

c. Review the District's Administrative policies and procedures as necessary.

d. Consult with appropriate Consultants as necessary to inform the deliberations and committee decisions as necessary.

II. Membership

The Committee shall consist of three Directors and four physicians. The CEO, COO, Risk Manager, and CNE shall support the Committee without vote but be counted towards a quorum as alternates.

III. Meetings

The Committee may establish its own meeting schedule annually. The Committee will adjourn into closed session to meet with the legal counsel and to hear reports of the Hospital and Medical Staff Quality Assurance Committees.

IV. Minutes

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

V. Reports

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

VI. Conduct

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

Approved by BOD: 9/29/11
Approved by BOD: 3/28/13
Approved by BOD: 5/29/14