TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
June 9, 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 May 2016 Meeting	3-9	2 min.	Committee
5.	New Business			
a.	Priority Project Dashboard	10		J. Piearson
b.	Consideration and Possible Approval of Policies and Procedures	11		All
	Patient Care Services			
	1. Accounting of Disclosure of Patient Information (PHI) Procedure	12-15		
	2. Release of Deceased Procedure	16-23		
	3. Infant Baptism Procedure (Spiritual Care for Family of Critically Ill or Deceased Infant)	24		
	Administrative Policies and Procedures			
	1. Business Visitor Visitation Requirements 8610-203	25-29		
	Unit Specific **Surgical Services**			
	1. Admission/ Discharge Criteria	30-33		
	Forms			
	1. High Risk Infant Follow-Up Standard Visit Form 7883-1002	34-42		
	2. Progress Record 8720-1018	43		
6.	Review and Discussion of CLINICAL Contracts (*Discussion/ Possible Action*)	To be distributed	10 min.	Chair
7.	Motion to go into Closed Session		2 min.	Committee
8.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))		30 min.	Chair
9.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair

10.	Comments from Members of the Committee		5 min.	Committee
11.	The next meeting of the Professional Affairs Committee of the Board is on July 14, 2016.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
May 12, 2016

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

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

Others present: Rick Barton, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Kathy Topp, Sharon Davies, Rick Sanchez, Nancy Myers, Patricia Guerra and Karren Hertz.

Members Absent: Dr. James Johnson, and Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control.

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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of April 2016.	Director Mitchell called for a motion to approve the minutes from April 14, 2016 meeting.	Minutes ratified. Dr. Contardo moved and Director Schallock seconded the motion to approve the minutes from April 2016.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	Marcia reported on the measures for the Quality Outcomes Dashboard. Falls Falls associated with bathroom trips for patients continues to become a challenge. To help with this issue, there is a toileting pilot done in the floors. Some of the steps taken are: hourly rounding using 3Ps; remain with high-risk patients at all times during toileting/ showering; make a commode available if unable to ambulate. There was a question posed by Director Finnila if the hospital pays for the patient's rehab in cases of falls. It depends on a lot of factors one of them which is the existence of pre-existing conditions. The influenza immunization is consistently above target. There was also a brief discussion on the data concerning VTE Warfarin therapy discharge instructions.	Informational	Marcia Cavanaugh
b. ED Outpatient Measures	Dr. Showah presented a thorough report on the ED outpatient measures. He stated that there are three (3) things that are necesarry	Informational.	Dr. Henry Showah

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	to optimize the operations in the ED. 1. Space/ environment- Authorities have looked at our ED and have assessed that space limitation is one of the challenges in the patient flow in the ED. The BHU triage process has helped in making improvements but there still needs to be a configuration done to have a 5-team triage compared to the 2 that we have. This change will help us in seeing a lrage number of patients in the ED. 2. Nursing and registration staffing- Sharon and ED Director Candice have done a great job at optimizing the staff in the ED but we still have sick calls and a nursing shortage which affect 8% of the ED beds which in turn affects patient flow and number of patients being seen. 3. Process improvement- A proposal of changing from the traditional into a split team to help the flow is being considered and will be implemented as soon as other things are build out. Dr. Showah also touched on the issue of "boarding" patients and how LWOTS went down recently. They repurposed the fast track beds into ED BHUbeds which helped the LWOTS figures go down. This shows that a process improvement can help compensate for another challenge in the		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	department.		
c. Consideration and Possible Approval of Policies and Procedures			
Patient Care Policies and Procedures:			
1. Collection of Blood Specimen by Skin Puncture Procedure	A question was raised on the amount of blood draw needed for blood specimen. Also, the vein viewer will be shown to the group at a future meeting.	**ACTION:** The Patient Care Services policies and procedures were approved. Director Finnila moved and Director Schallock seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Consent for Minors Policy	A formatting change will be made on the table contained in this policy.		
3. Nitrazine Test on Vaginal Fluid Procedure	There was a small clarification on the equivocal results for the reporting part of the policy.		
4. Siemens Rapidpoint 405 Procedure	This procedure is considered a point of care testing only.		
5. Urine Chemistry Uisng a Urine Dipstick, measuring Procedure	No discussion on this policy.		
6. Urine Dipstick Analysis Using Siemens Clintek Status + Connect procedure	No discussion on this policy.		
7. Witnessing a Patient Signature on Patient's Personal Documents	There was a question on the availability of a notary public in the hospital. There is one available for staff but not for patients; there		

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Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	was a suggestion to have some standard referrals so patients will know where to go if they need a notary public.		
Administrative Policies and Procedures			
1. Fax Waiver 635	No discussion on this policy.	**ACTION:** The Administrative policies and proceudres were approved as moved by Director Schallock and seconded by Dr. Worman.	Patricia Guerra
2. Library Services Mission and Scope of Services 287	There was short clarification on the inter library loan process of TCMC with academic centers and other medical libraries. Reciprocity is used with this process so we hardly pay for services.		
Unit Specific Infection Control			
1. Surveillance Program	Handwashing was noted as it plays an integral part of this policy.	**ACTION:** The Infection Control policy was approved. Director Schallock moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Medical Staff			
1. Supervision of Resident in Emergency Medicine	It was noted there is direct and indirect supervision for the residents in the ED. The sample of an evaluation form will be added as an attachment to this policy.	**ACTION:** The Medical Staff policy was approved. Director Finnila moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
NICU 1. Bathing, Newborn Infant 2. Chest Tube, Care of Infants with Pneumothorax 3. Dietitian, Role in the NICU 4. Measuring Infant Length in the NICU	The first 2 policies were deletions. There was no discussion on this policy. There was no discussion on this policy.	**ACTION:** The NICU policy was approved. Director Sc hillock moved and Dr. Worman seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Women and Newborn Services 1. Amniocentesis	There was no discussion on this policy.	**ACTION:** The WNS policy was approved. Director Schallock moved and Dr. Worman seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
6. Clinical Contracts	In the review of clinical contracts, there were four physicians whose contracts were were tabled until corrections/ modifications are made.	**ACTION:** These clinical contracts will be corrected and reviewed for next month's meeting.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Finnila seconded and it was unanimously approved to go into closed session at 1:05 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed	There were no actions taken.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Session			
10. Comments from Members of the Committee	No Comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:24 PM		Director Mitchell

Tri-City Medical Center ADVANCED HEALTH CARE...FOR YOU

Severe Sepsis Management

Presenter: Bruce Bainbridge, RN

June 2016

Tri-City Medical Center ADVANCED HEALTH CARE...FOR YOU

Aim Statement

The development of screening tools to identify patient in or at risk for severe sepsis or septic shock. To provide an efficient and reliable process to initiate appropriate treatment. This process must also meet CMS guidelines as provided in the Sepsis Clinical Quality Measure.

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

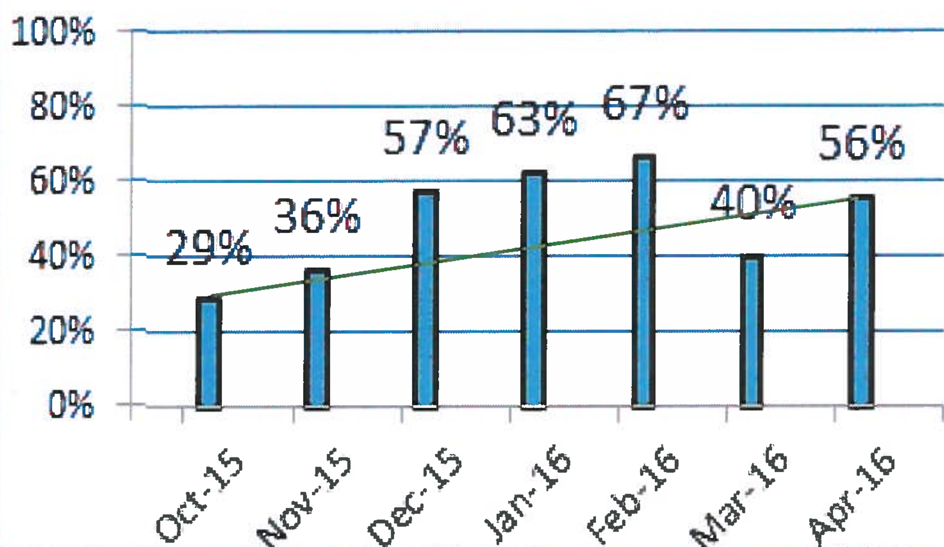
I – Education of phlebotomists to document patient refusal of repeat lactate blood draw.

I – Education to ED and Hospitalist MD's encouraging use of the Sepsis Order sets and Focused Exam templates.

Run Charts/ Data

Increased compliance with **Septic Shock** measures when Sepsis Order sets are used. **When used 65% pass rate.**

When not used 38% pass rate.



Barriers/ Lessons Learned

1. Improvement in providing required bolus. Using prescribed volume order.
2. New challenge of prescribed repeat lactate being missed or late. Patients refusing draw, not documented. Education to phlebotomists done to document refusal.
3. Several documentation requirements are missed in the MD Focused Assessment for Septic Shock patients. There is a template available for use that includes all required aspects.

Recommendations and Next Steps

- Encourage use of the use of the Sepsis Order Set by ED and Hospitalist physicians.
- Encourage use of Focused Assessment template by ED and Hospitalist physicians.

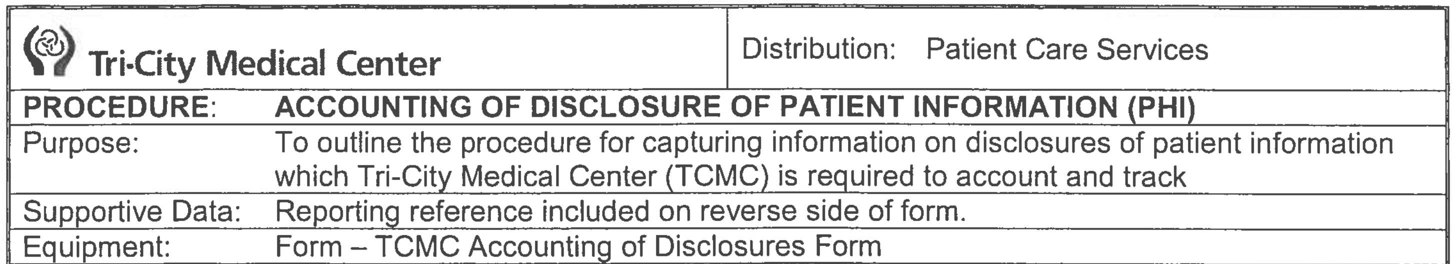
Team Members

Bruce Bainbridge - Lead
Dr. Henry Showah
Dr. Scott Worman
Sharon Schultz
Candice Parras
Marcia Cavanaugh
Jami Pierason
Ingrid Stuiver
Lina Sprague
Melanie Bruce
Rosemary Mervosh

PROFESSIONAL AFFAIRS COMMITTEE
June 9, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
Accounting of Disclosure of Patient Information (PHI) Procedure	3 year review, practice change	
Release of Deceased Procedure	Practice change	
Infant Baptism Procedure (Spiritual Care for Family of Critically Ill or Deceased Infant)	3 year review, practice change	
Administrative Policies & Procedures		
Business Visitor Visitation Requirements 8610-203	3 year review, practice change	
Unit Specific		
Surgical Services		
Admission/Discharge Criteria	Practice change	
Forms		
High Risk Infant Follow-up Standard Visit Form 7883-1002	Practice change	
Progress Record 8720-1018	Practice change	



Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ACCOUNTING OF DISCLOSURE OF PATIENT INFORMATION (PHI)**
Purpose:	To outline the procedure for capturing information on disclosures of patient information which Tri-City Medical Center (TCMC) is required to account and track
Supportive Data:	Reporting reference included on reverse side of form.
Equipment:	Form – TCMC Accounting of Disclosures Form

A. **PROCEDURE:**

1. Clinical Departments and Nursing Units:
   a. Complete and forward the attached form for each disclosure referenced, to the Privacy Officer.
   b. Record the patient identifying information (patient name, medical record number, account number)
   c. Record specific information relating to the recipient of the disclosed information
      i. Name of Requestor (person's name)
      ii. Name of Entity (facility name)
      iii. Current Address (location of the entity)
   d. Record the purpose of the disclosure by marking off the appropriate box on the form. Check only one box per disclosure.
   e. Record the reason for the disclosure by marking off the appropriate box.
      i. State or Federal law or regulation
      ii. Court order (attach accompanying supporting documentation)
      iii. Other – specify reason for the disclosure
   f. Record a description of the information disclosed (i.e., lab results, Form #1234)
   g. Record the treatment date for the information disclosed.
   h. Identify the originating location of the information disclosed (i.e., medical record for lab results)
   i. Record the method of disclosure by marking off the box that describes how the information was disclosed. Multiple answers to this question may apply and can be recorded on the single form.
   j. Print the name, department, and date of disclosure.
   k. Forward the completed sheet to the Privacy Officer for data entry into the ~~Accounting of Disclosures~~ **Release of Information** database.
2. Privacy Office/Release of Information
   a. Stamp the Accounting of Disclosures form upon receipt.
   b. Log into the ~~Affinity Release~~ **Cerner** of Information/Correspondence module.
   c. Identify the patient based upon the identifying information provided on the disclosure form.
   d. Insert/Add the disclosure utilizing the following information
      i. Name of Entity (Organization)
      ii. Purpose of Disclosure (response that begins with prefix PRI)
      iii. Reason for Disclosure
      iv. Description of Information disclosed
      v. Method of Disclosure
      vi. Name of Person who disclosed (record in comments field)
   e. Date and initial entry of the information into the tracking system
   f. ~~Forward~~ **Scan** completed document to the ~~Privacy Officer for filing~~ **patient's medical record**.

B. **FORMS:**

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
7/03, 3/06; 03/09, **4/16**	07/11, **05/16**	08/11, **05/16**	NA	09/11	09/11

1. **Accounting of Disclosures Form**
2. **Disclosure Tracking References Form**

TCMC - Accounting of Disclosures Form

Complete and submit to Medical Records/Health Information (Attn: Privacy Officer)
NOT PART OF THE PERMANENT RECORD

Disclosures to be entered in the Accounting:

Patient's Name: ____
Last First MI

Patient MRUN: ____________________ Acct #: ____________________

Disclosure made to:

Name of Requestor: ____________________ Name of Entity: ____________________

Current Address: ____

City: ____________________ State: ______ Zip Code: ______ Phone #: ____________

Purpose of Disclosure (check only one)

- ☐ Animal Bites
- ☐ Assault & Battery to on-duty Health Care Personnel
- ☐ Assault Victims – Domestic Violence
- ☐ Child Abuse (suspected)
- ☐ Chromosomal Defects in Fetus or Infant
- ☐ Drug Use (illegal)
- ☐ Elder and Dependent Abuse
- ☐ Firearms reporting
- ☐ Infectious Diseases (reportable)
- ☐ Lapses of Consciousness/Seizures
- ☐ Locating suspects, fugitives, and witnesses
- ☐ Mental Health Holds beyond 24 hours
- ☐ Missing Patient
- ☐ Multiple bee stings
- ☐ Neural Tube Defects in a Fetus
- ☐ Newborn Screening Test Refusal (PKU)
- ☐ Occupational Injuries/Illnesses (if not for payment)
- ☐ Patient Death (not LifeSharing and Funeral Homes/Directors - standard releases)
- ☐ Patient Injury/Death due to faulty equipment
- ☐ Patient Transfer Violation
- ☐ Pesticide Poisoning
- ☐ PKU Specimen not obtained
- ☐ Research if done without authorization
- ☐ Reye Syndrome
- ☐ Threat to Kill
- ☐ Unusual occurrences that threaten the welfare of the patient, staff or visitors
- ☐ Vendors/Contractors (if not for Treatment, Payment, Operations)
- ☐ Other (specify)

Why Disclosure Made: (check only one)

☐ State or Federal law or regulation ☐ Court Order ☐ Other ____________________

Brief Description of Information Disclosed:

____

This record was for treatment date: ____________________

This information is in a: ☐ Medical Record ☐ Billing Record ☐ Other (specify) ____________

Method of Disclosure: ☐ Phone Call/Verbal ☐ Form Submission/Fax ☐ Other (specify) ____________

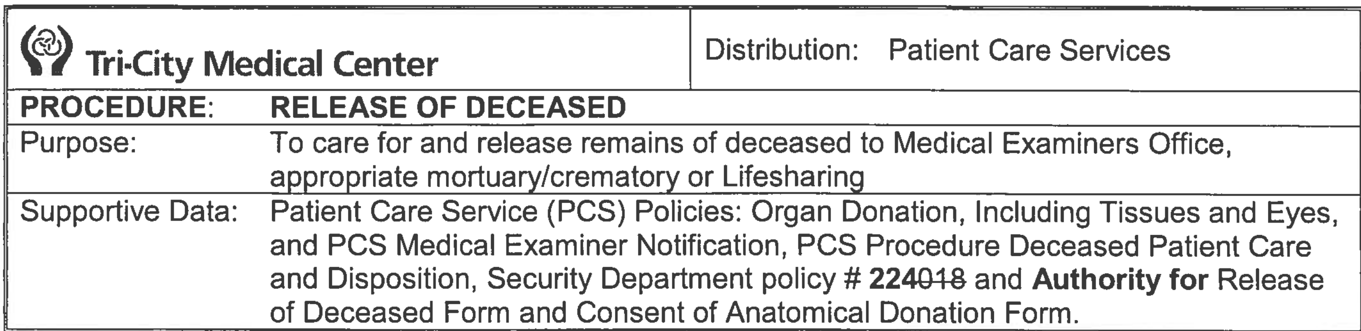
Person Disclosing Records: (please print)

____ **Last Name**

First Name **Department** **Date**

Disclosure Tracking References

	Disclosure Type	Disclosed by	Disclosed To	Method of Disclosure
1	Animal Bites	Emergency Department Business Office	Humane Society	Phone Call
2	Assault & Battery to on-duty Health Care Personnel	Security Department - Director	Law Enforcement, Employee Health, Risk Management	Phone call
3	Assault Victims - Domestic Violence	Emergency Department Business Office Registrars, Social Services, Security, Risk Management	Law Enforcement	Phone Call with written report follow-up
4	Cancer Reporting-Neoplasms	Oncology Data Registry	Dept of Health Services Cancer Protection Service	Data Abstract/Cnet
5	Certificate of Birth	Birth Certificate Clerk	San Diego County Registrar	Birth Certificate/AVSS
6	Child Abuse (suspected)	Social Services, Health Practitioner, Child Care Custodian	Child Protective Services, Local Law Enforcement	Phone Call with written report follow-up
7	Chromosomal Defects in Fetus or Infant	Lab performing the analysis or physician making diagnosis	Dept of Health Services	
8	Drug Use (Illegal)	Security Department	Oceanside Police	Phone Call with written report follow-up
9	Elder and Dependent Adult Abuse	Social Services, Health Practitioner, Care Custodian	County Adult Protective Services	Phone Call with written report follow-up
10	Firearms Reporting	BHU Nurse Designee	Dept of Justice	Firearms Report
11	Infectious Diseases (Reportable)	Physician, Nursing Staff, Emergency Department, Infection Control, Laboratory	Public Health Dept	Phone Call with written report follow-up
12	Lapses of Consciousness/Seizures	Central source of Medical Staff Support Services	Department of Motor Vehicles	Form (PM110) completed and faxed
13	Locating suspects, fugitives, and witnesses	Privacy Officer, Risk Management	Law Enforcement	Verbal with written report follow-up
14	Mental Health Holds beyond 24 hours	Director of Emergency Services	Dept of Health Services	Phone Call with written report follow-up
15	Missing Patient	Security Department	Law Enforcement	Phone Call with written report follow-up
16	Multiple bee stings	ED Nursing Staff Designee	Dept of Health Services	Phone Call with written report follow-up
17	Neural Tube Defects in a Fetus	MRD/HIM Director	Dept of Health Services - Alpha-Feto Protein Screening Program	Written report
18	Newborn Screening Test Refusal (PKU)	Maternal/Child Health Representative	Department of Health Services - Genetic Disease Branch	Written report (#NBS-PR)
19	Occupational Injuries/Illnesses (if not for payment)	Physician	Employer & Employee, Insurer	Written report
20	OSHPD (Office of State Healthwide Planning & Development)	MRD/HIM - semi-annually	OSHPD	Data Abstract/Electronic
21	Outbreaks or undue prevalence of infectious or parasitic disorder	Infection Control	Dept of Health Services	Form (PM110) completed and faxed
22	Patient Deaths	Health Care Practitioner, Physician	LifeSharing (organ donation), Medical Examiner, Funeral Homes/Directors, Dept of Health Services as required	Phone immediately
23	Patient Deaths due to unusual circumstances	Health Care Practitioner, Risk Manager	Law Enforcement, Medical Examiner, Dept of Health Services. HCHA (if relate	Phone Call with written report follow-up
24	Patient Injury/Death due to faulty equipment	Health Practitioner, Risk Manager	Federal Drug Admn - Medical Device & Lab product problem reporting program	Phone Call with written report follow-up
25	Patient Transfer Violation	Risk Manager	Dept of Health Services, HCFA	Phone Call with written report follow-up
26	Pesticide Poisoning	Emergency Department Nurse	Dept of Agriculture Health Officer	Phone Call
27	PKU Specimen not Obtained	Maternal/Child Health Representative	Dept of Health Services - Genetic Screening Branch	Form (BS-No-90)
28	Research if done without authorization	IRB Coordinator	Regulatory Agencies	Written
29	Reye's Syndrome	ED Dept, Central Source - Medical Staff Support Services	Dept of Health Services	Form (CBC Reye Syndrome) completed and submitted
30	Subpoenas, court orders, discovery request of other lawful process (unless authorization is provided)	MRD/HIM Release of Information Desk	Entities as outlined in the subpoena/court order.	Copy service copies as designated or copy mailed/delivered to court.
31	Threat to Kill	Psychotherapist, Behavioral Health Manager, Security, Risk Manager	Law Enforcement, Intended Victim	Phone immediately with written report follow-up.
32	Unusual occurrences that threaten the welfare of the patient, staff or visitors	Health Care Practitioner, Risk Manager	Dept of Health Services, Law Enforcement	Phone Call with written report follow-up



Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**RELEASE OF DECEASED**
Purpose:	To care for and release remains of deceased to Medical Examiners Office, appropriate mortuary/crematory or Lifesharing
Supportive Data:	Patient Care Service (PCS) Policies: Organ Donation, Including Tissues and Eyes, and PCS Medical Examiner Notification, PCS Procedure Deceased Patient Care and Disposition, Security Department policy # **2240**~~18~~ and **Authority for** Release of Deceased Form and Consent of Anatomical Donation Form.

A. **AFTER A PATIENT'S DEATH, THE STAFF NURSE WILL**:

1. Notify physician to pronounce the patient or to obtain physician's order for the Administrative Supervisor **(AS)** or ~~designee~~**specially trained Registered Nurse (RN)** to pronounce patient dead.
    a. Notification of the family of the patient's death is the responsibility of the physician.
        i. Provide next of kin's name and phone number to physician.
        ii. Ask the physician who will be responsible for signing the death certificate and complete the Expiration Record in Cerner with this information.
    b. **For neonatal deaths see PCS Procedure: Miscarriage and Stillbirth Identification and Disposition Process and PCS Deceased Newborn/Stillborn, Care of.**
    c. **For forensic deaths see Forensics Procedure: Release of Deceased of an Incarcerated Patient.**
2. Notify the Medical Examiner of reportable deaths within one hour of death and do not remove any lines unless this is waived by the Medical Examiner. (Refer to PCS Policy ~~IV.Z~~ Medical Examiner Notification for criteria for reportable deaths and process for reporting). Explain procedures involved to family.
3. Indicate in the Expiration Record in Cerner if the Medical Examiner is notified or not.
    a. If the Medical Examiner is notified and waives the case make sure to enter the waive number in the Expiration record.
    b. If the Medical Examiner accepts the case document in Cerner the Medical Examiner accepts case.
    c. The Medical Examiner's office will pick up decedent.
4. Notify the donor referral line (Lifesharing) as soon as possible and within one hour of the death at 1-888-423-6667 (refer to PCS Policy Organ Donation, Including Tissues and Eyes). Note the date and time of this call and name of the referral line staff on the Expiration Record in Cerner.
    a. If LifeSharing identifies the patient as a candidate for eye, bone or tissue procurement, a Lifesharing Representative shall contact the family regarding donation options (refer to PCS Policy Organ Donation, Including Tissues and Eyes) for referral, obtaining consent, and recovery process). If the representative calls back with donation information for consent purposes, the additional information on donation in the Expiration Record in Cerner needs to be completed.
    b. Only a Lifesharing Procurement Coordinator shall approach the family regarding donation option for organs.
        i. Verify that the family consent or refusal for donation option is documented in the ~~"~~Expiration Record~~"~~ in Cerner along with time of death.
        ii. Provide eye care for corneal / eye donation patients (close eyes, place light ice bags over the eyes). Corneas can be utilized up to twelve hours.
        iii. Document consent for donation in the "Expiration Record" in Cerner and place signed consent form in the front of the medical record. Leave the chart in the Nursing area at the main nursing desk on the floor in which the patient expired for the Procurement Coordinator to review. Document recovery procedure completion if done at bedside in the expiration record in the "other" comment box

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/94, 4/07, 3/10, 6/13,12/13	7/06, 4/07, 3/10, 6/13,12/13, **03/16**	8/06, 7/07; 4/10;6/13;12/13, **03/16**	8/06, 7/07, 4/10;7/13;1/14**, 04/16**	9/06, 8/07, 5/10;9/13;2/14	9/06, 8/07, 5/10;9/13; 2/14

of “Organ Donation Approval” section.

5. Notify ~~Patient Representative (760-940-7466 from 0730 – 1600, Mon-Fri) or~~ **AS** ~~Administrative Supervisor/designee~~**specially trained RN** ~~(~~760-644-6968 ~~from 1900 – 0730, M-F and 24 hours per day on weekends and holidays),~~ immediately after death.
   a. If **the** ~~Patient Representative or~~ **AS** ~~Administrative Supervisor~~ **is**~~are~~ not available, ~~s~~**S**ecurity will be point of contact.
6. Solicit assistance from Chaplain, Social Services and/or patient’s Hospice Nurse as needed for family support.
   a. If hospice is involved, they do not notify the mortuary to pick up the deceased only **the** ~~Patient Representative or~~ **AS** ~~Administrative Supervisor~~ makes this call.
   b. In the Emergency Room, **Social Services and** Trauma Interventional Program (TIP) is ~~also~~ available for family support.
7. Verify that the time of death is recorded in the ~~“~~Expiration Record~~”~~ in Cerner by the **AS** ~~Administrative Supervisor~~ **or by the physician who pronounced the death.** If the **AS**~~Administrative Supervisor~~ or ~~designee~~**specially trained RN** pronounces, the time will be entered into the note of pronouncement and expiration record, otherwise the time will be noted in the Physician’s Progress Note.
8. Provide family information regarding **funeral arrangements and support services**~~death procedures verbally and by offering the family a “We Care Brochure.”~~
9. Identify patient’s next of kin (e.g. spouse, parent, child, sibling, aunt/uncle, cousin).
10. Release patient belongings and valuables after recording inventory of all valuables and patient belongings in the ~~“~~Expiration Report~~”~~ in Cerner and then print ~~“~~Release of Deceased Report~~”~~ and place a patient label where indicated. Release belongings to family and obtain their signature on Release of Deceased Report.
   a. ~~Forward any~~ **Any** unclaimed valuables **will be secured** in valuables envelope and ~~belongings in labeled belongings bag~~**then the RN notifies Security to pick up the valuables.** ~~to Patient Representative or Administrative Supervisor~~. ~~Place a~~**A**ll unclaimed valuables **will be placed** in the hospital safe per **Patient Care Services** ~~p~~**P**olicy **Patient Valuables, Liability and Control** ~~Administrative Policy number 317~~ and **the** ~~forward~~receipt **forwarded** to ~~Patient Representative or~~ **the AS**~~Administrative Supervisor~~. **Security is to be contacted to provide patient valuables to family members when requested after a patient’s death.**
   ~~10.~~**b. If family is not present to take patient belongings, then the RN notifies Security to pick up the belongings and place them in a secure designated location.** Security is to be contacted to provide patient ~~valuables and~~ belongings to family members when requested after a patient’s death.
11. Print Cerner report ~~“~~Release of Deceased~~”~~ for signatures.
   a. If ~~“~~Release of Deceased~~”~~ Report is signed by a legal representative, attach a copy of the documentation of legal representation, e.g. Power of Attorney.
12. Forward the following to the ~~Patient Representative/~~ **AS** ~~Administrative Supervisor~~:
   a. **A**~~Two copies of~~ completed electronic ~~“~~**Authority for** Release of Deceased~~”~~ Report.
   ~~a.~~**b.** **Facesheet – 1 copy.**
   ~~b.~~**c.** 1 copy of documentation of legal representation of patient, i.e. Power of Attorney; Conservator, if applicable.
   ~~c.~~**d.** Valuables receipt.
   ~~d.~~**e.** Consent for Autopsy (if requested by family or physician and financial arrangements have been confirmed with Department of Pathology).
   ~~e.~~**f.** Consent for Anatomical Donation, for Tissue and/or Eye Donation (when procurement is complete).
   ~~f.~~**g.** Body donation program acceptance letter/forms.
13. After patient is properly identified and placed in body bag, notify Lift Team to transport the body from the patient care area to the morgue for temporary storage.

14. May also release patients to Medical Examiner's office or mortuary from the patient's room following the above process and sign off appropriately on the "**Authority for** Release of Deceased" Report.

B. <u>THE ~~PATIENT REPRESENTATIVE/~~ADMINISTRATIVE SUPERVISOR WILL</u>:

1. Call the mortuary when the body is ready for release from TCMC and provide them with the information requested from the completed "Release of Deceased" Report. Refuse release of body to any agency or transport service before hearing from next of kin and having authorization signed. Exceptions to this are as follows:
   a. The Medical Examiner will pick up the deceased on their authority.
   b. If the patient has made prior arrangements (pre needs), a copy of this document from the mortuary is acceptable.
2. Send ~~two copies of~~ the ~~"~~**Authority for** Release of Deceased~~"~~ Report and additional paperwork to the~~PBX~~ **AS** office even if patient is to be picked up from room or other areas of the Medical Center.
3. Notify Engineering when morgue bay is full to adjust temperature.
4. Respond to call from **Private Branch Exchange (**PBX**)** when a security officer is unavailable to release deceased from TCMC.

~~5. Pick up the second copy of Release of Deceased form clipboard in PBX. These will be picked up daily and archived in a binder in the Administrative Supervisor's office.~~

~~6.~~**5.** Notify Public Administrator if:
   a. Next of Kin of patient is unidentified and there is no identified court appointed Power of Attorney or Conservator/Guardian.
      i. Holding A Body Pending Disposition: The body of any person whose death occurs in this State, or whose body is found in the State, or which is brought in from outside the State, shall not be temporarily held pending disposition more than eight (8) calendar days after death, unless a permit for disposition is issued by the local registrar of the registration district in which the death occurred or the body was found.
   b. Parents or family of fetal demise have made no mortuary arrangements after eight (8) days.
      i. If parents or families are unable financially to obtain mortuary services they may contact the Public Administrator for assistance. This is done by the family placing the call to the San Diego County Public Administrator (858) 694-3500.
      ii. The Medical Center staff is prohibited from making mortuary referrals or financial arrangements for families.

~~7.~~**6.** Serve as a resource to the staff nurse regarding consent for tissue, organs, and eye donation, (refer to PCS Policy Organ Donation, Including Tissues and Eyes). The determination of donor suitability will be done by Lifesharing.

~~8.~~**7.** Contact Anatomical Gift Program to verify donation when patient has applied or been accepted into the anatomical gift program for body donation.
   a. If available, attach a copy of the acceptance forms and letter, from the University Medical Center or school to the ~~"~~**Authority for** Release of Deceased~~"~~ ~~R~~report. If not available from the family, call the Program Office at the School or University for a copy to be faxed to TCMC and attached to the "**Authority for** Release of Deceased" ~~R~~report.

~~9.~~**8.** In the case of an autopsy:
   a. Autopsies may be requested on any deceased patient by the physician or immediate family/legal guardian to determine exact cause of death but only with written consent.
   b. TCMC Pathologist reserves the right to honor the request based on written consent from the physician; no payment. If declined at TCMC, the family may request the ME or independent Pathology to perform at their request. In these cases the family is responsible for payment.
   c. Ensure family understanding that a physician's order for autopsy does not make TCMC financially responsible for the autopsy. The Family must make financial arrangements

for autopsy with the Department of Pathology prior to start of autopsy. The **AS~~Administrative Supervisor~~** ~~Patient Representative~~will assist the family in meeting with a representative of Pathology department to make such arrangements.

d. When a family requests an autopsy be performed at TCMC**:**

i. **T**~~, t~~he patient's physician, Pathology and Medical Records are notified**.**

ii. **A**~~ and a~~ll forms **are** signed.

iii. The chart is sent to Medical Records for processing and is forwarded to Pathology Department the same day for the autopsy.

~~i.~~**iv.** The canary copy of the autopsy consent is kept by **the** ~~Patient Representative/~~ **AS** ~~Administrative Supervisor~~ with **the** ~~"~~**Authority for** Release of Deceased~~"~~ Report copies.

~~d.~~**e.** The Secretary for the Department of Pathology notifies the ~~Patient Representative/~~**AS** ~~Administrative Supervisor~~ when the autopsy is complete. The original Authorization for Autopsy form stays with the chart, a carbon copy remains in the Laboratory. Upon notification of autopsy completion, the body may be released to the mortuary.

~~e.~~**f.** For autopsies to be completed at outside facilities (e.g. UCSD Medical Center or the Medical Examiner's office), the body will be released and signed copies of the "**Authority for** Release of Deceased" Report in the space provided for such agencies and Autopsy Consent (pink copies) provided. The **Authority for** Release of Deceased ~~R~~report will remain on the board for return of body if known. Remaining forms go to **the AS** ~~Patient Representative or Administrative Supervisor~~.

~~10.~~**9.** Once the body is released from the TCMC morgue it is no longer the responsibility of TCMC to accept the body back to our morgue. **Fetal demises will be released from Pathology to the ~~M~~mortuary of choice.**

C. **<u>THE SECURITY OFFICER WILL</u>**:

1. Upon notice by PBX of mortuary service or Medical Examiner's arrival, pick up **R**~~r~~elease **of Deceased** forms ~~from PBX box labeled "pick-up."~~ **from the AS~~Administrative Supervisor~~ office.** If no forms found, call **the** ~~Patient Representative or call~~ **AS** ~~Administrative Supervisor~~ (760) 644-6968.
   a. If the patient is to be picked up from their room, Security will follow the same process.
2. Go to the morgue or patient's room with above paper work, identify Medical Examiner's agent, appropriate mortuary service/procurement agency, and verify the deceased with all identification as below:
   a. Medical Examiner's agent: Request identification and verify the name of the decedent.
   b. Mortuary: Request identification and verify the name of decedent.
   c. Decedent: Check the ~~"~~**Authority for** Release of Deceased~~"~~ ~~R~~report and Patient Identification Label/name against the hospital armband and bag/toe tags.
   d. Verify that no personal belongings or valuables remain on the deceased. Return all valuables and/or belongings found to ~~the Patient Representative/~~ **AS** ~~Administrative Supervisor~~. **or Security.**
3. Legibly sign the ~~"~~**Authority for** Release of Deceased~~"~~ Report along with driver.
4. Provide driver with unsigned copy of ~~"~~Release of Deceased~~"~~ Report
5. Complete Morgue Disposition Log, logging patient out of morgue (or back into morgue, if patient is returning from Medical Examiners/procurement agency).
6. Deliver signed copy of **the Authority for** Release of Deceased Report to ~~PBX~~ **the AS~~Administrative Supervisor~~ office** and make a second copy of signed report.
   a. Place original copy on clipboard labeled ~~"~~Medical Records~~"~~ and place in ~~"~~Returns~~"~~ box, this will be picked up daily by Medical Records.
   ~~a.~~**b.** **Update Deceased Tracking Report with ~~M~~morgue ~~S~~status daily.**
      ~~i. Place second copy on clipboard labeled "Administrative Supervisor" and place in "Returns" box~~
7. Notify ~~Patient Representative/~~ **AS** ~~Administrative Supervisor~~ when a deceased is returned to the morgue from an outside agency.

8. Notify ~~Patient Representative~~ **AS**~~/Administrative Supervisor~~ if any problems with morgue, or if any deceased is not in a morgue bay with their name.

~~8.~~**9.** **Update ~~M~~morgue log with any deceased patient movement, either entering the Morgue or being removed from the ~~M~~morgue.**

~~9.~~**10.** Adhere to all aspects of Security Department Policy and Procedure #~~018~~ **224** regarding Morgue Release.

a. Security to get signatures with family.

~~10.~~**11.** Ensure that there is a family consent before allowing San Diego Eye Bank to take the body from the morgue and start the case. Security should first check with the **AS**~~Administrative Supervisor or Patient Representative~~ to ensure that consent exists.

D. **SECURITY AFTER HOURS PROCESS:**

1. When the **AS**~~Patient Representative or Administrative Supervisor~~ is not available, Security will be the point of contact for Release of Deceased matters to include: family members signing the Release of Deceased, communication with mortuaries, donation services and release of remains from TCMC.
2. After Hours Procedure:
   a. Lead Security Officer will be notified of request.
   b. Security shall contact/speak with family member and verify next of kin status or right to sign.
   c. Security shall request that the family member come in to sign the **Authority for** Release of Deceased form.
   d. Upon family signing, Security Officer will release personal belongings.
   e. Security will call the mortuary of choice for notification of release.
   f. Security will document on the **Authority for** Release of Deceased ~~T~~**t**ime, ~~D~~**d**ate and ~~S~~signature.
   g. Paperwork will remain with clip board in the PBX office.

E. **THE LIFT TEAM WILL**:

1. ~~Maintain~~ **Obtain** a morgue key, retrieve the covered morgue transport gurney from the morgue, and transport it to the requesting unit of a deceased patient.
   a. The patient should be in a body bag.
   b. Lift Team will assist with placing patient in body bag if patient is large.
2. Transport patient to and from the morgue as requested by **AS**~~Patient Representative/Administrative Supervisor~~ to accommodate family viewing or place patient on gurney in the morgue for viewing if needed a number 1 or number 2 will be written on the back side of the **Authority for** Release of Deceased form.
3. Record requested information on Morgue Disposition Log, logging patient into or out of morgue.
4. Notify the **AS** ~~Patient Representative/Administrative Supervisor~~ if morgue bays are full, body is not in a morgue bay, or morgue equipment is not functioning properly.
   a. **AS**~~Administrative Supervisor/Patient Representative~~ to notify Engineering for temperature adjustment.
5. Rotate bodies as directed when there are more bodies than morgue bays available, under the direction of the **AS**~~Patient Representative/Administrative Supervisor~~.
   a. Unclaimed bodies will be transferred to outside morgue #2 as determined by the **AS**~~Patent Representative~~.

~~F. WOMEN'S AND CHILDREN'S SERVICES STAFF IN THE EVENT OF AN INFANT DEATH WILL:~~

~~1. Maintain a morgue key.~~
~~2. Carry deceased infant, properly wrapped and labeled, to and from the morgue for family viewing.~~
~~3. Infants may be placed with adults in cooler compartments.~~
~~4. Record requested information on the Morgue Disposition Log when the infant is in and out of the morgue.~~

~~Determine if the fetus has died in utero and is a stillborn or miscarriage.~~
~~If fetus identified as a miscarriage it does not require family to be responsible for disposition of fetal remains.~~
~~Fetal remains are taken to pathology with tissue requisition.~~
~~If fetus fails to meet stillbirth requirements the patient may choose to have remains buried or cremated with a Mortuary. Refer to~~
~~5.~~ ~~A fetus that is delivered stillbirth requires the family to make disposition arrangements with a mortuary. A stillborn fetus will be handled according to Refer to PCS Deceased Newborn/Stillborn, Care of~~

~~G.~~F. **PROCESSING OF COMPLETED PAPERWORK BY ALL STAFF**:

a. Original copies of all paperwork (All Consents, authorizations, and the electronic "Release of Deceased" Report) will be forwarded to the **AS**~~Patient Representative or Administrative Supervisor~~ for processing.

~~H.~~G. **MANAGEMENT OF CALLS RELATED TO RELEASE OF DECEASED ISSUES:**

1. Addressed by the patient's nurse and **AS**~~Administrative Supervisor./Patient Representative.~~

~~I.~~H. **DECEDENT'S PROPERTY**:

1. Except when there is reason to know of a dispute over a deceased patient's personal property, California law permits a decedent's personal property to be turned over to the decedent's residence, the patient's spouse or relative, or to the conservator of the decedent/guardian of the decedent's estate. If the estate is being administered, however, the property must be delivered to the personal representative (i.e., executor or administrator of the will/estate) upon request of the personal representative. If no member of the family or legal representative appears within a reasonable time, or fails to respond to hospital correspondence, the hospital can deliver the property to the public administrator and obtain a receipt to be kept in the decedent's medical record.
2. The hospital may release the property promptly after the patient's death; however the recipient must provide reasonable proof of their status and identity. The hospital may rely on their driver's license, a passport, or photo identification card issued by the U.S. Government. The hospital must record the property released, and to whom the property was delivered, for a period of at least 3 years. The hospital must also obtain a signed receipt. Hospital will maintain a copy of the photo identification provided by the recipient, as well as the signed receipt, for the requisite time period.

~~J.~~I. **RELATED DOCUMENTS:**

1. Emergency Department Deaths of Pediatric Patients Procedure
2. PCS **Policy** Medical Examiner Notification
3. PCS **Policy** Organ Donation, Including Tissue and Eyes
4. PCS Policy Patient Valuables, Liability and Control
~~3.~~**5.** PCS **Procedure** Deceased Newborn/Stillborn, Care of
~~4.~~**6.** PCS **Procedure** Deceased Patient Care and Disposition
~~5.~~**7.** PCS **Procedure: Miscarriage and Stillbirth Identification and Disposition Process** ~~Differentiating Intrauterine Demise from Miscarriage~~
~~6.~~**8. PCS Procedure: Wasting Narcotics Documentation in the Pyxis Machine**

J. **FORMS**

1. Deceased Tracking Report - SAMPLE
2. Morgue Log - SAMPLE
~~Consent for Anatomical Donation Form~~
~~7. Release of Deceased Form~~
~~Release of Deceased Form and Consent of Anatomical Donation Form~~

DECEASED TRACKING REPORT – Sample

Patients Name:	Medical Record #	Room #	Expiration Date	Expiration Time	Coroners Case (Y or N)	Organ Donation (Y or N)	Autopsy (Y or N)	Paperwork Location	Mortuary: Physician and Mortician	Date Notified	Time Notified	Released Date	Released Time	Initials

MORGUE LOG SHEET- Sample

TOTAL BODY COUNT:____ ______

MAIN MCGUE

	NAME	MR #	DATE TO MORGUE	NOTES	LT / SECURITY SIGNATURE
1					
2					
3					
4					

LABORATORY (Neonates/fetus)

	NAME	MR #	DATE TO LAB	NOTES	LT / SECURITY SIGNATURE
1					
2					
3					

OVERFLOW MORGUE

	NAME	MR #	DATE TO MORGUE	NOTES	LT / SECURITY SIGNATURE
1					
2					
3					
4					
5					

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	~~INFANT BLESSING or BAPTISM~~**SPIRITUAL CARE FOR FAMILY OF CRITICALLY ILL OR DECEASED INFANT**
~~Purpose:~~	To outline the steps in performing **a Blessing or** ~~b~~**B**aptism of either a deceased or a critically ill infant.
Supportive Data:	Infant **blessing or** baptism may be desired by parents ~~of many Christian denominations (e.g. Roman Catholic, Anglican/Episcopalian, Lutheran, Presbyterian, Orthodox).~~
Equipment:	Sterile water

A. **PROCEDURE:**

1. Ask the parents if they **have any faith based practice they** wish **for** the infant ~~to be~~ **such as being blessed or** baptized.
    - ~~a. Infant baptism is not common in Judaism or other non-Christian religions. However, there may be specific rites/prayers associated with a stillbirth or critically ill infant. Ask the parents about any particular rituals for this situation.~~
2. Attempt to reach appropriate clergy if the family has not already done so.
3. If clergy is unavailable, any member of the medical or nursing staff may perform an emergency **blessing or** baptism.
    - a. It is preferable, but not necessary for the person performing the **blessing or** baptism to be of the same denomination as the family.
        - ~~4.~~**i.** ~~Pour small amount of sterile water over the head of the individual.~~ **If the parents are Christian or Catholic pour a small amount of sterile**~~the~~ **water** three times, saying: "I **bless or** baptize you in the name of the Father, and of the Son, and of the Holy Spirit."
    - ~~a.~~**b.** If infant has been named, use full given name in place of "you".
    - ~~b.~~**c.** If possible, another staff member should witness the **blessing or** baptism.

B. **DOCUMENTATION:**

1. Document in the medical record and on the Checklist for Assisting Parent(s) Experiencing Neonatal Death/Stillborn that **blessing or** baptism was performed with date, time, and name of person who performed **the blessing or** baptism.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/03, 6/09, 5/12, **04/16**	05/12, **05/16**	05/12, **05/16**	~~06/12~~ **n/a**	07/12	07/12

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE: 9/07

SUBJECT: BUSINESS VISITOR VISITATION REQUIREMENTS

REVISION DATE: 01/08; 07/11

POLICY NUMBER: 8610-203

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

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

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

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

5. All business visitors must sign in at the Reptrax kiosk in the main lobby.
   a. Business visitors visiting the Surgical Services division are required to ~~register~~ **check in** at the front desk of the Main Operating Room (OR) or the Sterile Processing Department (SPD), and must always be identifiable by badge.
   b. Business visitors denied access in Reptrax must report immediately to ~~Purchasing~~**Supply Chain Management to receive a temporary badge** before visiting any areas.
      i. **After hour business visitors to report to Security and receive a temporary badge.**
6. Business visitors must wear the Reptrax printed badge **or other appropriate TCHD vendor/visitor identification** and check in with the charge nurse prior to entering any clinical area.
7. Business visitors whose product competes with products covered by a sole or multiple source contracts **already in use at TCHD** shall not be seen unless the hospital is in the process of re-negotiating for these items and has requested representation.
8. Business visitors who are awarded national contracts with the hospital's affiliated Group Purchasing Organization may only discuss those products covered under the agreement.
   a. These discussions shall only take place after the Supply Chain Management department has completed the initial review and the business visitor has received authorization to proceed.
9. No products shall be left in hospital departments without approval from Clinical Values Analysis Team. ~~(Refer to Administrative Policy, *Product Standardization Evaluation*)~~
10. TCHD employees and business visitors are expected to employ the highest ethical standards in business practices regarding source selection, negotiation, determination of contract awards, and administration of all purchasing activities to foster public confidence in the integrity of the procurement process.
    a. Neither party shall disclose third party confidential information including contract pricing, information to any outside party, or use of confidential information for actual or anticipated personal gain without express consent by the other party **or as required by law**.
11. Any business visitor not complying with these rules shall be issued a ~~verbal~~ warning **in Reptrax**. If a second offense occurs, TCHD reserves the right to ban that particular business visitor representative from doing business with TCHD. ~~for a period of five years.~~
~~11.~~**12. TCHD employees are prohibited from being vendors or suppliers of any product or service at TCHD.**

D. **PRODUCT REMOVAL AND REPAIRS:**
1. No TCHD owned equipment or instrumentation shall be removed from the Hospital unless accompanied by authorized paperwork.
~~1.~~**2. No instruments or trays (hospital or vendor owned), will be removed from SPD without SPD staff's knowledge and consent.**

E. **PRODUCT INTRODUCTIONS**~~S ANF REPLACEMENT PRODUCTS~~**:**
1. All products being brought into the hospital for review/evaluation must be 501**K**/FDA approved and at no cost to TCHD. All products for review, replacement, and/or evaluation must be submitted through the Supply Chain Management Department or Supply Chain Director in advance.
2. No in-service or product demonstration shall occur without the prior knowledge of the Unit Manager **and**~~or~~ Supply Chain Management.
   a. Under no circumstances are products used on patients without in-service/education for Medical Staff and Health Care providers prior to use of the product/equipment.

F. **DRESS CODE:**
1. All business visitors conducting business must dress according to unit policy.
   i. If the business visitor representative is required to wear scrubs~~:~~**,** ~~H~~**h**is/her temporary identification badge shall be clearly visible on the front left pocket of the scrub shirt.

ii. Scrub tops shall be tucked in at all times.
iii. All ~~TCMC~~**TCHD** owned surgical scrubs must be returned before leaving the hospital.

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

G. **PRICING:**

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

H. **LOANER INSTRUMENTS:**

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

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

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

10. Business visitors and vendors must remain present during surgical procedures to support use of their product.
11. Once the patient has entered the OR, the business visitor representative is not allowed in the OR until surgical drapes are applied and the procedure is ready to commence. The business visitor is allowed in the OR ONLY for the portion of the procedures related to use of the business visitor's product. Business visitor representatives shall ~~limit~~ ~~**to a minimum**~~**minimize** the number of times they enter/exit an operating suite once a procedure has started**.** ~~to a minimum.~~
    a. Only one business visitor shall be permitted in the OR, Catheterization Lab, and/or Interventional Radiology Room during a procedure unless authorized by the department **D**~~d~~irector or designee.
    b. Business visitor names/information is recorded on the intraoperative record.

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

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

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

M. **RELATED DOCUMENT**:

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

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES POLICY & PROCEDURE MANUAL

SUBJECT: ADMISSION / DISCHARGE CRITERIA

ISSUE DATE: 02/04
REVISION DATE(S): 07/06; 06/09; 09/12; 06/14

Department Approval Date(s): **07/14**
Department of Surgery Approval Date(s): **~~08/14~~02/16**
Department of Anesthesiology Approval Date(s): **02/16**
Pharmacy and Therapeutics Approval Date(s): **n/a**
Medical Executive Committee Approval Date(s): **05/16**
Professional Affairs Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To provide guidelines for admission and discharge of patients to or from the Operating Room

B. **DEFINITIONS:**
1. Operating Room: A specially equipped and staffed unit designed to meet the surgical needs of patients within the defined Scope of Service.

C. **POLICY:**
1. The Medical Staff shall be defined by administration.
2. All hospital personnel rendering patient care in surgery are skilled in performing basic perioperative care and equipment operation related to their position descriptions.
3. Additional training is provided for personnel in specialty areas.
4. The admission of patients to Surgical Services is based on physician-determined surgical need.
   a. **Patients admitted to surgery for elective scheduled procedures must have orders for preoperative admission available to the hospital per surgery scheduling guidelines.**
   b. **Patients admitted to surgery from the Emergency Department or Inpatient/Outpatient areas must be seen by their surgeon and consent for surgery obtained prior to transportation from the ED or Inpatient/Outpatient Area to the Operating Room/Pre-op Holding Area.**
   ~~a.~~**c.** On admission to **Pre-op Hold/s**Surgery ~~(or pre-op holding area)~~, the following documents shall be present: (**Note:** Patients will not be taken into the Operating room if required documentation is missing from the chart):
      i. Correctly completed consent form(s)
      ii. History and Physical, written, dictated **(must be viewable in electronic medical record)** or updated within the 24 hours prior to the procedure
         ~~ii.~~**1)** **For complete History and Physical requirements, see Medical Staff Policy "Medical Record Documentation Requirements".**
      iii. Physician Pre-Procedure Documentation form
      iv. Physician Orders
      v. Completed Preoperative Checklist
      ~~i.~~**vi.** Other documents may include but are not limited to:
         1) Anesthesia Questionnaire
         2) Anesthesia Consent
         3) Results of lab work and any other diagnostic tests per physician's orders
         4) Previous medical record

d. **For cases requiring surgical site marking (per Patient Care Services Procedure "Universal Protocol"), the surgical site must be marked by surgeon prior to transporting patient to the OR.**

e. **Endoscopy procedures performed with RN-administered moderate sedation: refer to Patient Care Services Procedure "Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures" for complete pre-operative requirements.**

~~c.~~**f.** The requirements above do not preclude rendering emergency surgical care to a patient in dire circumstances.

~~b.~~**g.** Routinely performed outpatient procedures may include, but are not limited to:
- i. Cosmetic Surgery Procedures
- ii. Laparoscopic procedures
- iii. Hernia Repair
- iv. Appendectomy
- v. Cholecystectomy
- vi. Hemorrhoidectomy
- vii. D&C
- viii. Cold Cone
- ix. Hysteroscopy
- x. ENT
- xi. Cystoscopy
- xii. Tubal Ligations
- xiii. Arthroscopic
- xiv. Ophthalmic

~~b.~~**h.** Anesthesia administered includes, ~~but~~ **but is** not limited to:
- ~~ii.~~**i.** General Anesthesia
- ~~i.~~**ii.** Regional Anesthesia
- **iii.** Monitored Anesthesia Care (MAC)

~~iii. **Local-only procedures are not performed in the Operating Room.**~~

5. Patient care is assigned to personnel based on the individual needs of the patient.
   - a. Each patient is assigned at least 2 surgical team members, 1 of which is the Registered Nurse circulator.
   - b. Procedures requiring additional resources, due to severity of illness of the patient or complexity of the procedure, shall be staffed with additional personnel.

   ~~Patient care is also assigned to personnel with documented specialty experience and training.~~

6. Patients shall be discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure.
   - a. The postoperative level of care ~~required by the patient shall be~~ **is** determined by the surgeon ~~and/~~**and/**or Anesthesiologist. ~~(when applicable).~~
   - b. Discharge to a level of care~~,~~ other than what was anticipated~~,~~ shall be communicated to all involved parties as early as possible.
   - c. Information related to the patient's postoperative assessment and plan of care shall be communicated to the receiving unit by the anesthesiologist and OR RN.
   - **d.** Postoperative transport shall be directed by the surgeon and/or anesthesiologist (when applicable) and involve the appropriate personnel and equipment to safely transport the patient.
     - i. **Endoscopy patients receiving RN-administered moderate sedation shall be transported by the RN to the designated recovery area, as determined by the procedural physician.**

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________ **(Last, First)** **HRIF I.D. #** __________

Required Field
Date of Visit: ☐☐/☐☐/☐☐☐☐ **(MM/DD/YYYY)**

VISIT ASSESSMENT

Core Visit	☐ #1 (4-8 months)	☐ #2 (12-16 months)	☐ #3 (18-36 months)
Zip Code of Primary Caregiver: ☐☐☐☐☐			
Chronological Age: ☐☐ Months ☐☐ Days		Adjusted Age: ☐☐ Months ☐☐ Days	

Interpreter Used	☐ No			
	☐ Yes:	☐ Spanish ☐ Cambodian/Khmer ☐ Hmong/Miao ☐ Russian ☐ Vietnamese ☐ Declined	☐ Arabic ☐ Cantonese ☐ Korean ☐ Sign Language ☐ Other	☐ Armenian ☐ Farsi/Persian ☐ Mandarin ☐ Tagalog ☐ Unknown

Insurance (Check all that apply)

☐ CCS	☐ Commercial HMO	☐ Commercial PPO	☐ Healthy Families
☐ Medi-Cal	☐ Point of Service/EPO	☐ No Insurance/Self Pay	☐ Other
☐ Unknown			

PATIENT ASSESSMENT

Weight	**Length**	**Head Circumference**
☐☐.☐☐ (kg) or ☐☐(lbs) ☐☐ (oz)	☐☐☐.☐ (cm) or ☐☐.☐☐ (in)	☐☐☐.☐ (cm) or ☐☐.☐☐ (in)

GENERAL ASSESSMENT

Is the Child Currently Receiving Breastmilk? ☐ Exclusively ☐ Some ☐ None

Living Arrangement of the Child	☐ Both Parents ☐ Other Relatives/Not Parents ☐ Foster Family/CPS ☐ Unknown	☐ One Parent ☐ Non Relative ☐ Pediatric Subacute Facility	☐ One Parent/Other Relatives ☐ Foster/Adoptive Family ☐ Other
Education of Primary Caregiver	☐ <9th Grade ☐ Some High School ☐ High School degree/GED	☐ Some College ☐ College Degree ☐ Graduate School or Degree	☐ Other ☐ Unknown ☐ Declined
Caregiver Employment	☐ Full-Time ☐ Part-Time ☐ Temporary	☐ Multiple Jobs ☐ Work From Home ☐ Not Currently Employed	☐ Unknown ☐ Declined
Routine Child Care	☐ **None** ☐ **Yes** If Yes, Check all that apply: ☐ Child Care Outside of Home ☐ Specialized Medical Setting	☐ **Unknown** ☐ Home Babysitter/Nanny ☐ Other	 ☐ Not Used Routinely
Caregiver Concerns of the Child	☐ **None** ☐ **Yes** If Yes, Check all that apply: ☐ Behavioral ☐ Frequent Illness ☐ Medications ☐ Sensory Processing ☐ Sleeping/Napping	☐ **Unknown** ☐ Calming/Crying ☐ Gastrointestinal/Stooling/Spitting-up ☐ Motor Skills, Movement ☐ Speech & Language ☐ Vision	 ☐ Feeding & Growth ☐ Hearing ☐ Pain ☐ Stress ☐ Other

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________ (Last, First) HRIF I.D. # ______________

INTERVAL MEDICAL ASSESSMENT

Does the Child have a Primary Care Provider?	☐ No	☐ Yes	☐ Unknown
Does the Primary Care Provider Act as the Child's Medical Home?	☐ No	☐ Yes	☐ Unknown

Hospitalizations Since Last Visit

☐ No ☐ Yes: ☐☐ Number of Hospitalizations ☐ Unknown

If Yes, Check all that apply

Hospitalization Reasons	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Gastrointestinal Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meningitis infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nutrition/Inadequate Growth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Respiratory Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Tract Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Infection(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Rehospitalization(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having Surgeries During Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Surgeries Since Last Visit

☐ No ☐ Yes: ☐☐ Number of Surgeries ☐ Unknown

If Yes, Check all that apply

- ☐ Cardiac Surgery
- ☐ Inguinal Hernia Repair
- ☐ Tracheostomy
- ☐ Other Gastrointestinal Surgical Procedures
- ☐ Other Surgical Procedures
- ☐ Circumcision
- ☐ Retinopathy of Prematurity
- ☐ Tympanostomy Tubes
- ☐ Other Genitourinary Surgical Procedures
- ☐ Unknown
- ☐ Gastrostomy Tube Placement
- ☐ Shunt/Shunt Revision
- ☐ Other ENT Surgical Procedures
- ☐ Other Neurosurgical Procedures

Medications Since Last Visit

☐ No ☐ Yes ☐ Unknown

If Yes, Check all that apply

- ☐ Actigall
- ☐ Antibiotics/Antifungal
- ☐ Cardiac Medications
- ☐ Diuretics
- ☐ Inhaled Steroids (daily)
- ☐ Anti Reflux Medication
- ☐ Antihypertensive
- ☐ Chest Physiotherapy (daily)
- ☐ Inhaled Bronchodilators (daily)
- ☐ Inhaled Steroids (inter.)
- ☐ Anti Seizure Medication
- ☐ Caffeine
- ☐ Chest Physiotherapy (inter.)
- ☐ Inhaled Bronchodilators (inter.)

☐ Nutrition Supplements (make selection): ☐ Enteral Nutrition ☐ Dietary Supplements

☐ Oral Steroids

☐ Oxygen (if discontinued also enter chronologic post-natal age: __________ months __________ days)

☐ Viagra (Pulmonary Hypertension) ☐ Synagis/Palivizumab ☐ Other

☐ Unknown

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HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________________ (Last, First) HRIF I.D. # ______________

INTERVAL MEDICAL ASSESSMENT - *continue*

Equipment Since Last Visit	☐ No ☐ Yes ☐ Unknown If Yes, Check all that apply ☐ Apnea/CR Monitor ☐ Braces/Castings/Orthotics ☐ Enteral Feeding Equipment ☐ Helmet ☐ Nebulizer ☐ Ostomy Supplies ☐ Tracheostomy ☐ Ventilator/CPAP/BIPAP ☐ Wheelchair ☐ Other ☐ Unknown

MEDICAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Medical Services?
☐ No (Skip to Neurosensory Assessment) ☐ Yes (Complete below) ☐ Unknown (Skip to Neurosensory Assessment)

Service	Status	Referred, but Not Receiving (check reason)	
Audiology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Cardiology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Craniofacial	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Endocrinology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Gastroenterology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Hematology/Oncology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Metabolic/Genetics	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Nephrology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Neurology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

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INFANT NAME: ______________________ (Last, First) HRIF I.D. # ______________

MEDICAL SERVICES REVIEW *continue*

Service	Status	Referred, but Not Receiving (check reason)	
Neurosurgery	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Ophthalmology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Orthopedic	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Otolaryngology (ENT)	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Pulmonology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Surgery	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available
Urology	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason	☐ Visit Pending ☐ Insurance/HMO Denied ☐ Service Not Available

NEUROSENSORY ASSESSMENT

Vision Assessment History

Does the Child Have History of Retinopathy of Prematurity (ROP)? ☐ No ☐ Yes
Eye Surgery and/or Treatment with Anti-VEGF (i.e. Avastin)? ☐ No ☐ Yes ☐ Scheduled ☐ Unknown
Location of ROP: ☐ Unilateral ☐ Bilateral ☐ Unknown

Does the Child Have Visual Impairment?
☐ No (Skip to Hearing Assessment History)

☐ Yes A. Impairment Due To: (check all that apply)
☐ No, Type of Impairment at Visit

☐ Strabismus:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Cataract:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled
☐ Retinoblastoma:	Eye Surgery?	☐ No	☐ Yes	☐ Scheduled

☐ Cortical Visual Impairment ☐ Refractive Errors
☐ Nystagmus ☐ ROP
☐ Other ☐ Unknown

B. Location of Impairment:	☐ Unilateral	☐ Bilateral	☐ Unknown
C. Corrective Lens(es) Recommended:	☐ No	☐ Yes	☐ Unknown
D. Corrective Lens(es) Used:	☐ No	☐ Yes	☐ Unknown
E. Is There Functional Vision?	☐ Yes	☐ No *(complete below)*	
Location of "Blindness"	☐ Unilateral	☐ Bilateral	☐ Unknown

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INFANT NAME: ______________________ **(Last, First)** **HRIF I.D. #** ____________

*Required Field

NEUROSENSORY ASSESSMENT *continue*

☐ Unknown Visual Impairment

Why is Visual Impairment Unknown?

☐ Exam Results Unknown
☐ Needs Referral for Exam
☐ Referred, but Service Not Available
☐ Referred, but insurance/HMO Denied Services
☐ Referred for Functional Vision Assessment
☐ No Ophthalmology Exam Performed
☐ Referred for Exam, Not Received
☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Messed Appointment
☐ Functional Vision Assessment in Progress

Hearing Assessment History

Does the Child Have a Hearing Loss (HL)?

☐ No (Skip to Neurologic Assessment)

☐ Yes

A. Is There Loss in One or Both Ears? ☐ One ☐ Both ☐ Assessment in Progress ☐ Unknown

B. Does the Child Use an Assistive Listening Device (ALD):
☐ No
☐ Yes, ALD Recommended and Received
☐ Yes, ALD Recommended, but Not Received
☐ Unknown

C. Type of ALD(s) Used (check all that apply) ☐ BAHA ☐ Hearing Aid ☐ Cochlear Implant ☐ Other ☐ FM System ☐ Unknown

☐ Unknown Hearing Loss

Why is Hearing Loss Unknown?

☐ Exam Results Unknown
☐ Needs Referral for Exam
☐ Referred, but Service Not Available
☐ Referred, but Insurance/HMO Denied Services
☐ No Audiology Exam Performed
☐ Referred for Exam, Not Received
☐ Referred, but Parent Declines/Refuses Services
☐ Referred, but Missed Appointment

☐ Hearing Assessment in Progress (Skip to Neurologic Assessment)

NEUROLOGIC ASSESSMENT

*Was a Neurologic Exam Performed During this Core Visit?

☐ Yes

Date Performed: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ No Reason Why Exam **NOT** Performed:
☐ Acute Illness
☐ Known SEVERE Developmental Disability
☐ Significant Sensory Impairment/Loss
☐ Behavior Problems
☐ Primary Caregiver Refused
☐ Other Medical Condition
☐ Examiner Not Available
☐ Primary Language
☐ Other

Summary of Neurologic Assessment

☐ Normal (skip to Developmental Assessment)

☐ Abnormal
☐ Suspect

A. Oral Motor Function – Age Appropriate Responses for the Following:

Feeding:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Swallowing:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
Management of Secretions:	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine

B. Muscle Tone

Neck	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Trunk	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect	☐ Unable to Determine

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________________ **(Last, First)** **HRIF I.D. #** ______________

**Required Field*

NEUROLOGIC ASSESSMENT *continue*

C. Is There Scissoring of the Legs on Vertical Suspension? ☐ No ☐ Yes

D. Deep Tendon Reflexes:

Right Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Left Upper Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Suspect		☐ Unable to Determine
Right Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine
Left Lower Limb:	☐ Normal	☐ Increased	☐ Decreased	☐ Clonus	☐ Suspect	☐ Unable to Determine

E. Are Persistent Primitive Reflexes Present? ☐ No ☐ Yes ☐ Unknown

F. Are Abnormal Involuntary Movements Present? ☐ No ☐ Yes (check all that apply) ☐ Ataxia ☐ Choreoathetoid ☐ Tremors ☐ Unknown

G. Quality of Movement and Posture: ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Functional Assessment

A. Bimanual Function ☐ Normal ☐ Abnormal ☐ Suspect ☐ Unable to Determine

Only Complete if the Child is ≥ 15 Months Adjusted Age

B. Right Pincer Grasp	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine
C. Left Pincer Grasp	☐ Normal	☐ Abnormal	☐ Suspect	☐ Unable to Determine

CEREBRAL PALSY (CP)

Does the Child Have Cerebral Palsy (CP)?

☐ No (skip to Developmental Assessment)

☐ Yes

☐ Suspect

Gross Motor Function Classification System (GMFCS) Adjusted Age: (check only one)

Child 18 - 24 months of age adjusted for prematurity		*Child ≥ 24 - 36 months of age adjusted for prematurity*	
☐ Level I	☐ Level IV	☐ Level I	☐ Level IV
☐ Level II	☐ Level V	☐ Level II	☐ Level V
☐ Level III	☐ Unable to Determine	☐ Level III	☐ Unable to Determine

☐ Unable to Determine

DEVELOPMENTAL CORE VISIT ASSESSMENT

*Was a Developmental Assessment Screener or Test Performed During this Core Visit?

☐ Yes
Date Performed: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

☐ No Reason Why Assessment **NOT** Performed:

☐ Acute Illness	☐ Behavior Problems	☐ Examiner Not Available
☐ Known SEVERE Developmental Disability	☐ Primary Caregiver Refused	☐ Primary Language
☐ Significant Sensory Impairment/Loss	☐ Other Medical Condition	☐ Other

DEVELOPMENTAL SCREENERS

Bayley Infant Neurodevelopmental Screener (BINS) – *check appropriate range*

Overall Classification	☐ Low Risk	☐ Medium Risk	☐ High Risk	☐ Unable to Assess

Battelle Developmental Inventory Screening Test, 2nd Edition (BDIST) - *check appropriate range*

Adaptive Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Communication	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	☐ Pass	☐ Refer	☐ Unable to Assess	☐ Did Not Assess

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HRIF STANDARD VISIT FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________________ **(Last, First)** **HRIF I.D. #** ______________

DEVELOPMENTAL SCREENERS *continue*

Bayley Scales of Infant and Toddler Development Screening Test, 3rd Edition (Bayley-III Screener) *- check appropriate range)*

Cognitive	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Competent	☐ Emerging	☐ At Risk	☐ Unable to Assess	☐ Did Not Assess

The Capute Scales/The Cognitive Adaptive Test/Clinical Linguistic and Auditory Milestone Scale Screener (CAT-CLAMS) *enter score*

Language Auditory (CLAMS)	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Adaptive (CAT)	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Full Scale Capute	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Screener: ______________________________ *- check appropriate range*

Cognitive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

DEVELOPMENTAL TESTS

Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Hardcopy" *- enter score*

Cognitive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Social-Emotional Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive-Behavior Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Bayley Scales of Infant and Toddler Development, 3rd Edition (Bayley-III) "Computer" *- enter score*

Receptive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scaled Score	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Language Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

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HRIF STANDARD VISIT FORM

7883-1002

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________________ **(Last, First)** **HRIF I.D. #** ________________

DEVELOPMENTAL TESTS *continue*

Battelle Developmental Inventory, 2nd Edition (BDI-2) - *enter score*			
Adaptive Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Communication Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Motor Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Cognitive Domain	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Revised Gesell and Amatruda Developmental and Neurologic Examination (Gasell) - *enter score*			
Language Development	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Adaptive	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Mullen Scales of Early Learning - AGS Edition (Mullen) - *enter score*			
Gross Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Visual Perception	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Fine Motor Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Receptive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Expressive Language Scale	Score: ________	☐ Unable to Assess	☐ Did Not Assess
Early Learning Composite	Score: ________	☐ Unable to Assess	☐ Did Not Assess

Other/Not Listed Test: ____________________ *- check appropriate range*					
Cognitive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Receptive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Expressive Language	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Language Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Gross Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Fine Motor	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Motor Composite	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Personal-Social	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Adaptive	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess
Other	☐ Normal	☐ Mild/Moderate	☐ Significant	☐ Unable to Assess	☐ Did Not Assess

AUTISM SPECTRUM SCREEN (Optional)

Was an Autism Spectrum Screen Performed During this Visit? ☐ No ☐ Yes *(complete below)*

Screening Tool Used: ☐ M-CHAT ☐ CSBS DP ☐ PDDST-II ☐ Other/Not Listed

Screening Results: ☐ Pass ☐ Did Not Pass

Was the Infant Referred for Further Autism Spectrum Assessment? ☐ No ☐ Yes

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HRIF STANDARD VISIT FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________ **(Last, First)** **HRIF I.D. #** ______________

EARLY START (ES) PROGRAM

Is The Child Receiving Early Intervention Services Through Early Start (Regional Center and/or LEA)? Check all that apply:

☐ No ☐ Yes ☐ Referred ☐ Referral Failure ☐ Parent Refused Service ☐ Determine Ineligible by ES ☐ Unknown

MEDICAL THERAPY PROGRAM (MTP)

Is The Child Receiving Services Through CCS Medical Therapy Program (MTP)? Check all that apply:

☐ No ☐ Yes ☐ Referred ☐ Referral Failure ☐ Parent Refused Service ☐ Determine Ineligible by ES ☐ Unknown

SPECIAL SERVICES REVIEW

Is the Child Receiving or Being Referred for Special Services?

☐ No (Skip to Resources and Social Concerns) ☐ Yes (Complete below) ☐ Unknown

Service	Status	Referred, but Not Receiving (check reason)	
Behavior Intervention	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Early Intervention Specialist ☐ Other	☐ Licensed Clinical Social Worker ☐ Unknown	☐ Psychologist
Feeding Therapy	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Early Intervention Specialist ☐ Occupational Therapist ☐ Registered Dietitian ☐ Other	☐ Certified Lactation Consultant ☐ Physical Therapist ☐ Registered Nurse ☐ Unknown	☐ Home Health Agency ☐ Public Health Nurse ☐ Speech/Language Pathologist
Infant Development Services	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Early Intervention Specialist ☐ Physical Therapist ☐ MSW ☐ Unknown	☐ Licensed Clinical Social Worker ☐ Psychologist ☐ Speech/Language Pathologist	☐ Occupational Therapist ☐ Registered Nurse ☐ Other
Hearing Services	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Audiologist ☐ Speech/Language Pathologist ☐ Unknown	☐ Early Intervention Specialist ☐ Teacher of the Deaf	☐ ENT ☐ Other

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INFANT NAME: ______________________ (Last, First) HRIF I.D. # ______________

SPECIAL SERVICES REVIEW *continue*

Service	Status	Referred, but Not Receiving (check reason)	
Nutritional Therapy	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Certified Lactation Consultant ☐ Registered Dietitian ☐ Unknown	☐ Public Health Nurse ☐ Registered Nurse	☐ Physician ☐ Other
Occupational (Therapy (OT)	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Occupational Therapist	☐ Other	☐ Unknown
Physical Therapy (PT)	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Physical Therapist	☐ Other	☐ Unknown
Speech/Language Communication	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ American Sign Language ☐ Speech/Language Pathologist	☐ Early Intervention Specialist ☐ Other	☐ Teacher of the Deaf ☐ Unknown
Social Work Intervention	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Clinical Social Worker ☐ Physician ☐ Unknown	☐ Marriage & Family Therapist ☐ MSW	☐ Psychologist ☐ Other
Visiting, Public Health, and/or Home Nursing	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	☐ Missed Appointment ☐ Re-Referred ☐ Service Not Available ☐ Parent Declined/Refused Service	☐ Waiting List ☐ Insurance/HMO Denied ☐ Service Cancelled ☐ Other/Unknown Reason
	Service Provider: ☐ Licensed Vocational Nurse ☐ Registered Nurse	☐ Physician ☐ Other	☐ Public Health Nurse ☐ Unknown

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HRIF STANDARD VISIT FORM

HIGH RISK INFANT FOLLOW-UP QUALITY OF CARE INITIATIVE

INFANT NAME: ______________________ (Last, First) **HRIF I.D. #** ____________

SPECIAL SERVICES REVIEW *continue*

Visitors Services	☐ Does Not Need ☐ Receiving ☐ Complete ☐ Referred at Time of Visit	**Referred, but Not Receiving (check reason)** ☐ Missed Appointment ☐ Waiting List ☐ Re-Referred ☐ Insurance/HMO Denied ☐ Service Not Available ☐ Service Cancelled ☐ Parent Declined/Refused Service ☐ Other/Unknown Reason
	Service Provider: ☐ Low Vision Specialist (Optometrist) ☐ Orientation & Mobility Specialist ☐ Other	☐ Low Vision Specialist (Ophthalmologist) ☐ Physical Therapist ☐ Unknown ☐ Occupational Therapist ☐ Teacher of the Visually Impaired

SOCIAL CONCERNS AND RESOURCES

Caregiver-Child Disruptions or Concerns *Single parent, divorce, prolonged separation (incarceration, military service) multiple changes in caregivers/daycare, caregiver chronic illness*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Economic/Environmental Concerns/Stressors *Housing insecurity, lack of resources-$$, insurance (or high co-pay), lack of reliable transportation for medical needs*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Community & Relationship Concerns *Emotional support from family/friends, supportive and safe intimate relationship, safe neighborhood, and resources for needs*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources
Parent-Child Concerns *Feeding & growth, calming, behavior, sleep, other*	☐ No	☐ Yes, Referral Not Necessary ☐ Yes, Referred to Social Worker ☐ Yes, Referred to Other Community Resources

CHILD PROTECTIVE SERVICES (CPS)

Is a Child Protective Services Case Currently Opened?
☐ No ☐ Yes ☐ Referred at Time of Visit

DISPOSITION *(Required Field)*

☐ Scheduled to Return ☐ Will be Followed by Another CCS HRIF Program (1)

DISCHARGED

☐ Graduated
☐ Family Moving Out of State/Country
☐ Will be Followed Elsewhere
☐ Closed Out of Program
☐ Family Withdrew Prior To Completion
☐ Completed HRIF Core Visits, Referred For Additional Resources

(1) Complete the Transfer Patient Records Process for patient's who will be followed by another CCS HRIF Program.

MD / NNP	DATE / TIME	SW	DATE / TIME
RN	DATE / TIME	RD	DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME
OT / PT / ST	DATE / TIME		DATE / TIME

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HRIF STANDARD VISIT FORM

Unapproved Abbreviation	*Preferred Term*	DATE	TIME	Note: Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, instruction to Patients.
c.c.	**"mL"**			
U	**"Units"**			
IU	**"International Units"**			
Q.D.	**"Daily"**			
Q.O.D.	**"every other day"**			
T.I.W.	**"3 times weekly" or "three times weekly"**			
Trailing zero (X.0 mg)	**Never write a zero by itself after a decimal point (X mg)**			
Lack of leading zero (.X mg)	**Always use a zero before a decimal point (0.X mg)**			
MS MSO_4	**"morphine sulfate"**			
$MgSO_4$	**"magnesium sulfate"**			
S.C. or S.Q.	**"Sub-Q", or "subQ"**			
μg	**"mcg" or "micrograms"**			
DO NOT use abbreviations for chemotherapeutic agents				

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PROGRESS RECORD

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(Rev 02/16)